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Fraternité – Travail – Progrès

ESSENTIAL MEDICINES GLOBAL INITIATIVE COUNTRY STRATEGY, NIGER

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ACRONYMS

ASC:	Agents de Santé Communautaire - Community Health Agents
ARI:	Acute respiratory infections
C4D:	Communication for Development
CHW:	Community Health Worker
COGES:	Comité de Gestion
CS:	Case de Santé- Health Post
CSI:	Centre de Santé Intégré- Type 1 and 2 - Integrated Health Centre
DGSR:	Direction Générale de la Santé de la Reproduction
DOS:	Direction de l´Organisation des Soins
DTK:	Diarrhoea Treatment Kit
DPHL/MT:	Direction de la Pharmacie, des Laboratoires et de la Médecine Traditionnelle
DSME:	Direction de la Santé de la Mère et de l´Enfant
EML:	Essential Medicines List
HIPC:	Highly Indebted Poor Countries
HR:	Human Resources
iCCM:	Integrated Community Case Management
IGPL:	Inspection Générale de la Pharmacie et des Laboratoires
IMCI:	Integrated Management of Childhood Illness
INS:	Institut National des Statistiques
KAP:	Knowledge, Attitude and Practices
KFP:	Key Family Practices
MDG:	Millennium Development Goal
MoH:	Ministry of Health
NGO:	Non Governmental Organisation
ONPPC:	Office National des Produits Pharmaceutiques et Chimiques
ORS:	Oral Rehydration Salts
PDS:	Plan de Développement Sanitaire- Health Development Plan
RC:	Relais Communautaires
RHF:	Recommended Homemade Fluids
SM:	Social Marketing
SONIPHAR:	Société Nigérienne des Industries Pharmaceutiques
SWS:	Safe Water System
TMA:	Total Market Approach
UNICEF:	United Nations Children´s Fund
WHO:	World Health Organisation

Exchange rate: $1= Fcfa 491.978 (Dec 2011)

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EXECUTIVE SUMMARY

Niger is ranked 12th in the world in terms of its mortality of children under 5. Two of the main causes of death are diarrhoea and pneumonia. In order to achieve the 2015 Millennium Development Goals (MDGs) it is necessary to reduce the number of deaths due to these easily treatable diseases. When looking at the main barriers to access to drugs this study has found that:

- The majority of the issues found are systemic and not only related to the availability of ORS, zinc, amoxicillin or cotrimoxazole
- It is a complex situation the basis of which is a lack of adequate funds and inadequate management of resources
- Many initiatives are already in place to improve the situation however the main barriers to drug availability for children under 5 will require serious investment and changes which may not have an impact until after 2015. These are:
  - the reimbursement of fees to health centers
  - finding a long term solution to the cash flow challenges raised by the system of "gratuité"
  - a more aggressive restructuring of the ONPPC (Office National des Produits Pharmaceutiques et Chimiques or Niger´s Government´s procurement body) in terms of its systems, processes, financial and management structure including making it an autonomous entity

During field research the availability of zinc was found to be inadequate and limited to that which had been supplied by UNICEF. The extreme situation has informed the need to propose two product specific interventions to rapidly address this profound shortfall.
All the proposed interventions are intended to complement the activities already in place or planned under the "Plan de Développement Sanitaire 2011-2015" (PDS) or Health Development Plan, whilst having an impact in the short /medium term; they include:

1. **To develop a road map for the implementation of an iCCM programme through "relais communautaires":** although integrated Community Case Management (iCCM) has been proven to be very effective even in the treatment of severe Pneumonia, there does not seem to be a road map in place that will drive its implementation. This is perceived as a critical activity in the reduction of mortality for children under 5, and therefore this intervention intends to jump start and complement the activities already planned in the PDS through the development of a clear national strategy. All the planning activities could take place in 2012 with a phased implementation starting in 2013.
2. **To increase coordination and information amongst partners**: this approach can be implemented through already existing structures such as the "cadre de concertation" which is planned to meet more regularly from beginning 2012. There should also be a review of existing processes.
3. **To create opportunities for the private sector to get involved by investing in it so it can become the partner that the country needs**: this is in line with the PDS plan to build a partnership with the private sector optimizing the coverage of essential health needs. The objective of this intervention is to engage the private sector further so it becomes a real partner increasing access to drugs and treatment. To do this it will be important to educate, include and integrate it with the public sector as well as encourage its growth. This intervention would start in 2012 with the implementation of certain activities in 2013.
4. **To carry out national research studies to inform the improvement of the quality of care**: little is known about the quality of care patients are receiving and although much has been done to train staff it is still difficult to understand what the challenges/issues

are that patients face when it comes to receiving good care. To make the right adjustments it will be necessary to understand this information. This intervention could take place between 2012 and 2013.

5. **To increase the availability of zinc**: the intervention will encompass various low costs activities to systematically include zinc in the treatment of all diarrhoea episodes. This intervention consists of short term activities such as including zinc in the ONPPC ordering form to longer term ones such as carry out advocacy work to increase prescription of zinc. This intervention will take place mainly in 2012.
6. **Improve populations' access to diarrhoea treatment through social marketing**: By launching a social marketed Diarrhoea Treatment Kit (DTK) a clear gap between the costly private sector and the free public sector could be filled providing patients with greater choice and greater access to ORS and zinc. This intervention will have an impact at various levels:
    - Making a DTK available in the market will ensure ORS is taken together with zinc for the treatment of Diarrhoea,
    - Increasing access to low-osmorality ORS and zinc will provide an alternative to the stock outs currently occurring at private and public level,
    - A social marketed DTK will reduce pressure on public sector resources,
    - Patient demand will be built for a DTK enticing the private sector to also enhance its offer of low-osmorality ORS and zinc.

The total estimated required budget for 2012 -2014 for all the proposed interventions and UNICEF´s commodities donation totals**: $ 9,490,742**.

This report was developed through one to one meetings, field visits and the help of public, private and NGO partners involved in the fight against pneumonia and diarrhoea (see list of Key Stakeholders interviewed in Annex). The interventions were validated during a partners´ meeting that took place March 2012.

ANALYSIS & STRATEGIC CONTEXT

1. Access to essential medicines

Niger is considered to be one of the poorest countries in the world. In 2010 the population in Niger was estimated at 15,203,822. Extreme poverty is defined by the World Bank as an average daily consumption of $1.25 or less and means living on the edge of subsistence. 65.9% of the population in Niger lives under $1.25 per day. In total, 85.6% live with under $2 per day which is the average poverty rate[1]. Poverty is a major problem especially in the rural areas affecting 63.5%[2] of its population. Because of the high concentration of the population in rural areas (80%), nine out of ten poor people in Niger live in rural areas.

The population of under 5 year old children is estimated by UNICEF Niger to be 4,723,007 based in the number of children they vaccinated in 2011.

Food security remains a major challenge with cyclical crisis that can take place every 3 to 5 years. This makes malnutrition a consistent problem and great barrier to improving the health of children and to reducing the mortality of children under 5.

Despite all of this the mortality rate of children under 5 was 198/1,000 in 2006 (EDSN MICS) and a latest survey showed that in 2010 mortality the rate had gone down to 130.5/1,000 which means that Niger could be close to making its MDG 4 target in 2015 (108.7/1,000) if current efforts are ramped up.

Interventions such as measles and Hib 3 vaccinations, vitamin A supplementation and an enhanced water/ sanitation system are contributing towards this improvement.

However, malaria, diarrhoea and pneumonia are the main causes of death in under 5 children in Niger.

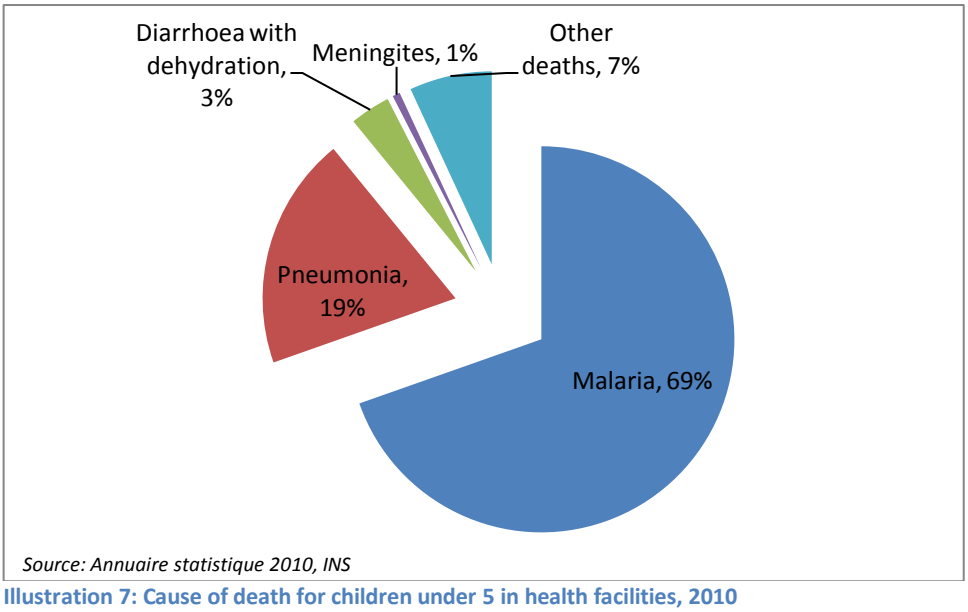
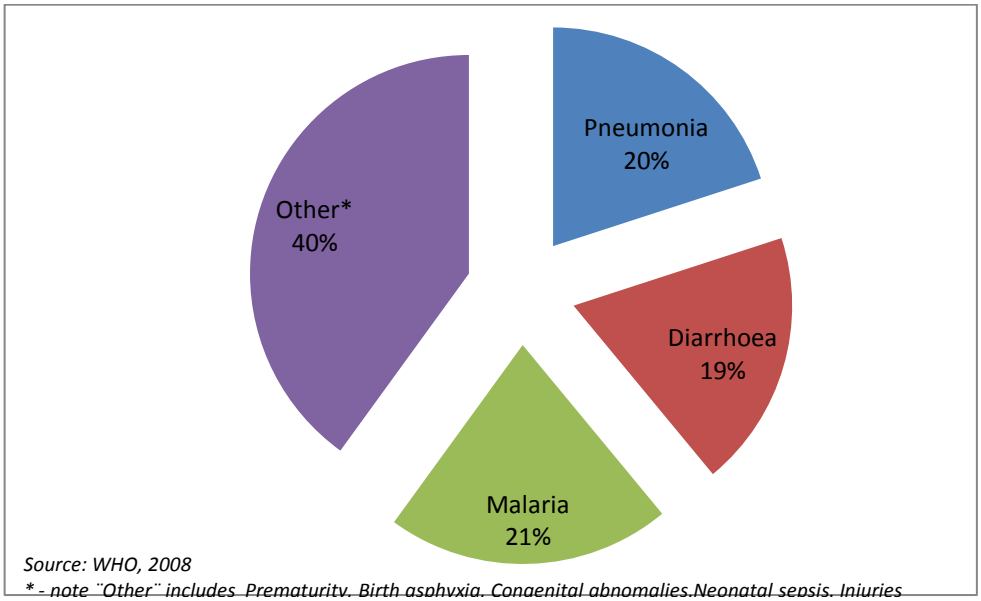


Illustration 7: Cause of death for children under 5 in health facilities, 2010

[1] International poverty line, World Bank statistics 2011

2 Bulletin d'Information », UNICEF NIGER – May 2011



Source: WHO, 2008
** - note ¨Other¨ includes Prematurity, Birth asphyxia, Congenital abnomalies,Neonatal sepsis, Injuries*

Illustration 8: Distribution of causes of death among children under 5 years 2008

As a fair amount of work has already been done in Niger on the barriers to malaria treatment, this report will analyse the barriers to treatment of pneumonia and diarrhoea. Most of the barriers found however are mainly systemic and not specific to any disease treatment.

