

PD-AA N-281

Prepared for:

Office of Program, Policy and Evaluation  
Bureau for Food for Peace and Voluntary Assistance  
Agency for International Development  
Washington, D.C.  
Under Contract No. PDC-0800-C-00-3066-00

MAURITANIA Food for Peace/Title II Evaluation

by

Betsy Stephens, Team Leader  
International Science & Technology Institute, Inc.

and

Ronald Parlato  
International Science & Technology Institute, Inc.

Prepared by:

International Science and Technology Institute, Inc.  
2030 M Street, N.W., Suite #300  
Washington, D.C. 20036  
(202) 466-7290

April 1980

**BEST AVAILABLE COPY**

## TABLE OF CONTENTS

	<u>Page</u>
Abbreviations .....	iii
1. Introduction .....	1
1.1. Purpose .....	1
1.2. The Evaluation Team .....	1
2. Methodology .....	1
3. Background .....	2
4. GIRM, CRS and USAID/M Expectations for the CRS Program .....	5
5. Outline of the Discussion .....	7
6. Enrollment/Targeting .....	8
6.1. Issues .....	8
6.2. Conclusions and Recommendations .....	9
7. Participation .....	14
7.1. Issues .....	14
7.2. Conclusions and Recommendations .....	16
8. The Ration .....	18
8.1. The Value of the Ration .....	18
8.2. Issues .....	19
8.3. Conclusions and Recommendations .....	20
9. Surveillance .....	21
9.1. Issues .....	21
9.2. Conclusions and Recommendations .....	22

	<u>Page</u>
10. Nutrition and Health Education .....	24
10.1. Issues .....	24
10.2. Conclusions and Recommendations .....	26
11. Personnel .....	28
11.1. Issues .....	29
11.2. Conclusions and Recommendations .....	29
12. Integration .....	31
12.1. Issues .....	31
12.2. Conclusions and Recommendations .....	33
13. Conclusion .....	35
APPENDIX I - Survey of Mothers in Nouakchott, March 27-31, 1983 ...	A-1
Questionnaire: Enquete sur le Programme de CRS a Nouakchott .....	A-4
APPENDIX II - Protocole d'Application du Programme CRS au Service de SMI .....	A-7
APPENDIX III - Project Outline: Nutrition/Health Education in Mauritania .....	A-10
APPENDIX IV - List of Interviews .....	A-12

## ABBREVIATIONS

AN	Nutrition Auxiliary
CAC	Community Feeding Centers
CM	Regional Medical Officer
CREN	Intensive Nutrition Rehabilitation Center
CRM	Red Crescent of Mauritania
CRS	Catholic Relief Service
CSA	Commission for Food Security
EEC	European Economic Community
EPI	Expanded Program of Immunization
MCH	Maternal and Child Health
MRD	Ministry of Rural Development
MOH	Ministry of Health
PMI	Maternal and Child Health Service
SF	Midwife
WFP	World Food Program

## 1. Introduction

### 1.1. Purpose

The purpose of the evaluation was to study the Title II CRS Food and Nutrition Program in order to: (1) assess program operations -- distribution of the food, nutritional surveillance, and nutrition and health education -- and to recommend modifications that would help improve the functioning and performance of the program; and (2) to determine the degree to which the CRS philosophy and operations are oriented towards the stated objectives and priorities of the Government of Islamic Republic of Mauritania (GIRM) and to suggest alternative options that would better align the program with those priorities.

### 1.2. The Evaluation Team

The evaluation was a collaborative effort which included the following individuals: Mlle. Fatimata Sy, Director, Office of Nutrition, Maternal and Child Health Service, Ministry of Health; Ms. Patrice Flynn and Ms. Jill Gulliksen, Food and Nutrition Supervisors, CRS; Mr. Michael Kerst, Food for Peace Officer and Mrs. Heather Goldman, Nutritionist, USAID; and Mr. Ronald Parlato and Mrs. Betsy Stephens, Consultants, AID/W Evaluation Team.

## 2. Methodology

The Evaluation Team had two and a half days of meetings in Washington and then spent three weeks in Mauritania (March 17 - April 8, 1983). The evaluation process included the following:

- 1) A review of all available documentation on the CRS program in Mauritania and relevant background information on the country.
- 2) Briefing meetings in Washington with AID and CRS/NY.
- 3) Discussions with CRS/M and the GIRM (and to a lesser extent the CRM) about their objectives, both present and future, and about program operations.

- 4) Discussions with USAID/M about their perspectives concerning CRS and GIRM objectives and operations.
- 5) Discussions with representatives of related GIRM departments in Nouakchott and in the regions.
- 6) Field visits to eight CRS centers in Nouakchott and in the regions.
- 7) A survey of 185 participating mothers in 3 centers in Nouakchott. (see Appendix I)

### 3. Background

The Catholic Relief Services (CRS) program began in 1975 as a food relief project. It was formally transformed into a Food and Nutrition program in 1978 but did not make the substantive transition until 1980. Over the last three years, CRS has gradually created a network of centers that provide a regular and uniform program. Out of 23 existing centers, 3 are in Nouakchott and 20 are in rural towns. In January 1983, CRS signed a new Protocol with the GIRM which sets forth 13 points of agreement concerning program objectives, operations, and responsibilities. (see Appendix II)

During 1982, the program only reached 80% of its Annual Estimate of Requirements. The maximum number of beneficiaries in a single month was about 57,000, including approximately 14% of the 0 - 6 population of Mauritania. The number of beneficiaries fluctuated considerably due to the closing of several centers because of personnel problems, disruptions resulting from complications in the institution of the mothers' contributions by the Ministry of Health (MOH), problems with commodity deliveries because of weather, the weeding out of irregular registrations, and measles outbreaks. Moreover, many of the centers were not visited more than once or twice during the year as one of the two Food and Nutrition supervisor positions was vacant during most of 1982 and trips into the interior are long and arduous and periodically impeded by sandstorms in the desert and flooding in the riverine areas.

The CRS program is well integrated with the Ministry of Health. Seventeen of the 23 centers, are operated through MCH clinics, the others operate in cooperation with the Red Crescent of Mauritania (CRM). At central level, CRS collaborates with the Office of Nutrition within the Maternal and Child Health Service of the Ministry of Health and with the Red Crescent. All CRS data are forwarded routinely to the Ministry and to CRM, there are regular monthly meetings between CRS, the MOH, and the CRM, and the supervision of centers is done jointly by CRS and MCH or CRS and CRM supervisors, as appropriate. CRS also collaborates with the MOH by providing rations to the intensive rehabilitation centers for severely malnourished children (CRENs), which have been established in all MCH clinics throughout the country, and to selected community feeding centers (CACs) recently instituted by the MOH.

A center operating at full capacity can serve 1600 mothers per month, i.e., 40 mothers per session, two sessions a day, five days a week, four weeks a month. Each mother may enroll a maximum of two children. Large centers with a full program have three nutrition staff, smaller centers in smaller communities have two. The staff are either Nutrition Auxiliaries (AN) (of whom there are 9 working in 5 centers) or volunteers. The ANs were trained for four months by the MOH, the volunteers receive 3 to 6 weeks training. Each center is supervised by the Midwife (SF) who is in charge of the affiliated MCH clinic.

There is an established program sequence for each session. When the mothers arrive at the appointed hour, they pay 20 UM (\$.40) and receive numbers. They are required to attend a group lecture which is followed by the weighing and recording of the individual children's growth status on the

Master Chart and individual growth charts. Then there is a cooking demonstration and the children are fed. Finally, the rations are distributed. Each mother receives one ration for herself and one for each child in the program.

