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## Niger: Nutrition Profile

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Malnutrition in childhood and pregnancy has many adverse consequences for child survival and long-term well-being. It also has far-reaching consequences for human capital, economic productivity, and national development overall. The consequences of malnutrition should be a significant concern for policymakers in Niger, since around 1.8 million children under 5 years (42 percent) suffer from chronic malnutrition (stunting or low height-for-age) and 10 percent suffer from acute malnutrition (wasting or low weight-for-height) (Institut National de la Statistique (INS) et al. 2016).

### Background

With a population of about 20 million and poverty rate of 44.1 percent, Niger is one of the poorest nations in the world. Although poverty is declining in Niger, it remains widespread, especially in rural areas (World Bank 2017). Because of the country's extremely high fertility rate (7.6), which is the highest in the world, over half (57 percent) of Niger's population is under 15 years of age (INS and ICF International 2013). Unchecked population growth driven by high fertility is thwarting Niger's development efforts, and gives the country the unfortunate distinction of having the lowest Human Development Index in the world (INS and ICF International 2013; UNDP 2016).

Since 2010, Niger has had a functioning multi-party democratic system. However, regional instability has led to an influx of refugees into Niger from Mali and Nigeria, exacerbating food insecurity (USAID 2017). Niger has some of the lowest education and literacy rates in the world, as 60 percent of men have no education and 58 percent are illiterate, and 72 percent of women have no education and 85 percent are illiterate. This lack of literacy and education sharply curtails livelihoods, business opportunities, and life skills (INS and ICF International 2013). Extreme poverty, limited livelihood opportunities, profound and deeply entrenched structural gender inequities, and recurrent environmental shocks all contribute to food insecurity in Niger (USAID 2017). The 2017 Global Hunger Index reports that Niger faces a serious level of hunger, ranking it 111<sup>th</sup> out of 119 countries (International Food Policy Research Institute, Concern Worldwide, and Welthungerhilfe 2017).

Largely rain-fed and oriented toward production of staple crops for consumption and domestic commercialization, the agriculture sector in Niger employs over 80 percent of adults, contributing about 43 percent of the GDP (World Bank 2013a). GDP growth is being outstripped by rampant population growth, so GDP growth per capita only grew around 1 percent per year from 2001 to 2010, and has fluctuated significantly since then (World Bank 2013b).

Currently, Niger ranks 151st out of 157 countries in progress toward meeting the Sustainable Development Goals (SDGs) (Sachs et al. 2017). In 2015, Niger was ranked 175 out of 179 countries on the Mothers Index, according to Save the Children's *State of the World's Mothers Report*. This is because women in Niger have a 1 in 20 lifetime risk of maternal death. Although maternal mortality has been reduced, it is still very high at 535 maternal deaths per 100,000 live births (INS and ICF International 2013). In addition, although Niger still has some of the highest under-5 (U5), infant, and neonatal mortality rates in the world, all three rates have dropped since 2006. Between 2006 and 2012, U5, infant, and neonatal mortality declined from 198 to 127 deaths, 81 to 65 deaths, and 33 to 24 deaths, respectively, per 1,000 live births (IRIN 2014; INS and Macro International, Inc. 2007; INS and ICF International 2013). This is likely due, in part, to increased access to and utilization of obstetric services and health services for children under 5 years, although issues with the health system also remain (e.g., supply chain management issues that slow the re-stocking of essential drugs) (Mathys, Oot, and Sethuraman 2017). According to the 2012 Demographic and Health Survey (DHS), the leading causes of child mortality are malaria (27 percent), cough and cold (19 percent), pneumonia (11 percent), and diarrhea (10 percent), with malnutrition most likely a large underlying contributor (INS and ICF International 2013).