In Niger only 60% of children are receiving an appropriate treatment for pneumonia whilst 51% are getting ORS or RHF and for only 24.1%[3] is Zinc added to the treatment of diarrhoea.

	% of total child deaths (0 to 5 years old)4	Prevalence rate[5]	Total episodes per year	Proportion receiving appropriate treatment[6]	Untreated cases per year
Pneumonia	20%	6.32%	1,408,330	60%	844,998
Diarrhoea	19%	25.5%	2,960,243	51% ORS/RHF 24.1% Zinc	ORS: 1,509,724 Zinc: 713,419

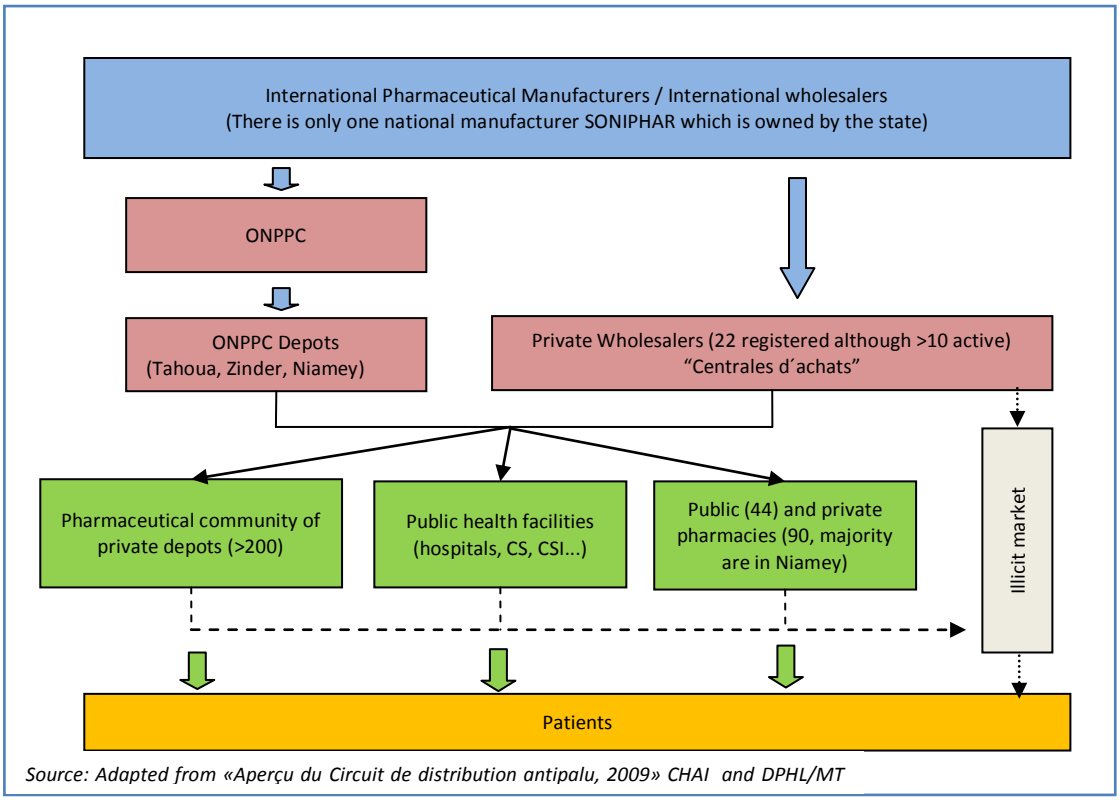
Table 8: Disease burden

Access to health care has considerably increased in the last few years thanks to the role played by the "Case de Santé" (CS) or Health Posts providing early diagnosis and treatment in rural communities and increasing health coverage rate[7], from 44% in 2000 to 72% in 2008[8]. However access to essential medicines is still a challenge with frequent stock outs caused by many bottlenecks.

1.1. The retail system

The supply chain relies on both public and private structures (the public system is provided by the ONPPC) to make medicines available to the general population. They complement each other and reduce the number and length of stock outs.

[3] Enquête Nationale sur la survie des enfants de 0 à 59 mois et la mortalité au Niger 2010, INS Niger
[4] WHO data 2008
[5] Enquête Nationale sur la survie des enfants de 0 à 59 mois et la mortalité au Niger 2010, INS Niger
[6] Enquête Nationale sur la survie des enfants de 0 à 59 mois et la mortalité au Niger 2010, INS Niger
[7] Population living 5km or less from a health facility
8 Information Bulletin, UNICEF Niger May 2011



Source: Adapted from «Aperçu du Circuit de distribution antipalu, 2009» CHAI and DPHL/MT

Illustration 9: Retail supply system

The retail system is more diverse than in other countries with 4 legal outlets where patients can access medicines:

Type	Role	Supplied by
Public pharmacies-«Pharmacies Populaires»	They supply health facilities as well as patients with essential medicines	ONPPC
Pharmacies inside health facilities-"Pharmacies para-publiques"	They supply public sector patients with drugs at a cost unless they are covered by the "gratuité" scheme (children under 5, pregnant women and family planning products)	ONPPC and private sector
Private pharmacies	The majority are based in Niamey. A pharmacist is responsible by law	ONPPC and private sector wholesalers
"Dépôts"	These are private retailers. They buy from either the public or the private sector. They are allowed to be open only where there is no pharmacy and have to be closed as soon as a pharmacy opens in the same area. They need authorization from the Ministry to open.	ONPPC and private sector (sometimes also the illicit market)
Informal market outlets	Is made of street vendors and little permanent stands but also encompasses all non registered products that are sold in depots and pharmacies.	Private sector (neighbouring countries such as Nigeria and Ghana) and goods diverted from the public sector (e.g. donations)

Illustration 10: Types of pharmaceutical retail outlets

However, a 2010 supervision exercise lead by UNCEF and the DPHL/MT described what reports in 2006 and 2008 were already relating (and what we saw during our field visits): universal access to essential medicines at all levels of the public sector and more especially at CS and Centre de Santé Intégré (CSI) or Integrated Health Centres level is still a challenge.

1.2. Public sector

1.2.1. Description

In Niger, the health system is made of three types of actors (public, private, traditional medicine) and of three administrative and care levels (local & district level, intermediate/regional and central/national level).

Managed from the district level, the community level health access increased considerably between 2006 and 2010 especially in the rural areas. This was the result of an improved access to treatment facilitated by the CS and their outreach activities. The CSs which were started in the 1990´s by a Dutch NGO are since 1999 a community participation structure created by ministerial decree.

CS opened in villages with a population of at least 5,000 people in a range of 5km, that did not have a health centre yet, and that were located at over 10km of the CSI.

2,175 out of the 2,493 health posts that existed in 2010 (or 87% of the total) were created in the context of the Special Programme funded the by Highly Indebted Poor Countries fund (HIPC), leading to an important increase in the health coverage rate.

They are managed by Agents de Santé Communautaire (ASC) or Community Health Agents who have a monthly salary paid by the Government with HIPC funds. They are in theory hired with a level of education equivalent to secondary school. They are based at the CS and do not generally do home visits. She/he is most of the time chosen by his/her community and trained at the District Referral Hospital for 6 months on basic care.

In 2007, the Ministry of Public Health chose to integrate the treatment of malaria and diarrhoea on top of ARI/pneumonia, and started to train ASCs. The scale up was done with the support of UNICEF, and with funds made available in the context of the Canadian-led Catalytic Initiative. Since 2008, ASCs are involved in the case management of malaria, pneumonia and diarrhoea as well as the screening of malnutrition, distribution of oral contraception, Communication for Development (C4D) and earlier immunization playing a big role in improving access to health particularly for the children under 5.

As a result, the demand for first-level health services has soared: 86.4% of the demand for health care that is directed to health services is divided between CSI and CS. CSs attract by themselves 40% of the demand.

There are also “Relais Communautaires” (RC) chosen by the community and trained for two weeks by NGOs on different areas such as malnutrition or hygiene. Their role is currently limited to behaviour change communication (C4D activities) and referral of patients to the CS or CSI especially cases of malnutrition or pregnant women for follow up and delivery. They are volunteers and do not get paid. The lack of clear definition of their role, their legal status and their support & supervision systems is recognised as a weakness in the PDS.

The second level is based in the districts. There are currently 42 health districts with 33 hospitals of which 26 have surgery facilities. At regional level there are 8 Public Health Regional Management units coordinating the health activities in the districts. In the regions there are also 6 Regional Hospitals which have maternity wards for reference and 7

"mother-child" centers are being built. Finally, at National level there are 3 National Hospitals and a Maternity reference unit.

1.2.2.Public sector supply system

The ONPPC, the government procurement body, has a good network of warehouses, depots and pharmacies providing an adequate national coverage. It also in some cases stores and distributes products on behalf of the "financial partners" (i.e.: multilaterals, bilaterals and NGOs) as well as the products procured by specific programmes (e.g.: malaria, HIV, etc...). However, these partners also distribute the medicines directly to the districts themselves.

The Government also owns a manufacturer: SONIPHAR. It used to be part of the ONPPC and was partially privatised between 1998 and 2000. However as a result of its poor management it reverted back to the state whilst staying independent from ONPPC. SONIPHAR´s mission is to provide the ONPPC with drugs and can only sell its surplus production to the private sector.

The public health facilities are meant to procure products from the ONPPC however, when there are stock outs at the ONPPC, they will reach to the private sector.
There are two financial systems possible for the payment of drugs at the CS/CSI level. The decision of which one will be used is usually made by the COGES (the local representatives of the community manage the funds coming from the payments made by those not covered by the "gratuité".)

- *"Caisse Autonome":* the health facilities are financially independent and buy their own drugs. The district are only responsible for verifying and approving their orders (Pull system)
- *"Caisse Unique":* there is one single budget which is then allocated to the CSIs and CSs based on their needs (Push system)

The distribution of donated goods also follows a "Push" system by which financial partners will decide the quantities they will donate and these are then assigned to the regions and districts.