While, according to the statistics provided by the Growth Surveillance System, the average rate of malnutrition among CRS program children is 36.6% (Jan.-Sept. 1982), CRS/M recognizes that the growth surveillance statistics are not very reliable. There are serious difficulties in ascertaining age in Mauritania and problems teaching inexperienced center personnel to accurately record the weight for age data. Nonetheless, these are the only nutritional status statistics available in Mauritania at present.

CRS has established a smoothly functioning logistical support system. There is an excellent, well-managed warehouse in Nouakchott and adequate storage facilities in all of the centers. The inland transport is efficiently organized, mostly through private transporters, and deliveries are regular (excepting in poor weather). There is good accountability for the commodities at all levels. Responsibility for losses from Nouakchott to the centers is borne by the transporters. The documentation required from centers enables CRS staff to cross check and immediately pick up inconsistencies between commodity status and participation reports. The end-use checker and/or international staff visit centers immediately when problems arise.

According to CRS projections for July 1983 - July 1985, 31% of the CRS operating budget will be covered by the GIRM. This includes the contributions of MCH, CRM, and community staff and local warehousing, and participant fees. Eight percent will be covered by CRS, 9% by private donors, and 52% by USAID (Outreach Grant).

CRS projects that, by the end of 1985, the GIRM will be able to take over a higher proportion of the operating costs. Although inland transport charges are exceptionally high (averaging \$80/T), it is anticipated that a 50% increase in recipient fees will partially cover these costs. In addition, it is planned that GIRM personnel will take on more responsibility for end-use checking and center supervision. Nonetheless, given the current dependence of the GIRM on foreign subsidies for 60% of national expenditures and two-thirds of all food consumed, it is likely that the CRS program will continue to require significant external support in the foreseeable future.

#### 4. GIRM, CRS and USAID/M Expectations for the CRS Program

The CRS stated objective for the program is to provide an economic aid to the family and to ensure that a part of this aid will go to the child to improve her/his nutritional status, and thus her/his health. The child's growth is monitored, using the Growth Surveillance System which provides the indicator of change in nutritional status. The CRS philosophy is to target poor families, to provide them with the economic assistance that is necessary to enable them to provide adequately for their children, and to educate mothers about health and nutrition practices that are necessary to maintaining the well-being of their children. CRS believes that by locating the program in poor communities and employing an open enrollment policy, the program will reach needy families who need this support to prevent deterioration among adequately nourished children and to help improve the status of the malnourished.

CRS criteria for opening new centers are the availability of commodities and CRS managerial resources, as well as support from the MOH or CRM at national level. At the local level there must be adequate physical facilities

in which to operate the program and store the commodities, a designated administrator and competent staff who can be trained to run the program, and community interest.

The GIRM views the CRS program as the major nutrition activity in the country and therefore would like to have the program philosophy more closely aligned with the government's objective which is to reduce malnutrition in the 0-5 population. The GIRM believes therefore that the primary objective of the CRS program should be to reach the malnourished, with priority given to the 0-3 population. The GIRM has also sought CRS collaboration with the nutrition activities established by the MOH. CRS is presently providing commodities and a portion of the recipient fees (2,000 UM/mth.) to the intensive rehabilitation centers for the severely malnourished that operate at the MCH clinics. The MOH has recently launched a program to develop community based on-site feeding centers (CAC) for the rehabilitation of the moderately malnourished and CRS has been providing small quantities of commodities for those centers.

The GIRM believes that the present CRS program does not effectively reach malnourished children, largely because of its conviction that take-home food is distributed to all members of the family and not given just to the malnourished. In a report\* of a recent National Nutrition Seminar it was recommended that the CRS/CRM/PMI nutrition program should be re-oriented to "better rehabilitate severely and moderately malnourished children" and that measures to be taken should include:

- better and more appropriate training;

---

\* Rapport du Seminaire National sur la Nutrition, MOH, 14-17 December, 1982, Nouakchott, (pp. 6-7).

- a change from "fixed" centers to a more mobile approach, based on community contact and community participation;
- better coordination among concerned agencies (CRS, CRM, PMI);
- creation of a national food and nutrition commission.

The GIRM supports expansion of the CRS program because of the concern to extend nutrition activities into unserved areas. Moreover, the GIRM attaches a very high priority to establishing services in the rural areas in an attempt to stem the extremely high rates of rural to urban migration.

USAID/M considers the CRS program to be a significant component of the USAID/M strategy to encourage a development oriented approach to national food needs. The CRS program supports the USAID/M strategy to improve nutrition and preventive health services in Mauritania and to expand those services into rural population centers in an attempt to help reduce the rural exodus.

Although there is excellent cooperation between USAID/M and CRS, and CRS depends on AID for the commodities and for a significant proportion of the operating budget, USAID/M respects the independence of CRS, recognizing that, as a Private Voluntary Agency it is a partner in development and is not controlled by USAID.

##### 5. Outline of the Discussion

A discussion of selected aspects of the CRS program follows with particular emphasis on: 1) description of the existing situation; 2) analysis of the implications and issues; 3) possible alternative measures to be taken for program improvement; and 4) actions that are recommended by the Evaluation Team. The headings for this analysis are:

- Enrollment/Targeting
- Participation
- Ration

- Surveillance
- Health and Nutrition Education
- Personnel
- Integration

## 6. Enrollment/Targeting

### 6.1. Issues

The CRS targeting objective is to enroll children 0-5 years old from poor and disadvantaged communities. In theory, this should ensure the enrollment of substantial numbers of malnourished children. In fact, CRS figures indicate that only approximately 36.6% of its program participants are under 80% of median weight for age. As there are no other nutritional data from Mauritania, it is not known whether this is representative of the population as a whole. Nonetheless, it is clear that there are many malnourished children who aren't being served. The GIRM believes that the CRS program should more directly target those children.

Presently, CRS has a stated policy of open enrollment in the communities in which they operate: that is, first come, first served until either the operational maximum is met (1600 mothers or less, depending on the capability of the center staff) or all of those seeking inscription have been inscribed. In smaller communities CRS is able to meet the demand, however, there may be an unmet need -- i.e. families with malnourished children who do not seek enrollment because of ignorance or other socio-cultural reasons. In larger communities there is unmet demand, including families with malnourished children, and unmet need.

Although little is known about non-participants or about the motivation of those who self-select to participate in the CRS program, the survey of

mothers\* found that 78% of respondents had been living in Nouakchott for more than 5 years. This is significant considering that the population of Nouakchott is thought to have nearly doubled in the last five years. Thus, for whatever reasons, recent migrants are not well represented in the CRS program.

## 6.2. Conclusions and Recommendations

### 6.2.1. Targeting

It is recommended that the CRS program more effectively target malnourished children by introducing as many of the following alternative actions as possible, given the CRS philosophy and administrative constraints.

- (1) Graduate nourished children at the age of 3 and limit enrollment to children ages 0-2, thus ensuring at least one full year of surveillance.

Reducing the age of graduation from 60 months to 36 months (excepting the malnourished) would immediately increase the proportion of malnourished in the program as the rates of malnutrition are significantly higher in the under 3 population. This would also ensure a higher proportion of those children most needing health and nutritional surveillance. Moreover, since the health and nutrition education offered at the CRS centers is primarily oriented toward the nursing and weaning periods of a child's life, it is more relevant for the mothers of children under 36 months.

Although the MCH/MCH program targets all children 0-5, the Ministry believes that priority should be given to children under 36 months. CRS/M, however, believes it is important to keep children in the

---

\* See Appendix I.

program until age 5 in order to: 1) maintain the economic supplement as long as possible; 2) maintain nutritional surveillance until the critical age of 5, after which most children survive; and 3) keep children in the MCH program.

