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World Vision Relief & Development Inc.

MIDTERM EVALUATION REPORT
CHILD SURVIVAL/VITAMIN A PROJECT
WORLD VISION MAURITANIA
ASSABA REGION

Beginning Date: October 1, 1989
Ending Date: September 30, 1992

Submitted to:

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ABBREVIATIONS

ASC	Agent de Santé Communautaire (community health worker)
BCG	Bacile Calmette-Guérin (tuberculosis vaccine)
BHU	Basic Health Unit
CHC	Community Health Committee
CHW	Community Health Worker
CS	Child Survival
DIP	Detailed Implementation Plan
DPS	Direction de la Prevention Sanitaire (Directorate of Preventive Medecine)
DRASS	Direction Regionale des Affaires Sociales et Sanitaires (Regional Directorate for the Health and Social Affairs)
DTP	Diphtheria/tetanus/pertussis vaccine
FVA/PVC	Bureau for Food for Peace and Voluntary Assistance, Office of Private and Voluntary Cooperation
FY	Fiscal Year
GW	Guinea Worm
HIV	Human Immunodeficiency Virus
ICV	Infants Completely Vaccinated
IRM	Islamic Republic of Mauritania
MOH	Ministry of Health
NGO	Non-governmental Organization
PHC	Primary Health Care
PVO	Private Voluntary Organization
SSS	Sugar/Salt Solution
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid Vaccine
USAID	U.S. Agency for International Development
VHW	Village Health Worker
WV	World Vision
WVM	World Vision Mauritania
WVRD	World Vision Relief & Development Inc.

I/HODH EL CHARGHI
I_1 AMOURJ
I_2 BASSIKONOU
I_3 DJEGUENI
I_4 NEMA
I_5 OUALATA
I6 TIMBEDRA

II/HODH EL GHARBI
II_1 AIOUN
II_2 KOBENI
II_3 TAMCHEKETT
II_4 TINTANE

III/ASSABA
III_1 BARKEUL
III_2 BOUMDEID
III_3 GUEROU
III_4 KANKOSSA
III_5 KIFFA

IV/GORGOL
IV_1 KAEDI
IV_2 MAGHAMA
IV_3 MBOUT
IV_4 MONGUEL

V/BRAKNA
V_1 ALEG
V_2 BABABE
V_3 BOGHE
V_4 MAGTA-LAHJAR
V_5 MBAGNE

VI/TRARZA
VI_1 BOUTILIMIT
VI_2 KEUR MACENE
VI_3 MEDERDRA
VI_4 OUAD NAGA
VI_5 RKIZ
VI_6 ROSSO

VII/ADRAR
VII_1 AOUJEFT
VII_2 ATAR
VII_3 CHINGUETTI
VII_4 OUADANE

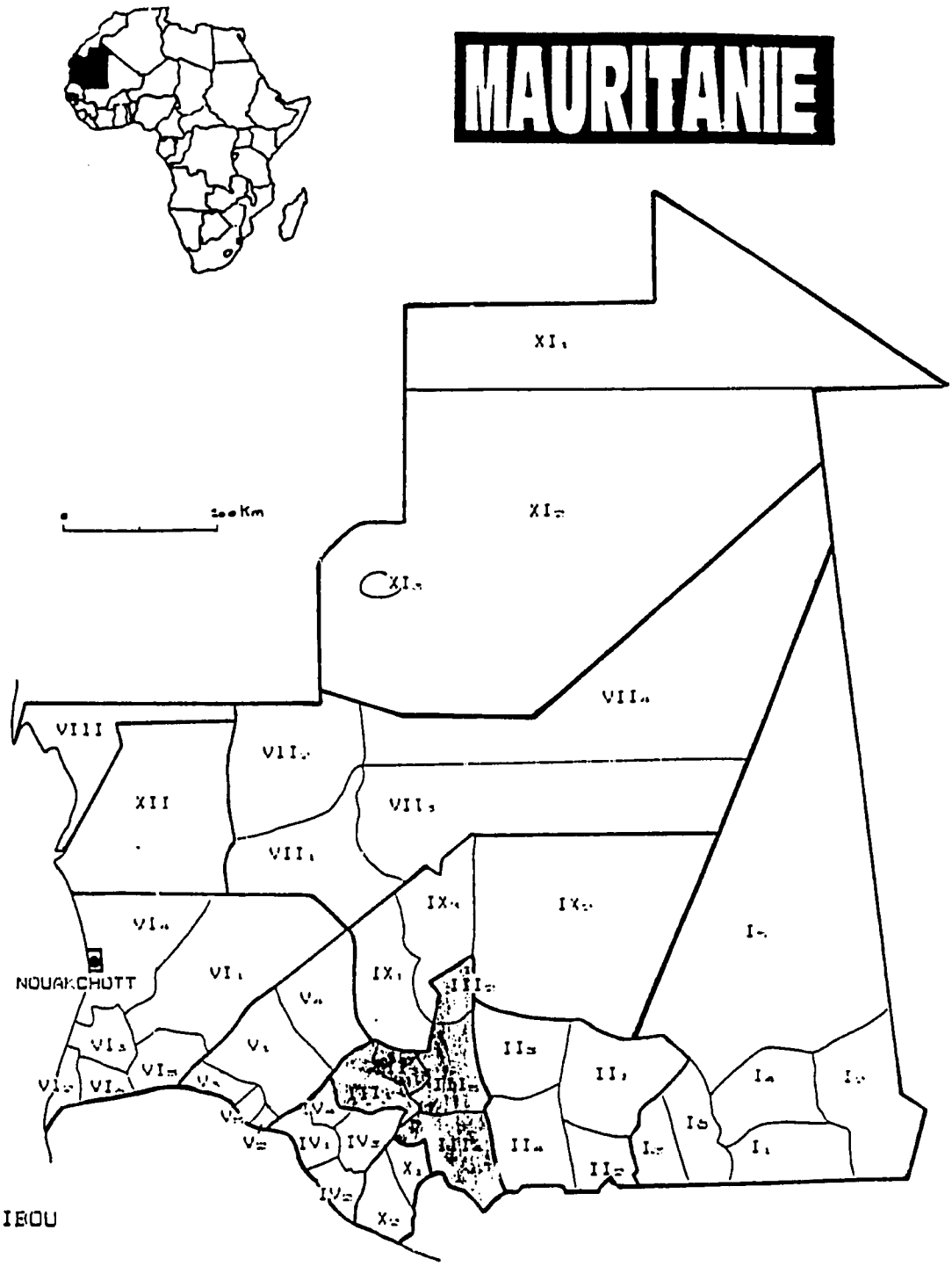
VIII/DAKHLET NOUADHIBOU

IX/TAGANT
IX_1 MOUDJERIA
IX_2 TICHIT
IX_3 TIDJIKJA

X/GUIDIMAKHA
X_1 OULD YENGE
X_2 SELIBABI

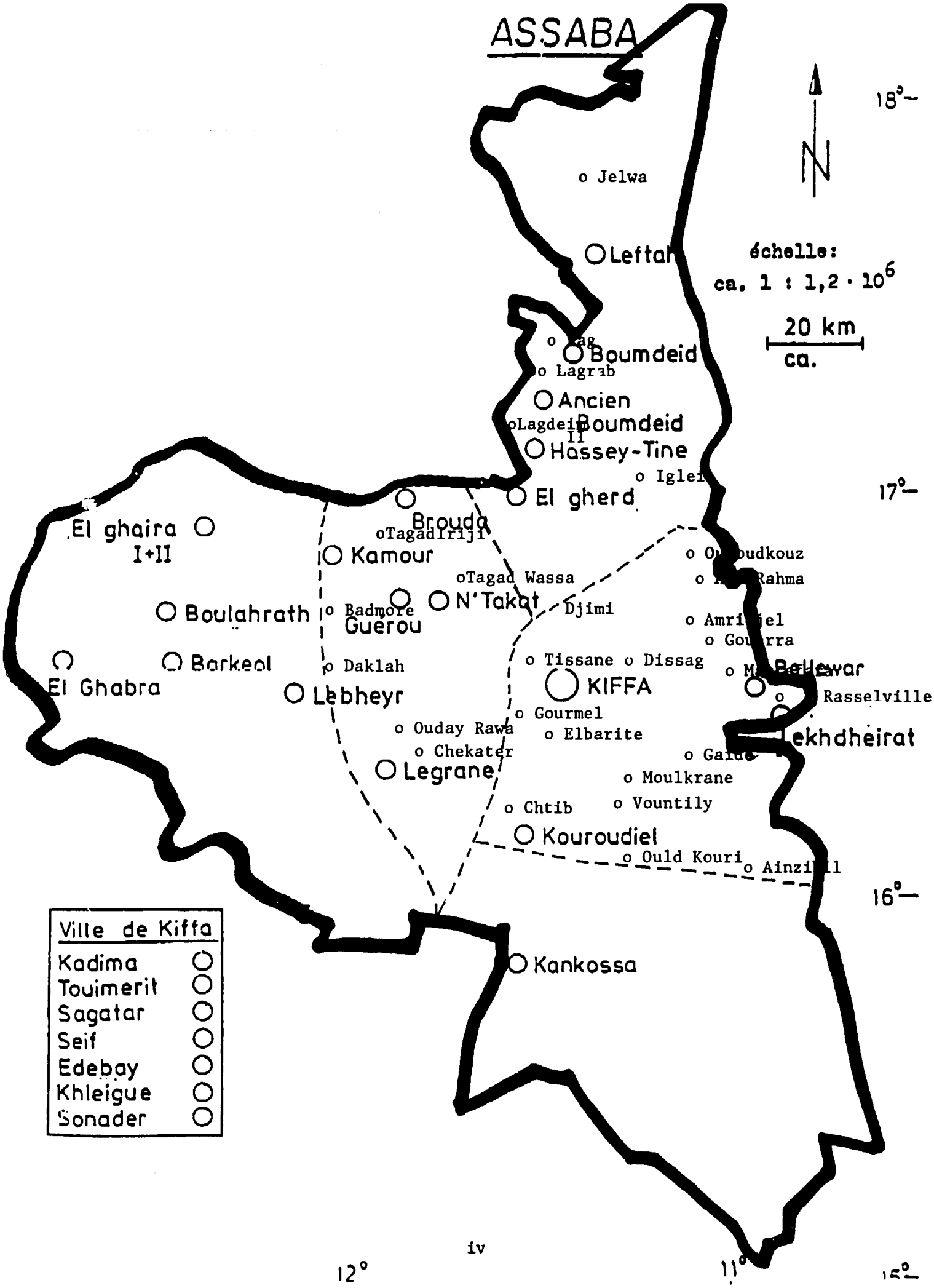
XI/TIRIS ZEMMOUR
XI_1 BIR MOGHREIN
XI_2 FDERIK
XI_3 ZOUERATE

XII/INCHIRI



DIVISIONS ADMINISTRATIVES DE LA MAURITANIE (WILAYA ET MOUGHATAA)

— Limite de département (moughataa)
— Limite de région (wilaya)
I_1 Numéro de classification des unités administratives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Kamour
oTagad Wassa
N'Takat
Djimi
Boulahrath
o Badmore
Guerou
o Amri el
o Daklah
o Tissane o Dissag
KIFFA
Barkeol
El Ghabra
Lebheyr
o Gourmel
o Ouday Rawa
o Elbarite
o Chekater
Legrane
o Moulkrane
o Chtib
o Vountily
Kouroudiel
o Ould Kouri
Rasselville
Lekhdheirat
16°
Kankossa
Ville de Kiffa
Kadima
Touimerit
Sagatar
Seif
Edebay
Khleigue
Sonader
12°
11°

I. EXECUTIVE SUMMARY

World Vision Mauritania (WVM) received a matching grant from the FVA/PVC Office of USAID to extend its two-year (1987-1989) Child Survival/Vitamin A project for three years from October 1, 1989, through September 30, 1992. After 15 months of vaccination, Vitamin A distribution, diarrhea control, nutrition promotion, training and social mobilization activities, WVM participation in the project was interrupted for approximately 10 months (December 1990—October 1991) due to the Gulf War crisis. In October 1991, WVM resumed its activities and, in collaboration with the Regional Ministry of Health, revised the project objectives (as stated in the Detailed Implementation Plan [DIP]) to correspond with the time frame remaining until the end of the project.

As of the date of this evaluation, the project in collaboration with the Regional Ministries of Health, Agriculture, Hydraulics (water), and other NGOs and international agencies has managed to accomplish the following of its major objectives in Basic Health Unit (BHU) villages:

	Objective	Actual
• Train MOH staff in CS/Vitamin A activities		
• Train MOH staff in training and supervision techniques	20	33
• Train community health workers	45	34
• Train traditional birth attendants	45	34
• Assist communities to create health committees	45	34
• Vaccinate children <1 yr with DTP_3/polio-3	75%	28%
• Vaccinate women with infants <1 yr old with 2 doses	*	61%
• Mothers to give only breast milk to infants <5mos.	*	81%
• Children 6-59 mos. received Vitamin A within last six mos.	*	68%
• Mothers who delivered during past year and received Vitamin A within first month after delivery	*	54%

As indicated above, most objectives are well on their way to being achieved. However, more important than obtaining service delivery objectives during the beginning phases of the project were the achievements of informing, educating and sensitizing MOH, other Ministry personnel, and the population in general on how to improve the well-being and quality of life in the communities. These aspects, along with the creation of community health committees (CHC), training community health workers (CHW), and introducing cost-recovery measures, will not only help to develop and strengthen the health infrastructure in Mauritania but will contribute to the sustainability of primary health care (PHC) activities after completion of WVM efforts.

It is from this perspective that the team recommends extension of the CS/Vitamin A project in Mauritania at least through September 30, 1993, and that WVM and the MOH weigh the advantages of decentralizing project operations to the service-provision level of the districts. It is the consensus of the evaluation team that developing the health infrastructure at the service level will improve and increase services, be more cost-effective, and contribute to sustainability of activities.