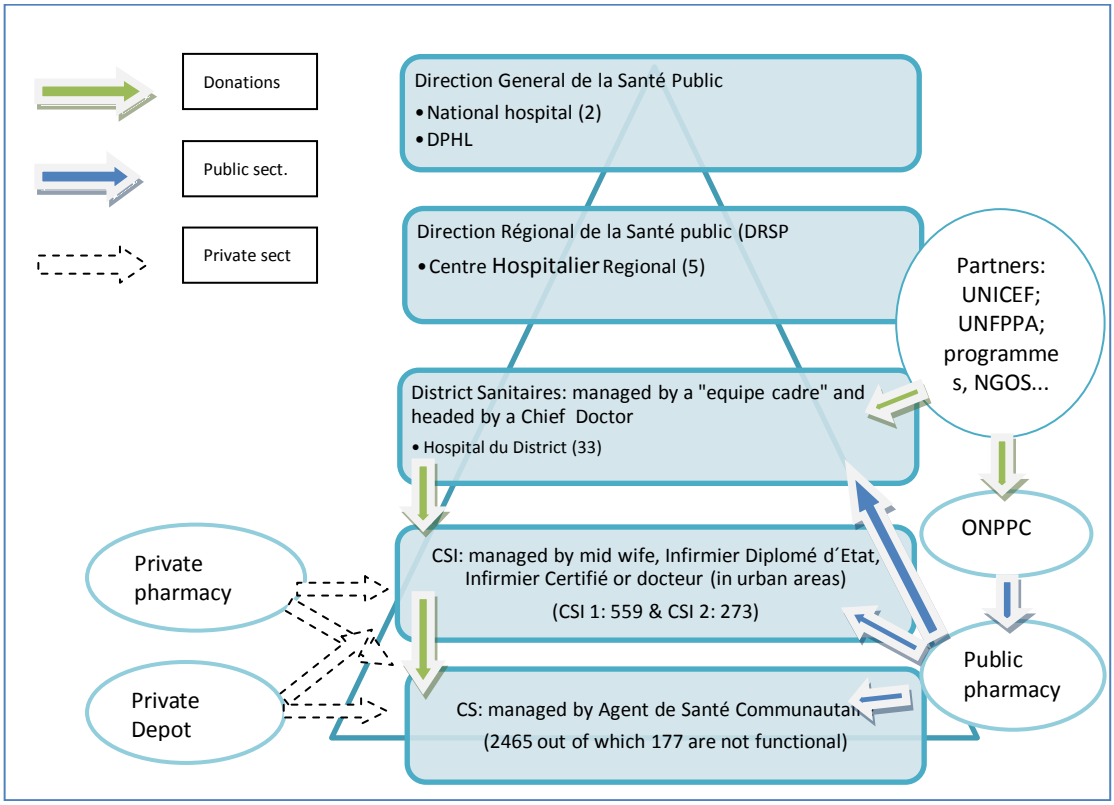


Illustration 11: Product flow in the public system

1.2.3. Cost and financing of treatment

Although public expenditure is on the rise (7.85% of the national budget in 2010) it is still below the 10% recommended by WHO and even far from the 15% of the Abuja Declaration. This is compounded by the fact that only 80% of the budget was actually disbursed in 2011.

The "gratuité" (free services and drugs) was established in 2006 (although it was fully implemented only in 2008) to make certain health services free, including caesarean sections, antenatal care, contraception and curative care for children under 5. The treatment of children under five represents almost 80% of the expenses linked to the "gratuité".

Services	Quantity	Amount (in Fcfa)	Proportion of total
Treatment of children 0-5 years	7,314,250	6,690,603,200	78.3%
Prenatal Consultations	705,902	705,902,000	8.3%
Caesareans	8,797	502,055,000	5.9%
Gynaecological cancer screening	5,485	8,227,500	0.1%
Management of gynaecological cancer	943	634,579,094	7.4%
Total		***8,541,366,794***	

Source: Annuaire Statistique 2010, DSS/RE

Table 9: "Gratuité" expenditure in 2010

Between 2006 and 2011 out of the Fcfa 27,708,022,565 spent nationally in the "gratuité" only Fcfa 12,024,23,030 were reimbursed in 2011. Agadez is the region which has received the highest reimbursement (55.24%) whilst Tahoua has only been reimbursed for 29.25% of its expenses[9].

[9] Cellule Gratuité des Soins-MSP

A minimum and a maximum range was set for the reimbursement of each treatment included in the "gratuité". The CSI will for example be reimbursed by the state between Fcfa 250 and Fcfa 500 for each treated child under five.

Outside of the "gratuité" system drugs and services need to be paid for by the patient. Due to an almost inexistent social security system, 99% of the household health expenses come from direct payments.

1.3. Private sector

1.3.1. Description

Private health providers are mainly concentrated in Niamey. There are around 30 clinics and 43 private surgeries. There are also 4 private non-profit hospitals.

In 1996 the importation of drugs and pharmaceutical products was liberalized to allow organisations other than the MoH to import drugs. The private pharmaceutical sector is made of 22 registered wholesalers- although only 8/9 are currently active, around 90 private pharmacies and over 200 private depots. This sector has increased the general availability of drugs as it is very flexible and able to fulfil any specific demand at short notice. However this flexibility also comes from being sometimes less compliant with regulations, health policies or even on occasion being less demanding about the level of quality required.

The private sector is still underdeveloped and its warehousing, geographical coverage and distribution capacity are still more limited than the public sector´s.

1.3.2. Cost of treatment

Private health facilities will charge Fcfa 2,000 to 6,000 per consultation depending on their location (inside or outside Niamey)

In 2006 a study[10] carried out by WHO and Health Action International on behalf of the MoH found that in general the prices of all drugs in Niger were higher than average international prices. Although the price of generic products was somewhat acceptable, in the private sector prices were often 1.5 to 9 times more expensive. The informal prices were higher than in the public sector but still affordable.

This is due mainly to underperforming procurement systems, a high customs tax of 4% and relative high margins.

Type of margin	Generic drug	Patented drug
Wholesale margin	27%	20%
Pharmacist margin	35%	35%

Source: Arrêté Nº73/MSP/LCE/DPHL/MT/MT 06 May 2005

Table 10: Set margins for pharmaceutical products

1.4. Illegal market

A 2009 study[11] found that providers believed that the informal market represented 25% to 75% of the total drug market. This happens especially in the rural areas where there are more depots.

[10] «Rapport de l´étude sur les prix des médicaments au Niger» Ministère de la Santé Publique et de la lutte contre les endémies, Direction Générale de la Santé Publique, Direction de la pharmacie des laboratoires et de la médecine traditionnelle, 2006

[11] «Etude de la distribution des antipaludéens sur le secteur privé au Niger dans le but de renseigner la proposition «Affordable Medicines Facility-malaria (AMFm)»CERMES, 2009

The illegal market is currently satisfying the gaps left by the public sector where stock outs are common and the private sector which products are often too expensive for the majority of the population. This market is clearly growing fed by a lack of adhesion to national laws and regulations. Its volume is hard to measure. It feeds from the international market as well as from local wholesalers, from leakages in the public sector and even internationally donated products. (see illustration 3)

The range of products it offers is however restricted due to the limited cash available in the market.

1.5. Treatment seeking behaviour

Regarding patients and their treatment seeking behaviour, qualitative research[12] shows that in general caregivers will first attempt to treat the child at home before going to the health centre. Self-treatment often starts by waiting to see if the child gets better and then going to the traditional healer or the street vendors. If nothing works treatment will then be sought at CS and CSI level. If the child is too sick she/he will then be referred to a higher level health facility.

1.6. Diarrhoea specific issues

1.6.1. Treatment

The recommended treatment of diarrhoea is in line with the national Integrated Management of Childhood Illness (IMCI) guidelines:

1. Low-osmorality ORS: 50-100ml after each stool for children up to 2 years and 100-200ml for children older than 2y
2. 10 tablets of 20mg zinc sulphate from the age of 2 months per episode

1.6.2. Cost

ORS and zinc are only legally available from health facilities and pharmacies/depots but they do not require a prescription.

Under the "gratuité" scheme diarrhoea treatment is free for children under 5 when acquired through a public health facility.

The following table recaps the prices of ORS observed in 14 different establishments in Tahoua, Dosso and Tillaberi in November 2011.

ORS	Public health centre	Private pharmacy	Public pharmacy	Depot	Illicit market
Generic/Brands	Generic: UNICEF and Holden Medical	Generic: Da-Hai-Co, Eala-Pharma, Realab	Generic: Sprukfield	Product not found	Product not found
Formulation	600ml, unflavoured, low osmo.	For 1 litre Flavoured and unflavoured	For 600ml Orange flavoured	Product not found	Product not found
Price	Free	Fcfa 80-125	Fcfa 100	Product not found	Product not found
Origin	Germany, Netherlands	India, China	Togo	Product not found	Product not found

Source: data collected in 4 public pharmacies, 6 private pharmacies, 2 depots and 1 illicit market and 11 health facilities in Niamey, Tahoua, Tillabéri and Dosso.

Table 11: Average price of ORS available in the market by sector, November 2011, Dosso, Tahoua, Niamey, Tillabéri

[12] «Recensement et analyse des facteurs structurels et comportementaux relatifs a l´adoption de quatre pratiques familiales essentielles dans la commune de Sarkin Yama- Département de Nadaroufa.» UNICEF, Juillet 2008

We did not see a big variety of ORS products available at pharmacy level mainly because of the stock outs caused by the fact that big quantities of the product had been sent back because it was about to or had expired. However we found orange flavoured and unflavoured ORS. The packaging often mentioned that it was the formula "recommended by WHO" however we were unable to verify if the ORS was low-osmorality or not.

The only Zinc that we saw available was in public health facilities and was the one donated by UNICEF (ZinCfant 20 mg). We also found it in an illegal pharmacy for: Fcfa 200 for a blister of 10 tablets.

As an addition to ORS some private pharmacies are offering Smecta (from Ipsen Pharma), a treatment for acute diarrhoea, that contains diosmectite which is a type of clay. It comes in sachets of 10 and costs Fcfa 1,435. This product is not currently recommended by the national IMCI guidelines for the treatment of diarrhea.

If products are not available through the public sector health facilities, the average cost of the correct treatment of a child under 5 for one single diarrhoea episode will be:
Fcfa 100 x 6 sachets of ORS on average= Fcfa 600.

If Zinc was available in the private sector it would be priced at around Fcfa 200 for a blister of 10 tablets.

The total cost of the treatment of a diarrhoea episode outside of the public sector is: Fcfa 800 ($1.63). Considering that 85.6% of the population live with under $2 per day which is the average poverty rate[13] this would be a considerable cost for any family.

1.6.3. Access to treatment

A quantitative study done in the commune of Sarking Yamma (department of Madarounfa) in 2008[14] reported that 92% of caregivers accessed ORS through the CS and CSI. There is no study available at this point that illustrates what is happening nationwide.

1.7. Pneumonia specific issues

1.7.1. Treatment

The recommended treatment for pneumonia is also in line with the IMCI guidelines:

1. Cotrimoxazole as first line therapy: twice a day for 5 days
   - 1 adult tablet: 80mg/400mg for children 10-<19kg, half dose if 4-<10kg
   - 4 child tablets: 20mg/100mg for children 10-<19kg, half dose if 4-<10kg
   - 10ml syrup: 40mg/200mg for children 10-<19kg, half dose if 4-<10kg
2. Amoxicillin for second line therapy: twice a day for 5 days
   - 1 and ½ 250mg tablet for children 10-<19kg, 1 for 4-<10kg
   - 15ml 125mg/5ml syrup for children 10-<19kg, 10ml if 4-<10kg

1.7.2. Cost

As per previous comments, the treatment of pneumonia for children under 5 through the public sector is free.

	Formulations recommended by IMCI	Public health facility	Private pharmacy	Public pharmacy	Depot	Illegal pharmacy
Cotrimoxazole	*80mg/400mg*	free	Generic: Fcfa	Fcfa100 for	100 for 10	n/a

[13] International poverty line, World Bank statistics 2011

[14] «Recensement et analyse des facteurs structurels et comportementaux relatifs a l´adoption de quatre pratiques familiales essentielles dans la commune de Sarkin Yama- Département de Nadaroufa.» UNICEF, Juillet 2008

	tablet		100-170 (for 10) Branded: Fcfa 2,280-2,597 (for 20)	10		
	20mg/100mg tablet	n/a	n/a	n/a	n/a	n/a
	Syrup 40/200mg (100ml)	free	Generic: Fcfa 600-890 Branded: Fcfa 2,040-2,047	Suspension Fcfa 250	Fcfa 625	Fcfa 800
Branded/Generic		Generic	Generic& branded	Generic	Generic	Generic
Manufacturer		IDA/Soniphar/ Da-Hai-Co	IDA/Da-Hai-Co/Enough Corp/TM Roche/Soniphar/Phyto	IDA, Soniphar	Da-Hai-Co	Syndi Phar
Origin		India, Niger, China	India/Ghana/ China/Togo/ France/Niger	India, Niger	China	India

Source: data collected in 4 public pharmacies, 6 private pharmacies, 2 depots and 1 illicit market and 11 health facilities in Niamey, Tahoua, Tillabéri and Dosso.