Moreover, CRS is fearful that if only nourished children were graduated at 3 years, mothers might keep their children malnourished in order to be eligible to remain and suggested that, if there were to be graduation at 3 it should be for all children.

Given the GIRM's stated priorities and the assumption that many malnourished children are not being reached, the Evaluation Team favors graduation of the well-nourished at 3, and keeping the malnourished until 5.

- (2) Give priority to inscribing malnourished children: in new centers, enroll malnourished children first; in existing centers, as new places become available, enroll malnourished children first. Well-nourished children would be enrolled if there were space available.

Both the MOH and CRS/M and the Evaluation team supported this option.

- (3) Develop an outreach program whereby an active effort to find and recruit malnourished children would be made. Such an outreach program would enroll all severely malnourished children into the CRENs and all moderately malnourished children into the CRS center. Nourished children would be accepted on a first come, first served basis if space were available.

The development of such an outreach program is obviously difficult. Given the heavy demands already being made on the MCH and CRS staff, it would probably require an active community action effort to be successful. Some of the MCH clinics have already initiated a census of children in the community. These could be used as the basis for identifying children for the nutrition programs.

(4) Develop Community Feeding Programs (CAC) as integral parts of the MOH and CRS nutrition program. That is:

- severely malnourished children go to CRENS
- moderately malnourished children go to CACs, where they receive on-site feeding
- referrals from CRENS and CACs -- recuperated children -- go to CRS centers for nutritional maintenance until the age of 3.

The MOH has already introduced CACs on a trial basis into several neighborhoods in Nouakchott. The principles of the CACs are:

- community nutrition surveillance
- on-site feeding to guarantee consumption
- community management
- MCH technical supervision

The development of such CAC programs is considered to be of high GIRM/MOH importance for the following reasons:

(a) CAC centers, in principle, will better meet the nutritional needs of what is thought to be a significant portion of the under-5 population - those children moderately malnourished (i.e., 60-80 percent of median weight-for-age). At present, although CRS programs do reach this group -- all malnourished children in CRS programs.

are moderately malnourished by definition, since those under 60 percent are automatically referred to CRENs - the GIRM believes that only on-site feeding can effectively and definitively reach them.

(b) CAC centers, being community-based, -operated, and -managed, can more effectively run outreach programs designed to: 1) find malnourished children; 2) provide information concerning the importance of enrollment in nutritional programs; and 3) provide community follow-up.

(c) CAC centers, being community-based, offer the opportunity for increased community financing.

(d) CAC centers offer the potential for becoming community Primary Health Care centers - offering a range of preventive and curative services.

Although attractive in theory, the CAC concept will present many administrative problems, especially in the more rural communities. In order to generate active community involvement and to maintain good management and accountability, they will require continuous supervision and training of community participants.

The MOH has requested CRS to provide additional commodities to the CACs and it is recommended that CRS support the program on an experimental basis in selected communities in which there is a well-run MCH clinic and an active community organization. If successful, the CACs would gradually become more integrated with CRS activities, enabling the CRS centers to be more community-oriented, to get more support from the communities, and to better meet their needs.

The administrative arrangements for providing the commodities will have to be negotiated. There are three options:

- CRS would allocate commodities separately for the CACs;
- all rations at the related CRS center would be reduced by a given fraction and that portion of the center's allocation would be given to the CAC;
- withhold the rations of the moderately malnourished children in the CRS program during the period they participate in the CAC and transfer their allotment to the CAC (the present arrangement for CREN participants).

- (5) Begin discussions with the Commission for Food Security (CSA) to determine whether they, as part of the Emergency Food Aid program, can give priority to distributing food aid to mothers and children who have graduated from the CRS programs.

At the present time CSA operates both a commercial sale and Emergency Food Aid program. The latter, designed to provide food to "needy" (sinistré) families and communities, suffers, according to AID and the Evaluation Team, from a lack of well-defined priorities, both in terms of selection criteria and period of distribution. It is believed that a more rational distribution system would result in better coordination with existing nutrition programs and better overall targeting within communities. This would help CSA to better meet its own objectives and reinforce existing non-CSA food and nutrition programs. CSA, however, has a long history of bureaucratic and political independence, and may not be entirely receptive to such proposals.

### 6.2.2. Research

In order to plan and evaluate a well targeted program, the MOH and CRS will need information on the nutritional status of children in Mauritania and on the numbers and characteristics of families who do not participate in the CRS program in communities in which there are centers. Therefore, if there is to be a health status study in connection with the Trarza Project or the planned Primary Health Care Project (as has been suggested), it is recommended that the sample include communities with CRS centers and that the necessary questions be incorporated to ascertain malnutrition rates and to identify pertinent characteristics of participants and non-participants in the CRS program.

## 7. Participation

### 7.1. Issues

Although CRS has enrolled a relatively high proportion of the total estimated 0-6 population, the levels of active participation in the program vary significantly. Throughout 1982, there were fluctuations in the numbers of beneficiaries related both to disruptions in the program and to irregular participation. According to CRS figures for January and February 1983, the participation rates were 76% and 79% respectively (although the figures are somewhat underestimated as not all graduates had been removed from the enrollment totals).

A number of hypotheses have been suggested that may, singly or in combination, explain this irregular attendance:

- (1) The economic value of the ration may not be great enough to motivate the mothers. This is doubtful, given the estimated high value of the ration relative to average capita income (14%); and particularly doubtful given the fact that every family is entitled to a

minimum of 2 rations (one for the mother, and one for each child) representing 28% of average per capita income. Yet, the value of a woman's time in the home may have been underestimated, and it may be worth more than the perceived value of the ration. (Nonetheless, there is some circumstantial evidence indicating that the value of the ration affects attendance. When the mothers learned of a planned reduction in the sorghum from 4 kg. to 2 kg. -- a reduction that, in fact, was never introduced -- the participation rates temporarily fell in at least one center in Nouakchott and in the center in Rosso).

- (2) Although the market value may be high, mothers may be discouraged from selling the commodities, therefore potentially lowering their value (by forcing substitution).
- (3) The food has limited acceptability considering local taste preferences and dietary patterns.
- (4) Semi-sedentary and nomadic populations may not be able, even given the supposed high economic value of the ration, to leave their fields or to come the long distances implied by a nomadic life.
- (5) There may be little motivation for other services provided at the CRS center. Classically in such food distribution programs, most mothers come for the food, and not the ancillary support services offered. Thus, if the food is not of a high enough perceived value, the attraction of other CRS/MCH services will not be great enough to motivate participation.

- (6) Poor program management and organization may mitigate against full participation -- mothers are discouraged by the attitudes of clinic staff, confusion and crowding at the center, misunderstandings about the day or time of their expected attendance, etc.
  
- (7) The existence of other food distribution programs may, to some degree, inhibit full participation in the CRS program. In the town of Moudjeria, for example, there were Commission for Food Security (CSA), CRM, and CRS food distribution programs. Although each program may have well-specified objectives, a confusion may occur in the minds of potential CRS participants. In addition, each program may have a different size ration or distribute different commodities for which there are local preferences.

## 7.2. Conclusions and Recommendations

7.2.1. It is recommended that a small study of irregular attendees be carried out with particular emphasis on:

- migratory patterns
- personal, cultural, and domestic constraints
- perceptions of the CRS program
- perceived economic and value of the ration

The Anthropology Unit of USAID/M has indicated an interest in assisting with such a study.

7.2.2. Based on the findings of the research, there are a number of options for modifying the program that could be considered in an attempt to increase participation rates:

- (1) If it is found that semi-sedentary or nomadic populations cannot get to town for regular feeding, the options are: enforce the present regulation that a participant is dropped from the program after three absences; allow participants to remain in the program despite periodic absences; develop outreach programs.

