In brief: Country indicators
Total number of community health workers (CHWs): 23,892 relais communautaires (RComs)
Breakdown of CHWs by gender:
Women: 9,557
Men: 14,335
Overview of community health

Strengthening the community health system in Niger is based on several pillars:

- **Deployment of community health workers (relais communautaires, RComs)** in all communities, offering community-based integrated management of childhood illness (IMCI) (a complete set of preventive, promotional and curative services) to populations living more than 5 km from a health facility and promotional and preventive packages for populations living within 5 km of a health facility.

- **The gradual transformation of health houses (cases de santé) into Integrated Health Centres**, which are responsible for supervising the health houses and RComs to ensure continuity of care provision in the community.

- **Building community participation and ownership** through: (1) collaboration with communities; (2) community participation through health committees (COSAN) and management committees (COGES); (3) an expanded network of community actors/community-based organizations (CBOs), including community development workers, community associations and groups and other actors with links to different sectors, both formal and informal.

**VISION:** “Niger aspires to be a modern and emerging nation where citizens enjoy universal access to quality health care and services without any form of exclusion or discrimination with their full participation” as stipulated in the National Health Policy 2016-2035.

**STATUS OF NATIONAL PLAN:**
Urgent investment actions:

1. Implement PSNSC 2019-2023 in the context of primary health care (PHC)
2. Develop an investment case and gap analysis for community health funding
3. Update a detailed mapping of partners to support the funding and operationalization of the strategic plan
4. Annually update the mapping of RComs (completed in 2021)
5. Hold regular statutory meetings of the national coordinating committee for community health interventions and ensure the alignment of technical and financial partners (TFP) who support the PSNSC
6. Mobilize state counterparts to pay in order to incentivize RComs
7. Support ongoing efforts to strengthen the health system in the context of supplying inputs all the way to the last kilometre, including at the level of RComs, and eliminating parallel structures
8. Strengthen the health information system to include the community dimension and the monitoring of indicators already set up in DHIS2
9. Ensure a participatory and inclusive process, with particular attention to gender dynamics, in the development and implementation of interventions
Overview of the community health system

Scale-up (from 2018 to 2021):

• **RComs trained and functional:**
  19,787 (2018) to 23,892 (2021)

• **Current coverage of the community health programme:**
  from 2,241,585 (i.e., 12% of the general population) to 7,200,000 (i.e., 80% of the population living more than 5 km from a health facility) for the treatment of children’s diseases

• **RCom:**
  the employment/population ratio reflects expectations for the RCom’s role
  (1 RCom per 1,000 inhabitants within 5 km of the health facility, 1 RCom per 500 inhabitants in villages more than 5 km from the health facility, and 1 RCom per village)

• **Population density, geographic constraints and travel requirements.**

Cadres:

• **Relais communautaires (RCom):** 23,892
  • **Agents de santé communautaire (ASC):** 2,038.

Community-based structures include health houses with ASCs (part of the health pyramid) and non-governmental organizations that accompany the implementation of curative, preventive and promotional service packages.
Key facts

All partners must align with the comprehensive integrated package that is part of the PSNSC 2019-2023. RComs offer two types of service package to children under 5 years of age and women of reproductive age; the packages are included in the RCom training module and communication materials.

1. The complete package (curative, preventive and promotional services) for those living more than 5 km from the health facility, with children aged 2 to 59 months being the main target for curative services. The curative package includes the treatment of malaria, pneumonia and diarrhoea, and the screening/referral of cases of malnutrition to health facilities.

2. The promotional and preventive package for those living within 5 km of the health facility. The package promotes 13 essential family practices and supports the establishment of infant and young child feeding support groups.

User fees

RCom services are free for children. Medications and other commodities and services offered at community level are also free.

Currently, such inputs, including COVID-19 inputs, are provided by TFPs (Global Fund, UNFPA, UNICEF, USAID, World Bank).

Costs of RCom motivation are covered through state and TFP contributions.
Overview of the community health system

Direct Supervision
The role of the RComs is clearly defined and documented.
RComs are directly supervised monthly by the heads of Integrated Health Centres and health houses. In some districts, support for RCom supervision is provided by local partners/NGOs and volunteers from the Niger Volunteer Development Agency, which is at the level of the Ministry of Community Development.

At least every 3 months, a dedicated supervisor conducts supervisory visits, which include reviewing reports and providing support to RComs to resolve issues. Supervisors are trained and have basic supervision tools (supervision grid) to assist them.