Table 12: Average price of Cotrimoxazole available in the market by sector, November 2011, in Dosso, Tahoua, Tillabéri, Niamey

Half of the retail outlets visited had some form of Cotrimoxazole mainly in its generic version (even in private pharmacies).The 80mg/400mg (for adults) was more widely available whilst the syrup forms were rarer and more expensive. Health facilities also tended to have 80mg/400mg rather than the other dosages.

	Formulations recommended by IMCI	**Public health facility**	**Private pharmacy**	**Public pharmacy**	**Depot**	**Illegal pharmacy**
Amoxicillin	250mg tablet	Product not found (only in oral suspension or in capsule)	n/a (only in syrup)	n/a	n/a (only syrup)	n/a
	Syrup 125mg/ 5ml	Product not found (only in oral suspension)	Branded: Fcfa 810-1120 Generic: Fcfa 570-775	Branded: Fcfa 808-1069 Generic: Fcfa 700	Fcfa 800	Branded: Fcfa 1000 Generic Fcfa 600
Branded/Generic		Generic	Generic & Branded	Generic & Branded	Generic	Generic & Branded
Manufacturer		Sprukfield/ Da-Hai-Co	UBI/Philco/Ubigen/ Glaxo	GSk/Bristol/Soniphar	Da-Hai-Co	GSK/North China
Origin		Togo/China	Netherlands/Senegal/ France	UK/France/Niger	China	China/France

Source: data collected in 4 public pharmacies, 6 private pharmacies, 2 depots and 1 illicit market and 11 health facilities in Niamey, Tahoua, Tillabéri and Dosso.

Table 13: Average price of Amoxicillin available in the market by sector, November 2011, in Dosso, Tahoua, Tillabéri and Niamey

A greater variety of Amoxicillin formulations were available in all retail outlets than at public health facilities. In general children formulations: syrups, oral suspension were less available. We did not find dispersable tablets.

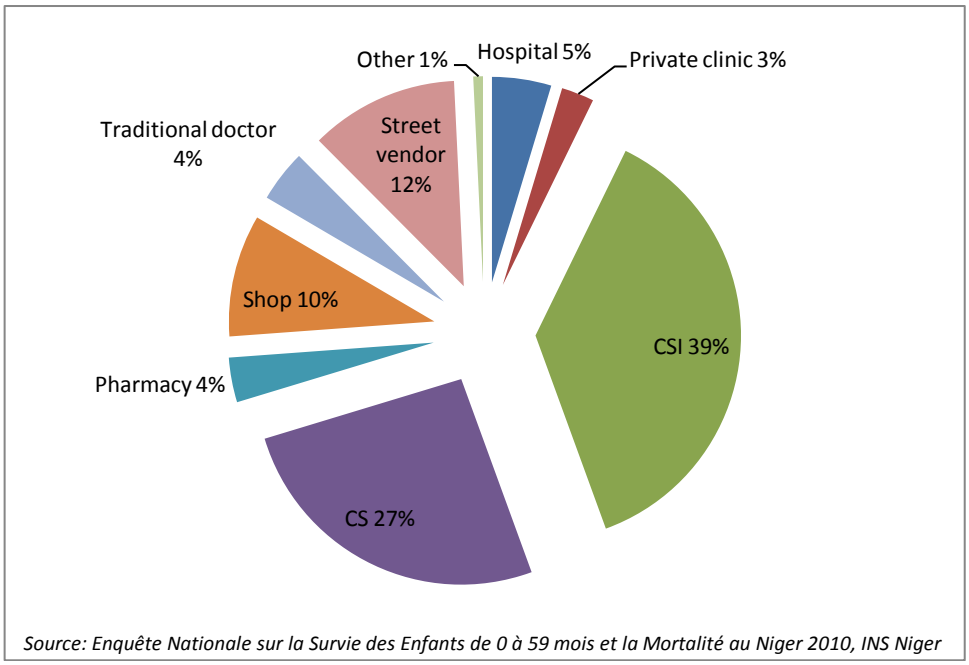
As expected, the private sector had the greatest variety of formulations especially of Amoxicillin in branded and generic version.

For a child between 1 and 5 years old to access 1st line treatment outside the public health sector facilities it could cost on average:

1. with Cotrimoxazole 80mg/400mg (10 tablets)
   - Generic: Fcfa: 135 ($0.27)
   - Branded: Fcfa 1,345 ($2.73)
2. with Cotrimoxazole Syrup 40/200mg Generic
   - Generic: Fcfa: 745 ($1.51)
   - Branded: Fcfa 2,055 ($4.17)

1.7.3.Access to treatment

Just like for diarrhoea, for the treatment of Acute Respiratory Infections (ARI) caregivers tend to go to the CSI or to the CS. Private clinics only represent 2% of the market whilst street vendors, "shops" and traditional vendors represent 24% illustrating the above mentioned tendency to self medicate through the illicit and traditional vendors.



Source: Enquête Nationale sur la Survie des Enfants de 0 à 59 mois et la Mortalité au Niger 2010, INS Niger

Illustration 12: Distribution by location where treatment was sought for ARI

2. Assessment of key barriers/issues to access

The following table summarises the key barriers/issues to access that are linked to systemic challenges or directly to the treatment of diarrhoea and pneumonia.

Table 14: Summary of key barriers

	Patient	Public sector supply/provision (incl. community-level)	Private sector supply/provision
Across-disease	• Cultural issues • Current limited understanding of attitudes, behaviour and practices of caregivers at national level.	• Financial and management challenges • Cash-flow issues • Limited qualified HR • Limited supervision and monitoring of health facilities • Limited understanding of health providers attitudes • Lack of stakeholder coordination • Limited enforcement of regulation • Limited role of outreach CHWs (Relais communautaires) • No national strategy for CHW programme • Growing illegal market	• Limited geographical coverage • Quality of products cannot always be guaranteed • Some work outside national regulation • Do not always follow national health policy • Suffering from the financial strain caused by public sector cash flow issues
Diarrhoea	• Low usage and knowledge of zinc • Limited access to ORS as there temporary stock outs in public or private pharmacies	• Dependence on UNICEF´s donation of zinc • Not included in ONPPC´s ordering form • Zinc not registered at the DPHL/MT • ORS is expiring stock outs in public pharmacies • ORS can only be obtained in health facilities or public pharmacies/depots	• Perceived low margins of zinc & ORS • ORS is no longer manufactured in country. No zinc manufacturing either • Low demand of zinc is not driving offer • Low awareness of IMCI and health policy • Not actively adding zinc to diarrhoea treatment • ORS cannot be sold outside pharmacies/depots
Pneumonia	• Low knowledge of danger signs • Limited availability of paediatric formulations	• Paediatric formulations are more likely to be out of stock • Budget constraints may be limiting the quantities that are bought	• Limited access to private pharmacies and health facilities in rural areas • Low awareness of IMCI and health policy

2.1. Patient barriers

2.1.1. Cross-disease patient barriers

- Cultural issues such as:
  - Negative influencers: a project in Zinder[15] has shown that activities are currently too focused on mothers of children under 5 and other women and men are left out when it comes to health communication.

[15] «Connaissances, attitudes et pratiques en santé de l´enfant dans la région de Zinder » Crois Rouge/ Centre de Recherche Action par la Médiation Sociale, Janvier 2011

  - Amount of work load placed on women makes it very hard for them to look after their sick children properly.[16]
  - In Madaroufa´s department a survey done in July 2008[17] showed that people tend to self medicate with traditional remedies or drugs they buy in the illicit market before going to the health centre.
  - The same survey also showed that living location and mothers´ education level are key to accessing appropriate care:
    - Rural children are less often taken to an appropriate provider
    - Children with poorly educated mothers more often lack appropriate care
    - Poorer children more often lack appropriate care
- There is limited information about caregivers attitudes, knowledge and practices at national level (there is no National Knowledge Attitude and Practices -KAP survey available) as well as the barriers they face
- There is a lack of Communication Strategic Plan especially for diarrhoea and pneumonia although they are somewhat covered in the 9 "Key Family Practices" (KFP) UNICEF lead communication efforts. One of them focuses on increasing the recognition of danger signs for acute respiratory infections and adopting adequate treatment whilst two other look at the usage of RHF and the recognition of diarrhoea danger signs as well as its adequate treatment. The usage of zinc is not specifically tackled by the KFPs.

2.1.2. Disease-specific patient barriers

2.1.2.1. Diarrhoea

- There is a gap between caregivers' knowledge about ORS and their behaviour
- There is a high knowledge of ORS but no mention of zinc
- The use of ORS is closely linked to the proximity of a health centre where ORS is available
- ORS can only be sold in pharmacies/depots or given at the health centre which limits its availability at community level
- The same survey in Madaroufa referred to above also mentioned other barriers:
  - Concerns about the taste of the ORS
  - Difficulty with the usage of ORS due to the length of time it requires to administer
  - Popular belief of not giving anything to drink and/or reduce feeding to a child that has diarrhoea
  - Salt and sugar are expensive to make RHF at home
  - Limited access to clean water

2.1.2.2. Pneumonia

- The limited knowledge of the danger signs of Pneumonia is often mentioned in surveys as one of the less well known KFPs
- Due to the limited availability of paediatric formulations children are often given small amounts of adult formulations (tablets) which are harder to administer and are often not taken in full by the child

2.2. Supplier/provider barriers

2.2.1. Cross-disease supply barriers

2.2.1.1. Public sector supply/delivery

[16] «Connaissances, attitudes et pratiques en santé de l´enfant dans la région de Zinder» Crois Rouge/ Centre de Recherche Action par la Médiation Sociale, Janvier 2011

[17] «Recensement et analyse des facteurs structurels et comportementaux relatifs à l´adoption de quatre pratiques familiales essentielles dans la commune de Sarkin Yama- Département de Madaroufa.» UNICEF, Juillet 2008

Stock outs are common mainly due to a combination of financial constraints and weak procurement, distribution and management systems:

- Although the PDS planned for an increase of 17.68% of its total health budget and an increase of 6.7% for drugs and other inputs in 2011 vs. 2010, the Government´s expenditure on drugs is still limited. In 2012 the situation could worsened due to 2011´s bad harvest and the security issues caused by the war in Libya. These could force the redirection of funds.
- The "gratuité" has had a knock on effect in the increased number of visits to health facilities and in the mortality reduction. However there has also been an increased demand for pharmaceutical products. The increased demand together with the decreased revenue (around 70% of the health facilities revenues came from the treatment of women and children) has created a major cash flow problem at all levels of the health system. The length of time it is currently taking the central government to reimburse the facilities (up to two years in some case) is worsening their cash flow situation especially at the lowest levels. These circumstances have pushed certain health centres to reduce the number of drugs they buy, and sometimes give patient two prescriptions, one for the public sector and the other for the private sector where more drugs are available but are expensive. These delays in reimbursement of the CS and CSI also mean that the already weak financial situation of the ONPPC has also worsened
- The ONPPC has been restructured a number of times. The latest reorganization happened in 2001 with financial back up from the EU and the World Bank. However the ONPPC is still facing financial as well as management challenges. Its coordination with other partners procuring drugs as well as clarification of its responsibilities need improving
- SONIPHAR no longer produces ORS or any dry oral formulations because their equipment is too out of date. It needs an investment of Fcfa 150-200 million (approx. $400,000) which they are hoping to get from the Government.
- There is a lack of transparency and a need to improve best practices and good governance
- The public sector has very limited and qualified human resources across the country (e.g. there are around 100 pharmacists in the country). The number of qualified staff is well below WHO guidelines across the board (see Annex 1). There is also a clear lack of accountability and sometimes motivation which has an effect on the quality of the service patients receive
- The supervision of staff is limited due to work/time constraints of supervisors
- There is a limited understanding of health providers´ attitudes, motivations, and practices. There is also little information about the quality of the services provided
- A poor stock management at CS and CSI level. (i.e.: they tend to order when there are no more products left)
- The limits set by the 1999 legislation for the reimbursement of the treatment of an under 5 children may be out of date
- The reimbursement procedure may need reviewing to make sure that health facilities are not over estimating the number of patients treated under the system of the "gratuité".
- The limited availability and access to information in order to accurately forecast needs (NGOs mentioned this as a main barrier in the areas they work). At peripheral level the sharing of information makes particularly difficult the monitoring and evaluation of the facilities.
- There are many actors involved in the procurement and distribution of drugs making it harder to control and coordinate all the activities (e.g. Public sector, NGOs, multilaterals...) at regional and national level causing products to expire (e.g. recent

situation with ORS in public sector pharmacies). There is no integrated system for the distribution of all donated products.