## **Nutrition and Food Security Situation**

In the past decade, Niger has continued to see mortality rates (e.g., maternal, infant, child) fall; however, the country is still plagued by extremely high levels of both chronic and acute malnutrition that not only impact the health of the nation, but its development and economic goals, as well. Chronic malnutrition (stunting) has remained above 40 percent for the last quarter century, with minimal improvement in that time. According to the 2016 National Nutrition Survey, referred to as the SMART survey, 42 percent of children under 5 years are stunted, which is “very high” according to the 2017 WHO/UNICEF public health prevalence thresholds (INS, UNICEF, and WFP 2016; WHO and UNICEF 2017). Stunting prevalence differs quite dramatically by region, with the highest prevalence of stunting in Maradi (54 percent) and Zinder (50 percent) regions, and the lowest prevalence in Niamey (19 percent) (INS et al. 2016). While there were slight reductions in stunting prevalence in several regions between the 2012 DHS and the 2016 SMART survey, stunting remained consistently high across most of the country. Nationwide, there has been little improvement in 25 years; stunting prevalence was 45 percent in 1992. In addition, there is a huge disparity in stunting according to maternal education and wealth levels—23 percent of children whose mothers have secondary education or more are stunted, while the rate rises to 45 percent of children whose mothers had no formal education. Similarly, 35 percent of children in the highest wealth quintile are stunted, while 47 percent of children in the lowest wealth quintile are stunted (INS and ICF International 2013). Nationally, stunting is most prevalent among children 24–35 months (INS and ICF International 2013). Although the prevalence of acute malnutrition (wasting) has declined since 2012 (when it was 18 percent), it remains high at 10 percent (INS, UNICEF, and WFP 2016).

Poor infant and young child feeding (IYCF) practices are pervasive in Niger, including a very low prevalence of exclusive breastfeeding for the first 6 months of life (23 percent), low prevalence of early initiation of breastfeeding (53 percent), and inadequate complementary feeding (only 9 percent of children 6–23 months received a minimally acceptable diet). These are significant drivers of both stunting and wasting in Niger.

Poor maternal nutrition, which is highly prevalent in Niger, especially among adolescent girls, significantly contributes to an intergenerational cycle of malnutrition and poverty. Sixteen percent of women 15–49 years of age are underweight (BMI < 18.5), and among adolescent girls 15–19 years of age, 31 percent are underweight. Although undernutrition remains a significant issue in Niger, overweight/obesity are also becoming concerns, with 18 percent of women overweight or obese (INS and ICF 2013). Nationwide, more women are overweight or obese than underweight (18 vs. 16 percent), with overweight/obesity prevalence rising to 44 percent in Niamey and to 37 percent among women in the highest wealth quintile (INS and ICF International 2013).

In 2012, 75 percent of adolescent girls had begun childbearing by age 19, which is an increase from 2006, when 65 percent of girls had begun childbearing by age 19 (INS and ICF International 2013; INS and Macro International, Inc. 2007). The high prevalence of adolescent underweight combined with the persistent and high adolescent pregnancy rate is a disturbing trend. Adolescent pregnancy is associated with a 50 percent increased risk of stillbirths and neonatal deaths, and an increased risk of low birth weight, premature birth, asphyxia, and maternal mortality (Bhutta et al. 2013; WHO 2007). Reducing the adolescent fertility rate and delaying first pregnancies beyond adolescence will reduce the risk of low birth weight and stunting in children and will allow adolescent girls to grow to their full potential, protecting their own nutritional status over the long term.

Micronutrient deficiencies of iron, vitamin A, and iodine also continue to affect the health and well-being of Nigeriens. Although there are no recent data on iodine deficiency in the country, the 2013 National Strategy for the Prevention of Chronic Malnutrition "WADATA YARA" mentions that iodine deficiency is prevalent among school-age children (6–12 years), and coupled with the low levels of salt iodization (only 59 percent of households in Niger had iodized salt), it can be assumed that iodine deficiency is an issue in Niger (INS and ICF International 2013). According to the 2012 DHS, only 60 percent of children 6–59 months received vitamin A supplementation (VAS).<sup>1</sup> Coupled with the low consumption of

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<sup>1</sup> The 2014 UNICEF annual report indicates that VAS of children 6–59 months is 95 percent, an improvement from the figure cited in the 2012 DHS of 60 percent (UNICEF 2014; INS and ICF International 2013)

vitamin A-rich foods among children 6–23 months (37 percent), this indicates that vitamin A deficiency, particularly among children under 5 years, is likely an issue (INS and ICF 2013). In addition, anemia continues to be a widespread problem, with 73 percent of children under 5 years, 58 percent of pregnant women, and 26 percent of men suffering from anemia (INS and ICF 2013).

Overall, key drivers of malnutrition in Niger are inadequate access to quality health services (including treatment and prevention services and family planning), inadequate access to high quality and diverse foods (which is exacerbated by shocks, climate change, deep-rooted poverty, and population growth, among other factors), poor IYCF practices, high prevalence of childhood illness (which are likely worsened by poor hygiene practices, low access to sanitation facilities, and a lack of continuously reliable improved water sources), low levels of education, pervasive gender inequity, high levels of early marriage and pregnancy, and social norms that impede optimal nutrition practices (Mathys, Oot, and Sethuraman 2017; SPRING 2017).