II. Introduction and Purpose of Evaluation

World Vision Mauritania (WVM) initiated collaborative activities with the Ministry of Health in Mauritania in June 1984 by establishing nutritional rehabilitation centers in two regions. In November 1985, WVM began its program in the Assaba region when it took over a relief program started by the Swiss Disaster Relief Team. In 1986 WVM expanded these activities to include immunization, and health and nutrition education. In October 1987, WVM obtained funding from USAID for executing Child Survival and Vitamin A activities, and in 1989 the project was extended for three years.

This report presents the findings and recommendations of the midterm evaluation for World Vision Mauritania's extended Child Survival/Vitamin A project in the Assaba region of Mauritania.

The three-year project assists the Regional Ministry of Health to:

- Train MOH staff in Child Survival/Vitamin A activities, training and supervision techniques.
- Train CHWs and traditional birth attendants (TBA).
- Assist communities in creation of health committees.
- Promote appropriate breastfeeding and weaning techniques.
- Vaccinate childbearing-age women against tetanus in order to provide passive protection to newborns against neonatal tetanus.
- Vaccinate children under five years against tuberculosis, diphtheria, tetanus, pertussis (DTP), polio, and measles.
- Treat children under five years suffering from diarrhea with oral rehydration solutions.

- Distribute Vitamin A capsules to children from six months to nine years of age and to mothers within first month of delivery.

- Promote vegetable gardening, vegetable consumption and preservation.

Because of the Gulf War that resulted in a ten-month interruption of the project, WVM, in collaboration with the Regional Ministry of Health, revised the project objectives (as described in the DIP), taking into account the delay in activities.

Objectives of the evaluation:

- Measure the level of achievement of project objectives.

- Estimate the change in mothers' knowledge, attitudes, and practices related to health and nutrition of children under five through a comparative village study.

- Identify what elements of the project are successful.

- Suggest which activities need more attention and/or revision.

- Recommend actions to improve project performance.

- Outline factors and strategies for the sustainability of project activities.

III. Evaluation Methodology

This Midterm Evaluation was due in January 1991 but was not completed because of the suspension of WVM operations from December 1990 to October 1991 because of the Gulf War.

Arrangements for this evaluation got underway in June 1992, including preparations for a region-wide field survey which was later started on August 8 by WVM field staff and MOH Regional staff. The three field teams were later joined by three nonproject-related persons who were briefed at WV headquarters in Nouakchott on August 20 and traveled to Kiffa on the 21st. They helped complete the collection and analysis of data using the standard WHO 30-cluster-survey technique from August 22 through August 30, 1992.

During the field survey, additional questions were asked of the beneficiaries in an attempt to measure and/or compare not only vaccination coverage but Vitamin A distribution, knowledge/attitudes/practices of mothers concerning nutrition (including breastfeeding and weaning), and diarrhea control (see Appendices B and C for examples of survey questionnaires).

Nine of the 54 CHWs and nine of the 34 CHCs were observed and interviewed to determine their competence (see Appendices D and E for examples of questionnaires).

During the random selection of villages, only one with a community health committee and worker, commonly known as a basic health unit (BHU), was among the 30 selected. Therefore, in order to provide a more valid comparison between BHU villages and non-BHU villages, an additional nine of the 34 BHU villages were selected at random to be evaluated separately from the original 30.

Throughout the evaluation, project records and documents were reviewed, WVM headquarters and field staff were interviewed, and meetings were held with key NGO personnel (Lutheran World Federation) and Regional Ministries of Health, Agriculture and Hydraulics, as well as representatives from WHO, UNICEF, and Peace Corps (see Appendices F and G for the lists of persons and places visited and documents reviewed).

After the field survey results were tabulated and analyzed, an executive summary of the evaluation, including major recommendations, was presented to the Regional MOH director and the Governor of Assaba.

Logistics and personnel for the evaluation were well-mobilized and coordinated by WVM both in Nouakchott and Kiffa. Such mobilization and coordination reflects well on WVM's ability and capacity as a catalyst for development.

EVALUATION TEAM

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IV. BACKGROUND

The Islamic Republic of Mauritania (IRM) has approximately two million people and covers an area more than twice the size of France (397,950 sq. miles or 1,030,700 sq. km). Approximately 90% of its land mass is dominated by the Sahara Desert. The northern part of the country is desert which keeps expanding southward around six miles, or nearly 10 km per year. Hence the existence of the remaining narrow strip of Sahelian grassland is in danger. Still, the population reportedly is growing at an annual rate of 2.8%.

Nouakchott, the capital city, constitutes more than 25% of the population (550,000). Kiffa, the capital of the Assaba Region, is the fourth largest city in Mauritania, with an estimated population of 65,000. The Assaba Region, divided into five districts (moughatas), has a total population of approximately 200,000.

Severe droughts during the 1970s and 1980s forced this primarily nomadic population to urbanize. Today it is believed that less than 20% of the population is nomadic, while approximately 60% inhabit urban areas. The large majority of the population is impoverished and illiterate and poorly prepared to adapt to urban life. The social and economic upheaval brought on by drought and the spread of the desert was further exacerbated in 1989 by ethnic and border tensions between Senegal and Mauritania, resulting in civil unrest in both countries and the displacement of over 100,000 persons in Mauritania alone.

Moreover, the Mauritanian government lost substantial economic and political support from Western and Gulf countries when it sided with the Iraquis during the Gulf crisis. In recent months, Mauritania has begun to move away from political isolation as several Gulf countries resume relations, and the holding of democratic elections at the presidential and legislative levels give some people in the international community more hope for the country's future.

Health conditions in Mauritania are extremely poor, which is reflected in mortality and morbidity rates. The mortality rate for children under five years old, who compose over 20% of the population, is 223 per 1,000 live births. The infant mortality rate is 128 per 1,000 live births. Major causes of illness and death among children include diarrhea, respiratory infections, malaria, and malnutrition. Surveys completed in December 1990 showed that up to 57% of children age six months to three years suffer

malnutrition. It is estimated that more than 30% of children under five have mild to moderate malnutrition, while 10% at times are believed to be severely malnourished. In Vitamin A surveys, clinical Vitamin A deficiency was found among 0.4 to 2.7% of the children.

For planning public health activities, it is important to note that more than half of the population of the Assaba Region is found in the capital cities of the five Departments. The Departments and their capital cities share the same names:

CITY/DEPARTMENT	POPULATION CITY	POPULATION DEPARTMENT
Barkeol	10,000	48,000
Boumdeid	8,000	14,000
Kiffa	50,000	66,000
Guerou	20,000	30,000
Kankossa	20,000	42,000
TOTAL	**108,000**	**200,000**

V. FINDINGS

A. Objectives

Listed below are the objectives as reestablished by WVM and the Regional MOH in the 1991 Annual Report. Attainment of those objectives are as follows: (please note that the results attained apply to 34, not 45, BHU communities. For region-wide results and additional survey information, please see Appendix H).

TASK	OBJECTIVE	ATTAINMENT
Train regional MOH staff in CS/Vitamin A tasks, training and supervision	45	33
Train village hygiene assistants	45	34
Train traditional birth attendants	45	25
Establish village health committees	45	34
Vaccinate children <1 yr. old against DTP, Polio, Measles and TB	75%	28%
Vaccinate childbearing-age women with two doses of tetanus toxoid	70%	61%[1]

[1] Represents all BHU women who delivered within past 12 months.

TASK	OBJECTIVE	ATTAINMENT
Promote appropriate breastfeeding and weaning techniques among mothers in 45 BHU villages	60%	50%
Treat children 5 yrs. with diarrhea using oral rehydration solutions	50%	42%
Administer Vitamin A capsules to children < 5 yrs. every 6 months	40%	N/A
Administer Vitamin A capsules to children 5-9 yrs. every 6 months	35%	N/A
Administer Vitamin A to mothers who deliver in medical facilities within first month of delivery	70%	N/A
Administer Vitamin A to mothers who deliver at home within first month of delivery	25%	54%[1]
Promote gardening, vegetable consumption and drying in villages	90	N/A[2]

B. Project Design/Implementation Plan and Funding

Mauritania's Child Survival and Vitamin A project design and implementation plans were well defined in the Assaba, Mauritania Child Survival and Vitamin A Project DIP dated March 14, 1990.

The project was designed to be implemented in collaboration with the Regional Directorate of Health and Social Action (DRASS) at the regional level. Executing services from this level was probably the best way to launch the project, and the subsequent results have been good, particularly in assisting the communities in organizing, sensitizing and training CHCs and CHWs. However, delivery, supervision, and management of community services from this level is limited, especially in delivery of services such as vaccinations and Vitamin A distribution (e.g., it is physically impossible for two regional vaccination teams to visit approximately 500 villages three times per year. Thus, it is not surprising that less than half of the children in the Assaba Region received the first dose of DTP-polio before their first birthday, and only 13% completed the series in their first year of life).

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1 Represents all BHU women who delivered within past 12 months.

2 N/A: Survey question didn't correspond to stated objective.

Developing and/or reinforcing the primary health care infrastructure at the service level (i.e., the departmental level, with its health centers, dispensaries, and health posts) would facilitate more meaningful and comprehensive planning, execution, management, and supervision of primary health care services, thereby increasing and improving services.

Mobile services would still be necessary to cover those areas which cannot be covered by fixed centers and outreach. This kind of detailed and meaningful planning is more efficiently and effectively done at the service level.

Providing a World Vision assignee from the regional level to each of the departments to assist the Medecin Chef and his personnel in planning and managing primary health care (PHC) services with backup from the DRASS and World Vision would not only help institutionalize, improve, and increase services, but would contribute toward sustainability of those services.

Backup services from the DRASS and World Vision would include either assigning a vehicle to the department or providing a vehicle for a limited amount of time—corresponding to the needs as set forth in the department's plan of action. Other backup services would include the provision of monthly report forms, printing and photocopying services, vaccines/drugs/other supplies, supervisory visits, management reviews, etc.

Providing services to greater numbers of people should reduce significantly the cost per person. Cost recovery, such as that found in the Kankossa Department (assisted by UNICEF), and income-generating activities would help offset recurrent costs such as refrigeration and transportation fuel costs.

Funding:

World Vision Mauritania received a matching grant in FY90 from the FVA/PVC Office of A.I.D. to extend its Child Survival/Vitamin A activities for three years (October, 1, 1989—September 30, 1992) past the original two-year grant. After 15 months of project implementation, the project was closed in December 1990 for ten months because of the Gulf War crisis.

In October 1991, project activities resumed gradually with the revision of the initial DIP to reflect the changed realities in the project area. The revised objectives are documented in section V. A. of this evaluation. Because of the project's ten-month shut-down, accomplishment of the planned objectives has been delayed. Approval is hence being negotiated for a no-cost extension of the project from USAID for FY93 (October 1, 1992—September 30, 1993). Approximately $250,000 for FY92 project activities will be carried forward into FY93 to accomplish the remainder of the revised DIP (essentially what was

originally planned for FY92). The current CS/Vitamin A budget of $450,349 for FY93 leaves the project with a shortfall of approximately $200,000. WV support offices have been contacted for FY93 financial commitments to recompense the shortfall produced largely by the Gulf crisis shut-down.

In addition to regular CS/Vitamin A financial reviews, monthly meetings are held to review the project budget by the Project Manager, the Director of Finance and Administration, and the WVM Program Director. Levels of expenditures which may be authorized without additional approval have been established for the Project Manager and WVM Program Director.

The control of project expenditures and accounts has been decentralized from the program office in Nouakchott to Kiffa. The project's accounting system has been computerized during FY92. The project's Mauritanian accountant has been trained in Lotus 1,2,3 and manages the system himself. The logistical department has also computerized its internal control system for all its commodities and capital assets.

The budget has benefited from cost-recovery based on Bamako Initiative/ Essential Drugs at the village level and shows considerable under-expenditure in that line item. Cost recovery, introduced into the project during the second year, is seen as an important factor for financial sustainability of project interventions.

C. Interventions

1. Vaccinations

WVM assists the Regional MOH to vaccinate childbearing-age women against tetanus and children under five years of age against diphtheria, tetanus, pertussis, polio, measles, and tuberculosis. (Yellow fever vaccinations apparently have been discontinued.) WVM assistance includes training, planning, management, supervision, logistics, personnel, and social mobilization activities throughout the region.

Fixed vaccination sites exist in four of the five district capitals where about 100,000 people, or 50%, of the population lives. Two regional mobile teams, with help from WVM, attempt to provide vaccinations to the remaining population in more than 500 villages.

In general, conservation of vaccines is good, but stock-outs occur at the regional and peripheral levels. The region uses propane gas to fuel small chest-type refrigerators—a more reliable system than the kerosene-operated, standup-type refrigerators found in some African countries. However, vaccine is at risk if reserve gas tanks are not always on hand.

The evaluation team did not witness, but heard, that needles were being used in at least one fixed vaccination site to give more than one vaccination without having been sterilized. If this is so, the team implores all vaccinators, supervisors, and anyone else involved in immunization services to ensure that all needles and syringes are sterile when administering vaccines. It has always been dangerous to use unsterile needles, but today, because of HIV, the danger is manifold. Vaccinating with an unsterile needle can cause far more harm than good. It is far better to not vaccinate than to risk causing HIV infection by vaccinating with an unsterile needle.

Vaccination coverage rates of children in the Assaba Region vaccinated before one year of age and of women delivering in the past 12 months and having had two doses of tetanus toxoid:

	BCG	DTP/P-1	DTP/P-3	Measles	ICV	TT-2
Region 1/90	54%	53%	16%	28%	13%	33%
Region 8/92	52%	47%	13%	18%	10%	55%
BHUs 8/92	81%	79%	29%	47%	28%	61%

Almost all of the mothers (91%) in BHU villages and well over half (64%) in non-BHUs know that a child under one year must be vaccinated several times.