- There is little coordination between these actors who often do not know what other organizations are donating (e.g. MSF does not necessarily know what UNICEF is donating and vice versa) and when. Currently "financial partners´" meetings are taking place quarterly at regional level however the information is not always shared at national level
- The existence of many procurements circuits (e.g.: malaria programme, tuberculosis programme, NGOs, etc...) challenges the efficient distribution of products
- There are limited and often not applied regulations in which an illegal market is thriving boosted by the demand of drugs that are cheaper than in private pharmacies and more available than in the public sector
- The management of donations and products bought by the public sector are not always managed separately. They seem to be at regional and district level but not later on in the supply chain. It is therefore difficult to be sure that the products donated for children under 5 are not sold to adults or leaked to the illegal market
- No value is attached to the products donated and they are not accounted for at health facility level or at National level
- This also means that when reimbursement is sought by the health facilities, compensation for the products they received as a donation is included in the bill.
- The management of donated goods is a challenge at local level: health facilities are not always aware when they will arrive. When they arrive, they tend to come in big quantities which creates a challenge in terms of proper warehousing as well as speed of distribution

2.2.1.2. Community work

- The RC program is currently inadequate in terms of the number of health agents, their training and compensation as well as the lack of clear indicators measuring their impact. There is no clear national strategy either.
- The CHW not based in a health centre (RCs) are not currently allowed to carry and distribute products. Their main job is to refer pregnant women and children to the health centres as well as to promote KFPs

2.2.1.3. Private sector

The private sector´s role in improving the availability of drugs in Niger is restricted by 4 main challenges:

1. it geographical coverage is too limited
2. the quality of the products imported by the private sector can not be guaranteed
3. it often works outside of the limited national regulations and allows leakages from the private sector into the illegal market at different levels (importers, wholesalers and retailers)
4. it does not always follow national health policy

- This sector grew considerably since the legislation was changed (28th if November 1996, Ordonnance nº96-74) to allow organisations other than the ONPPC to import drugs. However, due to the limited enforcement of the existing regulations and gaps in the current legislation, the private sector operates without enough control of the products it distributes
- Private importers do not always follow the MoH guidelines and buy products that give them the best margin rather than what the health system requires (e.g.: there is little low-osmorality ORS in the private sector)

- Private wholesalers are also suffering from the effects of the public health facilities reduced purchasing power and carry important outstanding debts (some health facilities have not paid their debts for up to three years)
- At retail level, clinics and pharmacies in the private sector are not getting access to the same information, protocols and trainings as in the public sector. There is currently only a limited partnership between the private and the public sector
- The "depots" were allowed to open to improve drug access however the lack of control has meant that they are often working in the limits of the legislation not following the standards in terms of procurement, stock management or even the minimal qualification of the personnel
- Also, the distribution from private depots is not always done to authorised outlets and it feeds a sizeable and growing illicit/illegal market
- The private sector does not have a better infrastructure than the public sector (limited distribution, limited storage) and works often outside of the law. The quality of its products can also be questionable. It has however increased the access to drugs especially as the availability of products at public level is increasingly inadequate
- The availability of essential drugs and their selling prices remain an important barrier to their access by populations. Despite a regulation limiting taxes (11%) and the profit margin (35% on specialties) a study in 2006 found drugs to be often more expensive than what is stipulated by the law[18]
- Limited quality control of drugs: The quality control mechanisms are not working well for imported drugs. The control of neither the documentation nor the sampling is systematically done by LANSPEX.

2.2.2. Disease-specific supply barriers

2.2.2.1. Diarrhoea

2.2.2.1.1. Public sector

- During our visit the ONPPC in November 2011 mentioned that due to a lack of coordination with donors their ORS had expired. This was confirmed by the public pharmacies in Dosso and Birni N´Konni although they believed that the problem was also a result of the limited shelf life of the ORS they received from the ONPPC
- The only local drug manufacturer SONIPHAR stopped producing ORS in 2010. This has meant that some wholesalers have stopped buying it because imported ORS is too expensive and too bulky
- ORS can only be obtained in pharmacies and health centers. It is currently generally available (mainly the one from UNICEF) at health center level (district and community) however due to do the product expiration we did not find any in public pharmacies
- We also saw big quantities of ORS at district level. The districts have received big quantities from UNICEF to last them for over a year. This is causing warehousing problems and we saw products being kept in rooms that were not conditioned to store drugs
- Although zinc is included in the Essential Medicines List (EML) the ONPPC does not currently procure it because "health centers don´t order it"
- We also found that public pharmacies are unable to get zinc because it is not currently included in the ONPPC´s ordering form
- ZinCfant does not seem to be currently registered at the DPHL/MT
- The zinc currently available comes from UNICEF and other NGOs donations

[18] «Rapport de l´étude sur les prix des médicaments au Niger» Ministère de la Santé Publique et de la lutte contre les endémies, Direction Générale de la Santé Publique, Direction de la pharmacie des laboratoires et de la médecine traditionnelle, 2006

- During our visits CS and CSI mentioned their expectation to receive zinc from UNICEF as a reason not to order it. They had however not been informed if they would get any
- The use of zinc is caught in a vicious circle in which it is not being prescribed because it is not available while public & private pharmacies are not ordering it because there is limited demand
- Health facilities are currently not ordering zinc also because:
    - they do not always know it is part of the EML
    - they believe that it is too expensive (although they have never ordered it)
    - they count on UNICEF and NGOs donations (even if they do not know if/when they will come)

2.2.2.1.2. Private sector

- There was limited availability of ORS at private pharmacy level although the ones we interviewed all said that they normally carry it
- ONPPC and Laborex (one of the country´s main wholesaler) mentioned that they had had big quantities of ORS that went out of date. As a result certain wholesalers such as Laborex are not procuring it anymore
- The private sector does not see ORS as a profitable product because it is bulky and expensive to carry. Not all wholesalers carry it
- There is no understanding of the different types of ORS and their quality which means that selection of a product is made based only on price
- As imports are based on demand there is little zinc in the private market
- Private sector is not necessarily aware of IMCI guidelines that refer to the need to give ORS with zinc. Pharmacists for example are not actively giving their customers advice on this
- The only zinc we found in the private sector was in the informal market

2.2.2.2. Pneumonia

2.2.2.2.1. Public sector

- Similar to the private sector, paediatric formulations are more likely to be out of stock
- Stock outs of Amoxicillin syrups tend to happen at community level and even in some public pharmacies
- We did not see dispersible tablets of 250mg Amoxicillin in the private or public sector even if it is included in the IMCI guidelines

2.2.2.2.2. Private sector

- There does not seem to be problems of availability of Cotrimoxazole (even in the syrup form) or Amoxicillin
- Paediatric formulations are however less frequently available
- Private sector health facilities are is not necessarily following IMCI guidelines (e.g.: a private clinic was prescribing Amoxicillin as first line treatment for pneumonia)

Current MoH/partners' efforts and identification of priority areas

As part of the 2011-2015 PDS, 8 strategic areas have been prioritised. Amongst these are:

- The staffing of the health structures with competent and motivated human resources according to their needs
- The permanent availability of drugs, vaccines (…)
- The strengthening of the governance and leadership at all levels of the health care system
- The development of the health sector financing mechanisms

The PDS also sets the following goals:

- Reduction of mortality of children under 5: from 198/1,000 (2006) to 114/1,000
- Increase use of ORS: from 34% (2010) to 90%
- Increase the inclusion of zinc in the treatment of diarrhoea: from 0% (2010) to 30%
- Increase the use of antibiotics in the treatment of pneumonia for children <5: from 17% (2010) to 30%
- Increase the treatment of pneumonia in newborns in the community: from 2% (2010) to 5%
- Increase the case management of pneumonia in newborns at community level: from 2% (2010) to 5%

In order to reach these goals and to ultimately meet the MDG goals of reducing mortality of children under 5 by two thirds (i.e.to 108.7/1,000) by 2015 an analysis was done to identify the barriers/issues and the current efforts that are already in place or have been planned as part of the PDS. Whenever there was a barrier /issue where insufficient or no activities are planned or in place to resolve it, it was highlighted **as a gap in bold**.

	Patient		Public sector supply/provision (incl. community-level)		Private sector supply/provision	
	Barriers/Issues	Current efforts	Barriers/Issues	Current efforts	Barriers/Issues	Current efforts
Across diseases	1. Cultural issues 2. Current limited understanding of attitudes, behaviour and practices of caregivers at national level. **3. There is no information on patient´s perception of the quality of the**	1. The UNICEF C4D programme on KFPs is including local leaders in their activities to reach men through cinema and theatre activities targeting the whole village. A campaign about the dangers of using drugs from the illegal market is also in	1. Financial and management challenges 2. Cash flow issues 3. Limited qualified HR 4. Limited supervision and monitoring of health facilities 5. **Limited knowledge about health providers´ service delivery attitude and actual**	1. Strengthening of procurement and logistics systems incl. ONPPC restructuring planned in PDS with a working group currently in place 2. Planned increase of health budget until 2015 and study of alternative sources of financing such as health insurance or social funds as part of PDS 3. On-going training and planned recruitment of qualified staff (e.g.:	**1. Limited geographical coverage** 2. Quality of products sold cannot always be guaranteed; some wholesalers work outside national regulation **3. Wholesalers and health providers do**	**1. None** 2. Tougher implementation of regulations across the board is planned in the PDS (incl. strengthening capabilities of