Training
For experienced RComs: 9 days for the promotional and preventive package and 14 days for the complete package.
For new RComs: 14 days for the promotional and preventive package and 28 days for the complete package.
RComs are retrained every 2 years on the promotional package and every 3 years on the complete package.
Initial training is provided to all RComs upon recruitment. Health knowledge and skills are tested, and RComs must meet a minimum standard before they can practice. Arrangements are in place for RComs to retest if necessary.

Motivation
RComs are volunteers. They receive a monthly financial incentive of 20,000 CFA francs (including 5,000 CFA francs from the Government and 15,000 CFA francs from TFPs, including NGOs). For training and meetings, RComs also receive 5,000 CFA francs per day and 2,000 CFA francs to cover transportation costs.

An in-kind incentive is offered by NGOs in the form of basic foodstuffs and clothing.
ASCs of the health houses are paid 77,000 CFA francs per month, and women community mediators are paid 2,000 CFA francs per day for 22 days per month.
The different approaches are moving towards a single, integrated RCom.
Niger has a National Health Information System (SNIS) managed by the Directorate of Statistics, which is responsible for the collection, processing and transmission of health data at all levels. RComs are required to submit monthly reports (paper or electronic/mHealth) on all their activities including the management of medication. Community-level data are transmitted to the Integrated Health Centre, which synthesizes and transmits the data to the health district for the regional and central levels. The data are integrated into the SNIS/District Health Information System, version 2 (DHIS2). The community-level report is set up in DHIS2.

**Connection to the health system**
RComs are recognized at the community level. Once trained and provided with equipment, RComs are installed by mayors and district doctors in their communities.

**Community involvement**
Community engagement has a prominent place in the National Strategy for Community Health Participation adopted by the Council of Ministers in June 2017. Outreach of this strategy is a priority of the Ministry of Health at the request of the Association of Elected Officials of Niger Municipalities. The health committees are at different levels of operationalization.
Community health system structure and delivery channels

Ministry responsible for community health: Ministry of Public Health, Population and Social Affairs. The Community Health Directorate (DSC), created in May 2021, has three divisions: Promotion of Care at the Community Level, Community Participation, and M&E. DSC is attached to the General Directorate of Public Health (DGSP).
Community health priorities and progress

Curative, preventive and promotional services

**Priorities (2021-2022)**

- Increase the availability, utilization and performance of quality community health service provision by:
  - (i) building the capacity of community actors,
  - (ii) strengthening communication for service demand and utilization,
  - (iii) improving the availability of medication and health inputs, and
  - (iv) integrating disaggregated, community-level data into DHIS2

- Strengthen the involvement of local communities, CBOs and local governments in community health development

- Develop community health governance, leadership and management capacity at all levels

**Progress (September 2021)**

- Updated guide to implementing community interventions
- Planning tools available
- Implementation of PSNSC-defined interventions in 8 health districts
- Revitalization of COSAN and COGES in 25 health districts
- National Functional Coordinating Committee’s semi-annual meeting, held in June 2021
Integration of activities related to the COVID-19 response

**Priorities (2021-2022)**

- Build capacity of community actors
- Improve people’s knowledge, practices and skills with regard to the transmission of diseases (TB, HIV, COVID-19, malaria, etc.) and prevention measures
- Community-based surveillance
- Advocacy for social and behavioural change to combat COVID-19
- Address human rights and gender-related barriers to accessing services
- Coordination and M&E of community activities to combat COVID-19

**Progress (September 2021)**

- National Community Response Plan for COVID-19 available
- Capacity building and provision of protective equipment
- Outreach tools incorporating COVID-19
- Integration of COVID-19 into community-based monitoring and establishment of community-based monitoring committees

Recruitment and certification

**Priorities (2021-2022)**

Respond to specific technical issues within the national strategic plan: addressing community health in urban and peri-urban areas

**Progress (September 2021)**

- A quality assurance approach to community health is being implemented
- Replication of models tested elsewhere
Training
Priorities (2021-2022)
• Illiteracy among RComs remains an issue to be addressed

Supervision
Priorities (2021-2022)
• Improve the consistency and quality of supervision
• Increase the level of government supervision of health posts, ASCs and RComs