2. ***Oral Rehydration Therapy***

During the Assaba Regional Survey conducted in January 1990, 38% of children under five years old had diarrhea within the past two weeks. Twenty-one percent of the children with diarrhea were treated with oral rehydration solutions. More than two and one half years later, approximately the same percentage of children (40%) had diarrhea within the past two weeks of the August 1992 survey, and region-wide, 28% were treated with oral rehydration solutions. The percentage of children treated in the BHU villages was 42%.

All of the village health workers (VHW) and mothers knew how to prepare the packets of oral rehydration salts. Most VHWs knew how to prepare sugar/salt solution (SSS), but most mothers didn't. However, all mothers knew that it is important to give oral rehydration solutions to children with diarrhea. In addition, all VHWs and mothers knew that it is imperative to continue breastfeeding children with diarrhea and to continue giving other foods as well. Therefore, it would be good to promote giving liquids in

general to children with diarrhea rather than insisting on SSS. It is necessary also to have sufficient quantities of ORS available for mild and severe cases of dehydration.

3. *Vitamin A Distribution*

It is estimated that the prevalence of nightblindness in children under 10 years of age ranges between 0.1% to 1.9%. During a baseline survey in the Assaba Region in January 1990, clinical cases of corneal perforation and permanent loss of vision due to Vitamin A deficiency were detected.

Vitamin A capsules are distributed in health facilities and schools and by mobile vaccination teams and CHWs. The capsules are to be distributed to children from six months to ten years of age every six months. Women are to be given Vitamin A within one month after delivery.

Distribution of Vitamin A is considered a temporary measure until sufficient sources of Vitamin A become available by promoting planting of more vegetable gardens. Vitamin A distribution has been evaluated in 1990 and again in 1992, showing the following results:

	Jan./90 Region	Aug./92 Region	Aug./92 BHUs
Children 6 mos.-5 yrs. who received Vitamin A within past 6 mos.	27%	34%	68%
Children 6 mos.-5 yrs. who received Vitamin A within past 12 mos.	52%	53%	75%
Children 6-10 yrs. who received Vitamin A within past 6 mos.	25%	29%	49%
Children 6-10 yrs. who received Vitamin A within past 12 mos.	25%	47%	51%
Mothers who delivered within past 12 mos. and received Vitamin A within first month after delivery	15%	21%	54%

4. *Nutrition*

In November and December 1990, the project checked the nutritional status of over 300 children from six months to three years using the mid-upper arm circumference measurements. Using this method, it was determined that the nutritional status was normal in less than half of the

children. Eleven percent of the children were considered to be severely malnourished.

Although routine growth monitoring is not one of the project's interventions, obviously malnourished children are referred to a community child feeding center. It is far more helpful to take this sort of positive action with a malnourished child than to routinely weigh babies and record the weights but not take remedial action as has occurred in some CS projects.

The project has chosen to combat malnutrition by assisting the MOH to promote appropriate weaning and infant feeding practices, develop locally appropriate weaning foods, promote milk consumption and vegetable gardening. Results of these efforts as reflected in the August survey are as follows:

- Eighty-one percent of mothers give only breast milk to infants less than five months old.

- Fifty percent of mothers supplement breastfeeding for infants 5-11 months old.

5. *Gardening*

Vegetable gardens are promoted in the Assaba Region to achieve better nutrition and to provide a long-term solution to Vitamin A deficiencies. Carrots, tomatoes, lettuce, onions, and potatoes are among the vegetables grown in 89% of the BHU villages. Many more gardens are found throughout the region for which the project provided only the seeds to get them started.

Vegetables that are sold to others in the community contribute to a better nutritional status and, at the same time, are a source of income generation.

6. *Guinea Worm Elimination*

During the last national guinea worm (GW) search in 1990, over five percent of the villagers in 79 villages were reported infected with GW in the Assaba Region. This is higher than any of the other 11 regions in Mauritania.

This year (1992) the Government of Mauritania embarked on a GW elimination program to reduce transmission of GW to zero by 1995.

WVM has already lent its support to this MOH priority by assisting the Regional MOH to communicate GW elimination plans to all the health districts and begin the training of personnel and education of the villagers. The CS/Vitamin A projects intend to continue to assist the MOH in this endeavor.

D. Strategies

1. Social Mobilization/Community Participation

Results of social mobilization activities are more than encouraging when one considers the knowledge of the CHCs, the CHWs, and, most of all, the mothers concerning vaccinations, oral rehydration, hygiene, and nutrition.

Since educating, training, and organizing at the community level is indeed the bottom line of WVM's assistance in the Assaba Region, it would be good to review the community's participation in more detail. When reviewing results of the evaluation surveys, BHU villages are almost always remarkably better off than non-BHU villages. It must be kept in mind that there are only 34 BHU villages and that only nine of those were visited. Hence, there may be some biases when making comparisons with non-BHU villages.

a. Community Health Committees

All of the CHCs were elected by a general assembly. Seventy percent of the members that the evaluation team met knew their roles and responsibilities. Meetings are initiated by different members. Of all the meetings organized since the creation of CHCs, almost all are called by the CHW or the CHC president. The committees are composed of seven members, and, on average, four of the members are present at monthly meetings. For most CHCs, the last meeting took place in August.

Overall the CHCs meet on a regular basis and are familiar with the procedure of distributing and restocking medicines. Of all the monthly meetings held by CHCs, the following topics were the most frequently covered.

- Health/hygiene
- Vegetable gardening
- Hydraulics (water)

Among problems solved, the following indicates the solutions according to frequency.

- Village cleanliness/upkeep
- Medical supplies
- Community feeding centers
- Disinfection of wells
- Training of traditional birth attendants
- Planting vegetable gardens
- Well construction

Since April 1992, 33% of the villages restocked their medicine supplies twice; other villages (22%) restocked them once. Cash on hand from drug sales among the villages visited is less than 5,000 UM (1,000 UM = $14.) for 12% of the villages, between 5,000 to 10,000 UM for 37%, and more than 10,000 UM for the remaining 51%. Eighty-nine percent of the committees do not pay their CHWs. The other 11% compensated their CHW sthrough a form of work assistance.

b. Community Health Workers

All of the nine CHWs are literate in French and/or Arabic. Most received five weeks' training in one of three training groups. Eight of the nine CHWs were elected by the villagers during a general meeting; the other volunteered his services. Two of the CHWs are women. All of the CHWs are monitored and supervised every two months by WVM. Some 33% have been monitored and supervised jointly by WVM and the DRASS.

The vast majority (78%) of the CHWs know how to prevent night-blindness in children. Forty-four percent of the CHWs know the vaccination schedule. In addition, 55% of the workers correctly described the preparation of SSS. All nine know how to prepare ORS using packets. Seventy-eight percent of the CHWs know the age at which food should be introduced to infants in addition to breast milk. More than 89% know the ideal duration of two years for breastfeeding. Eighty-nine percent of the villages where CHWs work have vegetable garden cooperatives as well as individual gardens. The most common vegetables found are tomatoes, carrots, cabbage, turnips, beets, and potatoes. Moreover, 67% of the CHWs indicated that vegetables are a source of vitamin A. Most CHWs (78%) are familiar with vegetable conservation through drying. As for increasing the participation of villages in health activities and promotion, CHWs suggested that more education was needed.

c. Mothers

The average age of the mothers surveyed was 29 years. In general, mothers indicated that the information that the CHWs provided was very helpful because it pertained to both curative and preventive health measures. According to 77% of the mothers surveyed, the CHWs carried out the curative activities better than the preventive ones. More than half of the mothers indicated that they had heard several health programs on the radio. They ranked the importance of the health education subjects covered on the radio as follows:

- Hygiene
- Use of health services
- Vaccination
- Diarrhea and weaning foods

When questioned about which subjects were retained the best, 50% of the women replied hygiene, 20% said information on diarrhea control, 14% said immunization, and 7% weaning foods and the use of health services, respectively.

Almost half of the mothers in the BHU villages and non-BHU villages were familiar with the preparation of ORS packets. Few mothers (15%) knew the preparation of SSS in BHU villages. None of the mothers in non-BHU villages knew how to prepare SSS.

While half of the mothers questioned in BHU villages knew the usefulness of Vitamin A, only 24% of the mothers in non-BHU villages knew of the positive effects of Vitamin A. Both BHU and non-BHU villages have vegetable gardens in more or less the same quantity.

Almost all of the mothers (91%) in BHU and 64% in non-BHU villages know that a child under one year must be vaccinated several times. Few mothers (10%) from BHU villages and none of the mothers from non-BHU villages knew the recommended age, type of vaccination, or the number of doses necessary to protect mothers against tetanus.

2. *Training*

Training of project staff is done through weekly inservice training sessions and also through participation in national and international seminars. Thirty-three MOH staff were trained in Supervision and Child Survival/

Vitamin A activities in two organized seminars (see Appendix J). CHWs (34 hygienists and 25 TBAs) were trained in three groups for five weeks.

In Kiffa town, a special training session of four days was organized for 26 mothers known as mother health monitors. These monitors are in charge of about 30 other mothers. They are responsible for health education and promotion of health and growth monitoring of children through regular weighing sessions. Each mother works only in her own neighborhood where she is acquainted with the other mothers. The monitors are volunteers and are given incentives of food supplements and, in some cases, a token fee.

Date	Training Seminar/Workshop	Participants
14-20 Oct. '91	6th Africa (Francophone) Regional PVO Child Survival Workshop, Sikasso, Mali	Prosper Sapathy
23-27 Nov. '91	Assaba Regional Planning Seminar	All Project and 30 MOH Staff
1-13 Dec. '91	CHW/TBA Refresher Training	13 CHW/TBA
3-10 Jan. '92	Rapid Rural Appraisal Training	20 Staff/Part
5-11 Feb. '92	Training of Trainers	8 MOH Staff
5-11 Feb. '92	Training for Mother Monitors	26 Mothers
25 Feb.-30 Mar. '92	CHW/TBA Training	28 Graduates
5-11 July '92	Seminar on "Local NGO"	Majed & Diallo + 18 Others

Training materials were developed by the project to teach CHWs about nutrition, vaccination, and oral rehydration.

3. *Management Supervision*

The CS/Vitamin A project sends monthly, quarterly, and annual reports to WVM in Nouakchott and WVRD in California. Information for the reports is collected from the CHWs, the Regional MOH, and the WVM staff.

Occasionally, reporting is not well coordinated between the Regional MOH and the project, and since both submit their own reports through the chain of command, incomplete and/or conflicting reports sometimes result.

Reports from the MOH or the project do not routinely reflect whether objectives are being met or not—thus limiting peripheral, intermediate, and central level analyses of activities and, therefore, limiting the management aspects of the reporting. (e.g., reporting 300 doses of DTP[3] administered in a given area during a given month is difficult to appreciate if one doesn't know how many doses are needed to be given during that month to meet objectives.) Unless it is known and understood what has happened, what is happening and what is going to happen in a project, effective management is not possible.

Collaboration between the project and the Regional MOH to improve reporting procedures and content would help managers make informed decisions. For example, if the monthly report shows how many Vitamin A capsules were received, distributed, and remain during the month in a health facility, managers at all levels can know:

- If the health facility is managing its activities.
- If the facility has enough stock on hand.
- If the facility ran out of stock.
- If the facility orders stock in a timely manner and when needed.
- If the facility is actually using stock, therefore providing services.
- If amount of stock used corresponds with amount of services provided.

A MOH monthly report form already exists for use in health facilities. However, the extent of its use, exploitation, and analysis seem to be limited. Whether enough health facilities maintain adequate records to facilitate filling in the monthly report form needs to be determined and assistance provided by WVM if so needed and requested.

A monthly report also exists for the VHW which could include status of supplies to help manage community health activities.

E. Sustainability

Looking at the ten-month interruption of WVM's CS/Vitamin A activities during the Gulf crisis, one might immediately question the sustainability of the project. Many vaccination services were interrupted, Vitamin A distribution by the mobile vaccination teams ceased, and supplies from Nouakchott dwindled.

On the other hand, a number of project activities continued to function:

- Health committees were still in place.
- Village health workers still provided some services.
- Gardens were still planted.
- Villagers still knew about nutrition.
- Mothers knew about proper weaning.
- Mothers continued treating children suffering from diarrhea with oral rehydration solutions.

VI. CONCLUSIONS

As witnessed during this midterm evaluation, without the presence of the WVM project, some activities slowed down or halted, but others continued to function in one fashion or another. More importantly, however, the knowledge that the project shared with the MOH and the communities was not lost when WVM was not present. What caused some activities to halt? Vehicles and fuel.

It is not realistic to imagine that developing countries, especially those whose viability is questionable under the best of circumstances, can sustain present level health care services without outside assistance. It would be hard to imagine developing countries being able to purchase sufficient vaccines from their national budgets should UNICEF and other donors not make them available.

The same is true for vehicles and fuel. However, now that regions and departments have a functioning budget, and cost recovery for some health services is beginning to get underway, it may be reasonable to expect that some recurrent costs such as drugs and fuel for vehicles and refrigerators can be assumed by them.

It should also be noted in this section that:

- Mothers don't understand what tetanus toxoid vaccine is and why it's given (some mothers think that it is used to sterilize them).

- Mothers don't know how to mix sugar/salt solutions.

- SRO packets are not always readily available for mild and severe cases of dehydration.

- Questions on the 30-cluster survey (August 1992) did not always correspond to the objectives as stated in the DIP.

VII. RECOMMENDATIONS

1. World Vision Relief & Development (WVRD) needs to secure approval for a no-cost extension from USAID for fiscal 1993 (October 1, 1992, through September 30, 1993) for the WVM Child Survival/Vitamin A Project.

2. WVRD needs to provide/obtain $200,000 to complete the $650,000 needed to achieve the project objectives that were interrupted and subsequently revised due to the Gulf War crisis.

3. Increase the number of BHU villages to at least 10 of the largest villages in each of the five districts before the end of September 1993.

4. WVM and DRASS/Assaba weigh the advantages and disadvantages of decentralizing Child Survival/Vitamin A project services from the regional to the departmental (district) level as described in section V.B. of this report, and if a decision to decentralize is made, begin necessary steps before calendar year 1993.

