MID-TERM EVALUATION
OF THE
RURAL HEALTH SERVICES I
PROJECT
ON THE
ISLAMIC REPUBLIC OF MAURITANIA

Contract No. 682-0230-A-30041

Prepared by
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I. PURPOSE OF THE EVALUATION

The mid-term evaluation of the Mauritanian Rural Health Services Project (RHS) has four basic objectives as defined in the terms of reference, for the evaluation team prepared 13 March 1986:

A) Review status of inputs, outputs, verifiable indicators and Project issues

B) Determine their continuing validity and relevance

C) Determine reasons for changes from the Project Implementation Plan

D) Recommend revisions in Project design and Implementation Plan

The terms of reference (TOR) were prepared by the National Evaluation Team consisting of representatives from the Rural Health Services Project (the Government of Mauritania), USAID (Health Office and Project Development Office), and the technical assistance team provided under contract with John Snow Incorporated. The TOR were reviewed with the external evaluation sub-team upon their arrival in Nouakchott, 28 June, 1986. No changes were made. (See Annex 1 for Terms of Reference.) The period set for the evaluation was 27 June to 28 July (28 days including weekends).

II. TERMS OF REFERENCE:

The terms of reference (TOR) are divided into two parts, reflecting the two technical divisions of the RHS Project: The Expanded Program for Immunization (EPI) and Primary Health Care (PHC).

With respect to the EPI component, the TOR focused on the following:

- a general status report on the implementation of this component;
- an assessment of the general managerial functions in the implementation;
- an assessment of technical aspects of program operations
- an assessment of strategies for achieving EPI goals.

With respect to the PHC Component, the TOR focused on the following:

- "estimate" progress made to date in the achievment of goals and objectives of the project

- assess status of implementation of training programs for the four categories of personnel implicated in this component

- make recommendations for a revised project

The TOR for the EPI Component were fairly straightforward. The major design implications concerned possible future operational strategies.

The TOR for the PHC Component predicated the need for major changes. Discussions of the TOR on 28 June emphasized that the evaluation of this component should in effect be a re-design. Background information at this juncture catergorized this component as a major problem. Questions of viability, commitment and competence relative to implementation and achievement of goals had led to suspension of activities by USAID.

Evaluation results were required to assist in determining whether or not this component should be continued, how it should be done, and what modifications to the original project design should be made.

III. PROJECT DESCRIPTION

This RHS Project is an amalgamated extension of two previous projects supported by USAID: the EPI and the Rural Medical Assistance Project. The latter terminated in December, 1983. The new project contract was signed in July the same year, so there was a 5 month overlap.

Project Goals and Purpose

The Project goal is a general one of improving health status. The purpose is also general: to improve EPI effectiveness and to develop an expanded, integrated, community-based PHC program in three selected regions. The purpose of the Project will be met, for EPI, if the cold chain is maintained and coverage reaches 50% of the target population; for PHC, if village-based health care is functioning and supervision systems are working; for the Project as a whole, if integrated teams are operational and a health information system is in place.

The first region is Tranza, which constitutes a continuation and consolidation of activities begun in the two previous projects.

The second region is Guidimaka, which lies east of Trarza. It receives USAID economic development assistance in agriculture and road building. In terms of rainfall and ground water, its agricultural productivity is relatively high. The criteria for choosing the third region are not indicated. Except for a 60% EPI national coverage, the purpose is defined in qualitative indicators, which require further definition for agreement on verification.

Outputs:

EPI outputs relate to the whole country. PHC outputs are largely related to the three regions. There are six outputs: one deals with policy (National Commission on PHC), one with training for PHC and EPI, one with infrastructure development related mainly to EPI activities, three with information (studies, research and health information systems). The outputs are expressed in quantifiable indicators: number of training events, number of persons trained, numbers of centers improved.

The training component is extremely complicated. Sixteen different kinds of training experiences have to be developed in-country: four training experiences for PHC personnel, five training experiences for EPI, seven seminars and workshops on a variety of management and technical areas related to PHC. In addition, there are four short-term participant training programs and three long-term participant training programs planned. Studies, research, and information gathering activities are also heavily loaded onto the Project. In the first year alone, four major studies were scheduled to take place.

Inputs:

Sixty per cent of the net budget goes to operating costs (commodities, local transportation and personnel), 36.5% to technical assistance, and 3.2 % to information activities.