	services they received	place 2. A survey is currently taking place in 4 districts to monitor the progress of the KFP activities. **3. None**	**practices**. 6. **A system with a multiplicity of players and procurement channels challenges the coordination and the management** 7. Limited enforcement of regulation **8. No national policy or clear strategy for community health interventions and the increase role of RCs** 9. "RCs" currently not allowed to carry drugs 10. Growing illegal market as an alternative to the expensive private sector and the stock outs of the public sector 11. Lack of reliable data that limits the understanding of the health system´s real needs	UNICEF partnering with MoH to build capacity at CS and CSI level around stock management, IMCI...) 4. Planned strengthening of the Health Management system incl. new indicators to monitor CS and CSI. Supported by CIDA/UNICEF Catalytic Initiative. **5. None** 6. "Cadre de Concertation is planned to meet more systematically in 2012 improving partner coordination and communication. The MoH has also signed in April 2011 IHP+Compact. A "Fond Commun" or Common Basket was also put in place to finance the yearly implementation plans in coordination with partners. Development of a national strategy to insure availability of drugs led by DPHL/MT in progress **Coordination and improving information sharing processes will be very important** 7. DPHL/MT plans to improve the capacity of the IGPL to increase inspection of pharmacies and depots **8. The PDS plan recognizes the importance of the role of RCs and its potential. It plans for 2011-2015 the development of an integrated community health approach. Some ground work done in the past by partners and UNICEF.** 9. Pilot projects planned for the community distribution of ACTs 10. Work with NEPAD and planned advocacy work by DPHL/MT as well as planned capacity strengthening of LANSPEX. Also, the	**not always follow national health policy**	IGPL to increase inspection of pharmacies) **3. None**

				implementation of a tracking system is planned for 2012. 11. Improvement included in the national strategy currently being developed		
Diarrhoea	1. Low usage and knowledge of zinc 2. Limited access to ORS as there are temporary stock outs in public or private sectors	1. Ongoing IMCI BCC campaign as part of the promotion of KFPs implemented with the support of various NGOs 2. Ongoing UNICEF and other NGOs product donations to public health facilities	**1. Dependence on UNICEF´s donation of zinc** **2. Not included in ONPPC´s ordering form** **3. Zinc is not registered at the DPHL/MT** 4. Due to lack of coordination ORS, expiration is causing stock outs in public pharmacies 5. ORS can only be obtained in health facilities or public pharmacies/depots	**1. None** **2. None** **3. None** **4. Information does not seem to be flowing down well** 5. None	**1. Perceived low margins of zinc & ORS** **2. ORS going out of date in the private sector and public pharmacies** **3. ORS available is often not low-osmorality** 4. ORS is no longer manufactured in country. No zinc manufacturing either **5. Low demand of zinc producing low offer** 6. Not actively including zinc to diarrhoea treatment 7. ORS can not be sold outside pharmacies/depots 8. Low awareness of IMCI and health policy	**1. None** **2. None** **3. None** 4. Inclusion in PDS financing of SONIPHAR to revamp its facilities and equipment **5. IMCI guidelines have recently started to be included in the private sector education system** **6. None** **7. None** 8. **None**
Pneumonia	1. Low knowledge of danger signs **2. Limited availability of paediatric formulations**	1. Ongoing IMCI BCC campaign as part of the promotion of KFPs **2. Certain NGOs are donating paediatric formulation to fill in gaps**	Budget constraints may be limiting the quantities of paediatric formulation that are bought	Planned increase of health budget until 2015 and study of alternative sources of financing such as health insurance or social funds as part of PDS	**1. Limited access to private pharmacies and health facilities in rural areas** 2. **Low awareness of IMCI and health policy (prescribing Amox. as first line)**	**1. None** **2. None**

Based on the gap analysis, the points highlighted in bold prioritise the areas where no activities are currently taking place or are planned under the PDS. Such gaps are the starting point to recommend a limited amount of interventions that can be scaled up nationally pre 2015 and will complement currently planned activities. In this way they will have an impact on the goals set by the PDS and reduce under 5 child mortality in the short/ medium term.

PROPOSED PROGRAMME OF TARGETED INTERVENTIONS

1. Vision & objectives

The following interventions aim at complementing the activities already in place or planned under the PDS while having an impact in the short /medium term:

1. **To develop a road map for the implementation of an iCCM programme through "relais communautaires"**: although iCCM has been proven to be very effective even in the treatment of severe pneumonia there does not seem to be a strategy in place that will drive its implementation. This is perceived as a critical activity in the reduction of mortality for children under 5, and therefore this intervention intends to jump start and complement the activities already planned in the PDS through the development of a clear national strategy.
2. **To increase coordination and information amongst partners**: this approach can be implemented through already existing structures such as the "cadre de concentration" which is planned to meet more regularly. There should also be a review of current processes.
3. **To create opportunities for the private sector to get more involved whilst investing in it so it can become the partner that the country needs:** This is in line with the PDS plan to build a partnership with the private sector optimizing the coverage of essential health needs.
4. **To carry out national research studies**: little is known about the quality of care patients are receiving and although much has been done to train staff it is still difficult to understand what are the challenges/issues patients face when it comes to receiving good care. To make the right adjustments it will be necessary to understand this information.
5. **To increase the availability of zinc**: the intervention will encompass various low costs activities
6. **Improve populations' access to diarrhoea treatment through social marketing:** there is a clear gap between the more costly private sector and the free public sector that can be filled by social marketing providing patients with greater choice and greater access to ORS and zinc

2. Programme overview / programmatic framework

In the following table are described the interventions that have been selected as well as their rationale:

	Supply – public sector (incl. community-level)		Supply – private sector	
	Intervention	**Rationale**	**Intervention**	**Rationale**
Across-disease	1. Partners to include ONPPC as well as regions/districts in their communications on volume, value and timings of drugs donated with the DPHL/MT´s agreement 2. Develop a clear strategy to facilitate the availability of ORS, zinc and potentially antibiotics through "Relais Communautaires" 3. Gain a better understanding of health professionals´ motivations and challenges to provide high quality of care in order to be able to define new ways of engaging and motivating staff increasing empowerment and responsibility 4. Gain a better understanding of patient´s perceptions of the quality of the services they receive to better understand their barriers to access	1. Currently the information is not flowing down from the national level leaving the districts CS and CSI in the dark when it comes to understanding the volume of donations they will be receiving and their timings 2. Various ad hoc pilot projects are programmed however they do not seem to be part of a overarching strategy 3. Although a fair amount of time, effort and money has been spent on building capacity it is not clear what is understood about staff barriers to implementing the changes requested. Gaining a better understanding of health providers' attitudes and motivations will help to accurately target the bottlenecks these could be causing. 4. Equally, with a greater comprehension of patient´s perception of the quality of the services they receive from health facilities it will be easier to understand the barriers they face.	Engage the private sector: 1. Educate and inform the private sector about IMCI guidelines and other protocols on a regular basis 2. Include the private sector in capacity building activities 3. Analyse how best to integrate the private sector in the public sector system 4. Include private sector representatives as partners in public sector meetings 5. Develop a continuous education program for private sector providers 6. Study ways to motivate the growth of the number of private sector health facilities (e.g. through adaptation of laws, tax breaks…)	Currently the private sector is not being kept up to date with changes in national guidelines. This sector has a space even in the short term it will be small due to the country´s poverty level. However its development should be encouraged to increase access, reduce pressure on the public sector and offer greater choice to patients.
Diarrhoea	1. ONPPC to change ordering form to include zinc. 2. Register ZinCfant and encourage other manufacturers to register zinc products in Niger.	1. Health facilities are not currently able to order zinc because it is not included in the ONPPC´s form 2. To increase availability in the private and public sector ZinCfant needs to be registered with the DPHL/MT	Launch a Social Marketed diarrhoea treatment kit (DTK) including low-osmorality ORS and zinc together with a national marketing campaign to generate demand	This will : • Increase the general demand for both ORS and zinc which will then incentivise the increase offer • Creating competition with private sector and therefore incentivise the development of DTK by this sector • Reduce the burden on the public sector • Offer greater choice to patients

3. Key deliverables & outcome targets

Key interventions	Main deliverables	Milestones	Outcome targets	Desired impact
Development of a road map for the implementation of iCCM	Road map for the national implementation of iCCM programme	Create a working group to analyse lessons learned from previous pilots and other countries Develop national guidelines Develop implementation timeline Define indicators Test approaches Define processes and procedures as well as responsibilities.	Implementation of a nationwide iCCM programme through "relais communautaires"	% decrease mortality of children under 5 due to diarrhoea and pneumonia % increase of children getting the IMCI recommended treatment for diarrhoea and pneumonia % decrease time to treatment for diarrhoea and pneumonia of children under 5 Reduce incidence of severe pneumonia *This intervention will contribute towards the following PDS´s goals:* • *Use of antibiotics in the treatment of pneumonia for children <5: 17% to 30%* • *Treatment of pneumonia of newborns in the community: 2% to 5%* • *Case management of pneumonia of newborns at community level: 2% to 5%*
Increase coordination and information amongst partners	Improve information sharing between DPHL/MT, financial partners, private sector and ONPPC as well as regions and districts to reduce stock outs, facilitate stock management and reduce product leakages between sectors	Agree with the DPHL/MT an improved process to informing and coordinating with ONPPC, the private sector, regions and districts. Meet with partners at national level on a regular basis to share information on volume of donations, stock outs, challenges, etc...	• Better distribution of donations across the country • Improved management of donated products on arrival • Fewer product leakages between the public and the private sectors	% reduction of number stock outs % reduction of expired products % reduction of product leakages
Engagement of the private sector	Private providers are more engaged and	Learn from the AMFm process of engaging with the private sector wholesalers.	Greater availability of OMS recommended formulations	Increase % of patients that get IMCI recommended treatment for diarrhoea and

	informed about the treatment of diarrhoea and pneumonia and IMCI in general	Include private providers (wholesalers, pharmacists, health providers...) in public health capacity building activities to change prescribing and ordering habits Develop and implement a continuous education system for wholesalers, pharmacists and private sector health providers Analyse current challenges to the development of the private sector (pharmacies as well as clinics). Motivate its growth (through for e.g. adaptation of laws, tax breaks...) together with the proper regulations and supervision. Include private sector representatives (wholesalers, pharmacists and health providers) as partners in public sector meetings	(e.g.: low osmorality ORS and zinc). Private sector becomes a real partner and an alternative.	pneumonia % reduction of stock outs % increase in private health providers knowledge
National research studies	Quantitative and qualitative studies	Gain better understanding of health providers and their patients	In depth information that will be used to improve the quality of the services provided	% of patients that are satisfied with the service they receive in Public Health facilities
Increase availability of Zinc	Increase availability and prescription of zinc for diarrhoea treatment	Register ZinCfant and encourage the registration of generic brands Include zinc in the ONPPC order form Inform and educate the private sector about IMCI guidelines and especially about the importance of zinc in treatment of diarrhoea (and even pneumonia) Inform Districts, CS and CSI of donations expected for 2012.	% Increase availability of zinc and ORS % Increase prescription of zinc and ORS for diarrhoea treatment	40% [19] decrease mortality of children under 5 due to persistent diarrhoea *Contribute towards PDS goal of increasing the inclusion of zinc in the treatment of Diarrhoea to 30% by 2015*
Launch of a Social Marketed DTK	Launch of a SM DTK nationally to be sold through the private sector as well as through trained CHWs	• Identify donor • Select organization • Formative research • Develop program • Procure product • Develop product packaging and support materials • Recruitment of staff and training • Implementation through • Demand creation campaign • Monitoring and evaluation	Sales of DTK Availability of DTK Correct use of DTK	Increase availability and access to ORS and zinc Increase to 80% of children that get ORS and zinc as treatment for diarrhoea Reduce stock out in public sector facilities

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4. Detailed description of targeted interventions

The following interventions have been chosen because they could be implemented and taken to scale in the short/medium term whilst having a considerable impact in the reduction of mortality due to pneumonia and diarrhoea. They are also in line with the priorities set by the PDS 2011-2015. Two of the interventions are more product specific aiming at rectifying a situation where not only the availability of zinc was very limited but also the only product found during the field visits was donated by UNICEF.