5. If service delivery strategy is not decentralized to the department (district) level, WVM, in collaboration with DRASS, needs to review and revise vaccination coverage objectives to be more realistic, given the present physical restraints.

6. If service delivery is decentralized to the department level, WVM, in collaboration with DRASS, should increase the number of new BHU villages to at least 10 of the largest villages in each of the five districts before the end of September 1993.

7. Monthly vaccination and diarrheal disease reports be initiated by the appropriate level of the MOH, and assisted by WVM if requested, for distribution to the interested parties of each.

8. Technical support for the project be provided primarily by the MOH from the regional and central levels and, secondarily, from WVM in Nouakchott and WVRD/California.

9. MOH limit children's vaccination target-age group to <2 years with the exception of measles vaccinations, which should be given up to at least 5 years of age if the child has not been vaccinated nor had the disease.

10. Emphasis be placed on explaining anti-tetanus vaccinations to mothers during health education sessions and through the mass media.

11. More emphasis should be placed on mothers giving liquids in general to children with diarrhea rather than insisting on sugar/salt solution.

12. CS/Vitamin A project ensure that ORS packets are available in all BHU villages for treatment of mild and severe cases of dehydration.

13. WVM assist MOH Assaba to develop/improve the Regional Health Management Information System (HMIS) which is in place. (See section V.D.3. for details.)

14. WVM continue to assist the MOH in its efforts to eliminate guinea worm in the Assaba Region.

15. WVM assist DRASS/Assaba to organize and conduct at least quarterly staff meetings among the different ministries and NGOs.

16. WVM prepare a work plan for fiscal 1993 with clear, specific, measurable, and realistic objectives.

17. CS/Vitamin A work-plan objectives be used as stated in the document during surveys to measure project progress.

18. CS/Vitamin A project exploit the non-vaccination part of the August 1992 survey with the EPI-INFO software that exists in the WVM office in Nouakchott and compare with the hand-tabulated results.

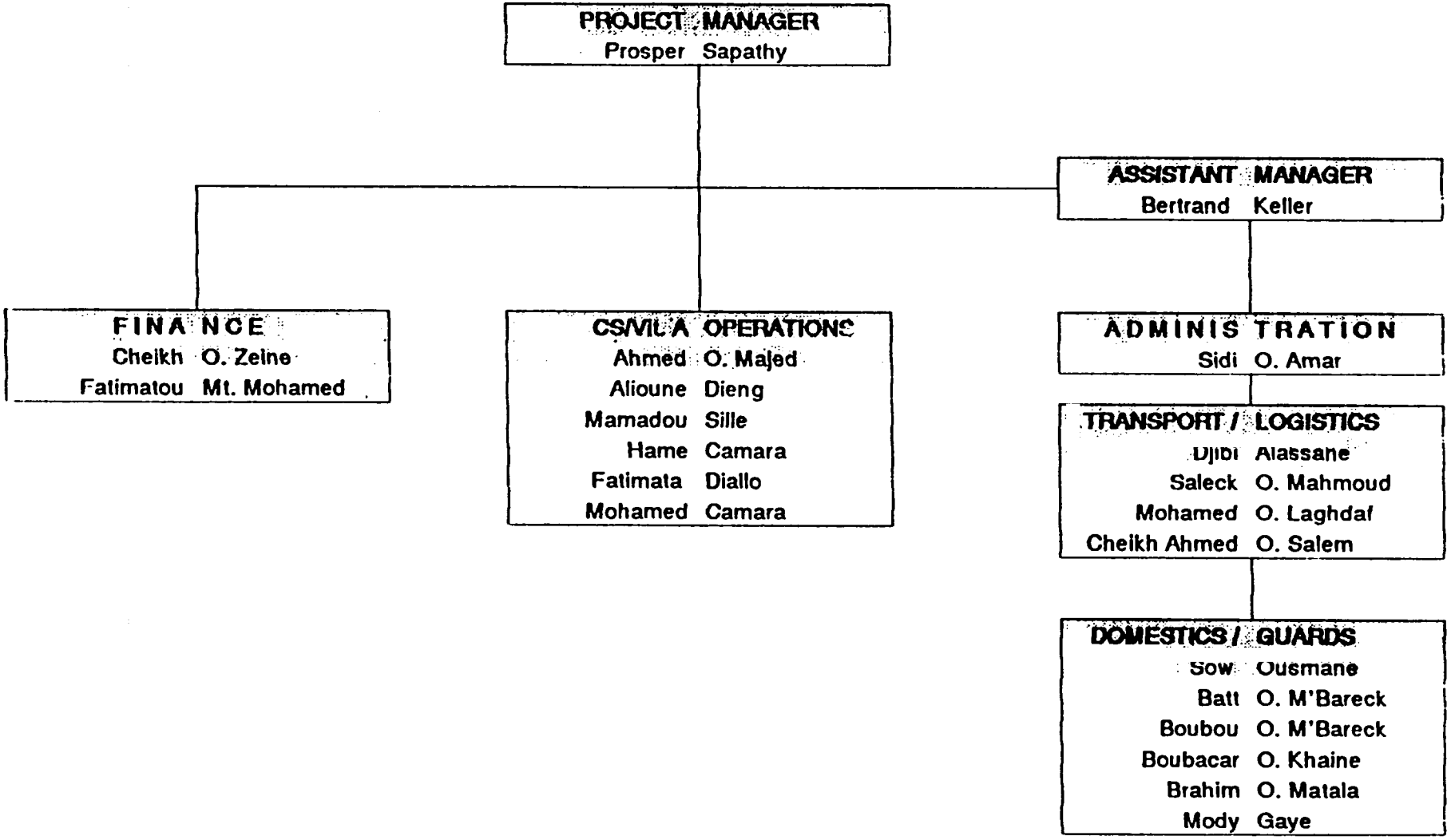
19. Project chauffeurs be trained to assist with project activities in the field, e.g., health education, social mobilization, etc.

20. WVM ensure that their field personnel fluently speak the language of the community in which they are working.

21. Executive Summary, Recommendations, and Explanation of Implementation Plan (Annex O) of this midterm evaluation be translated into French and circulated to WVM's francophone staff, appropriate MOH staff, and other interested parties.

APPENDIX A

WORLD VISION ASSABA C.S. / VIT. A PROJECT
FY92-ORGANIZATIONAL CHART



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APPENDIX B1

FORMULAIRE D'ENQUETE
PROJET SURVIE DE L'ENFANT/VITAMINE A – ASSABA
DU 8 AU 31 AOUT 92

Village _____ Grappe No _____

Remplissez une fiche si un des habitants de la maison
(1) a moins de 10 ans, ou (2) a accouche pendant les 12 derniers mois

I – COUVERTURE DE VITAMINE A

A. Femmes qui ont accouchées durant les 12 derniers mois :

Age	Lieu de l'accouchement		Carte de Vacc. VAT		doc. de 2 doses VAT		date dernière dose de Vit A		
	struct. sanit.	maison	OUI	NON	OUI	NON	7/91–12/91	1/92–pres.	pas recu
1.	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐	☐	☐	☐

B. Enfants de moins de 10 ans :

Age	sexe		carte de vacc.		date dernière dose de vit. A			Hémeralopie et durée		
	M	F	OUI	NON	7/91–12/91	1/92–pres.	pas recu	NON	<1 mois	>1 mois
1.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

II – PRATIQUES ALIMENTAIRES

A. Enfants de moins d'un an :

No	Date de naissance	Allaitement au sein		Allaitement artificiel		Autres aliments	
		OUI	NON	OUI	NON	OUI	NON
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐

B. Pratiques alimentaires de la famille

1. Quels légumes riches en vitamine A sont consommés chez vous ?

Carottes [_] Légumes verts [_] Ignoré [_]

Tomates [_] Autres [_] (à preciser) _____

2. Fréquence de consommation ?

Jamais [_] moins de 3 fois par an [_] plusieurs fois par an [_]

3. Pourquoi mange-t-on les légumes verts et jaunes ?

Bonne nourriture [_] Bonne vision [_] ne sait pas [_] Autres _____

4. Pratiquez-vous le jardinage ?

oui [_] non [_] sinon, pourquoi ? _____

C. COUVERTURE VACCINALE

POUR LES ENFANTS DE 12 A 23 MOIS

No enfant			
Carte de vaccination	OUI [_] NON [_]	OUI [_] NON [_]	OUI [_] NON [_]
Date de naissance			
Date de BCG/CIC			
Date de DPT 1			
Date de DPT 2			
Date de DPT 3			
Date de POLIO 1			
Date de POLIO 2			
Date de POLIO 3			
Date de rougeole			

D. [illegible] RÉHYDRATATION PAR VOIE ORALE

POUR LES ENFANTS DE MOINS DE 5 ANS

No	Diarrhée pendant les 2 dernières semaines		Parmi les enfants qui ont eu la diarrhée, étaient-ils traités avec RVO (sachets ou SSS) ?		
_____	NON [_]	OUI [_]	NON [_]	OUI [_]	_____
_____	NON [_]	OUI [_]	NON [_]	OUI [_]	_____
_____	NON [_]	OUI [_]	NON [_]	OUI [_]	_____

E. [illegible] SCOLARISATION [illegible]

1. Avez-vous assisté (au moins une fois) à une séance d'E.P.S. ?

oui [_] non [_]

Si oui, sur quels thèmes ?

Sevrage [_] Diarrhée [_] Hygiène [_] Vaccination [_]

Autres _____

F. TRAITEMENT DE L'ADULTE [illegible]

1. Qui consultes-tu dans le village quand tes enfants et toi êtes malades ?

H.S./A.T. [_] Infirmier [_]

Marabout/Guérisseur [_] Autres _____

2. Durant les deux derniers mois, combien de fois vous-êtes vous fait consulter dans le village ?

0 fois [_] 1 fois [_] 2-3 fois [_] fois et plus [_]

APPENDIX C

WV MAURITANIA, MIDTERM EVALUATION QUESTIONNAIRE'92

NOM: AGE: VILLAGE:

DEPT: AGE DE LA DERNIERE ENFANT:

1. QUELLES SONT LES ACTIVITES DE L'ASC DANS LE VILLAGE?

2. QUELLES SONT LES ACTIVITES QUE L'ASC DEVELOPPE LE MIEUX?

3. ET CELLES QU'IL DEVELOPPE LE MOINS?

4. COMBIEN DE FOIS AVEZ-VOUS ENTENDU DES SEANCES D'E.P.S. SUR LA RADIO?_____

5. QUELS ETAIENT LES THEMES DEVELOPPES?

6. QUELS SONT LES POINTS LES PLUS IMPORTANTS QUE VOUS-AVEZ RETENUS?

7. COMMENT PREPARER LES SOLUTIONS SSS ET SRO?

8. A QUELS MOMENTS ADMINISTRER LA T.R.O?

9. AVANT L'AGE D'UN AN, COMBIEN DE FOIS UN ENFANT DOIT ETRE VACCINE?

10. A QUEL AGE COMMENCE LE VACCINATION DES FEMMES? AVEC QUEL VACCIN? ET NOMBRE DE DOSES MINIMUM?

11. MONTRER UNE CAPSULE DE VITAMINE "A" ET DEMANDER AUX MERE A QUOI ELLE SERT?

12. AVEZ VOUS UN JARDIN? SI NON, POURQUOI?

APPENDIX D

WV MAURITANIA, MIDTERM EVALUATION QUESTIONNAIRE-ASC '92

NOM: VILLAGE: DEPT:

1. ALPHABETISE oui - non

2. DATE DE VOTRE FORMATION:

3. COMMENT AVEZ-VOUS ETE CHOISI?

4. PAR QUI ETES-VOUS SUPERVISE?

5. QUEL EST LE RYTHME DE SUPERVISION? RESPECTE?___

6. COMMENT FAIRE LA PREVENTION DE LA XEROPHTALMIE?

   ENFANTS: <6 MOIS_____; de 6 à 11 mois_____; >11 mois_____

7. QUEL EST LE CALENDRIER VACCINALE?

   BCG_____; DTC_____; POLIO_____;

   ROUGEOLE_____; VAT_____.