In view of the high rates of mobility in Mauritania and the significant amount of malnutrition among the nomadic and semi-nomadic population groups, it is recommended that every attempt be made to keep these people in the CRS program even if they are absent for extended periods. Clearly, outreach programs would be highly desirable but, unless they could be organized and managed by the communities themselves, CRS does not have the resources to provide the necessary logistical and programmatic support.

- (2) If it appears that program management and organization are inhibiting factors, then corrective action would have to be taken. This would require some reorganization of center operations, retraining of center staff, and careful supervision.
- (3) If it were found that, given other social, economic, and domestic constraints, the market or substitution value or the acceptability of the food is too low to motivate regular participation, the ration size and/or composition could be altered to better suit local demand. If prohibitions against participants selling the food are found to affect participation, CRS and the GIRM could change the policy concerning the sale of commodities.

7.2.3. In view of the multiplicity of food aid programs in Mauritania and the need to coordinate these programs in order to ensure the maximum and most effective coverage of the needy population, it is recommended that a National Food and Nutrition Planning Board be established. The Board would include representatives from relevant GIRM departments -- e.g., CSA, Ministry of Plan, MOH, and MRD, and the donors, such as WFP, EEC, USAID, CRS, and others.

Discussions held with the Director of Planning, Ministere du Plan et de l'Amenagement du Territoire, indicated that the Ministry was ready and willing to take the initiative towards the establishment of such a Board. The expected difficulty in effecting real joint cooperation was underlined, however. Presently, little if any coordination, or even communication, exists among government agencies, donors, and executing agencies (such as CRS). Sectorial and political interests - according to the Director of Planning - have tended to keep food and nutrition planning unilateral and independent. It appears that such interests will remain strong for both GIRM agencies, donors and executing agencies in the near future and that, although the goal of coordination should remain, expectations should not be too high.

## 8. The Ration

### 8.1. The Value of the Ration

#### 8.1.1. Ration Size

A single monthly ration is 7 kg., including 4 kg. sorghum, 2 kg. non-fat dried milk, 1 litre oil. One ration is given for each child participant with a maximum of 2 children per family. One ration is given for the mother.

#### 8.1.2. Caloric Value of 1 ration

One ration equals 120% of the daily caloric needs of a child 0-12 months.

One ration equals 74% of the daily caloric needs of a child 13-26 months.

### 8.1.3. Economic Value of 1 Ration

The estimated value of 1 ration on the local market is:

Milk	120 UM
Sorghum	120 UM
Oil	60 UM
	<hr/>
	300 UM = \$5.68

The annual value of one ration is \$68.18 which is the equivalent of:

- 14% of average national per capita income
- 23% of average rural sedentary per capita income
- 33% of average rural nomadic per capita income

### 8.2. Issues

The purpose of distributing the ration is to ensure that the participating child receives an adequate diet that includes the ration, or its equivalent in local foods, with the goal of improving the child's nutritional status. In fact, the effect of the ration on the nutritional status of participants is not known. One small study that was conducted by the WHO Nutrition Advisor in Nouakchott found that 73% of participants improved after a minimum of 12 months in the program (although this improvement could not necessarily be attributed to the program). None-the-less, there is a high rate of malnutrition among participants -- averaging 36.6%.

Despite the high economic and nutritional value of the ration, it may not be having the desired effect on the nutritional status of participating children. There are numerous hypotheses that individually, or in combination may explain this:

- the ration is shared within the family and the equivalent amount is not acquired by the family (Evidence from the mothers' survey\* found that 70% of respondents had 6 or more people eating in the household.

---

\* See Appendix I.

Seventy percent said the sorghum lasted less than 15 days in the household, 57% said the milk lasted less than 15 days, and 73% said the oil lasted less than 15 days.)

- the ration is shared with others outside the family (Thirty-nine percent of respondents in the mothers' survey said the number of persons eating in the household increased after the ration was received.)
- the ration is sold or traded and the income is not used to acquire the equivalent amount of food (It may be that the ration when sold or traded does not have the full estimated value because the food has limited acceptability locally or, for other reasons, the market price varies.)
- the mother is not aware of or does not apply her knowledge of appropriate weaning and child practices
- the child has health problems (particularly diarrhea or measles) that prevent his/her body from absorbing and utilizing the food he/she receives.

### 8.3. Conclusions and Recommendations

8.3.1. In order to enhance the effect of the ration on the nutritional status of beneficiaries, it is recommended that the educational and health interventions discussed in the sections on education and integration be implemented. It is also recommended that support be given to the on-site feeding programs (CAC) as they are established, to ensure that:

- malnourished children receive the necessary amount of food
- the mothers learn and apply appropriate weaning and feeding practices
- the community becomes sensitized to and takes responsibility for the nutritional status of its under 5 population.

8.3.2. It is recommended that a consumption study be carried out among a sample of participating and non-participating families to ascertain the effect of the ration on food consumption patterns. The findings should be used to make appropriate adjustments in the size and composition of the ration, the selection of beneficiaries, and the education component of the program.

## 9. Surveillance

### 9.1. Issues

Although the Growth Surveillance System, based on weight for age measures, is presently maintained for all children attending CRS centers, there are certain qualitative problems:

- (1) It is very difficult to ascertain the precise age of children in Mauritania. Many children do not have birth certificates and mothers don't think in terms of the calendar year so they cannot give birth dates. Moreover, children are often physically retarded and so it is difficult to estimate their ages.
- (2) The center staff have difficulty registering age sequence -- that is, given either correctly determined age or putative age, subsequent relative ages are not calculated and/or recorded properly.

The implications of these problems are clear:

- Unless age information is valid and reliable, detection of malnutrition becomes difficult, if not impossible. Particularly in the case of young children, where a month's error can be significant, accurate age calculations are critical.
- Unless age information is correct and growth curves can be correctly established, no appropriate educational message can be given to a

mother. If, for example, a child is much younger than is presumed, she/he may easily fall into the under 80% category when, in fact, he/she may be adequately nourished.

- Without accurate age information, little useful information can be collected concerning rates of malnutrition in CRS children.

There are a number of alternative approaches that could be introduced to improve the validity of the growth monitoring in the CRS program:

- (1) Improve the training of the volunteers and nutrition auxiliaries so they are better able to determine age at the time of inscription:
  - require mothers to bring birth certificates if they have them
  - develop event calendars and teach the staff to probe the birth date with mothers
  - introduce techniques of estimating age by studying physical attributes, such as number of teeth, proportion of hands to arms and of head to body, etc.
- (2) Improve the training of volunteers and auxiliaries in the correct recording of the relative age sequence, of participants.
- (3) Introduce a weight for height chart.

## 9.2. Conclusions and Recommendations

It would obviously be advantageous for CRS to keep the system presently in use. However, unless the age measure can be ascertained and plotted with reasonable accuracy, the surveillance tool may have to be changed. Training staff to accurately record the relative age should be simply done as it implies only the calculation of the number of months elapsed since the child's

last visit to the center. Improving the accuracy of age determination through event calendars or physical observation is more problematic, particularly among staff with limited education and little clinical experience.

The institution of the weight for height measure has the advantage of using definitive measurements -- weight and height. Although it has been suggested that significant errors can be expected because of the introduction of two measuring tools, these errors may be no more than the two used in weight for age. The weight for height measure has the purported advantage of being a more sensitive instrument for detecting malnutrition, particularly for children over one year old.

The Ministry of Health has begun to introduce the Thinness Chart into the experimental community nutrition program (CAC). CRS also has a weight for age tool which simply substitutes height for age on the Master Chart and individual growth charts. CRS has the charts available and would be amenable to having them tested and introduced into the program provided the weight for height measure proves to be a more appropriate and useable tool for surveillance than the one currently in use.