Project Implementation:

The first program year was designed as a transition year: existing EPI and PHC activities were to continue as under the separate projects while a series of infrastructural activities for the new project was carried out to facilitate expansion and management. These included (a) setting up the foundation for a management or health information system, (b) importing equipment for intensification and extension of EPI activities, (c) training major personnel for technical responsibilities in expanded PHC and EPI activities, and (d) establishing a basic organizational structure to set and enforce national PHC policy.

The second year marks the start of technical assistance for EPI and PHC, the beginning of the Project's PHC expansion to a second region, and the implementation of the new integrated team strategy for supervision. As of year two, the Project embarks on

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curriculum development; I.E.C.; regular cycles of training activities for trainers, supervisors, village Health workers, traditional birth attendant, and mobile teams; continuing EPI activity, continuing disease surveillance and information system development; and development of educational centres. The functional relations between EPI and PHC activities in the three regions are the mobile team supervisory system and some of the base-line data gathering studies.

Project Management:

The Project Office per se is conceived as a separate functional entity in the Ministry of Health and is directly related to the office of the Director of Health, though out of the normal bureaucratic structure. Therefore there is no decision-making relationship to other Services. To compenstate for this gap, an Comité Inter Service (CIS), composed of the heads of the three Services, is set up to coordinate the EPI and PHC activities. This is seen as a precursor to a National Commission on Primary Health Care, which would formulate a national policy for the Project and the country as a whole.

The Project administration is divided into four separate activities: procurement, budget, program, and technical assistance, and is split among three organizations:

- USAID handles overseas procurement of commodities.

- A Project Office deals with the annual operating budget for program activities and with local in-country procurement and disbursement for local training, for example.

- The EPI program is run by the Service de Medecine Preventive in the MOH.

The PHC program component is run through the Project Office, in many respects as a Service, although without a direct relationship to existing Ministry Services.

Operationally, all program activity is under the supervision of the Regional Chief Medical Officer, who represents at the regional level the various Services in the Ministry of Health.

The main management functions (planning, organization, and implementation) are distributed throughout the several organizations, in complicated ways that tend to engender fundamental role conflict. The Director of Health is the Chairmen of the Comité Inter Service. The Director of the Project is responsible for overall program development and management; on the other hand, his role in EPI is limited to that of a budget officer. Although responsible for PHC activities, his relation to the Maternal Child Health Service has no clear institutional

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links. Most important, the Regional Chief Medical Officer's role in the management of PHC activities is not clearly defined in terms of institutional relationships and responsibilities.

The two long term technical assistance roles are different. The only EPI technical assistance relates to a specific activity in the Preventive Medecine Service, while the PHC position relates to the Project Director, and thus is outside the Ministry of Health system.

IV. THE SITUATION AT THE TIME OF EVALUATION

The evaluation, although originally planned for March 1986, took place in July 1986, at the end of the Project's third year. Several months behind schedule, the evaluation was of particular interest because certain critical decisions were dependent upon it. These were the continuation of the Project's primary health care component, and the composition of the technical assistance package provided by the Contractor, John Snow Inc.

The main issues related to the first decision were the following:

Progress on PHC development was considered to be extremely slow. Throughout 1985, USAID and the Contractor had brought to the attention of the Ministry of Health and the Project Direction their feeling that the pace in carrying out projected activities warranted an overall review of this component to determine whether objectives were realistic, and whether the extent of MOH imput required to realize these objectives could be provided in a timely manner. USAID's concern was in regard to the provision of required personnel to manage the Project in the two regions, particularly in light of the anticipated departure of several key technical persons. Following correspondence with the Director of Health (June 85) and the Minister of Health (September 85) and the airing of a technical assistance assessment of the PHC Component (September 85), USAID took unilateral action in January 1986 to temporarily suspend further activity in PHC.

However, it should be noted that the 1986 budget provided resources to carry out several PHC training programs: a refresher course for 67 community health workers and a training for 67 technical birth attendants of the Tranza region, including a week-long preparatory/training seminar for supervisors and trainers. In addition, PHC supervisory activities within the structure of the integrated mobile teams continued. The suspension of PHC activities mainly affected the expansion of the Project to a second region, Guidimaka, where a PHC promotional and sensitization program had begun in April 1985 for 36 villages. In spite of the absence of financial and technical support, the program has continued.

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The results of the evaluation were expected to determine to what extent the PHC component could continue in its original conception and what alternatives were possible if the original conception were no longer viable.