8. COMMENT PREPARER LE:

   SSS -

   SRO -

9. A QUELS AGES FAUT IL INTRODUIRE DES ALIMENTS EN PLUS DU LAIT MATERNEL CHEZ UN ENFANT?

10. QUEL EST LA PERIODE IDEALE PENDANT LA QUELLE UN ENFANT DOIT ALLAITER?

11. COMBIEN DE JARDINS MARAICHERS Y A T-IL DANS VOTRE LIEU I TRAVAIL?

12. QUELS SONT LES LEGUMES QUI SONT SEMES ?

13. A QUOI SERVENT-ILS?

14. COMMENT FAITES-VOUS POUR LA CONSERVATION DES LEGUMES

15. SELON VOUS, QUE PEUT-ON FAIRE POUR AMELIORER LA PARTICIPATION COMMUNAUTAIRE ? (noter au verso)

APPENDIX E

WV MAURITANIA, MIDTERM EVALUATION QUESTIONNAIRE-CSC '92

VILLAGE: DEPT:

1. QUEL EST LE ROLE DEVOLU A VOTRE COMITE? (CHAQUE MEMBRE PRESENT DOIT EXPLIQUER SON ROLE POUR NOTER AU VERSO)

2. LE COMITE A ETE CHOISI COMMENT?

3. QUI PREND L'INITIATIVE POUR LES REUNIONS DU COMITE?

4. COMBIEN DE MEMBRES?_____

5. COMBIEN DE MEMBRES EN MOYENNE ASSISTENT AUX REUNIONS?

6. QUEL EST LE RYTHME DES REUNIONS?

7. QUEL EST LA DATE DE VOTRE DERNIERE REUNION?

8. DE QUOI AVEZ VOUS DISCUTE?

9. QUEL PROBLEMES AVEZ VOUS RESOLU?

10. COMMENT ET COMBIEN DE FOIS AVEZ VOUS RENOUVELER VOTRE TROUSSE DE MEDICAMENT?

11. QUEL ET LA DATE DU DERNIER RENOUVELLEMENT?

12. QUELS EST LE MONTANT DES DERNIERES RECETTES?

13. QUEL EST VOTRE DISPONIBILITE ACTUELLE EN ARGENT?

14. L'ASC EST-IL REMUNERE? COMMENT?

15. QUI REMUNERE L'ASC?

APPENDIX F

LIST OF PERSONS AND PLACES VISITED

1.	Dr. Yaya Diallo	Epidemiologist, WHO Nouakchott
2.	Mr. William	Dir., Oxfam, Nouakchott
3.	Ms. Mary Pecaud	Dir., U.S. Peace Corps, Nouak.
4.	Mr. Théophille Gnambodoué	Chief of Training, WHO, Nouak.
5.	Mr. Bertrand Keller	Logistician, WVM, Kiffa
6.	Mr. Tall Ousmane	Reg. MOH-EPI Supervisor, Kiffa
7.	Mr. Hame Kamara	Community Health Facilitator, WV/Kiffa
8.	Mr. Alioune Dieng	Nurse, World Vision, Kiffa
9.	Mr. Mohamed Camara	Comm. H. Facilitator, WV/Kiffa
10.	Mr. Naji Ould Yekber	Nurse, Kiffa
11.	Ms. Michetou Mt Ahmed	Mid-wife, Regional MOH, Kiffa
12.	Mr. Diallo H. Silley	Comm. H. Facilitator, WV/Kiffa
13.	Ms. Yaye F. Diallo	Comm. H. Facilitor, WV/Kiffa
14.	Dr. Bah O. Moctar O. Sidi	Reg. Agric. Director, Kiffa
15.	Mr. Sidi Med O. Eleyouta	Reg. Hydraulic (Water) Dir., Kiffa
16.	Mr. Justin Lovenou	Dir., Lutheran World Federation, Kiffa
17.	Mr. Mohamed O. Abdallahi O.	Governor, Assaba Region, Kiffa
18.	Dr. Yemehlou	District Medical Officer, Kankossa
19.	Mr. Diallo Mamadou	Nurse-In-Charge, Elghaire
20.	Mr. Med Lemine O. Horma	Nurse-In-Charge, Aghoratt
21.	Ms. Angela Martin	U.S. Peace Corps, Nouakchott
22.	Ms. Jennifer Pelsner	Peace Corps Volunteer, Dakfagh, Barkeol

APPENDIX G

LIST OF DOCUMENTS REVIEWED

1. DIP, ASSABA VITAMIN-A/CS PROJECT, 15 APRIL 1988
2. DIP, ASSABA CS/VITAMIN-A PROJECT, 14 MARCH 1990
3. ANNUAL REPORT, CS/VITAMIN-A PROJECT, 17 OCTOBER 1988
4. INTERIM REPORT, CS/VITAMIN-A PROJECT, 20 MARCH 1991
5. ANNUAL REPORT, CS/VITAMIN-A PROJECT, 5 NOVEMBER 1991
6. MID-TERM EVALUATION REPORT, CS/V-A PROJECT, JANUARY 1989
7. FINAL EVALUATION REPORT, CS/V-A PROJECT, JANUARY 1990
8. MONTHLY CS/V-A PROJECT REPORTS (9) NOVEMBER 1991-JULY 1992
9. REGIONAL MINISTRY OF AGRICULTURE WORKPLAN FOR 1992
10. REGIONAL MINISTRY OF HYDRAULICS WORKPLAN FOR 1992
11. HEALTH EDUCATION GUIDE FOR HYGIENE, 1988
12. HEALTH EDUCATION GUIDE FOR DIARRHEA, 1988
13. HEALTH EDUCATION GUIDE FOR NUTRITION, 1988
14. NATIONAL VACCINATION COVERAGE SURVEY, 1989
15. REGIONAL VACCINATION COVERAGE SURVEY, 1990

APPENDIX H

RESULTS OF SURVEY

Indicateur	Jan 90 Region	Aout 92 Region	Aout 92 U.S.B.
Pourcentage des mères accouchées pendant les 12 derniers mois et ayant reçu 2 doses de VAT.	32.7% (153)	55.4% (166)	60.9% (46)
Pourcentage des mères accouchées pendant les 12 derniers mois à domicile (non-assistées).	79.5% (153)	72.9% (166)	63.0% (46)
Pourcentage des mères accouchées pendant les 12 dern. mois ayant carnet de vacc	55.5% (153)	69.3% (166)	73.9% (46)
Pourcent. des mères accouchées pendant les 12 derniers mois ayant reçu des capsules de Vit A	15% (153)	20.5% (166)	54.3% (46)
Pourcent. des enfants de 6 mois - 5 ans ayant reçu des capsules de Vitamine A pendant les 6 derniers mois.	27.4% (657)	34.4% (691)	68.0% (253)
Pourcent. des enfants de 6 mois - 5 ans ayant reçu des capsules de Vitamine A pendant les 12 dern. mois	52% (657)	52.7% (691)	75.1% (253)
Pourcent. enfants de 5 - 10 ans ayant reçu des capsules de Vit. A pendant les 12 dern. mois	47.1% (263)	47.3% (315)	51.3% (230)
Pourcent. enfants de 5 - 10 ans ayant reçu des capsules de Vit. A pendant les 6 dern. mois	24.7% (263)	28.9% (315)	49.1% (230)
Pourcent. des mères qui donnent à leurs enfants 0 - 4 mois que le lait maternel	-	91.4% (93)	81.4% (27)
Pourcent. des mères d'enfants de 5 - 11 mois qui donnent autre aliments que le lait maternel	45.5% (77)	44.8% (67)	50% (16)

ANNEX H: RESULTS OF SURVEY (continued)

Indicateur	Jan 90 Region	Aout 92 Region	Aout 92 U.S.B.
Pourcent. enfants de moins de 5 ans ayant la diarrhée pendant les deux dernières sem.	37.7% (738)	40.1% (713)	38.1% (218)
Pourcent. enfants moins de 5 ans ayant la diarrhée pendant les deux dernières semaines et traités avec RVO (sachets SSS)	20.5% (278)	28.3% (286)	42.1% (83)
Pourcent. de menages ayant mentionner au moins un légume riche en Vit. A.	69% (504)	70.9% (490)	71.7% (145)
Pourcent. de menages n'ayant consommé aucun légume riche en Vit. A.	31.1% (499)	28.1% (477)	25.9% (143)
Pourcent. de menages ayant consommé au moins 3 fois par an des légumes riches en Vitamine A.	54.3% (499)	71.9% (477)	74.1% (143)
Pourcent. des mères ayant participé au moins 1 fois à 1 séance d'E.P.S.	-	40.7% (489)	63.6% (143)
Pourcent. des mères ayant participé à une séance d'EPS ayant pour thème:		(199)	(91)
- sevrage	-	13%	10.9%
- diarrhée	-	57.7%	49.4%
- vaccination	-	6%	10%
- hygiène	-	69.3%	59.3%
- autres	-	3.5%	15.3%
Pourcent. des mères ayant consulté -	-	(488)	(143)
-l'H.S./A.T.	-	8.4%	85.5%
-infirmier	-	43.4%	2%

ANNEX H: RESULTS OF SURVEY (continued)

Indicateur	Jan 90 Region	Aout 92 Region	Aout 92 U.S.B.
- marabout/guérisseur	-	17.8%	0%
- personne	-	30.4%	12.5%
Pourcent. des ménages qui n'ont jamais consultés durant les 2 derniers mois	-	54.9%	48.2%
Pourcent. des menages qui ont consulté pendant les 2 derniers mois:		(488)	(143)
- 1 fois	-	23.5%	20.2%
- 2 à 3 fois	-	15.5%	21.6%
- 4 fois et plus	-	4.9%	7.6%
Pourcent. enfants moins de 5 ans ayant des carnets de santé	-	76.5% (719)	86.1% (252)
Pourcent. d'enfants de 12 - 23 mois avec carnet de santé.	- -	61.9% (210)	84.2% (57)
Pourcent. enfants de 12-23 mois ayant reçu les doses avant 12 mois.	(207)	(210)	(57)
B.C.G.	54.1%	52.3%	80.7%
Polio 1	53.1%	47.1%	78.9%
Polio 2	25.1%	26.1%	56.1%
Polio 3	16.4%	13.3%	28.7%
DTC 1	53.1%	47.1%	78.9%
DTC 2	25.1%	26.1%	56.1%
DTC 3	16.4%	13.3%	29.82%
Rouvax	28%	18%	47.3%
E.C.V.	13%	9.5%	28%
<u>Pourcentage enfants de 12 - 23 mois:</u>		(210)	(57)
B.C.G.		75.2%	100%
POLIO 1		58.5%	89.4%

ANNEX H: RESULTS OF SURVEY (continued)

Indicateur	Jan 90 Region	Aout 92 Region	Aout 92 U.S.B.
POLIO 2		40.4%	80.0%
POLIO 3		22.3%	52.6%
D.T.C. 1		58.5%	87.71%
D.T.C. 2		40.4%	80.7%
D.T.C. 3		22.8%	52.6%
ROUVAX		45.2%	75.4%
E.C.V.		20.4%	49.1%

APPENDIX I

LIST OF MOH PERSONNEL TRAINED IN SUPERVISION AND CS/VITAMIN-A ACTIVITIES

1.	Dr. Moulaye Ould Hacen	DRASS, Kiffa
2.	Aichetou Mint Ahmed	"
3.	Sy Mamadou	"
4.	Tall Ousmane	"
5.	Sy Ahmed	"
6.	Dr. Khattry	Kiffa Health Center
7.	Zeinabou	Kiffa M.C.H. Center
8.	Mohamed O. Demba	Tenaha Health Post
9.	Hamoud Idrissa	Lewessy Health Post
10.	Sy Birane	Legdeim I Health Post
11.	Eyda O. Naha	Guiler Health Post
12.	Abdallahi O. Hamadi	Kouroudjel Health Post
13.	Diallo Mamadou	Elghaire Health Post
14.	Med Lemine O. Horma	Aghoratt Health Post
15.	Moutaly O. Ahmed	PK 70 Health Post
16.	Cheikh Elbou	Elghabra Health Post
17.	Dr. Med Mahmoud O. Mazouz	Boumdeid Health Center
18.	Mohamed El Moctar	"
19.	Dr. Yemehlou	Kankossa Health Center
20.	Dr. Bounena	Barkeol Health Center
21.	Dr. Yacoub	Guerou Health Center
22.	Fatimata Kane	"
23.	Mounena Mint	"
24.	Kane Moussa	"
25.	Coumba Demba	"
26.	Benbella	Boulaharath I Health Post
27.	Cheikh Tourad	Barkeol Health Center
28.	Bah Abdoulahi	Hasseytine Health Post
29.	Mohamed O. Oumar	Bougadoum Health Post
30.	Aba ould	Legrane Health Post
31.	Kebe Bayal	Kamour Health Post
32.	Sidi Ahmed O. Wenass	Sagatar Health Post
33.	Mamadou Houleye Niang	Libher Health Post

APPENDIX J

COMMUNITIES WITH HEALTH COMMITTEES, VILLAGE HEALTH WORKERS, TRADITIONAL BIRTH ATTENDANTS

(Creation, training and/or retraining assisted by World Vision and DRASS)

DEPT	VILLAGE	NAME OF VHW & TBA	BEGINNING DATE
Guerou	Oudey Jrid	Med. O/ Carabah* Vileila mt Med El Abd*	1988
Guerou	Oudey Rahma	Moustapha O/ Boubacar* Isslemhoum mt Bechir*	1988
Guerou	Taghada Wassa	Ahmed Taleb O/ Nourba* Lekhìra mt Ramdane*	1988
Kiffa	Dissagh	M'Bareck O/ Saleck* Sghaìra mt Hamady*	1988
Kiffa	Bellewar	Loudéa O/ Saleck* Zaghara mt Soueilik*	1988
Kiffa	Ould Kouni	Ahemedna O/ Kathra* Soueilika mt Mariem*	1988
Boumdeid	Jelwa	Laghdaf O/Mahmoud Fatimetou m/ M'barek	1990
Boumdeid	Leftah	Toutou m/ Med El Hadj Marieme m/ M'tar M'lud	1990
Boumdeid	Legneb	Ahmed O/ Bilal Malouma Mmud L'la	1990
Boumdeid	Legleib	Lemrabott O/ El Bar Marieme Val m/ Sidi Med	1990
Kiffa	Oumoulkhouz	Isselmou O/ Mohamed Soueilka m/ Bilal	1990
Kiffa	Ain Rahma	Med El Haj O/ Cheikh Marieme mint Sidi	1990
Kiffa	Amredjiel	Mohamedou O/ Sid Ahd Marieme m/ Yehdih	1990
Kiffa	Gouvava	Diallo Marieme Meimouna M'barom	1990

DEPT	VILLAGE	NAME OF VHW & TBA	BEGINNING DATE
Kiffa	Rass Elvil	Zeinebou m/Hamaday H.S.	1990
Kiffa	Ehel Barik	Med Lemine O/ Abdellahi Teslem m/ Taleb	1990
Guerou	Dakhle	Med Abderah O/ Memoud Fatimetou m/ Sidi Mld	1990
Boumdeid	Boumdeid	Marieme m/ Moustapha	1990
Kiffa	Magtasféra	Sidi M'tar O/Rachid Rabiye m/Nouss	1992
Kiffa	Djime	Sidi Med O/Ahmed Marieme m/Ahmed	1992
Boumdeid	Legdeim II	Kleithime m/ Dedde	1992
Kiffa	Freikika	Bocar Sandigui Koumba Nyana	1992
Kiffa	Aint Zbel	Poulal Ba Moly Ba	1992
Kiffa	Gaide	Salif Samba Sira Ousmane Ba	1992
Kiffa	Oumoulkeeran	Med Yehdih O/ Med Ahd Matlouba m/ Abderahmane	1992
Kiffa	Vountilly	Moustapha O/ Sidina Moila m/ Ethmane	1992
Kiffa	Ch'tib	Zeidane O/ El Mamy	1992
Kiffa	Gourmel	Feitme m/ Batme	1992
Guerou	Chkata	Dah O/ Med Lemine	1992
Guerou	Bameria	Med Abderrah Nassredin	1992
Guerou	Gueiva	Aicha m/ Sidi Abdallahi	1992
Guerou	Taghada Irij	Sidi Moctar O/ Radhi	1992
Boumdeid	Rag	Vala m/ Abeid Nass Tislem m/ Avgueirich	1992

DEPT	VILLAGE	NAME OF VHW & TBA	BEGINNING DATE
Kiffa	Tissane	Lemrabott O/ Dey Fatimetou m/ Dey	1992

* Installed by the PRSSR (Rural Health Care Project)

APPENDIX K1

REPUBLIQUE ISLAMIQUE DE MAURITANIE - MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES. ورية الإسلامية الموريتانية - وزارة الصحة والشؤون الاجتماعية

PAGE 1 صفحة ١

RAPPORT MENSUEL / TRIMESTRIEL D'ACTIVITES

شهري/فصلي للنشاطات

FORMATION SANITAIRE _____ المركز الصحي MOUGHATAA _____ مقاطعة WILAYA _____ ولاية ANNEE [ ][ ] سنة MOIS [ ][ ]

رمز المركز الصحي Code Formation Sanitaire [ ][ ][ ][ ][ ][ ][ ][ ] Matémité أمومة [ ] Dispensaire مستوصف [ ] PMI حماية الأمومة والطفولة [ ] PMR حماية الأمومة بالريف Tupe de Formation Sanitaire : لمركز الصحي

I. Nombre de Consultations _____ عدد الإستشارات Visites de Supervision Reçues dans le Mois _____ الزيارت التي أجريت خلال الشهر بهدف المراقبة والإطلاع

II. Consultations SMI / PF

شوف بخصوص صحة الأم والطفل وتنظيم الأسرة والحالات المرفوعة حسب نوعها .