It is recommended that AID/W provide a growth surveillance expert to advise the MOH and CRS on testing and selecting the most appropriate growth surveillance tool for use in Mauritania. An evaluation of the alternative charts should consider:

- whether or not, within the Mauritanian context, age information can be accurately collected;
- whether either the Thinness Chart or the CRS weight for height surveillance tool offers an improvement over even an improved weight for age system;

- the relative facility with which existing CRS/MCH staff can use either of the weight for height tools compared with the existing weight for age tool;
- the relative accuracy of the alternative measures;
- the relative value of the alternative charts as a means of educating the mothers.

Although any final decision on the ultimate selection of a growth surveillance instrument will have to wait until the above mentioned research has been completed, it is recommended that: (a) only one tool be adopted and used nationally; and (b) the final decision be made collaboratively between CRS and the MOH.

## 10. Nutrition and Health Education

### 10.1. Issues

Although the small survey of mothers in Nouakchott indicated that many mothers have a basic awareness of appropriate home remedies for diarrhea (93%) and that they understand the growth chart (75%), the team found that the educational component of the CRS program was generally weak. The basic problems appear to be:

- (1) There is no time for an individualized educational session with each mother which is thought to be necessary to:
  - determine the possible causes of a child's falling off the growth curve;
  - suggest possible remedial action to be taken.

In some instances determination of cause and effect may be simple -- such as learning that a child has diarrhea. The child can then be

referred immediately for treatment. In other cases, the process of exploring causes and eventual appropriate remedies within social, cultural, and economic constraints may be far less simple, requiring periodic contact and personalized attention.

- (2) The basic teaching principle of the group education lectures appears (from a review of the teaching aids that are used by the ANs and volunteers) to focus on general, ideal prescribed solutions to nutritional problems rather than on small, realistic modifications in behavior.

For example, although in the seances the ANs and volunteers may explain what ORT is and how dehydration solutions are prepared; or how early supplemental feeding should be begun, they do not focus on the social, cultural, and economic constraints that inhibit adoption of new behavior. Such orientation of both problems and solutions within a socio-cultural and economic context is thought to enhance credibility and make education more appropriate.

- (3) Little use, apparently, is made of actual mothers' experience relating to health, food, and nutrition. It is believed that taking specific, acknowledged case-study problems based on experiences of CRS mothers, and presenting them for discussion, would help personalize the seances and encourage group participation.
- (4) The setting and milieu of the present seances is neither conducive to learning under present teaching techniques or under those suggested above.

## 10.2. Conclusions and Recommendations

10.2.1. It is recommended that the sessions be reorganized to allow more time for personal contact between the AN or volunteer and the individual mother at the time her child is weighed. For example, since mothers come into the centers gradually, perhaps the weighing and discussion could take place as they arrive. It may be that the numbers of mothers per session will have to be reduced in some centers, depending on the capability of the staff.

10.2.2. Although it is advisable to give individualized attention to all mothers, time constraints may not permit it. Therefore, it is recommended that clinic staff be trained to spend the most time with mothers of children who need it the most. Based on the results of the weighing, mothers fall into one of three categories:

- those whose children have grown and need only be congratulated;
- those whose children have not grown, but not lost weight, with whom the staff must discuss the possible reasons and offer counselling;
- those whose children have lost weight and need immediate educational attention and/or medical/nutritional referral.

Those mothers who fall into the third category should get extra individualized educational attention, and that education should either take place at the time of weighing, or, perhaps more practically, at another pre-determined time while the mother is still at the center.

10.2.3. It is recommended that the following substantive changes be made in nutrition and Health Education training:

- (1) The amount of educational information given in seances should be reduced to the barest minimum. Most countries have opted for:
  - ORT and diarrheal management;

- immediate breastfeeding (colostrum);
- regular, early, and frequent supplementary feeding after the age of 3-6 months.

It has been assumed that once a child has reached the age of 2, and certainly by the age of 3, and can eat from the common pot, he will eat what the family eats and will be subjected to the same constraints as the rest of the family; that is, education on a balanced diet, although helpful, will probably have little impact.

- (2) The educational approach used in the seances should be modified to include more use of participatory techniques, greater focus on existing socio-economic and cultural constraints, and a greater emphasis on problem-solving rather than on the presentation of prescribed solutions to problems.
- (3) Training and re-training of all personnel involved either in group education (seances) or proposed individualized education should be modified to include sessions on: a) understanding community constraints; b) techniques of group participation; c) techniques of individualized education and participatory problem-solving.

10.2.4. It is recommended that Technical Assistance, presently available through centrally-funded AID/W projects, be provided to CRS and the GIRM to aid in the implementation of the above-cited recommendations.

In order to ensure that the weaning component of the education program is relevant, it is recommended that a small applied research project be supported to study regional weaning habits and the availability of local weaning foods.

A suggested project outline incorporating the above elements is attached to this report as Appendix III.

10.2.5. The implementation of these Nutrition/Health education and communications components into the CRS centers will require increased supervision by CRS, CRM and MCH staff. It is therefore recommended, that Outreach Grant funds, if available, be used to support an additional Food and Nutrition Supervisor for the CRS staff.

## 11. Personnel

### 11.1. Issues

#### 11.1.1. Training

The nutrition auxiliaries and volunteers working in CRS centers have a minimal educational background, limited experience, and relatively little training. Most of the auxiliaries and volunteers have the equivalent of a sixth grade education (some of the ANs have less). The auxiliaries were trained in 1981 for 4 months by the MOH and have received no in-service training since that time. The volunteers are trained jointly by MCH/CRS or CRM/CRS in Nouakchott. The training period varies from approximately 3 to 6 weeks, including a three day orientation by CRS to the GSS and CRS program operations and a few weeks experience in a functioning center. The midwives, who are responsible for supervising the CRS centers, receive a few hours of nutrition training in the basic pre-service program but they do not get any formal training in the operations and management of the CRS centers.

As a result of the inadequate background of the staff, very few of the centers (approximately 6) operate what CRS considers a satisfactory program. In addition to the weaknesses in substantive areas of the program -- maintaining the GSS and providing the educational component -- many centers have

problems with the operations, e.g. the registrations are confused, mothers' attendances are not properly scheduled, the sequence of activities is not carried out in an orderly way, there is too much noise and confusion to talk individually with mothers and few of the participants hear the group lecture, there may be poor control over the distribution and accountability for the commodities, etc.

#### 11.1.2. Salaries

Prior to the introduction of the mothers' contributions, CRS center staff were paid by CRS, and all staff received a monthly stipend whether or not they had a full work load. Presently, in the larger centers, the contributions are adequate to cover the AN and volunteer salaries. However, in the smaller centers, the work load is lower and CRS still has to supplement the salaries.

### 11.2. Conclusions and Recommendations

#### 11.2.1. Training

It is recommended that a standardized, 3-4 months, pre-service program for nutrition auxiliaries and volunteers be developed that will be operated by the MOH, in collaboration with CRS, possibly in conjunction with the planned Primary Health Care and Health Education Training Center proposed by USAID.

It is also recommended that in-service training programs be developed for auxiliaries, volunteers and midwives that will be operated by the MOH, in collaboration with CRS, and offered, whenever possible, at regional, or CRS center level. A retaining program for all present staff of 2-4 weeks will be required. In the future, all CRS center staff should have at least 3-5 days of in-service training every year.