The major issues related to the composition of the JSI technical assistance team were as follows:

The tour of the Chief of Party/EPI Advisor was nearing termination (mid-August 1986). A replacement had been identified who had largely the same qualifications and who, it was anticipated, would have a similar job description. The questions raised during the evaluation about the qualifications and experience of the new consultants is: What technical, managerial, and epidemiological skills are needed to maintain and expand the current level of accomplishment of the EPI, and to complement anticipated technical assistance by UNICEF through a grant from the Italian Government?

The PHC advisor resigned from the with Project voluntarily in March 1986. It was decided to suspend a decision with regard to his replacement pending the outcome of the evaluation.

Issues concerning the technical assistance package included designation of Chief of Party, and the relative effectiveness of long- and short-term technical input to meet the various needs and achieve project objectives. In general, the Project Direction, JSI, and USAID representatives expressed a strong concern that continued technical assistance be appropriate to the operational needs of the Project, and that consultants be chosen by mutual agreement of all parties.

V. METHODOLOGY

Prior to the arrival of the external evaluators, a larger National Evaluation Team, consisting of representatives of the Project Office, Ministry of Health, USAID, JSI and collaborating organizations, had been formed. This team had carried out a "pre-evaluation assessment" and prepared a document reviewing progress toward accomplishment of the major goals and outputs of the Project, as well as providing further information about its management and administration. In addition, a schedule for interviews of key Project-related personnel in the MOH and USAID; field trips, and preparation, presentation and review of the evaluation report had been prepared. Thus the duration of 21 days had been blocked out. Eventually several modifications were made, as indicated below. (See final schedule).

The terms of reference indicated the major themes and issues which the evaluation would have to cover in order to make recommendations on the current project design. Design issues comprise project management structure, policy and approaches to primary health care, and technical assistance requirements.

The external evaluation team decided to review the Project from four levels: central, regional, departmental and local. The central level consists of the donors, contributing agencies, technical assistance contractor and the Director of Health and his chiefs of Services; the regional level consists of the Regional Chief Medical Officer, the Regional Health Commission, and Maternal and Child Health (MCH) centers. The department level consists of the Department Medical Officer, PHC supervisor, and dispensary. Finally, the community level is made up of the village health committees (VHC), village health workers (VHW) and traditional birth attendants (TBA).

All the levels share some strategic, technical and operational responsibilities and relationships in the Project. Interviews with Governeurs and Prefets were included in order to determine understanding of and reaction to PHC policies and concepts on the part of the civil authorities.

Two regions, Trarza and Guidimaka, were chosen for the field visits in order to assess the existing PHC program and the current state of preparations for the expansion into the second region, in which village sensitization and PHC promotion activities have been under way since mid-1985.

Questionnaires were developed for each level and intensive interviews were carried out. The National Evaluation Team participated in data-gathering activities at the regional and departmental level in the Trarza and Guidimaka regions and was divided into subgroups assigned to particular interviewing tasks. The external evaluators stayed together in one of the groups. In order to permit intensive interviews, the number of villages was limited to two per department. The villages and departments were selected randomly from the list of villages currently inscribed in the PHC program. In addition, the team encountered mobile teams which permitted interviews with EPI personnel and PHC supervisors.

In addition to interviews with individuals, the external evaluators organized three two-hour "debates" between the Project Director, the COP of Technical Assistance Contractor and the USAID Health Officer on three key features of program design: management structure, policy and strategy, and technical assistance requirements.

Since the data to be collected were mostly qualitative, it was determined that open-ended questions followed by probing would be the best way to understand the issues affecting policy, structure, and technical assistance needs. Other data would be available from the Project, the contractor, and USAID. In addition the pre-evaluation assessment provided an excellent data base for verification of quantitive outputs.

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The debate, interviews, and review of documents produced a considerable amount of data which had to be sifted, categorized, and analyzed. The data were first organized with respect to issues identified in the terms of reference; they were then reviewed to determine if there were secondary issues which had to be addressed. These were then reviewed in light of reports, indicators, project papers etc, and reformulated where necessary. Linkages among the various issues were examined, and mutual implications analyzed until it was possible to make recommendations that were consistent with one another.

The results of the analysis are presented below. They include a) an assessment of the status of the Project as of July 1986, b) a review of the key issues and recommendations: c) conclusions vis-a-vis the four key areas to be covered in the terms of reference and d) general recommendations and proposed Implementation Plan for the second half of the Project.

VI. ASSESSMENT OF PROJECT STATUS - JULY 1986

In assessing the Project status, the evaluation team will examine project activity in relation to the end of Project status as presented in the logical framework of the project. There is the assumption that outputs are consistent with purpose and that the indicators are relevant measures of the outputs. In assessing the Project status, the following questions were asked: 1) Are the outputs as they currently exist consistent so far with the purpose of the project; 2) to what extent are the outputs to date leading to the achievement of the purpose? 3) to what extent are the problems and discrepencies between the planned and actual outputs likely to present obstacles to achieving the Project's purpose.