4.1. Intervention 1: Development of a national road map for integrated community case management

The objective is to develop a detailed road map for the national implementation of an iCCM programme to improve the treatment of pneumonia and diarrhoea through “relais communautaires”. This intervention will be in line with the PDS´s plan to expand and clarify the role of RCs.

The intervention will include the creation of a working group responsible for analyzing existing papers and success stories from other countries as well as other programmes (e.g.: a pilot has been planned for 2012 for the management of malaria at community level). It will also involve the development of national guidelines, processes as well a detailed implementation plan that will take into consideration:

- Ensure a clear coordination and integration between health areas to avoid vertical interventions including the different ministries
- Define clear roles and responsibilities between the CSs and the RCs
- Develop a training program and standardization of materials (e.g.: communication, ordering forms, etc...) including job aids based on existing successful materials
- Analyse different motivation models to positively influence CHW (e.g.: look at performance related remuneration)
- Analyse and define the supply system, reporting mechanisms, monitoring and supervision together with clear indicators of performance
- Adapt and improve the current drug supply system to make it more reliable
- Map the location of existing partners and their activities
- Develop a clear time line for its implementation throughout the country taking into consideration the activities already in place. This information would then dictate the implementation schedule.
- Set up a monitoring system for the different activities and integrate the data collected into the national statistics
- Sign agreements with implementing partners

Year 1 will focus on developing the programme as well as doing small tests on the ground. Implementation would start in the districts with pre-existing partners. During year 2 and 3 new agreements will be signed to move into new districts (in total there are 42 districts)

The DGSR and DOS will be responsible for this activity partnering with local and international NGOs.

To make the project self-sustainable the following should be considered:

1- A small payment by the patient for either the products or the service equal to the cost of travelling to the nearest health centre to contribute to the CHW salary
2- A small contribution from the community/municipality towards the CHW transport

These small contributions could increase CHW motivation, reduce staff turnover and increase the project´s sustainability.

In parallel a national community health policy should frame and define the roles and responsibilities of ASC and RC, their mode of operation and supervision, the scale-up plan and the institutional and technical support necessary to promote community-based activities, prevention and disease treatment as planned on the PDS.

4.2. Intervention 2: Increase coordination and communication amongst partners

The lack of coordination and sharing of information is causing major challenges at various levels:

- Expiration of products at public and private level leading to stock outs
- Difficulties to manage arrivals of big quantities of commodities that were not expected at District level
- Uneven quantities of commodities donated to different districts due to a lack of coordination between financial partners (e.g.: NGO do not necessarily know what volume of donations UNICEF is making)
- Difficulties to forecast needs and identify gaps
- Limited amounts of children´s formulations for pneumonia treatment
- Proliferation of supply systems

In 2012:

- With the agreement of the DPHL/MT, develop a new communication process between financial partners, the regions and districts to share information such as volume, timing of deliveries of donations and types of products to be donated (incl. formulations) to increase coordination and reduce the number of supply systems
- Communications will include representatives of the private sector as well as financial partners (multilaterals, bilateral and NGOs) in the “Cadre de Concertation” already planned by the DPHL/MT

- Improve collection, analysis and information sharing regarding distribution, volume, timings and costs of donations and government bought products. The reporting of product leakages and stock outs together with activities put in place to resolve the problem could also be done in these meetings. Whilst information is already been collected through an existing system (CHANEL), it will be important to improve the central (e.g. DPHL/MT) level capabilities of data analysis. Expanding the use of CHANEL through capacity building at regional and district level will also be important.
- Systematically share information during regular meetings as well as through a quarterly report published on the MoH web site to minimise costs.
- Organise meetings at regional/district levels to review new communication processes and make modifications should take place on a regular basis

Defining clear roles and responsibilities as well at all level as performance indicators will be crucial to ensure the sustainability of this intervention.

The responsibility of this intervention will fall under the DPHL/MT.

4.3. Intervention 3: Engagement of the private sector

The objective of this intervention is to engage the private sector further so it becomes a real partner increasing access to drugs and treatment. To do this it will be important to educate, include and integrate it with the public sector as well as encourage its growth. The successful consultative process that followed the launch of the AMFm programme showed that the private sector wholesalers and pharmacists are prepared to engage and participate in public health activities if informed and included in the decisions.

2012: 2nd quarter

- Organisation of meetings through the associations of pharmacists and of private doctors with wholesalers, private pharmacies and private practitioners to inform them about WHO recommended treatment of diarrhoea and pneumonia and IMCI guidelines. They would also like to be informed about zinc and low-osmorality ORS manufacturers
- Improvement of long term involvement. Representatives of the private sector (e.g.: head of the Pharmacists Association) should be part of regular meetings (e.g. the ones planned as part of the “Cadre de Concertation”) with the public sector and international partners to better understand the country´s needs. Sharing information about volume of donations and government procurement as well as their timings would help reduce stock outs and products´ expiration. Focal points could also be designated amongst the private sector stakeholders to improve communication channels between the private and public sectors.

2012: 2nd 4th Quarter

A deeper analysis of how to better integrate the private sector in the public sector systems needs doing together with a the proactive engagement of the private sector.

- The implementation of a continuous professional education programme should also be considered to ensure that the private health professionals stay up to date with new health policies. Just like in other African countries, it would be interesting to develop a programme that private health professionals can attend to stay up to date with new developments. A point system could be considered to encourage providers to attend the trainings
- Although long term financing of the private sector continuous education should be covered by the private sector, it would be advisable to provide technical assistant for the analysis of both the integration and the continuous education curriculum using lessons learned from at other countries
- Equally, an in-depth analysis of the challenges limiting the growth of the private sector should be done. With this analysis, work could take place to reduce barriers to entry (e.g.: tax breaks, etc...) and encourage further the development of the sector together with the proper regulations and supervision

The sustainability of this intervention will depend on the level of engagement of the private sector and its leadership.

DSME and DOS will be responsible for the implementation of this intervention.

4.4. Intervention 4: To carry out national research studies to inform the improvement of the quality of care

In order to be able to improve the quality of care provided to patients as planned in the PDS it will be important to get a clear picture of the existing challenges staff and patients face. The objective of this intervention will be to carry out a national qualitative and quantitative study that will build a better understanding of the barriers created by the attitudes and the lack of motivation of health providers. By also including patients' perceptions it will be possible to understand the hurdles (real or perceived) they have to overcome to access treatment.

The study would look into:

- patient management
- effective implementation of the training
- management of internal and external communication
- quality of initial training
- staff motivation
- sanctions for non-compliance with standards
- expectation and satisfaction of the customers

The responsibility for this intervention should lie with the DGR and DOS.

4.5. Intervention 5: Increase availability of zinc

The objective is to systematically include zinc in the treatment of all diarrhoea episodes. This will be achieved by short and medium term activities:

2nd quarter 2012

- Verify registration and if necessary request Nutriset to register ZinCfant with the DPHL/MT
- Include zinc in the ONPPC´s ordering form so public sector facilities can order it
- Announce the change to the health facilities
- Inform the districts as well as the CSs and CSIs of the amount of zinc and ORS they will be receiving as donations in 2012

2nd to 4th quarter 2012

- Encourage other zinc manufacturers to register their products to increase product choice and competition
- Inform and update the private sector wholesalers, pharmacists (and their staff) through the pharmacists association and through meetings about WHO´s recommended treatment of diarrhoea
- Carry out advocacy work to increase the prescription in the public and private sectors of zinc following national IMCI guidelines. This advocacy can be done during current communication channels such as supervisory activities, staff meetings in hospitals, etc...

The responsibility for the implementation of these activities will lie with DPHL/MT.

Need for funding could be limited to:

1. Organizing two short meetings in 2012 in Niamey to inform the private sector of the IMCI guidelines. After this, the private sector should be included in already existing trainings
2. Printing and sharing IMCI guidelines as well existing papers on the treatment of diarrhoea during the meetings with the private sector stakeholders including the depots

This intervention aims at breaking the cycle in which zinc is caught: it is not prescribed because it is not available, and it is not available because there is no demand. If zinc was prescribed automatically this would then create the demand that would encourage wholesalers to buy the product. This should be a relatively low cost high impact activity.

4.6. Intervention 6: Improve populations' access to diarrhoea treatment through social marketing

Although the investment in this activity is higher it will also have a greater impact at many levels:

1- Making a DTK available in the market will ensure ORS is taken together with zinc for the treatment of diarrhoea,
2- Increasing access to low-osmorality ORS and zinc will provide an alternative to the stock outs currently occurring at private and public level,
3- Reducing pressure on public sector resources
4- Enticing the private sector to also enhance its offer of low-osmorality ORS and zinc.

Activities in 2012:

- Contact PSI Benin to organise a trip from various officials to travel and learn from their DKT programme
- Identify a donor
- Develop a detailed proposal
- Procure products that add value to the products that already exist in the market (e.g.: flavoured low osmorality ORS and flavoured Zinc)
- Receive technical assistance from PSI Benin in country
- Carry out formative research (e.g.: test packaging and support materials from existing DTK in neighbouring Benin, look at purchasing power to decide price to consumer)
- Develop/adapt packaging, pricing, support materials, marketing campaign, interpersonal communication materials...)
- Recruit and trained staff
- Q4 2012 launch DTK in 2 districts as a pilot

Activities in 2013 and onwards

- Demand creation activities mass media and interpersonal communication
- Sales through private sector and network of community health workers in rural areas
- Expansion of the programme

While achieving full sustainability for social marketing programs is difficult, financial, institutional, and market sustainability should be aimed for. The financial sustainability of this program would need to be built up with time to create a revolving fund covering the cost of the commodities.

A Total Market Approach (TMA) will be essential to maximize the health impact of this social marketing programme. The goal of the TMA is to achieve a marketplace

where all segments of society are reached with high quality products and services according to their ability to pay. In a balanced TMA, the poorest populations access products and services through free distribution, those who are somewhat better off through subsidized products and those with greater ability to pay through commercially-distributed products. Social marketing organizations are essential to growing the overall market volume by attracting new user groups into the market and opening up new markets, particularly in rural areas through community based distribution. Supported by social marketing, the TMA seeks to correct market inequities and develop more sustainable solutions to health problems by providing wider and more effective choices.

For the success of this intervention and to achieve a successful TMA it will be important to make sure that the market is well segmented, that SM targets the "middle income" population without cannibalizing the private sector and that donations do not cannibalize neither the private nor the social marketing activities.

The responsibility for this intervention should lie with DSME and with a NGO that will be in charge of the implementation of the activities.

4.7. UNICEF´s donations

In addition to these interventions, UNICEF will carry on with donations of zinc, ORS, amoxicillin and cotrimoxazole to the public sector in 2012, 2013 and 2014. The volume of the products to be donated described below takes into consideration the country´s needs as well as the projected volume to be sold through social marketing. The formulations selected are in line with the country´s IMCI guidelines and are intended to rectify the identified lack of paediatric formulations available in the public sector.

Description	Unit	Year 1	Year 2	Year 3
sulfameth+trimeth 400+80mg tabs	pack of 500	4,700	4,841	4,986
sulfameth+trimeth powder 240mg	100 ml bottle	196,000	201,880	207,936
zinc sulphate 20mg	pack of 100	60,000	61,800	63,654
ORS new formula with local text for 1 litre	100 sachets	36,000	37,080	38,192
amoxicillin 250mg disp. Tablet	pack of 100	12,600	12,978	13,367
amoxicillin pdr. Oral sus. 125mg75ml	100ml bottle	84,000	86,520	89,116

WORKPLAN & BUDGET

For details please see attached more detailed budget in Annex.