Substantively, the training for auxiliaries and volunteers should include:

- management of CRS center operations
- maintenance and interpretation of the child growth chart
- simple diagnosis of basic health and nutrition problems
- nutrition and health education
- communications and educational techniques

The training for midwives should include:

- CRS program operations
- use of the child growth chart
- management of nutrition education

It is recommended that AID support a project to assist the MOH and CRS with the development of the training program. The project should include technical assistance to aid in the development of the curriculum and the training of trainers. It should also include funding for the development and reproduction of didactic materials and support for the training programs themselves. (see Appendix III)

#### 11.2.2. Salaries

The solution to the salary problem already introduced by CRS into a number of centers is to reduce the working hours of the staff to accommodate the number of participants (e.g. from 4 weeks to 2 weeks per month) and adjust the salary accordingly. The workload is then in accord with the number of participants and the contributions cover the costs. Where possible, CRS should plan an appropriate balance when opening a new center so the volunteers' obligations and salary are understood from the beginning. It is easier to expand and increase the workload and salaries than to reduce them.

## 12. Integration

### 12.1. Issues

#### 12.1.1. Central and regional level

At the central level there is good coordination between CRS and the MOH and CRM. The program is planned and monitored jointly. All CRS data are routinely forwarded to the MOH and CRM and there are regular monthly meetings to discuss issues of mutual concern. A member of the CRM staff has been seconded full time to CRS as a Food and Nutrition Supervisor to collaborate on the supervision of CRS/CRM centers. The staff person in the MOH who is responsible for supervising the MCH clinics and nutrition programs also supervises the CRS/MCH centers jointly with the CRS supervisors.

At regional level, the joint CRS/MCH and CRS/CRM supervisory teams try, during their supervisory visits, to meet with the Regional Medical Officer (CM), who is responsible for supervising all MCH activities in the region, and with the local government officials who have administrative responsibility in their areas. However, sometimes the supervisory teams don't have time to visit the regional medical and administrative officials or they are unavailable when the teams are in the area. Thus, these officials are not well-informed about CRS activities in their regions. There have been misunderstandings among regional officials about the CRS program and inadequate support from them in interpreting the program to the community and in providing assistance with operational problems.

#### 12.1.2. Center Level

Mutual reinforcement of preventive and curative health and nutrition services is essential to improving the nutritional well-being of malnourished children. The existing coordination between the CRS and MCH programs provides

the basis for this reinforcement. However, in practice, the services are not optimally integrated.

In principle, CRS activities enhance the MCH preventive and curative services by providing: surveillance of the health and nutritional status of children and referrals of sick children; health and nutrition education; and an incentive which attracts a target population for vaccinations. The MCH service supports the CRS program by: supervising operations; treating referrals; giving vaccinations; and providing in-service training of auxiliaries and volunteers.

Although the child growth chart is supposed to be used as a tool for detecting health problems, the center staff are not adequately trained to recognize symptoms of illness and there is no systematic mechanism for referral from CRS centers to the MCH clinics. Moreover, the MCH clinics do not have a tool for monitoring child health. An additional problem is, of course, that the MCH diagnostic and treatment facilities are relatively meagre.

All CRS participants are supposed to be vaccinated. However, many are not which may be because of mothers' ignorance, lack of motivation, cultural constraints, or because vaccinations are not always available at the MCH clinics. Unvaccinated children are at risk of contracting preventable diseases to which they are particularly susceptible if they are poorly nourished and which, in turn, can adversely affect their nutritional status. In the past year there have been serious outbreaks of measles that affected CRS program children. Because of the contagious nature of the disease, mothers are, rightly, prohibited from bringing infected children for their routine monthly visits. However, this has significantly affected attendance rates in some centers and has meant that children are not getting the nutritional and health services at a time they are at risk.

## 12.2. Conclusions and Recommendations

### 12.2.1. Support at the Regional Level

In order to ensure that the local governmental and regional medical officials will fully support the CRS program, it is recommended that there be increased coordination and exchange of information at central level between the MCH service and the governmental departments in which the regional officials work.

It is also recommended that there be more systematic contact between CRS, CRM, the MCH service and local officials. Prior to the opening of a new center, meetings should be held with the responsible Regional Medical Officer, governor, and with the local prefect and other concerned administrative officials. Each time a supervisory team plans to visit a center, a letter should go out from the MCH service to local authorities introducing the team and requesting cooperation. The team should meet with the authorities -- inform them of the center's activities and supportive needs and alert them to any potential or actual problems.

### 12.2.2. Coordination of Nutrition and Health Services

#### 1) Child Growth Chart

It is recommended that the following steps be taken to improve the coordination of services by using the child growth chart (whichever chart is selected) as the tool for monitoring, referring and following up on all aspects of the nutritional and health status of children:

- train CRS staff to interpret the child growth chart and to use it as a tool for identifying sick children;
- use the child growth chart as the "ticket" of referral from CRS to MCH services;

- introduce the child growth chart into the MCH clinics for all children, whether or not they are CRS participants, and train midwives and nurses to use and interpret the chart;
- use the child growth chart card to record all vaccinations as well as diagnoses and treatments, adding an insert if all the existing space for "notes" is filled. (This will ensure that the child's entire health history is maintained in one place.)
- train CRS staff to refer to records of vaccinations and episodic illnesses when counselling the mothers at the time their children are weighed.

## 2) Vaccinations

It is recommended that every effort be made to ensure that all CRS participants are vaccinated:

- train CRS staff to systematically monitor the vaccination status of participants;
- provide vaccinations, whenever possible, to CRS participants during CRS program sessions to ensure maximum coverage of the target population;
- the resources of the EPI teams should be used to assist the MCH clinics when they do not have vaccinations available.

## 3) Primary Health Care Teams

If the planned primary health care project is implemented, it is suggested that the mobile teams that will be supervising community based nutrition and health activities help to coordinate the CRS program with the community based primary health care activities in those areas.

13. Conclusion

CRS, in collaboration with the MCH service of the MOH and the CRM, has in a very short time, done a laudatory job in establishing a network of centers that are well supported logistically and that successfully distribute food. However, given the rapid growth, the overall lack of infrastructure in Mauritania, the paucity of well qualified personnel to staff the centers, and an inadequate training program, the programmatic elements in most of the centers are weak. The major areas requiring significant effort over the near term are:

- selection and implementation of the most appropriate growth surveillance system (even if the present system is retained retraining will be required);
- restructuring of the educational component;
- development of standardized and relevant programs for pre-service and in-service training of all personnel working in the CRS centers;
- in-service training of auxiliaries, volunteers, and midwives;
- institutionalization of smoothly functioning operations in all centers;
- experimentation with community feeding centers (CACs);
- integrated national food and nutrition policy planning.

Considering the major effort that will be required of CRS, the MOH, and the CRM to implement all of the necessary modifications, it is recommended that no new CRS/MCH or CRS/CRM centers be opened over the near term.

CRS and USAID are under pressure to expand because CRS is only reaching approximately 80% of its present Annual Estimate of Requirements. The GIRM supports expansion because of the priority to extend services into unserved

and rural areas. However, it is the view of the evaluation team that any growth at this time will further dilute a weak program and that, in the long run all parts of the country will be better served if the existing CRS program is strengthened first.

A-1

SURVEY OF MOTHERS IN NOUAKCHOTT, MARCH 27-31, 1983

A survey of 185 participating mothers in 3 CRS/CRM centers in Nouakchott was carried out during the week of March 27, 1983. The questionnaire (attached) was developed collaboratively by Mlle. Sy of the PMI service, and representatives of CRS, USAID, and the evaluation team. Interviewers representing the major language groups were recruited and trained by Mlle. Sy and supervised on-site. Respondents were selected randomly and interviewed separately.