نوعية الاستشارات Type de Consultations (1)	Pré et Postnatal قبل وبعد الولادة			PLANIFICATION FAMILIALE تنظيم الأسرة									Infantiles الأطفال		
													Inscrits المسجلين		
	قبل الولادة Prénatales (2)	أخر Autres (3)	بعد الولادة Post natales (4)	حبوب Pilule (5)	لولب DIU (6)	حقن Injectable (7)	واقي Condoms (8)	قاتلات النطاف Spermic. (9)	طبيعي Naturelles (10)	وسائل أخرى Autres (11)	لايوجد Aucune (12)	المجموع Total (13)	< 1 AN سنة (14)	١ - ٤ سنة 1- 4 ANS (15)	Total (16)
Nouvelles جديدة															
Anciennes قديمة															
Total المجموع															

Nombre de Grossesses à Risque Depistées : _____ عدد الحمول ذات الخطر المشخصة

Nombre de Grossesses à Risque Referées : _____ عدد الحمول ذات الخطر المحالة

Nombre de Consultations Visit (4) _____ : عدد الاستشارات زيارة (٤)

Nombre de Postnatales Referées à PF _____ عدد النساء المحالات بعد الولادة لتنظيم الأسرة

Nombre de Grossesses Accidentelles _____ عدد الحمول غير المقصودة

Nombre d'Enfants encore Allaités _____ عدد الأطفال الرضع

(1)	M.S.T. أمراض منتقلة من طريق الجنس				STERILITE العقم		استشارات نسائية أخرى Autre Cons Gyneco. (8)
	سيفيليس (زهري) Syphilis (2)	سيلان Gonorrhée (3)	مرض أخر Autre (4)	المجموع Total (5)	بدئي Primaire (6)	ثانوي Second (7)	
Nouvelles جديدة							
Anciennes قديمة							
Total المجموع							

IV. Consultations Externes الاستشارات الخارجية

Consultations Externes الاستشارات الخارجية						
شريحة عمر Tranche d'Age (10)	< سنة <1 AN (11)	١ - ٤ سنة 1 - 4 Ans (12)	٥ - ١٤ سنة 5 - 14 Ans (13)	Adultes البالغين		المجموع Total (16)
				رجال Hommes (14)	نساء Femmes (15)	
Nvelles جديدة						
Anci. قديمة						
Total المجموع						

Consultations Externes الاستشارات الخارجية				
المصدر Provenance (1)	A (0 - 4) Km (2)	B (5 - 9) Km (3)	C (10 et +) Km (4)	المجموع Total (5)
Nvelles جديدة				
Anci. قديمة				
Total المجموع				

REFERENCES حالات			
المجموع Total (1)	و ص ق ASC (2)	م ت AT (3)	AU

APPENDIX K2

PAGE 2 صفحة ٢

الولادات حسب نوعها
V. ACCOUCHEMENT PAR TYPE

	مجموع الولادات Total Accouchements (1)	TYPE D'ACCOUCHEMENT نوع الولادة				جنين واحد UNIQUE (6)	توائم GEMELLAIRE (7)	اجهاض AVORTEMENT (8)
		ولادة سهلة Eutocique (2)	DYSTOCIQUE ولادة عسرة					
			قيصرية Cesar. (3)	ملقط جنين Forceps (4)	أخرى Autre (5)			
TOTAL المجموع								

مآل الحمل
VI. ISSUE DE LA GROSSESSE

	مولود حي Né Vivant (1)	خديج Prématiré (2)	وزن أقل من ٢٥٠٠ غ Poids < 2500 g (3)	الوليد متوفي Mort Né (4)	الوليد السابق حي Enfant Precédent Survivant (5)	الوليد السابق متوفي Enfant Precédent Décédé (6)	الوليد الحالي Enfant Actuel		وفاة الوالدة Décès Maternels (9)
							وفاة في قاعة الولادة Décès en Salle (7)	وفاة في ٢٤ ساعة Décès 24 h (8)	
TOTAL المجموع									

التلقيح
VII. VACCINATIONS

العمر CLASSES D'AGE	ب س ج BCG (1)	شلل 0 POLIO (2)	شلل 1 POLIO (3)	شلل 2 POLIO (4)	شلل 3 POLIO (5)	الثلاثي 1 DTC (6)	الثلاثي 2 DTC (7)	الثلاثي 3 DTC (8)	حصبة ROUGEOLE (9)	حمى صفراء FIEV. JAUNE (10)	لقاحات كاملة VACCIN. COMPLETE (11)	كزاز VAT 1 (12)	كزاز VAT 2 (13)	كزاز VAT 3 (14)
أقل من سنة MOINS D'UN AN														
أكبر من سنة PLUS D'UN AN														
مجموع الأطفال TOTAL ENFANTS														
نساء حوامل FEMMES ENCEINTES														
نساء في سن الإنجاب EN AGE DE PROCREER														
مجموع النساء TOTAL DE FEMMES														

OBSERVATIONS _____ الملاحظات

_____

_____

_____

XI. NOUVEAUX CAS D'AFFECTIONS (CONSULTANTS) الحالات الجديدة للإصابات

رموز منظمة الصحة العالمية CODE OMS	بعض الإصابات أو الأمراض الرئيسية AFFECTION OU SYMPTOME PRINC...	٠ - ١ سنة 0 - 1 AN	١ - ٤ سنوات 1 - 4 ANS	٥ - ١٤ سنة 5 - 14 ANS	رجال HOMMES > ١٥ سنة > 15 ANS	نساء FEMMES > ١٥ سنة > 15 ANS	المجموع TOTAL
001	Choléra كوليرا						
002	Fiévres Typhoïdes حمى التيفود						
004/67	Dysentéries / Amibiases الزحار / الأميبي						
009	Diahrée Gastro - entérites الإسهالات / إلتهاب المعدة والأمعاء						
0011	Tuberculose Pulmonaire السل الرئوي						
0033	Coqueluche السعال الديكي						
036	Méningites إلتهاب السحايا						
037	Tétanos > 28 Jours الكزاز > ٢٨ يوما						
771 - 3	Tétanos Nouveau né (0 - 28 Jours) كزاز الوليد < ٢٨ يوما						
045	Polyomélite شلل الأطفال						
055	Rougeole الحصبة						
060	Fiévre jaune الحمى الصفراء						
070	Hépatite Virale إلتهاب الكبد						
071	Rage مرض الكلب						
076	Trachôme التراكوم (التهاب الملتحمة التراخومي)						
084	Paludisme الملاريا						
345	Epilepsie الصرع						
091	Syphilis الزهري (السفلين)						
098	Gonorrhée السيلان						
120	Schistosomiase منشقات الجسم (بلهارسيا)						
125 - 7	Dracunculose (ver de Guinée خيطية المدينة أوغينيا (بوروت)						

رموز منظمة الصحة العالمية CODE OMS	بعض الإصابات أو الأمراض الرئيسية AFFECTION OU SYMPTOME PRINCIPAL	٠ - ١ سنة 0 - 1 AN	١ - ٤ سنوات 1 - 4 ANS	٥ - ١٤ سنة 5 - 14 ANS	رجال HOMMES > ١٥ سنة > 15 ANS	نساء FEMMES > ١٥ سنة > 15 ANS	المجموع TOTAL
129	Parasitoses intestinales الطفيليات المعوية						
254	Tyroïdites التهاب الدرق						
263	Malnu. Prot-calorique سوء التغذية البروتيني الحروري						
285	Anémies فقر الدم						
372	Conjonctivites إلتهاب الملتحمة						
381 - 2	Otites إلتهاب الأذن						
463 - 3	Angine, Pha. aigues إلتهاب اللوزات إلتهاب الحنجرة الحاد						
481 - 5	Pneumopathies إعتلالات الرئة (أمراض)						
487	Grippe چريب (انفلونزا)						
521	Caries dentaires تسوس الأسنان						
599	Infections des voies urinaires إلتهاب المجاري البولية						
614 - 6	Aff. Pel. Fém الإلتهابات الحوضية النسائية						
729	Aff. Rhum. / Mialgies الإصابات الرثوية (روماتيزمية) آلام عضلية						
780	Etats morbides mal définis حالات مرضية غير محددة						
829	Fractures الكسور						
869	Traumatismes الرضوض						
870 - 97	Plaies الجروح						
949	Brûlures الحروق						
401	HTA ارتفاع ضغط الدم						
366	Cataracte ساد						

APPENDIX K5

MEDICAMENTS الأدوية				QUANTITES الكميات						
الرمز CODE 1	وحدة القياس UNITE DE MESURE 2	التصنيف DESCRIPTION 3	ثمن المفرد COUT UNITAIRE 4	المخزون في بداية الشهر STOCK AU DEBUT DU MOIS 5	وصل هذا الشهر RECU CE MOIS 6	وزع هذا الشهر DISTRIBUE CE MOIS 7	بيع هذا الشهر VENDU CE MOIS 8	الضائع والتالف PERTES ET AVARIES 9	الرصيد في نهاية الشهر SOLDE A LA FIN DU MOIS 10	مدخول الشهر بالأوقية U.M. RECUES CE MOIS 11
01		Acide Acetyl Salycilyque								
02		Acide Ascorbique								
03		Amoxicline								
04		Aminophilline								
05		Ampiciline 1G								
06		Atropine 1/4 MG								
07		Benzatine Peniciline								
08		Benoate Benzyl								
09		Chlorexidine								
10		Chloroquine								
11		Chloramphenicol								
12		Cotrinoxazole								
13		Diazepan								
14		Digoxine								
15		Dexametazole								
16		Eau pour Préparation Injection								
17		Epinephrine								
18		Erythromycine								
19		Fer + Acide Folique								
20		Furosenide								
21		Glucose 5%								
22		Gentamycine								
23		Griseofulvine								
24		Hydrixide D'Aluminium								
25		Indometacine								
26		Merindazole								
27		Melosamide								
28		Methylergometrine								
29		Macromolecules (Dextran)								
30		Nystatine								
31		Oxytocine								
32		ONULENT WITHFIELD								

APPENDIX K6

MEDICAMENTS الأدوية				QUANTITES الكميات						
الرمز CODE 1	وحدة القياس UNITE DE MESURE 2	التصنيف DESCRIPTION 3	ثمن المفرد COUT UNITAIRE 4	المخزون في بداية الشهر STOCK AU DEBUT DU MOIS 5	وصل هذا الشهر RECU CE MOIS 6	وزع هذا الشهر DISTRIBUE CE MOIS 7	بيع هذا الشهر VENDU CE MOIS 8	الضائع والتالف PERTES ET AVARIES 9	الرصيد في نهاية الشهر SOLDE A LA FIN DU MOIS 10	مدخول الشهر بالأرقية U.M. RECUE CE MOIS 11
01		Acide Acetyl Salycilyque								
02		Acide Ascorbique								
03		Amoxicline								
04		Aminophilline								
05		Ampiciline 1G								
06		Atropine 1/4 MG								
07		Benzatine Peniciline								
08		Benoate Benzyl								
09		Chlorexidine								
10		Chloroquine								
11		Chloramphenicol								
12		Cotrinoxazole								
13		Diazepan								
14		Digoxine								
15		Dexametazole								
16		Eau pour Préparation Injection								
17		Epinephrine								
18		Erythromycine								
19		Fer + Acide Folique								
20		Furosenide								
21		Glucose 5%								
22		Gentamycine								
23		Griseofulvine								
24		Hydrixide D'Aluminium								
25		Indometacine								
26		Merindazole								
27		Melosamide								
28		Methylergometrine								
29		Macromolecules (Dextran)								
30		Nystatine								
31		Oxytocine								
32		ONULENT WITHFIELD								

VIII. ACTIVITES DES C.R.E.N., ETAT NUTRITIONNEL ET EDUCATION POUR LA SANTE. CENTRE DE RECUPERATION NUTRITIONNELLE (C.R.E.N.)