INTERVENTION	DESCRIPTION	RESPONSIBLE					Year 1					Year 2
Intervention 1	Development of a national road map for iCCM	DGSR					**$1,242,750**					**$ 588,500**
Activity 1.1	Advocacy work by the DGSP, DGSR, DPHL with the MoH		X									
Activity 1.2	Advocacy work between SG/MSP, SG/MCC and SG/MPDC		X									
Activity 1.3	Creation of a working group			X								
Activity 1.4	Analysis of lessons learned in and outside of Niger			X								
Activity 1.5	Development of guidelines and plan of action				X							
Activity 1.6	Mapping and recruitment of implementing partners				X	X						
Activity 1.7	Testing of processes (incl. commodities, travelling, etc...)					X						
Activity 1.8	Validation of strategy with partners					X						
Activity 1.9	Development and printing of materials					X		X	X	X	X	
Activity 1.10	Training of RCs, supervisors and other relevant staff					X		X	X	X	X	

Activity 1.11	Official launch of programme and beginning implementation							X				
Intervention 2	Increase coordination and communication amongst partners	DPHL/MT					**$172,000**					**$55,000**
Activity 2.1	Develop an implementation plan			X								
Activity 2.2	Implementation of new plan			X								
Activity 2.3	Invite private partners to the regular meetings of the “cadre de concertation”			X								
Activity 2.4	Meet in districts/regions to revise information sharing processes			X	X	X		X	X	X	X	
Activity 2.5	Improve central level capacity to analyse and collect information (e.g.: incl. Buying a new software+ training)			X	X	X		X	X	X	X	
Activity 2.6	Scale up capacity building of management software at regional, district				X							
Activity 2.7	Collection, analysis and sharing of information (incl. Improve MOH web site)				X	X						
Activity 2.8	Review and adapt process as needed							X	X	X	X	
Intervention 3	Engagement of the private sector						**$100,000**					
Activity 3.1	Organise meeting with private sector to inform them about IMCI and more specifically treatment of diarrhoea and pneumonia (inc. Printing of some materials for meeting			X								
Activity 3.2	Include private sector in “cadre de concertation » (see activity 2.2)			X								
Activity 3.3	Analysis and recommendations on how to increase integration of the private sector as a partner in the health system			X								
Activity 3.4	Sharing of analysis and recommendations of activity 3.3			X								

Activity 3.5	In-depth analysis of the challenges limiting the growth of the private sector and recommendation of how to reduce barriers to entry			X	X							
Activity 3.6	Sharing of analysis and recommendations of activity 3.5					X		X	X	X	X	
Activity 3.7	Work with private sector providers and MoH to develop curriculum for pharmacists (all private pharmacies and wholesalers have a pharmacist) and pharmacy staff				X	X						
Activity 3.8	Start implementation of private sector continuous education programme					X		X				
Activity 3.9	Start implementation of changes suggested by activity 3.3							X				
Activity 3.10	Start implementation of changes suggested by activity 3.5							X				
Intervention 4	To carry out national research studies to inform the improvement of the quality of care	DSME and DOS					**$400,000**					**$10,000**
Activity 4.1	Select research organisation to implement study			X								
Activity 4.2	Carry out research studies			X	X	X						
Activity 4.3	Share and present findings							X				
Activity 4.4	Include findings in PDS plans to improve quality of care								X	X	X	
Intervention 5	Increase availability of zinc	DPHL/MT					**$90,000**					
Activity 5.1	Registration of ZinCfant		X	X								
Activity 5.2	Encouragement of other manufacturers to register Zinc		X	X	x	x						
Activity 5.3	Include Zinc in the ONPPC ordering form and inform health facilities (reviewing the entire form)		X									

Activity 5.4	Inform Districts and health facilities of the amount of Zinc and ORS they can expect to receive in 2012		X									
Activity 5.5	Inform and update private providers			X								
Activity 5.6	Advocacy work with public providers and influencers			X	X							
Intervention 6	Improve populations' access to diarrhoea treatment through social marketing	DSME and implementing NGO					**$1,549,000**					**$1,766,000**
Activity 6.1	Identify donor/funding			X								
Activity 6.2	Develop detailed proposal			X								
Activity 6.3	Receive technical assistance from PSI				X							
Activity 6.4	Technical trip to neighbouring country to learn about their programme			X								
Activity 6.5	Carry out formative research				X	X						
Activity 6.6	Develop/adapt product, price, distribution, communication			X	X	X						
Activity 6.7	Train staff				X	X						
Activity 6.8	Print and produce packaging, marketing and communication materials				X	X						
Activity 6.9	Procure DTK					X						
Activity 6.10	Launch event for DTK (incl. Event, materials for launch, samples, etc…)					X		X				
Activity 6.11	Branded and generic communication campaigns					X		X	X	X	X	
	UNICEF donations of products- zinc, ORS, cotrim. & amox.	UNICEF					$608,674					$626,934

IMPLEMENTATION ARRANGEMENTS

1. Risk assessment and challenges

- Lack of alignment of the RCs activities with KFPs and IMCI
- Challenge of self-sustainability of the CHW programme and its integration within the "gratuité" system
- Limited availability of information
- Lack of adherence to rules and regulations
- Current segmentation of the private sector makes it difficult to reach as a whole. However the intervention related to the private sector needs to be lead by the majority of the private sector stakeholders
- Current competitive/ mistrusting attitude between private and public sectors
- High number of partners
- Resistance to change of professional staff and population
- Lack of respect for regulations
- Unstable food security and security in general
- Lack of qualified HR at national level and staff turnover
- Donated products are currently competing with the private sector risking its development. A clear segmentation of the market is required and dispositions need to be taken to avoid the public sector leakages that hinder the development of the private and the social marketing sectors
- The responsibility of limiting the leakage of donated products into the illegal market sits with the DPHL/MT. However the responsibility of limiting the leakage of donations should be shared with the partners that have donated the products.
- These recommendations are based on the assumption that the activities planned by the PDS will be on their way before the end of 2015
- Proliferation of the illicit market
- Challenge of implementing a social marketing programme in a context where free products and services are expected for children under 5

2. Future studies

Although it is beyond the scope of this project, an issue that needs to be addressed is the quality of the products that are currently available in the public and private sectors. Evidence from other countries and across product categories suggests that sub standard and counterfeit products are likely to be prevalent and an in-depth analysis of product quality should be considered a matter of priority.

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Field visits:

Person interviewed	Type of establishment	Region
DRSP Adjoint	DRSP	Dosso
Point Focal PCIME	DRSP	Dosso
Private Pharmacy manager	Pharmacie DALLOLS	Dosso
Private Pharmacy manager	Pharmacie SARAOUNIA	Dosso
Health District Chief	CSI	Dosso
Pharmacy manager	District pharmacy	Dosso
Epidemiologist	Direction du District	Dosso
Chief doctor	Direction du District	Dosso
Major	CSI Tondobon	Dosso
Community Health Agents (CHA)	CS Agali	Dosso
CSI Chief, COGES president, midwife and CHA	CSI Kore Mairoua	Dosso
Public Pharmacy manager	Pharmacie populaire Birni N´Konni	Dosso
Private Pharmacy manager	Pharmacie GOURAMA	Dosso
Major	CSI urbain Birni N´Konni	Dosso
CHA	CS Dibissou, Birni N´Konni	Dosso
Major	CSI Juidan Eder, Birni N´Konni	Dosso
IMCI focal point	DRSP	Tahoua
Chief doctor	Centre Hospitalier de Réference	Tahoua
Pharmacist	Pharmacie du Centre Hospitalier de Réference	Tahoua
Owner and doctor	Private clinic TAMESNA	Tahoua
Director	Direction du District	Tahoua
Chief CSI, midwife	CSI Founkoye	Tahoua
Major	CS Kaloma	Tahoua
Health District Chief	District de N´Konni,	Tahoua

ANNEXES

Annex 1: Ratios doctors, nurses and mid wives by region in 2010

Region	Population	Doctors			Nurses			Mid wives		
		#	Ratio (1/…hts)	WHO guidelines	#	Ratio (1/…hts)	WHO guidelines	#	Ratio (1/…FAP)	WHO guidelines
Agadez	487,313	16	1/30,457	1/10,000	186	1/ 2,620	1/5,000	67	1/1,574	1/5,000
Diffa	473,563	15	1/31,571	1/10,000	75	1/6,314	1/5,000	8	1/12,815	1/5,000
Dosso	2,016,690	18	1/112,038	1/10,000	259	1/7,786	1/5,000	58	1/7,528	1/5,000
Maradi	3,021,169	67	1/45,092	1/10,000	706	1/ 4,279	1/5,000	156	1/ 4,192	1/5,000
Tahoua	2,658,099	27	1/98,448	1/10,000	385	1/6,904	1/5,000	67	1/8,589	1/5,000
Tillabéri	2,500,454	17	1/147,085	1/10,000	424	1/5,897	1/5,000	124	1/4,366	1/5,000
Zinder	2,824,468	45	1/62,766	1/10,000	526	1/5,370	1/5,000	76	1/8,046	1/5,000
Niamey	1,222,066	144	1/8,487	1/10,000	361	1/3,385	1/5,000	189	1/1,400	1/5,000
Niger	15,203,822	349	1/43,564	1/10,000	2 922	1/5,203	1/5,000	745	1/ 4 418	1/5,000

Source: DRSP

Annex 2: Detailed budget (see attached)

Annex 3: List of attendees to partners´ meeting in March

N°	Name	Organization
1	Mai Moctar Hassane	DGSP
2	Dr Karamoko Djibrilla	Banque Mondiale
3	Dr Belkissa Adamou	OMS
4	Kelessi Adamou	DS Niamey 3
5	Abdou Aboubacar	LANSPEX
6	Adamou Hamsatou	DSME
7	Jaime Del Rivero	AECID
8	Dr Adama Ouedraogo	Unicef
9	Dr Karimou Sani	DRSP Tahoua
10	Moutari Hamidou	DRSP Agades
11	Dr Fatima Sabo	ACH
12	Dr Issa Hamidou	Croix Rouge Nig
13	Abarry Hannatou	DSME
14	Tahirou Hamani	SONIPHAR
15	Mme Adamou Fassouma	DS Mirriah
16	Dr Abdoulaye Ousmane	ONPPC
17	Khaled Bensaid	Unicef
18	Sabrine Keller	HELP
19	Amadou Ousseina	Drsp Niamey
20	Rabiou Barira Salha	DOS
21	Dr Sambo Mariama	DPHLMT
22	Dr Diata Aissa	DSME
23	Ousmane Hajja	DRSP Tahoua
24	Aboubacar Tahirou	DS Mirriah
25	Dr Claude Ngabou	Save the Children
26	Wolfgans Weber	MSFB
27	Mme Amadou Mariama	IGS
28	Dr Mahamane Sekou	SAPHAR
29	Dr aichatou	DPHLMT
30	Dr Salamatou	DRSP Niamey
31	Mme Maiga Aissata	DEP /MSP
32	Dr Abdoulaye Soumana	DS Niamey 3
33	Mr Balarabé	Plan Niger

34	Dr Kalla	DRSP Agades
35	Dr Messan Halimatou	DPHLMT
36	Hachimou Fatima	Unicef
37	Adama Kémou	DSME
38	Boubacar Souley	DPHL/MT
39	Dr Chegou Yami	DGSP
40	Michèle Seibou	CONCERN