In July 1986, the RHS Project is ending the third year of its five year contract. A review of the outputs to date is presented in the table which follows (assessment of current status of RHS Project outputs), based on the indicators of the logical framework of the Project.

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ASSESSMENT OF CURRENT STATUS OF RHS PROJECTS OUTPUTS

OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
1) National Commission for Primary Health Care established and functioning	Commission coordinating integration of various levels of primary health care network.	A directive issued on 22 February 1984 has established an Inter Service Committee (CIS) to coordinate PHC activities for the project. However, this committee meets irregularly and has not developed any PHC policy. There has been no action on establishing a National Commission.	The slowness in establishing the National Commission may call into question commitment to PHC. On the other hand, the long term planning needed to prepare the terms of reference and objectives and methods of work was not done. The new RHS Project Director is currently trying to rectify this by developing a plan of action with the CIS to prepare a PHC strategy, a major part of the groundwork for a National Commission meeting.
		A Regional Commission for Primary Health Care has been established in Trarza Region, composed of 4 members under the direction of the Chief Regional Medical Health Officer. Members include a regional trainer, PHC Supervisors, SMI supervisor and head of regional mobile team. It supervises 6 departmental supervisors and the mobile teams and organizes the PHC program activities at the Regional level.	This is the key institutional requirement for PHC operations. It has been functioning on a regular basis in the Trarza Region since 1984 despite variable staffing. The commission managed a revitalization of the VHC program, succeeded in achieving and integrating 2 EPI/PHC mobile teams which completed 3 rounds of supervisory visits in the Trarza, produced task description of Health personnel in the regional PHC mobile team and a general description of the members of the mobile teams, and finalized a statute for official status to be submitted to the CIS. Now that it has a full complement, it's viability is jeopardized by the imminent departure of the health officer and regional trainer. Their

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OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
			replacements were recommended on 31 May 1986 to the MOH but no action has yet been taken. A second Regional Commission has been set up and trained in the Guidimaka as of Feb. 1985. With dynamic members, the Regional Commission has demonstrated it can be a successful technical and management arm of PHC operations for a region, capable of developing policy, and bringing about change. Its accomplishments in 2 years are rather remarkable Maintaining a full staffing complement at the regional & departmental level will be the limiting factor in performance.
2) Comprehensive PHC training curriculum developed and village health worker program operating	Health Education curriculum and visual aids developed and approved.	New VHW curriculum was not developed. A revised TA curriculum was developed by the members of the PRSSR, the MCH and Planning Services, WHO, and the National School of Public Health. A VHW retraining was program and prepared by the same team, which worked on a voluntary basis. The Project staff developed the training program for VH committees: "Manuel de Formation de Membre de Comite de Sante Communautaire"	The new curriculum was to be developed by JSI short-term consultants. They were not able to accomplish their job. However, the existing VHW curriculum is adequate and can be revised by local personnel to increase emphasis on preventive activity if judged necessary. The balance between curative and preventive tasks has been a subject of controversy, but rectification should tuned to policies and strategies affecting the VHW role in the community. The curriculum reflects current policy, albeit not formally articulated, and should remain the same until there is a policy-based reason to change.

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OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
	4 PHC Nurse supervisors and 4 trainers are trained	The following in-country training programs have been carried out related to PHC. -Atelier de Formation des Formateur- Superviseur du Guidimaka 16-18 March 1985 (Selibaby) -Atelier sur SSP Renforcement de l'Implantation du Trarza et Preparation des Techniciens du Guidimaka A cette Implantation Dans Leur Region SSP du Guidimaka, 2-7 Fev 1985, 23 participants. (Boutilimit) -Atelier de Formation de Formateur des CSC/Trarza 4-8 Fev 1986, 10 persons (2 med chef, 4 supervisor, 4 Superviseurs, 2 mobile team chiefs)	A series of training programs for trainers and supervisors has been carried out in 1985 and 1986 on a variety of topics related to initiating and reinforcing PHC activities. The pattern which seems to have been established of training superviseurs & trainers prior to the initation of an activity, is a sound approach to ensuring that skills are used and that training is practical. The July '86 training programs for TBA and Trarza Region CHW is also being proceeded by such a supervisor-training program.
	200 community level committees are re trained or upgraded	88 committees were retrained in Trarza during Feb.-March 1985 in 10 sessions at the departmental level by Department supervisors, Regional Commission members and PRSSR personnel.	For 2 members per committee, training was carried out in each department. The manual for training village health committee members, prepared by PRSSR staff for this program in Feb. 1986 is of high quality. The results of the new supervisory methodology and the new village based reporting system which will be introduced at this time should provide a basis for systematic evaluation of the retraining.

OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
	25 EPI nurses trained for mobile teams	10 mobile team leaders have been trained: -2 week EPI workshop in Sept. 1984 -1 week workshop on vaccination evaluation and coverage December 1984 -2 day workshop for national vaccination day in April 1986 -cold chain training in 2 day workshop in July '85 and April 1986.	The training programs are being carried out regularly. The problem, as with all training programs, is the post-training attrition, the difficulty in finding replacements, and the consequent need for supplementary training. Over a third or the personnel originally trained in 1984 have left the EPI program, for example. The EPI national seminar has been postponed several times because the chapters of the EPI manual dealing with national policy have not been written.
	60 fixed-center EPI nurses retrained and skills periodically upgraded.	The one week course for EPI nurses started on July 19th for 50 participants. In addition, they received training during tri-annual mobile team visits and the national vaccination day program, and during the installation of cold chain equipment.	Training has been incorporated into supervisory activities.
	175 new CHW and 150 new TBAs trained.	No new village health workers have been trained. 87 TBAs in the Trarza region are being trained in a program which began July 16 and is scheduled to last through September.	Of the 197 village health workers trained in the RMA Project, 116 (58%) are still operational. The Trarza program has endured a significant but not catastrophic attrition, probably owing to the slow pace of establishing a functional supervisory system following the initiation of the RHS project. On the other hand, a winnowing process is inevitable, and

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OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
			the remarkable fact is that 58% of the initial villages have remained in the program for so long a period. Why this is the case, what distinguishes a durable from a drop-out village, needs to be investigated to be able to determine in the long run what is the probable percentage of the targettable population that can function in a PHC mode. There are TBAs working in villages. Many of them work in the same villages alongside CHWs. These have been trained under a program of the MCH Service. Until recently, the PRSSR training program had intended to develop a separate TBA curriculum. However, the results of the contractor short term consultants in this regard were unsuccessful. It was subsequently decided to use the MCH curriculum. The PRSSR worked with a team of nurses and MCH personnel to revise the existing TBA curriculum which will be used for 88 TBAs who will be trained in the program mentioned above.

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OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
	In-service training for 250 CHW and 150 TBA and 15 trainers.	In-service training (1 week course) seems to have been given in Trarza department of Boutilimit in Jan. 1985. 7 CHW were retrained. However, it seems that the full scale in-service training is starting only in July '86 for the first batch of 67 CHW. There has been no in-service training for TBAs. There have been three courses for trainers.	Ideally, in-service training is dependent on the quality of the supervisory system. The latter requires stable competent supervisor staff following a regular supervisory schedule. This has just begun to emerge the Trarza Region.
		4 Regional trainer supervisors and 6 departmental trainer-supervisors have participated in several in-country training programs	Supervisor-trainers appear to be the most consistent beneficiaries of in-service training, as indicated above. If the pattern of holding five-day training programs to deal with new issues of support, reinforcement and preparation for training continues, this will become a significant activity for bringing new trainers into the system, dealing with problems, and inculcating new skills. Some focus on evaluating themselves as trainers would be useful as part of the IST focus.
	14 short term training courses	5 persons sent to Lome (WHO regional training center): -3 nurses: TOT/1984	Of the first 3, one is still a departmental superviseur: 2 have left the project. The Administrator is leaving for further training in

OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
		-PRSSR program administrator: Sante Communautaire (mid-level PHC mgt)/1985 -Chief of Maladie Transmissible TOT/1986 -PEV Central team member: Sante Communautaire/1986	September '86. 4 persons of 6 planned went for TOT training: two effectively remain, 2 of 4 planned went for Community Health Training: one effectively remains as of 9/86. The value of training abroad is therefore questionable.
	5 international conferences	-PRSSR Director participated in the Epidemiological Intelligence Service conference, April 1985	
	3 long term public health training	-4 persons started a 12 month certificate course in Public Health at the WHO Regional Health Development Center in Cotonou, Benin/September 1985 -3 persons to start post basic nursing program in CESSI/Dakar, which has a PHC oriented curriculum/October 1986 -1 person (Chief Preventive Medicine) scheduled to start an MPH in Epidemiology/September 1986 in the U.S.	The long term training was originally planned to be master's level training in epidemiology, health administration and health education at a U.S. school of public health. The Cotonou and CESSI/Dakar training programs are relevant and are more appropriate for non-physician personnel. They also don't require time/cost for English language competency. The problem as with all training, will be to ensure that, once trained and back in country, the people continue work in PHC in general and in the area of their training in particular.