نشاطات مراكز التعويض والتهذيب الغذائي / الحالة الغذائية / والتثقيف من أجل الصحة مركز التعويض الغذائي

تحت المراقبة منذ بداية شهر SOUS SURV. DEBUT MOIS (1)	ENTREES PAR CAUSES القبول حسب الأسباب								SORTIES PAR CAUSES الخروج حسب الأسباب					تاريخ انتهاء المراقبة نهاية الشهر SOUS SURV. FIN DU MOIS (15)
	إسهال DIAREHEE (2)	DESHYDRATATION تجفف			فقر دم ANEMIE (6)	سوء تغذية MALNUTRITON PROTEINICOCALORIQUE (7)	أخر AUTRE (8)	مجموع المقبولين TOTAL ENTREES (9)	شفاء GUERI (10)	مرفوع EVACUE (11)	تخلي المريض عن العلاج ABANDON (12)	وفاة DECES (13)	مجموع المتخرجين TOTAL SORTIES (14)	
		A (3)	B (4)	C (5)										

وزن الأطفال
IX. PESE DES ENFANTS

PESEE DES ENFANTS وزن الأطفال			
شريط أخضر BANDE VERTE (1)	شريط أصفر BANDE JAUNE (2)	شريط أحمر BANDE ROUGE (3)	مجموع الأطفال الموزونين TOTAL ENFANTS PESES (4)

التثقيف من أجل الصحة
X. EDUCATION POUR LA SANTE

الموضوعات المطروقة THEMES TRAITES	عدد الحلقات NOMBRE DE SEANCES	عدد المشاركين NOMBRE DE PARTICIPANTS
PRENATAL سير الحمل		
SANTE INFATILE صحة الأطفال		
PLANIFICATION FAMILIALE تنظيم الأسرة		
M.S.T. أمراض منتقلة عن طريق الجنس		
VACCINATION التلقيح		
HYGIENE ET ASSAINISSEMENT الإصحاح والتنظيف البيئي		
NUTRITION التغذية		
AUTRES (Specifiez) موضوع أخر (حددوا)		
TOTAL المجموع		

OBSERVATIONS الملاحظات

APPENDIX 18

ETABLISSEMENT DU RAPORT

إعداد التقرير

Date d'Etablissement	تاريخ الإعداد
Nom et Prénom du Responsable	الإسم الشخصي والعائلي لمعد التقرير
Signature	التوقيع
Date d'Envoi au Médecin Moughataa	
Date de Reception	تاريخ الإرسال إلى طبيب المقاطعة
Observations / Remarques	تاريخ الاستلام
Date d'Envoi au DRASS	ملاحظات
VISA	تاريخ الإرسال إلى المدير الجهوي للعمل الصحي والاجتماعي
	تأشرة
Date d'Arrivée à la DRASS	
VISA	تاريخ الوصول إلى الإدارة الجهوية
	تأشرة
Date d'Acheminement à la DHPS ou DPFC	تاريخ الإرسال إلى إدارة الوقاية والرعاية الصحية
VISA	أو إدارة التكوين والتخطيط والتعاون
	تأشرة
Date d'Arrivée	
VISA	تاريخ الوصول
	تأشرة

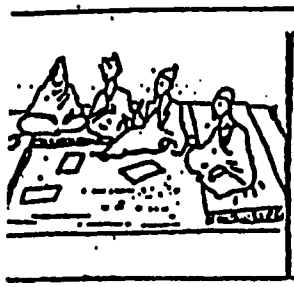
APPENDIX L1

REPUBLIQUE ISLAMIQUE DE MAURITANIE
MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

RAPPORT D'ACTIVITES DE L'HYGIENISTE/SECOURISTE

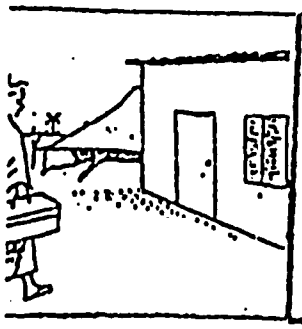
PERIODE DE: À:

VILLAGE DE:

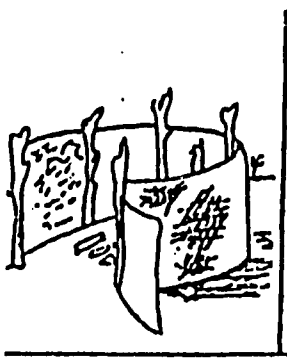


Nombre de reunions du CSC. عدد اجتماعات اللجنة الصحية

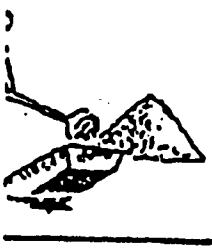
Nombre de séances d'E.P.S* عدد حصص التوعية الصحية



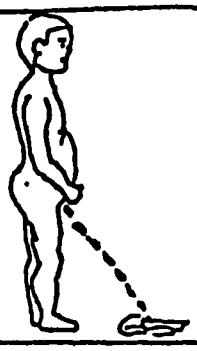
Nombre de visites à domicile. عدد الزيارات المنزلية



Nombre de latrines construites عدد المراحيض المبنية

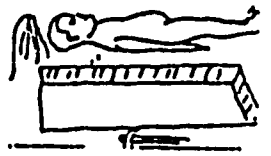


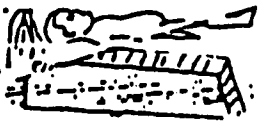
Nbre de trous à ordures construits عدد حفرات القمامات

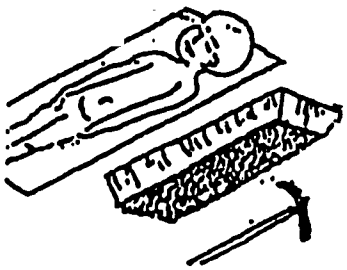


Nombre de cas de bilharziose — عدد حالات البلهراسيا

Nombre de cas de ver de Guinée — عدد حالات "بورُوث"

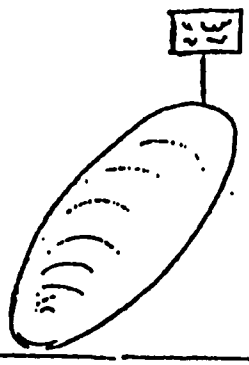
ROUGEOLE nombre de cas عدد حالات الحصباء	Nombre de décès عدد الوفيات
Moins de 5 ans اصغر من سنوات	
Plus de 5 ans اكبر من سنوات	

Coqueluche nombre de cas عدد حالات السعال الديكي	Nombre de décès عدد الوفيات
Moins de 5ans, اصغر من سنوات	
Plus de 5ans اكبر من سنوات	



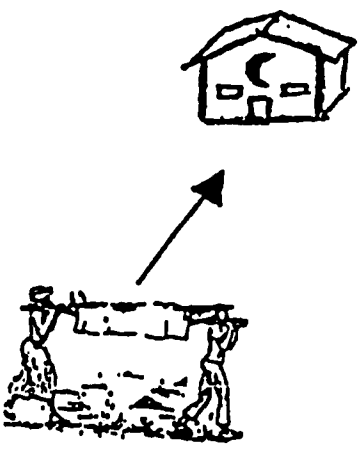
Nombre de décès chez les enfants de 0 à 5 ans

عدد الوفيات لدى الأطفال من ٠-٥ سنوات



Nombre de décès chez les enfants de plus de 5 ans et les adultes

عدد الوفيات لدى الأطفال الأكبر من ٥ سنوات والبالغين



Nombre d'évacuations au dispensaire

عدد الحالات الموجهة الى المستوصف

REPUBLIQUE ISLAMIQUE DE MAURITANIE
MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

ENQUETE COMPLEMENTAIRE ANNUELLE
HYGIENE / PREVENTION

ANNEE: DATE:

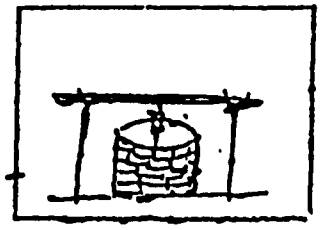
VILLAGE DE:

Nombre total de familles

العدد الاجمالي للعائلات

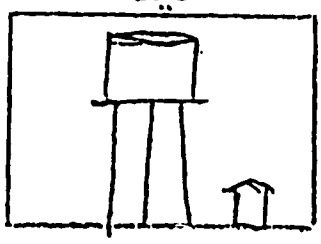
Source d'approvisionnement en eau

مصدر التزويد بالماء



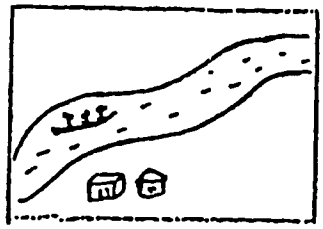
بير

Puits



حنفية

Forage



نهر

Fleuve

مستنقع

Marigot

Nombre de familles traitant l'eau par filtration.

عدد العائلات التي يصفي الماء

Nombre de familles traitant l'eau par javélisation.

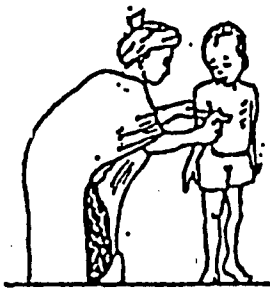
عدد العائلات التي يستعمل "جفل" في الماء

0 à 1 AN من ٥ الى سنة واحدة

0-11

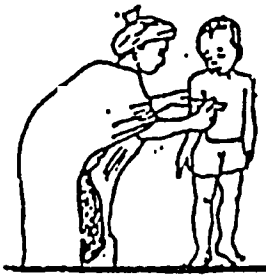
1 à 5 ANS من سنة الى ٥ سنوات

11



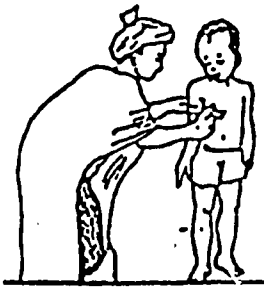
Nombre d'enfants dans la zone rouge

عدد الأطفال في المنطقة الحمراء



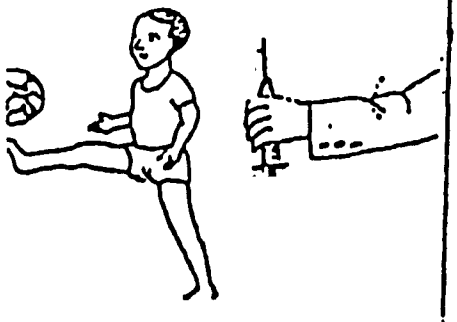
Nombre d'enfants dans la zone jaune.

عدد الأطفال في المنطقة الصفراء



Nombre d'enfants dans la zone verte

عدد الأطفال في المنطقة الخضراء



enfants complétement vaccinés.

الأطفال الملقحون تماما

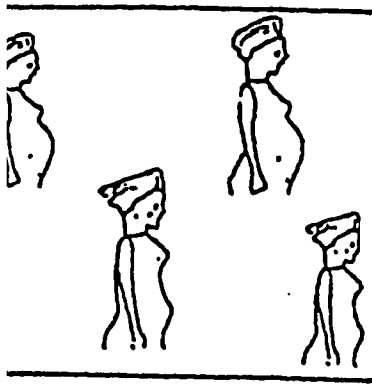
REPUBLIQUE ISLAMIQUE DE MAURITANIE
MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

RAPPORT D'ACTIVITES DE L'ACCOUCHEUSE TRADITIONNELLE

PERIODE DE: A:

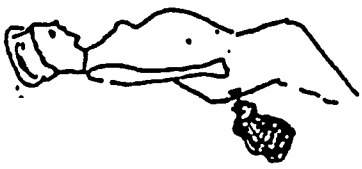
VILLAGE DE:

عدد اجتماعات التوعية الصحية المناهضة
من طرف الولادة التقليدية.



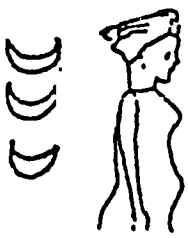
Nombre de femmes enceintes recensées

عدد النساء الحمل.