Supervisors:

M. Diallo Abdoullaye, PMI  
Ms. Betsy Brown, USAID  
Ms. Fatou Gueye, CRM  
Ms. Joan Mitchell, CRS

Interviewers

M. Diallo Abdoullaye, Supervisor/PMI  
Ms. Hawa Alassane, Nutrition Auxiliary/PMI  
Ms. Zeynabou Ba, Nutrition Auxiliary/PMI  
Ms. Diop Fatimata, Nutrition Auxiliary/PMI  
Ms. Fatou Gueye, Supervisor/CRM  
M. Sidi Mohamed, USAID  
Ms. Hawa Samba, Nutrition Auxiliary/PMI

Following is a brief outline of the major findings.

## 1. ETHNIC GROUP:

Moor	54%
Wolof	12%
Toucouleur	33%
Other	1%

## 2. LENGTH OF TIME IN NOUAKCHOTT:

0-6 mth	2%
7-12mth	0%
1-5 yr	20%
6-10 yr	39%
> 10 yr	39%

## 3. PRESENCE OF FATHER IN FAMILY:

73% of fathers present

## 4. SOURCE OF REVENUE:

Mother has a source of revenue	: 12%
Father has a source of revenue	: 62%
Family has another source of revenue:	6%

## 5. NUMBER OF PEOPLE EATING IN THE HOUSEHOLD:

0	4%
1-5	26%
6-10	44%
11-15	20%
16-20	5%
21 +	1%

## 6. NUMBER OF PEOPLE IN THE HOUSEHOLD AUGMENTS AFTER RECEIVING THE RATION: 39% of families.

## 7. DURATION OF THE RATIONS:

	Sorghum	Milk	OIL
< 7 dys	37%	24%	57%
8-15dys	33%	33%	16%
16-21dys	6%	15%	7%
22-30dys	23%	26%	16%
+ 30dys	1%	1%	
NA		1%	4%

## 8. MOTHERS' UNDERSTANDING OF WEIGHT CHART:

YES 75%

NO 25%

## 9. MOTHERS' UNDERSTANDING OF HOW TO KEEP CHILD

" IN THE GREEN "

YES 61%

NO 39%

## 10. MOTHERS' KNOWLEDGE OF APPROPRIATE HOME REMEDIES

FOR DIARRHEA:

YES 93%

NO 7%

.....

QUESTIONNAIRE : ENQUETE SUR LE PROGRAMME DE CRS à NOUAKCHOTTQuestions pour les Participants

- I. 1. a. Nom de la mère: \_\_\_\_\_  
 b. Nom du père: \_\_\_\_\_  
 c. Source de revenue de la mère: \_\_\_\_\_  
 \_\_\_\_\_  
 d. Le père est-il présent dans la famille ? \_\_\_\_\_  
 \_\_\_\_\_  
 e. Source de revenue du père : \_\_\_\_\_  
 \_\_\_\_\_  
 f. Autres sources du revenue familial : \_\_\_\_\_  
 \_\_\_\_\_
2. a. Depuis quand votre famille s'est-elle fixée à Nouakchott ? (Question doit être posée à la mère) \_\_\_\_\_  
 \_\_\_\_\_  
 b. Combien de fois retournez-vous en brousse ? \_\_\_\_\_  
 \_\_\_\_\_  
 c. Combien de fois quittez-vous Nouakchott ? \_\_\_\_\_  
 \_\_\_\_\_
3. a. Depuis quand êtes-vous inscrite au programme de CRS ? (vérifier sur la fiche individuelle) \_\_\_\_\_  
 \_\_\_\_\_  
 b. Combien d'enfants sont actuellement dans le programme de CRS ? \_\_\_\_\_  
 \_\_\_\_\_  
 c. Notez l'âge et l'état nutritionnelle de l'enfant le plus jeune dans le programme : \_\_\_\_\_  
 \_\_\_\_\_  
 d. En vous référant à la fiche individuelle notez la fréquence des absences et la durée des absences : \_\_\_\_\_  
 \_\_\_\_\_  
 s'il ya des absences demander pourquoi : \_\_\_\_\_  
 \_\_\_\_\_  
 e. Combien d'adultes et combien d'enfants ont mangé chez vous hier ? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

II. (en referrant à la fiche individuelle posez les questions suivantes)

1. a. Pouvez-vous expliquer ce qu'il veut dire quand la courbe monte ou descend ( ) ( )

Comprend non compris

b. Qu'est-ce-que vous pouvez faire pour garder votre enfant dans le vert ?

2. Qu'est-ce-que vous faites vous-même à la maison quand votre enfant a la diarrhée ?

3. Qu'est-ce que l'enfant a mangé hier le matin, midi et soir et entre les repas ?

Matin :

Midi :

Soir :

Entre-repas :

III. 1. Combien de temps durent les vivres dans votre famille ?

- Le Sorgho

- Le lait

- L'Huile

2. a. Est-ce qu'il y a parmi ces aliments un qui n'est pas donné à l'enfant ?

b. Pourquoi ?

3. Les jours après la distribution des vivres y-a-t-il plus de gens qui mangent chez-vous ?



REPUBLIQUE ISLAMIQUE DE MAURITANIE

/-/ONNEUR - FRATERNITE - JUSTICE

MINISTERE DE LA SANTE ET DES AFFAIRESSOCIALESNouakchott, le 12 JANVIER 1983No 055 /MSAS/S.PMI

LE MINISTRE

A MESSIEURS LES GOUVERNEUR DE REGION

MESSIEURS LES PREFETS

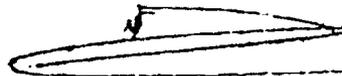
MESSIEURS LES MEDECINS CHEFS DE SSR

MESDAMES LES RESPONSABLES DES CENTRES DE PMI

J'ai l'honneur de vous transmettre le protocole d'application du programme de Nutrition CRS/SMI signé entre le Ministère de la Santé et des Affaires Sociales et le Catholic Relief Service.

Ce protocole reglementera désormais tout le fonctionnement de ce programme qui est un appui aux activités nutritionnelles des centres de PMI en faveur des enfants de 0 à 5 ans qui souffrent de malnutrition.

Je vous demande de veillez à son application et me tenir informé des dispositions prises dans ce sens./.

CDT MOHAMED MAHMOUD OULD DEH


PROTOCOLE D'APPLICATION DU PROGRAMMEC.R.S. AU SERVICE DE SMI.

En application de la convention signée entre le Ministère de la Santé et des Affaires Sociales et le Catholic Relief Service, en Avril 1978 le protocole ci-après est convenu entre le Service de SMI et la Direction du CRS pour définir les modalités d'exécution du programme CRS.

1°/ L'élaboration du Budget CRS et sa repartition dans le pays seront faites par un comité composé de =

- 2 Représentants de la Direction de la Santé dont le Chef de Service de la SMI.
- 1 Représentant du Croissant Rouge Mauritanien
- 1 Représentant de la Direction des Affaires Sociales
- 1 Représentant CRS.

2°/ La responsable de la Division de Nutrition (Service SMI) sera l'homologue National du CRS.

3°/ L'ouverture des Centres de Nutrition SMI/CRS se fera sur la demande de la Direction de la Santé.

4°/ Le recrutement et la formation du personnel devant travailler dans les centres SMI/CRS seront faits en collaboration avec le Service de SMI.

Le nombre d'unités est fixé à : 3 personnes pour les centres des grandes villes.

- 2 personnes pour les petites localités.

5°/ La vocation de ces centres est d'améliorer l'état nutritionnel et sanitaire des enfants de 0 - 5 ans, d'assurer la surveillance nutritionnelle et sanitaire ainsi que le dépistage de la malnutrition protéino-énergétique.

Les relations de ces centres avec les CRS (centres de Récupération et d'Education Nutritionnelles) seront systématiques.