Coordination
Priorities (2021-2022)
• Monthly RComs coordination meeting at the Integrated Health Centre level
• Quarterly coordination meeting at district level
• Biannual coordination meeting at the level of Regional Directorates of Public Health
• Biannual coordination meeting of the National Committee

Progress (September 2021)
Integrated meetings: community health, immunization, monitoring; reproductive, maternal, newborn, child and adolescent health (SRMNEA-N)
**Remuneration, reward and advancement**

**Priorities (2021-2022)**

- Community health funding lies outside the state budget, affecting RCom motivation
- Standardize RCom incentives and revise the monthly rate upwards, from 10,000 to 20,000 CFA francs (US$18 to US$36)

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**Information and data communication systems**

**Priorities (2021-2022)**

- Improve visibility of community data in DHIS2

**Progress (September 2021)**

- Integration of community-level data into DHIS2 (ongoing process with TFP contribution) / mHealth under way in 2 health districts (with UNICEF)
- Medic Mobile in perspective (with the World Bank)
Supply chain management (including commodities)

**Priorities (2021-2022)**
- Integrate inputs into the national logistics chain
- Create thematic groups on topics such as medication
- Address supply chain issues that hinder the work of RComs: frequent breaks in the supply chain for medications, and parallel supply chain
- Harmonize needs and funding

**Progress (September 2021)**
- Tools for quantifying needs at community level are available and operational

Health products

**Priorities (2021-2022)**
- Provide medications to remote areas
- Implement procurement system

**Progress (September 2021)**
- Provision of medications to remote areas is under way
- Procurement system is partially implemented
Finance

**Priorities (2021-2022)**
- Secure funding for the current strategic plan
- Develop the health investment framework (investment plan was developed in 2017)
- Update mapping of partners for PSNSC financing and operationalization (initial mapping was completed in Nov. 2020)
- Conduct mapping of RComs

**Progress (September 2021)**
- State counterpart to community health financing mobilized
- Advocacy conducted for the inclusion of community health financing in the state budget
- RCom mapping completed; financed by the Global Fund, UNICEF and Ministry of Health (June 2021)

Leadership and governance

**Priorities (2021-2022)**
- Implement PSNSC 2019-2023 (implementation has been halted by COVID-19)

**Progress (September 2021)**
- PSNSC implemented in 8 health districts of Maradi and Tahoua
System management and direction

Priorities (2021-2022)

• Transform the Community Health Division into a Directorate

• Establish focal points in each region with capacity building

• Mobilize the state's counterpart (constraint also due to insecurity)

• Mobilize resources for scaling up the implementation of community health policy

• Implement advocacy actions to mobilize political commitment for community health (Roundtable)

• Advocate for greater involvement and support from municipalities

Progress (September 2021)

• Creation of the Community Health Directorate in May 2021
Policy priorities

Priorities (2021-2022)

• Expand community health care (approximately 50% of the population lives more than 5 km from a health facility)

• Gender parity among RComs: the National Strategy for Community Health Participation is governed by a decree which stipulates that each village COSAN must include at least 25% women; and the National Guidelines stipulate that RCom teams must be made up of 50% men and 50% women.

Progress (September 2021)

• Most CHWs are women, and many are trained health workers. The movement towards gender parity among CHWs has been accompanied by improvements in the health care delivered to the population

• The minimum quota for women at the COSAN level is currently 30% women
Community Engagement

Priorities (2021-2022)

- Revitalize committees
- Increase community involvement in supporting community health activities; reduce barriers to community involvement
- Identify and involve civil society organizations (CSOs) in community health activities
- Secure funding for effective civil society engagement in community health

Progress (September 2021)

- Revitalization of COSAN and COGES achieved in 25 health districts
- Within the framework of COVID-19, the national roll-out and immunization plan takes into account risk communication and community engagement as a strategy
Financing the expansion of the RCom strategy

Cost of implementing the National Strategic Plan for Community Health (PSNSC), 2019-2023: US$ 1 million

Projected resource gap for the PSNSC: US$687,959

The community health investment roadmap for Niger projects that the cost of implementing the PSNSC will be 55.6 million CFA francs (US$1 million). Figure 1 illustrates the projected costs per year for the Community Health Programme. The total cost per capita (80% coverage) for the entire strategy (2019-2023): 2,995 CFA francs. The costs of the overall PSNSC 2019-2023 budget are divided by the three strategic objectives (see Figure 2 below). Table 1 shows the distribution of costs between internal and external funding sources.