<b>Niger Nutrition Data (DHS 2006 and 2012 Survey)<sup>2</sup></b>		
Population 2016 (UNICEF 2017)	20.7 million	
Population under 5 years of age (0–59 months) 2016 (UNICEF 2017)	4.2 million	
	DHS 2006	DHS 2012
Prevalence of stunting among children under 5 years (0–59 months)	50%	42% <sup>3</sup>
Prevalence of underweight among children under 5 years (0–59 months)	44%	36%
Prevalence of wasting among children under 5 years (0–59 months)	10%	10% <sup>4</sup>
Prevalence of low birth weight (less than 2.5 kg) (of children whose birth weights are known)	21%	12%
Prevalence of anemia among children 6–59 months	84%	73%
Prevalence of anemia among women of reproductive age (15–49 years)	46%	46%
Prevalence of thinness among women of reproductive age (15–49 years) (BMI less than 18.5 kg/m <sup>2</sup> )	19%	16%
Prevalence of thinness among adolescent girls (15–19 years)	34%	31%
Prevalence of children 0–5 months exclusively breastfed	14%	23%
Prevalence of children 4–5 months exclusively breastfed	8%	13%
Prevalence of early initiation of breastfeeding (i.e., put to the breast within 1 hour of birth)	48%	53%
Prevalence of children who receive a pre-lacteal feed	50%	49%
Prevalence of breastfed children 6–23 months receiving minimum acceptable diet	NA	6%
Prevalence of overweight/obesity among children under 5 years (0–59 months)	NA	<1%
Prevalence of overweight/obesity among women of reproductive age (15–49 years)	13%	18%
Coverage of iron for pregnant women (for at least 90 days)	14%	29%
Coverage of vitamin A supplements for children (6–59 months)	70%	60%
Percentage of children 6–59 months living in households with iodized salt	46%	59%

NA: Not Available

<sup>2</sup> The most recently published DHS was conducted in 2012. Fieldwork for the latest DHS was carried out from July to October 2017, but the results had not yet been released at the time this brief was prepared.

<sup>3</sup> Data for stunting and wasting were available from a 2016 National Nutrition Survey. Stunting in the 2012 DHS was 44 percent, while wasting was 18 percent.

## Global and Regional Commitment to Nutrition and Agriculture

Niger has made the following global and regional commitments to nutrition and agriculture:

Year of Commitment	Name	Description
2012	Committing to Child Survival: A Promise Renewed	Niger pledged to reduce under-5 mortality to 20 or fewer deaths per 1,000 live births by 2035 by reducing the leading preventable causes of child mortality, including undernutrition (A Promise Renewed 2017).
2011	Scaling Up Nutrition (SUN) Movement	In 2011, Niger joined SUN, a global movement that unites national leaders, civil society, bilateral and multilateral organizations, donors, businesses, and researchers in a collective effort to improve nutrition. The European Union is the convening donor for SUN in Niger. SUN's priority commitments in Niger for 2017–2018 are to strengthen the food safety control system, strengthen the national nutrition surveillance system, enhance the evaluation of nutrition interventions, and mobilize resources for the National Multisectoral Nutrition Security strategic plan (SUN 2017).
2009	Comprehensive Africa Agriculture Development Programme (CAADP) Compact	CAADP is an Africa-led program bringing together governments and diverse stakeholders to reduce hunger and poverty and promote economic growth in African countries through agricultural development.

## Nutrition Policies, Strategies, and Initiatives

Niger's commitment to improving nutrition is outlined in the following documents, which are aligned with the Government's Vision 2035:

- National Multisectoral Nutrition Security Policy "PNSN" (2016)
- National Protocol on Integrated Management of Acute Malnutrition (2012)
- National Food and Nutrition Policy (2011)
- National Strategy for the Prevention of Chronic Malnutrition "WADATA YARA" (2013)
- National Child Survival Strategy Document (2012)
- National Strategy for Infant and Young Child Feeding (2008)

In January 2016, the Government of Niger launched its first multisectoral nutrition security strategy, titled "Politique Nationale Multisectorielle de Sécurité Nutritionnelle" (PNSN), which seeks to address both the immediate and underlying causes of malnutrition. Also in 2016, the acting Minister of Health delivered a strong statement in support of breastfeeding and highlighted the importance of improving breastfeeding in the country to improve the nation's overall development.