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OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
	5 specialized workshops	-Health education in March 1986 carried out by Health Education section of MOH for participants including PHC supervisors -The pharmaceutical workshop was carried out following a special study on import and distribution methods.	Five workshops (health education (2), nutrition, pharmaceutical, nutrition education) and EPI were to be carried out.
	Annual Integration seminars for national, regional and departmental health personnel	2 seminars carried out; 1 regional at Rosso February 1985 and 1 departmental at Boutilimit in February 1985.	The questions of operational integration of EPI and PHC have been addressed in the Trarza region, and for the Guidimaka during the training programs for supervisor and trainers. At present, these are project oriented discussions rather than seminars of broader national interest. The latter depend on a national policy which clearly indicates how the RHS Project interfaces with a National PHC program and the extent to which RHS demonstrates that it can function as part of a larger program.
Improved health delivery infra-structure staffed and functioning	4 integrated mobile teams functioning in Trarza, Guidimaka and third Region.	2 integrated mobile teams are functioning in Trarza, one based in Rosso which was established in April 1985, one based in the department of Boutilimit which got underway in October 1985. In addition, the Regional PHC	The Regional PHC Commission is the key management unit for the PHC program as the integrated mobile team is key operational and technical component of the program. They represent the supervisory infrastructure which is the critical element in any primary

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OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
		commission functions as an integrated team for the entire region. The 2 mobile teams pick up the six department supervisors as they move around the region. A third integrated team is ready to start in the Guidimaka, as the regional PHC commission plus 2 department supervisors have been in place since February 1985. Job discriptions have been developed.	health care program, and as such the most difficult to create, train and maintain. Integration poses a host of difficulties in and of itself, and the time and effort required to create an integrated operational team cannot be underestimated. Difficulties do not mean impossibilities, though expectations have to be realistic for two types of activities with different goals, methods, objectives, hierarchical relationships, etc. to operate together. The fact that EPI and PHC personnel have been able to provide a semblance of team effort is remarkable and validates the effort made in establishing the teams.
	-6 EPI only mobile teams	7 Mobile teams are functioning in 7 other regions (Gorgol, Brakna, Assaba, Tagant, Hodhs, Adrar). Supervised by the Regional Chief Medical Officer, the teams operate 20 days per month, visiting each village of 200 at least 3 times annually. Supervision is also carried out from the central level 3 X per year using a standardized supervisory guide. The cold chain component of the EPI mobile teams is still being installed.	There are still some problems with the cold chain in ensuring temperatures are monitored correctly and temperature requirements of the different vaccines are respected. Cold chain refrigerators have arrived. The back-up batteries ordered from the U.S. in November/December 1985 only arrived in July '86 and are not suitable; they have been replaced by locally available suitable batteries. This problem has delayed the installation of the refrigeration facilities in the mobile units. Currently the cold chain uses cold boxes with ice packs and vaccine carriers. Maintenance problems with vehicles and refrigerators are a problem. The lack of a garage, the lack of a stock of spare parts, the lack of a competent mechanic and workshop can keep vehicles and refrigerators out of

OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
	30 EPI fixed centers re-equipped and functioning	31 centers were equipped with a cold chain system in July, August 1985. Monitoring of the cold chain is carried out by supervisory visits, and the 3-M cards which will be in all centers by end of 1986. The centers have also been equipped with basic medical equipment kits.	The 3-M card is being field tested in Rosso in the Trarza at present. At the end of workshops now being held, the midwives of the MCH centers and the heads of the mobile teams will be able to use the cards. MCH centers accounted for 20% of all persons fully vaccinated in 1985. However, the exclusion of those vaccinated on National Vaccinations Days raises the percentage of MCH coverage to 37% National Vaccination Days accounted for 44% of total coverage in 1985.
	10 Regional EPI and Central EPI depots with cold chain equipment	A regional base exists for each mobile team, which includes a cold chain room, a storage facility, and an office. The cold chain room is monitored regularly according to standard procedures.	The regional supervisors have trouble repairing refrigerators, so any break down even minor ones, needs to be referred to central headquarters, which causes long delays and disruptions in parts of the cold chain. A workshop in refrigerator maintenance is scheduled for the end of July 1986. The lack of a program truck to transport gas and vaccine leads to delays and diversions when other transportation means are used.
	13 dispensaries in 3 regions re-equipped	8 dispensaries (6 in Trarza, 2 in Guidimaka) have received most of the equipment planned.	

OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
4) Pharmaceutical Supply/ demand/ distribution marketing study conducted	Recommendations to Pharmarim on means of creating private pharmacies site selection, criteria, drug procurement and price structure.	The "Study of the Pharmaceutical System in R.I.M." was carried out in July 1984 by P. Knebel, then consultant to the Public Health Authority Regional Bureau of the Sahel/USAID, J-M Fleury, Financial Analyst, SOGELERG, Paris. There are an English and French versions of the document. It was submitted to USAID and distributed to the RHS Project, MOH and Pharmapro and. Pharmaprim personnel. A series of meetings was held in July 1984 to review the document. Representatives of the different Services in MOH participated. The meetings were organized by the RHS	There was no no follow-up to this meeting. The document is interesting. However, the suggested reforms in the pharmaceutical import and distribution system would require a major project of its own to implement. The issues of essential drugs, pricing structure, and supply system relate to the PHC program, but the reforms proposed to rationalise this system to the benefit of the Primary Health Care objectives are a long term enterprise. A more pertinent study underway is the methods of replenishing VHW drug supplies. This should be completed, analyzed, and disseminated for study at the national level.

OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
5) Epidemiological Surveys conducted periodically in 3 regions to assess health status and impact of PHC system.	Base-line studies completed during first year of project, follow-ups in years 3 and 5.	Baseline studies were not carried out in year 1. A base-line study was proposed and was to have been conducted by two consultants contracted by APHA. The study was cancelled at the last minute, and AID asked one of the consultants to do an ethnographic study instead. In January 1985, the contractor EPI Advisor submitted a plan for an information system which essentially replaced and incorporated the base-line and follow-up study by an epedemiological study of households in the PHC program in 2 regions. This proposition was reviewed by AID. Following this review, it was modified to take place in the Trarza region and include 400 household in PHC villages and 400 households in non-PHC villages. USAID critiqued both proposals and the discussions have drawn out over the past 18 months without resolution. JSI considered these criticisms invalid and decided not to respond. AID then suspended all action pending conclusion of the evaluation.	The basic issues surrounding this study as proposed by the contract team seem to be (1) the extent to which and the way in which the study is related to a proposed Health Information System which was to be developed during the project, (2) the extent to which the study is realistic vis-a-vis local capability to conduct and utilize its results, and (3) the cost and manpower requirements to carry it out. In the view of the evaluation team, the last critique of the revised study has not yet been fully addressed by the Contractor, and before any decision can be reached, the questions raised by USAID and cited above should be fully answered.

OUTCOME	INDICATOR	ACCOMPLISHMENTS	ASSESSMENT
6) Health Information System Operational	Flow of information provided on patient load, disease, referrals, etc. from village to departmental to regional to national levels.	A functional information system has been developed for EPI operations. The PHC component information system has suffered some setbacks. The original VHW reporting mechanism setup in the RMA project was abandoned (forms ran out), and finally revised. The supervisory documentation was also revised. The new VHW forms will be introduced in the VHW Recycloge program starting in July '86. The supervisory form was instituted in the last quarter of 1985. There are no feedback mechanisms. At the regional level, the regional supervisor consolidates reports and sends them to the MOH Director of Health with copies to the PRSSR. There is no analysis of any data at present.	The development of the HIS, which is an extremely complicated and lengthy process, has been held in suspension until resolution of the issue of the longitudinal epidemiological study. An underlying issue that confounds the others is the definition of a Health Information System and how it relates to a more general management information system for decision-making needs at the departmental, regional, and national level. Surveys and studies of the kind proposed in the L.E.S. are part of a general MIS. At present, activity seems to be focussing on big and small pieces of the system but not on the system as a whole. Unless this orientation changes, disputes may continue, and little substantial development is likely to occur.

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The next section summarizes the table and underlines the aspects which require special consideration in making an assessment of current status.

At the end of the third year of the Project the outputs suggest the following:

PHC INFRASTRUCTURE

The Project has tackled the most difficult aspect of a PHC program, supervision. Despite personnel crises that have occurred throughout the period, the Trarza has a functioning supervisory system in place, developing its own schedule of activities, tasks, and performance expectations. It is currently dealing with conflicting objectives and roles of the integrated mobile teams.