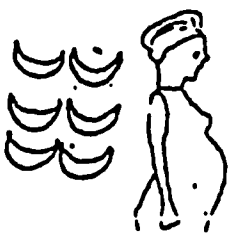
Nombre de femmes ayant fait une fausse couche

عدد النساء اللواتي أصبنة بإجهاض



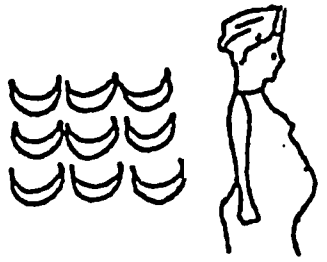
Nombre de femmes ayant subi la visite du 3è mois

عدد النساء اللواتي فحصن في الشهر الثالث



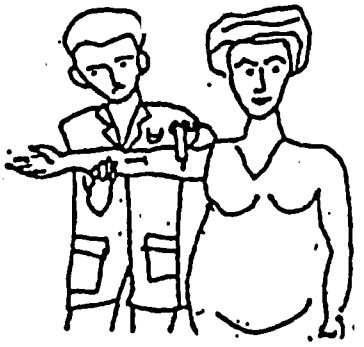
Nombre de femmes ayant subi la visite du 6è mois

عدد النساء اللواتي فحصن في الشهر السادس



Nombre de femmes ayant subi la visite du 9è mois

عدد النساء اللواتي فحصن في الشهر التاسع



Nombre de femmes ayant reçu le VAT عدد النساء اللواتي لقحن ضد الكزاز

1ère dose الجرعة الأولى	2ème dose الجرعة الثانية

Nombre de femmes enceintes ayant reçu une prophylaxie de l'anémie

عدد النساء اللواتي وجدن وقاية عن فقر الدم

Nombre de femmes anémiées dépistées au cours des visites

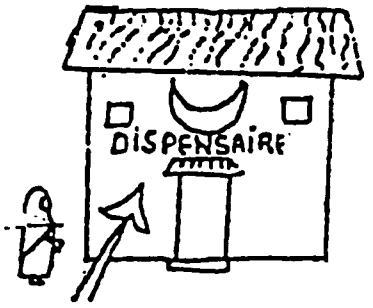
عدد النساء المصابات بفقر الدم

Nombre de femmes dénutries dépistées au cours des visites

عدد النساء المصابات بسوء التغذية

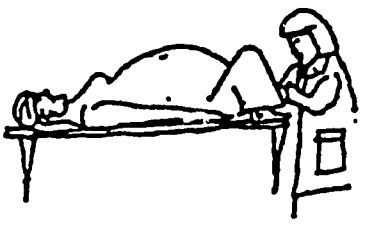
Nombre de femmes oedemateuses dépistées au cours des visites

عدد النساء المصابات بالورم



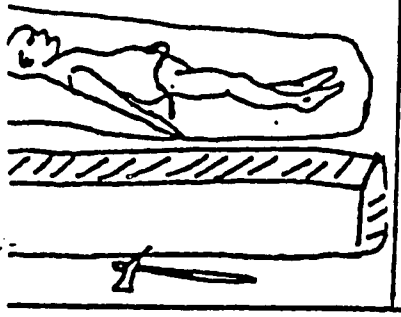
Nombre de femmes enceintes évacuées au dispensaire

عدد النساء الحمل الموجهات إلى المستوصف



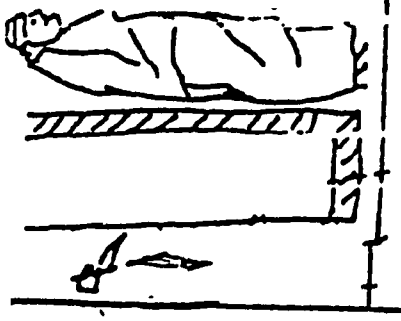
Nombre d'accouchements effectués par l'AT

عدد الولادات المجراة من طرف المولدة التقليدية



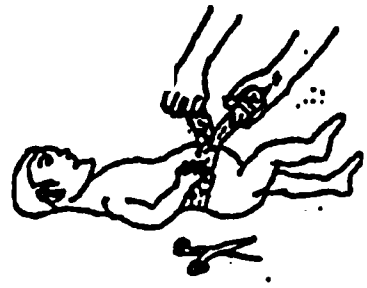
Nombre de nouveaux nés décédés

عدد وفيات المواليد حديثا



Nombre de femmes décédées lors de l'accouchement

عدد وفيات النساء خلال الولادة

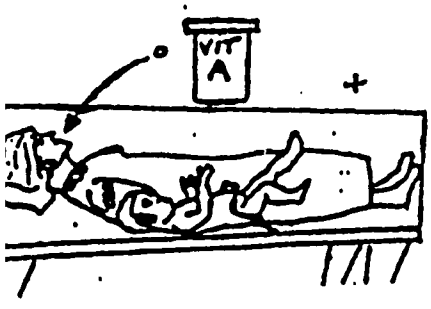


Nombre de pansements ombilicaux faits

عدد تضميدات السرة

Nombre de nouveaux nés ayant reçu du nitrate d'argent

عدد المواليد حديثا الذين أعطيت لهم قطرة من نيترات درجاه.



Nombre de femmes ayant reçu une capsule de vitamine A après l'accouchement

عدد النساء اللواتي وجدن قرصا من فيتامين "أ" بعد الولادة.

APPENDIX M

PROGRAMME ET PLAN D'EXECUTION DU PROJET

Le programme et plan d'exécution du Projet Survie de l'Enfant /Vitamine-A de Mauritanie avait été clairement défini dans le PLAN D'EXECUTION DU PROJET SURVIE DE L'ENFANT / VITAMINE A DE L'ASSABA- MAURITANIE daté du 14 mars 1990. Le Plan avait été initialement élaboré pour une période allant du 1er octobre 1989 au 30 septembre 1992. Cependant, après 15 mois de fonctionnement, World Vision a dû interrompre sa participation au Projet en raison de la crise du Golfe (de décembre 1990 à octobre 1991).

Par conséquent, les objectifs initiaux mentionnés dans le Plan d'exécution furent révisés et descrits dans le second rapport annuel daté du 5 novembre 1991.

Il était programmé que le Projet soit exécuté en collaboration avec la Direction Régionale de l'Action Sociale et Sanitaire (DRASS) au niveau de la région de l'Assaba. La meilleure manière de mettre en place ce Projet, fut d'exécuter les prestations depuis ce niveau régional. Les bons résultats en ont été la preuve. C'est particu- lièrement en assistant les communautés dans leur organisation, en sensibilisant et formant les comités et les agents de santé communautaire que nous avons pû constater ces résultats. Cependant, l'approvisionnement, la supervision et la gestion de ces services communautaires sont limités, et plus particulièrement encore au niveau des vaccinations et de la distribution de vitamine-A. Il est, par exemple, physiquement impossible pour deux équipes régionales de vaccination de visiter environ 500 villages trois fois par an. Il n'est donc pas étonnant que moins de la moitié des enfants de la région de l'Assaba aient reçu la première dose de DTC-polio avant l'age d'un an et que seulement 13 % des mêmes enfants soient complètement vaccinés.

Le fait de développer et/ou de renforcer l'infrastructure des soins de santé primaire au niveau des prestations (c'est-à-dire au niveau départemental, avec ses centres sanitaires, dispensaires et postes de santé), faciliterait la planification, l'exécution, la gestion et la supervision des prestations des soins de santé primaire. Ceci serait réalisable en accroissant et en améliorant les prestations d'un manière signiticative pour la population.

Les équipes mobiles seraient toujours nécessaires pour couvrir les zones qui ne peuvent pas être atteintes par les sites fixes et les strategie avancé. Ce genre de détails et de planifications auront une plus grande efficacité s'ils sont réalisés au niveau des services mentionnés plus haut.

World Vision pourrait mettre un délégué, du niveau régional, à la disposition de chaque Médecin Chef de département, ainsi que de son personnel. Ceci permettrait de planifier et de gérer des services de santé avec le support de la DRASS et de World Vision, non seulement dans le but d'institutionnaliser, d'améliorer et d'accroitre les prestations, mais également dans le but de contribuer à la pérénité de ces services.
ANNEX N: (continued)

Le support de la DRASS et de World Vision aux services départementaux, inclurait la mise à disposition - d'une manière permanente ou pour une durée limitée - d'un véhicule. Il devra correspondre aux besoins stipulés dans le plan d'action. Il serait également possible de soutenir ces services en leur fournissant des formulaires pour les rapports mensuels, des imprimés ou photocopies, des vaccins, médicaments ou autres fournitures, en faisant des

visites de supervision, en contrôlant la gestion, etc.

Le recouvrement des coûts et les activités génératrices de revenu qui sont introduites dans le département, pourrait aider à compenser les frais de transport ou les frais occasionnés par la réfrigération.

APPENDIX N

RESUME - PROJET S.E./VIT. A - EVALUATION MI-PARCOUR '92

World Vision/Mauritanie a obtenu, de la part du bureau FVA/PVC de l'USAID un don participatif, dans le but de prolonger le projet initial de deux ans (1987-1989) Survie de l'Enfant/ Vitamine A, à trois nouvelles années, du 1er octobre 1989 au 30 septembre 1992. Après 15 mois de vaccination, de distribution de vitamine A, de controle de la diarrhée, d'éducation sur la nutrition, d'activités sur la formation et sur la mobilisation sociale, les activités de WV ont du etre interrompues pendant environ 10 mois (de décembre 1990 à octobre 1991) en raison de la crise du Golfe. En octobre 1991, WV fit le bilan de ses activités, et, en collaboration avec la DRASS, révisa les objectifs du projet (comme descrit dans le plan de travail initial). Cette révision fut nécessaire afin que ces objectifs correspondent à la réalité de la situation, c'est-à-dire en tenant compte que les activités du Projet ont été interrompues et ont donc pris un certain retard.

Jusqu'à ce jour, le Projet a oeuvré dans le but d'accomplir les principaux points de ses objectifs ; ceci en collaboration avec la DRASS, l'Agriculture, l'Hydraulique et d'autres ONG et Agences Internationales: (* obj different dans le Plan)

	Obj.	Actuel
- Formation de membres du Ministère de la Santé dans les activités Survie de l'Enfant/Vit-A	45	45
- Formation de membres du Ministère de la Santé dans les techniques de formation et supervision	20	20
- Formation des ASC	45	45
- Formation des Accoucheuses Traditionnelles	45	34
- Assister les communautés pour créer de CS	45	34
- Vacc.enf.<1 an contre DTC-polio-3	75%	28%
- Vacc.femmes en age de procréer de 2 doses VAT	*	61%
- Mères d'enf. 0-4 mois qui donnent lait maternel	*	81%
- Distrib. vit-A enf. <72 mois pend. 6 dern. mois	*	68%
- Distrib. vit-A aux mères qui ont accouché pendant les 12 derniers mois	*	54%

Comme mentionné plus haut, certains objectifs ont déjà été atteints et d'autres sont en bonne voie pour etre réalisés.
Il y a cependant un aspect plus important que de réaliser certains objectifs durant les phases initiales, et qui est d'informer, d'éduquer et de sensibiliser le personnel du Ministère de la

Santé et d'autres Ministères, ainsi que la population en règle générale sur le bien-etre et la qualité de vie dans les communautés. Tous ces aspects ainsi que la création de comités de santé communautaires, la formation d'agents de santé et l'introduction d'un système de recouvrement de cout, ne vont pas seulement aider au développement de l'infrastructure sanitaire de la Mauritanie, mais vont aussi contribuer à la pérénité des activités de soins de santé primaire après l'achèvement du Projet du WV/Mauritanie.

Et c'est dans cette optique que l'équipe d'évaluation recommande la poursuite du Projet Survie de l'Enfant/Vitamine A en Mauritanie. Elle conseille également que WV et le Ministère de la Santé étudie ensemble les avantages de la décentralisation des activités du Projet vers les différents services départementaux.

L'équipe estime que le développement de l'infrastructure sanitaire au niveau des prestations rendues améliorera et augmentera ces services à moindre frais et contribuera à la pérénité des activités.

APPENDIX O

RECOMMANDATIONS - SE/Vit-A Projet, Eval. Mi-Parcour '92

1. World Vision Relief and Development (WVRD) assure que l'USAID accordera un rééchelonnement sans augmentation de fonds pour le Projet Survie de l'Enfant / Vitamine A de WV/Mauritanie pour l'année fiscale 1993 (du 1er octobre 1992 au 30 septembre 1993).

2. WVRD fournit/obtient $200.000 dans le but de complèter les $ 650.000 nécessaires pour achever les objectifs du Projet qui ont été interrompus et partiellement révisés suite à la crise du Golfe.

3. World Vision/Mauritanie et la DRASS/Assaba étudient les avantages et les inconvénients concernant la décentralisation des prestations du Projet Survie de l'Enfant/Vitamine-A d'un niveau régional vers un niveau départemental, comme decrit dans la section V.B. du présent rapport. Si une telle décision est prise, il sera nécessaire d'entamer la procédure avant l'année civile 1993.

4. Si ces prestations ne sont pas décentralisées vers le niveau départemental, WV en collaboration avec la DRASS devra revoir et réviser les objectifs de la couverture vaccinale en tenant compte des contraintes actuelles.

5. Si les prestations des services sont décentralisées au niveau des departements, il est recommandé d'augmenter le nombre des nouveaux villages BHU jusqu'au moins 10 des plus grands villages dans chacun des 5 departements avant le fin de Septembre 1993.

6. Des rapports mensuels sur la vaccination et sur les maladies diarrhéiques devront être rédigés par les services concernés du Ministère de la Santé, éventuellement assistés par WV (si une telle demande est présentée), dans le but d'être distribués aux parties concernées.

7. Dans le but de soutenir le Projet, un support technique doit etre fourni premièrement par le Ministère de la Santé (niveaux regional et central) et deuxièmement par WV/M Nouakchott et WVRD.

8. Le MSAS limite l'age cible a <2 ans pour le vaccination des enfants -- sauf pour le vaccination contre la rougeole qui concerne les enfants jusqu'au moins 5 ans si l'enfant n'a jamais eu la maladie ou n'a jamais été vacciné.

9. Il est indispensable d'expliques aux meres, lors des seances d'education sanitaire et également, a travers les masses-medias, let but des vaccinations antitétaniques.

10. Plus important encore, est le fait comprendre aux mères, de donner aux enfants souffrant de diarrhée, des liquides (en general) au lieu de persister a leur donner des solutions contenant du sucre/sel.

11. SE/Vit-A Projet assure que les sachets SRO sont disponible dans tous les village USB.

12. WV/Mauritanie assiste la DRASS/Assaba afin de développer / améliorer le Système Regional de Gestion et d'Information Sanitaire jusqu'à ce qu'un tel système soit mis en place au niveau national.

13. WV/Mauritanie continue d'assister le Ministère de la Santé dans ses efforts d'éliminer le ver de Guinée dans la région de l'Assaba.

14. WV/Mauritanie assiste la DRASS/Assaba pour organiser et conduire des réunions qui soient au moins trimestrielles du personnel de différents ministéres et des ONG.

15. WV/Mauritanie prépare un plan de travail pour l'année fiscale 1993 avec des objectifs clairs, precise, mesurables et réalistes.

16. Les objectifs du plan de travail SE/Vit-A consignés dans ce document permett de mesurer les progrés de ce Projet.

17. Le Projet SE/Vit-A exploite la partie non-vaccinale de l'enquete d'Aout 1992 en utilisant le logiciél EPI-INFO (qui existe dans le Bureau WV/M a Nouakchott) et comparer avec les resultats etablis à la main.

18. Les chauffeurs du Projet doivent etre formés pour assister les activités du Projet, par exemple : éducation sur la santé, mobilisation sociale, etc.

19. WV/Mauritanie assure que les equipes de terrain parle les memes langues que les communautés.

20. Traduire en francais les resultats de cette evaluation et diffuser parmi le personnel francophone de WV/M, le personnel approprié du MSAS et les autres parties interesseès.