6°/ L'exécution sur le terrain du programme CRS se fera sous la supervision du responsable du centre de PMI ou de l'infirmier Chef du dispensaire là où il n'existe pas de centre de PMI.

7°/ L'exploitation de toutes les données statistiques sera faite par le Service SMI et le CRS les résultats seront mis à la disposition du Ministère de la Santé.

8°/ Pour un meilleur impact des vivres sur l'état nutritionnel des enfants des centres d'alimentation communautaires seront adjoints à ces centres pour assurer la réhabilitation nutritionnelle des enfants atteints de malnutrition chronique.

9°/ La supervision de ces centres sera faite conjointement par le CRS et le Service SMI chaque centre sera visité au moins une fois par trimestre mais des missions ponctuelles peuvent être envisagées pour résoudre des problèmes spécifiques.

10°/ Dans le volet nutrition un tonnage de vivres décidé chaque année par la commission sera mis à la disposition des centres de nutrition et des CBEN.

11°/ Les vivres seront gérés par la responsable du centre de PMI ou l'Intendant Chef du dispensaire sous la supervision du Médecin Chef de la région. Le CRS se réserve le droit de visite des magasins de stockage par ses conseillers visiteurs.

12°/ Pour faire face au frais de fonctionnement des centres et des activités annexes (CBEN, jardinage, artisanat...) une cotisation mensuelle de 200M sera demandée à chaque femme qui participe au programme. La caisse sera gérée par le centre CRS. Un rapport financier mensuel sera envoyé au CRS et au Service SMI.

13°/ Pour une période indéterminée, le CRS s'engage à utiliser le Camion du Service de SMI pour le transport des vivres à l'intérieur du pays. En contre partie il assure l'entretien et les réparations du dit camion.

L'acheminement des vivres en Mauritanie est assuré depuis DAKAR pour des raisons pratiques par la SOCOPAO. Cette dernière choisit ses propres transporteurs et facture directement ses frais aux compagnies de navigation intéressées./.

Nouakchott, le

LE SECRETAIRE DU M.S.A.S.

AHMEDOU OULD HANNA KHATTAR

LE DIRECTEUR DU C.R.S.

MR. J. MONTOURCY

BEST AVAILABLE COPY

BEST AVAILABLE COPY

43

Project OutlineNutrition/Health Education in Mauritania

Ministry of Health and CRS

Introduction

Based on the analysis and recommendations contained in the Final Report, Evaluation of the CRS Program, Mauritania, it is proposed to provide Technical Assistance to CRS and the PMI Division of the Ministry of Health concerning Nutrition and Health Education (NHED). Such TA would include:

1. Restructuring of CRS operations to permit more time for individualized NHED but without compromising other program elements.
2. Development of new Terms of Reference for CRS Center staff concerning proposed new responsibilities for NHED.
3. Design of new NHED curriculum elements for both existing training and proposed in-service training for CRS Center staff and PMI supervisory staff (i.e., Sages-femmes).
4. Design of new teaching materials to be used in the instruction of the above-mentioned CRS Center and PMI personnel.
5. Training of the proposed trainers of this personnel.
6. Design of applied NHED research, such as a study of regional weaning habits and weaning foods.

TA Program

It is recommended that there be three visits of Technical Experts to Mauritania to work with CRS/MOH:

Visit 1

1 Anthropologist (2-3 weeks): to work with Dr. H. Goldman, Nutritionist, USAID/Nouakchott in the preparation of a small-scale weaning food/habits

survey to be undertaken by Dr. Goldman in conjunction with CRS and the MOH. The purpose of the survey will be specifically to determine appropriate NHED messages to be included in both CRS and other nutrition/health programs.

Visit 2 (after completion of Weaning Survey)

1 Nutrition Program/Training/Management Specialist (3-4 weeks);

1 Nutrition Curriculum/Materials Specialist (3-4 weeks) -- to design new NHED system within the CRS program (i.e., re-organizing CRS operations to both make better use of existing mother waiting time and to provide for additional time for priority mothers - that is, those with malnourished children); to develop appropriate curriculum and training materials to be used in formal pre-service and in-service training for CRS and PMI personnel: to set up pilot NHED programs in which new methodologies can be tested.

Both elements of this TA -- re-organization of CRS operations and development of curriculum and materials -- would be done in conjunction with CRS, PMI-Nouakchott, MOH Division of Health Education, and representatives of relevant training schools, such as the Ecole de Sages-femmes.

The Technical Assistants would help in the design of materials, development of pre-test methodologies, etc., and the production of materials would be the responsibility of the MOH and CRS.

Visit 3 (4-6 months after Visit 2)

1 NHED Trainer (3-4 weeks);

1 NHED Curriculum/Materials Specialist (as above) - (3-4 weeks): to finalize all curricula/materials developed during Visit 2; and to train the trainers of CRS and PMI personnel.

List of Interviews(1) AID/W

Mr. Max Williams, FFP  
Ms. Hope Sukin, FVA/PPE  
Ms. Judith Gilmore, FVA/PPE  
Mr. Allan Davis, FFP  
Ms. Peggy Sheehan, FFP  
Mr. Forest Duncan, FVA  
Ms. Terry Lucas, AFR/DR  
Ms. Maura Mack, Office of Nutrition  
Ms. Mellen Duffy, AFR/DR, CRS/NY  
Mr. James DeHarpporte, Ass. Reg. Director, CRS  
Mr. Michael Wiest, Asst. Director, CRS

(2) USAID/M

Mr. Michael Kerst, FFP Officer  
Dr. Heather Goldman, Nutritionist  
Ms. Betsy Brown, Public Health Advisor  
Dr. Peter Benedict, Mission Director  
Mr. Barry MacDonald, Evaluation Officer  
Mr. Richard Goldman, Agricultural Development Officer  
Dr. John Grayzel, Anthropologist

(3) CRS/M

Mr. Jacques Montouroy, Director  
Ms. Joan Mitchell, Commodity Manager and Program Assistant  
Ms. Patrice Flynn, Senior Food and Nutrition Supervisor  
Ms. Jill Gulliksen, Food and Nutrition Supervisor

(4) GIRM

Mme. Ba, Chief, Maternal & Child Health Service, MOH

Mlle. Fatimata Sy, Chief, Division of Nutrition, Maternal & Child Health Service, MOH

M. Diallo Abdoullaye, Food & Nutrition Supervisor, MCH Service, MOH

M. Assane Diop, Director of Planning, Ministry of Planning and Regional Development

M. Mamadou El Boe

Ms. Mona Grieser, Rural Medical Assistance Project

M. Hamdan, Dept. of Emergency Aid, Commission of Food Security

Dr. Traore, Regional Medical Officer, Trarza

M. Sy Mamadou Samba, Division of Education for Health, Preventive Medicine Service, MOH

M. Timera Bakari, Director, National School of Public Health

Dr. Dja, Chief, Planning Office, MOH

Prefect, Moudjeria

M. Wane, Regional Director, Moudjeria, CSA

Governor of Tagant

Adjoint d'Aleg

M. Senghott, EPI Manager

(5) CRM

Mme. Sall, President, Red Crescent of Mauritania

M. Sy, Chief, Social Affairs, CRM

Mlle. Fatou Gueye, Food and Nutrition Supervisor, CRM

(6) WHO

Dr. Rolf Kreysler, Nutrition Advisor

Dr. Sidatt, Country Representative

Dr. Joseph Kreysler, Nutrition Advisor

Mr. Ayoub, EPI Program Supervisor

49

(7) WFP

Mr. Ferdinand Appeau, Regional Director

(8) SITE VISITS

Rosso

Dieuk

Aleg

Moudjeria

Tidjikja

Boutilimit

First Arrondissement/Nouakchott

Fifth Arrondissement/Nouakchott