Figure 1.
Costs (in CFA francs) of implementing the PSNSC, 2019-2023

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost (CFA francs)</th>
<th>Total (CFA francs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>629,259,401</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>7,702,416,594</td>
<td></td>
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<tr>
<td>2021</td>
<td>10,117,295,514</td>
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</tr>
<tr>
<td>2022</td>
<td>16,175,383,112</td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>20,955,698,466</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>55,580,053,087</td>
</tr>
</tbody>
</table>

Exchange rate: 1 US dollar = 550 CFA francs
Table 1. Distribution of costs (in CFA francs), 2019-2023, by source of funding

<table>
<thead>
<tr>
<th>Name</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Cost of PSNSC</td>
<td>629,259,401</td>
<td>7,702,416,594</td>
<td>10,117,295,514</td>
<td>16,175,383,112</td>
<td>20,955,698,466</td>
<td>55,580,053,087</td>
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<tr>
<td>UNFPA projected contribution</td>
<td>1,456,000,000</td>
<td>1,456,000,000</td>
<td>1,456,000,000</td>
<td>0</td>
<td>0</td>
<td>4,368,000,000</td>
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<td>UNICEF projected contribution</td>
<td>3,283,577,450</td>
<td>2,228,456,212</td>
<td>1,493,464,711</td>
<td>376,451,111</td>
<td>352,501,072</td>
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<td>Global Fund projected contribution</td>
<td>845,220,766</td>
<td>743,634,305</td>
<td>1,344,726,831</td>
<td>758,905,241</td>
<td>878,780,959</td>
<td>4,571,268,102</td>
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<tr>
<td>World Bank projected contribution</td>
<td>—</td>
<td>955,103,279</td>
<td>847,148,279</td>
<td>0</td>
<td>0</td>
<td>1,802,251,558</td>
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<tr>
<td>Sub-total TFP projected contributions</td>
<td>5,584,798,216</td>
<td>5,383,193,796</td>
<td>4,294,191,542</td>
<td>1,135,356,352</td>
<td>1,231,282,031</td>
<td>17,628,821,937</td>
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<td>Total State + TFP projected contributions</td>
<td>5,608,738,738</td>
<td>5,397,999,318</td>
<td>4,313,197,063</td>
<td>1,159,753,319</td>
<td>1,262,599,877</td>
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<td>Projected resource gap</td>
<td>(4,979,479,337)</td>
<td>2,304,417,276</td>
<td>4,956,950,172</td>
<td>15,015,629,793</td>
<td>19,693,098,589</td>
<td>36,990,616,493</td>
</tr>
</tbody>
</table>
Development partners and coordination of interventions

**Donors:**
- Bill and Melinda Gates Foundation
- Gavi
- Global Affairs Canada
- Global Finance Facility
- The Global Fund
- Initiative présidentielle pour lutter contre le paludisme
- Italian Development Cooperation Agency
- LuxDev (Luxembourg Agency for Development Cooperation)
- UNFPA
- UNICEF
- USAID
- World Bank
- World Health Organization

**Implementing partners:**
- Action Against Hunger
- BFEN
- Concern Worldwide
- HELP
- ICF International
- KFW
- Doctors of the World
- Pathfinder International
- PLAN International
- Save the Children
- World Vision

**Coordination of interventions:**
- National Coordinating Committee for Community Health Interventions
- A smaller group (15 people) of Ministry of Health representatives and development partners meets regularly
- Community health focal point in each region
- Integrated statutory and coordination meetings
Acronyms and sources

Acronyms:

ASC - community health agents (*agents de santé communautaire*)
CBO - community-based organization
CHW - community health worker
COGES - management committee
COSAN - health committee
DHIS2 - District Health Information System, version 2
DGSP - General Directorate of Public Health (*Direction Générale de la Santé Publique*)
DHIS2 - District Health Information System, version 2
DSC - Community Health Directorate (*Direction de la Santé Communautaire*)
NGO - non-governmental organization
M&E - monitoring and evaluation
PHC - primary health care
PSNSC - National Strategic Plan for Community Health (*Plan Stratégique National de Santé Communautaire*)
RComs - community health relays (*relais communautaires*)
SNIS - National Health Information System
TFP - technical and financial partners

Sources:

Original country roadmap available at [www.communityhealthroadmap.org](http://www.communityhealthroadmap.org) and subsequent versions.