In the past, Niger's focus on malnutrition has mostly been on the treatment of acute malnutrition. Given the negative impact of chronic malnutrition on the health and development of the nation, however, Niger has recognized the need for prevention, developing a strategy to address the high prevalence of chronic malnutrition in 2013. The government's priority nutrition interventions are identified in its 2013 National Nutrition Strategy to Prevent Chronic Malnutrition "WADATA YARA." The document outlines the need for both nutrition-specific and nutrition-sensitive actions. Nutrition-specific activities focus on the need to improve IYCF, address micronutrient deficiencies, and improve preventive services (e.g., growth monitoring and promotion), while nutrition-sensitive interventions focus on addressing poor WASH practices, low utilization of pre- and post-natal care, and family planning.

## USAID Programs: Accelerating Progress in Nutrition

As of January 2018, the following USAID programs with a focus on nutrition were active in Niger. The U.S. Government selected Niger as one of 12 Feed the Future target countries for focused investment under the new U.S. Government Global Food Security Strategy.

<b>Selected Projects and Programs Incorporating Nutrition in Niger</b>		
<b>Name</b>	<b>Dates</b>	<b>Description</b>
RISE Initiative: Resilience in the Sahel Enhanced— Accelerated Growth (REGIS-AG)	2015–2020	REGIS—AG is part of USAID’s Resilience in the Sahel Enhanced (RISE) initiative; it is designed to increase incomes of vulnerable households by increasing the performance and inclusiveness of the cowpea, poultry, and small ruminant value chains. Ultimately, REGIS—AG aims to increase resilience in targeted agro-pastoral and marginal agricultural zones of Niger and Burkina Faso (CNFA 2018).
RISE Initiative: Sahel Resilience Learning Project (SAREL)	2014–2019	The Sahel Resilience Learning Project (SAREL) works to strengthen the capacity of key stakeholders to engage in adaptive, evidence-based learning in order to promote the adoption of methods and innovations that best enhance resilience in the region. SAREL accomplishes this through the following objectives: 1) Test, expand, and accelerate the adoption of proven resilience-enhancing technologies and innovations; 2) Develop, test, and promote widespread adoption of new models that integrate humanitarian and development assistance; 3) Promote ownership, build the capacity of national and regional institutions, and coordinate humanitarian and development interventions; 4) Address gender issues key to resilience and growth; and 5) Create a knowledge management database that will house a baseline assessment, ongoing monitoring data, and impact evaluations for the RISE Initiative (USAID 2015b).
Food for Peace PASAM-TAI Project (CRS)	2012–2018	CRS’ PASAM-TAI program seeks to address food security and malnutrition issues in the Zinder and Maradi regions of Niger.
Food for Peace SAWKI Project	2012–2018	Mercy Corps, Africare, and Helen Keller International are implementing the project “Sawki,” which is designed to respond to the food security and nutrition needs of more than 115,000 beneficiaries in Maradi and Zinder.
Food for Peace LAHIA Project	2012–2018	Save the Children, working with its sub-recipient World Vision International (WVI), is implementing the Livelihoods, Agriculture, and Health Interventions in Action (LAHIA) project. The priority components of the project include reducing chronic malnutrition among pregnant and lactating women and children under 5 years, with a focus on children under 2 years, as well as increasing local availability and access to nutritious food by diversifying agricultural productivity and rural household income and increasing resilience to shocks.
Resilience and Economic Growth in the Sahel— Enhanced Resilience (REGIS—ER) Project	2013–2018	Following repeated large-scale humanitarian emergencies in the Sahel, USAID recognized that continuing to treat these recurrent crises as acute emergencies is extremely costly and does not effectively address their underlying causes. Thus, USAID’s Resilience in the Sahel Enhanced (RISE) initiative has realigned existing and new humanitarian and development assistance efforts to strengthen resilience in agro-pastoral and marginal agricultural livelihood zones of the Sahel. USAID will reduce chronic vulnerability by increasing economic well-being, strengthening institutions and governance, and

		<p>improving health and nutrition status. REGIS—ER is RISE’s flagship multisectoral resilience project, which works to end the vicious cycle of crisis and help the Sahel’s most vulnerable populations stay firmly on the path to development. REGIS—ER addresses the root causes of chronic vulnerability by increasing the capacity of households, villages, and systems to adapt to and recover from shocks and stresses. REGIS—ER integrates sustainable livelihoods, natural resource management, governance, and health and nutrition activities in collaboration with local communities (USAID 2015a).</p>
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