This has been achieved in face of the challenge of trying to create an integrated team approach. The integrated teams still have many operational problems to sort out so that the PHC and EPI activities can be carried out to each member's satisfaction and expectation. The principal problems at the time of establishment of the mobile team were:

- posting of regional PHC supervisors
- posting of departmental supervisors
- acceptance of the idea of integration by the EPI members of the mobile teams

Since the teams have become operational, the problems have largely been ones of division of tasks and responsibilities. Strong leadership at the regional level by the Chief Medical Officer will be required to assure that the team gets through its next phase in managing its different but complementary activities. The anticipated changes in personnel, another instance of the ubiquitous personnel crisis syndrome, naturally creates concern, but the past resolutions, slow as they have been, establish the expectation that there will be additional positive resolutions.

A model has been established. This model seems workable and replicable to the other target regions, as well as in the rest of the country. The Regional Health Commission has been formed in Guidimaka and attended a joint training program with the Trarza Commission in February 1985. It has already completed two rounds of sensitization activities in 36 villages. With the experience of Trarza behind, the major hurdles of setting up an integrated team can be avoided. The 50 villages in the anticipated program extension fall within the supervisory capability of the two planned integrated mobile teams.

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PHC DEVELOPMENT

The Project has entered a maintenance phase in the Trarza region. A period of rapid expansion has been followed by transition to a steady state. Although there has been a 42% rate of attrition in participating villages in five years, already new villages have applied to join the program. One can expect a steady state to continue for some time now, villages entering and exiting the program, but over time gradually stabilizing and then slowly increasing in numbers. This state is desirable so that supervisory needs do not exceed current supervisory capacity. At present, three annual supervisory visits can be carried out for the 116 villages. If the projected 197 were in the program, the number of visits could not be more than two. Three visits are the minimum acceptable level. The capability to supervise is thus the PHC program's limiting factor, which has to be taken into consideration if the number of villages is to reach the level proposed (225). Already, the Regional Health Commission is discussing alternative means of transportation to increase PHC supervisory visits.

3) PHC TRAINING

The training programs have been carried out without any short-term technical assistance. Supervisor-trainer training activities have gone on regularly since the start of 1985; training programs for village health committees and TBA's, and VHW retraining programs have all been prepared by a team composed of Project staff, MOH personnel, WHO consultants, and instructors from the National School of Public Health. The resulting curricula are adequate and appropriate for the training to be done.

Some of the criticisms of the original VHW curriculum are academic. VHW performance in carrying out their tasks appears to be high, and the tasks that are carried out appear to meet village needs. There seems to be a general feeling among villagers that since the program started there is less illness. Villages are small enough so that these feelings may represent not only perceptable but also significant changes in disease occurrence.

This of course needs to be verified, and may be wishful thinking among those involved in the PHC Project. Unfortunately, this lack of data from an HIS or special studies means that the extent of impact cannot be measured. However, since there is anecdotal evidence that health conditions have improved in villages with village health workers, there is a good chance that the improvements are due to the health workers performance. If this is so, it is likely that the training program has successfully prepared them for their tasks.

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EPI DEVELOPMENT

The EPI in three years of activity has been an exceptional performer, especially since 1985. Three elements of the activity have contributed: mobile teams, MCH centers, and National Vaccination Days. The contribution of the MCH component has been relatively small in comparison with the estimated population the 31 PMI centers cover (20% of total activity, whereas 62% of the population is estimated to be in the urban areas). The National Vaccination Days have been effective in bridging the gap in urban coverage. The mobile teams have accounted for 35% of coverage, MCH centers 20% in urban areas, and National Vaccination days 44% in urban areas.

Logistics, equipment procurement, and general maintenance of the cold chain facilities present continuing problems. These problems include proper use of equipment, certainty of getting appropriate equipment when needed, uncertainty of goods on the local market, and the complicated procurement systems which donor organizations are required to use. These problems are typical of development programs, requiring substained effort from all parties to resolve them. EPI has several additional issues to resolve. These include development of a strategy with respect to balance between mobile teams and fixed centers, and the role of mobile teams and vaccination days in assuring coverage of the target population; the definition of the target population itself (up to 2 years or up to 5 years); and the establishment of an inhouse maintenance repair system for vehicles and cold chain equipment.

All these issues have monetary, social, and organizational considerations. Is the mobile team economically viable over the long run? To what extent should vulnerable but not-necessarily high-risk children be included in the target population? To what extent is an independent, full time staffed EPI Service (planning, statistics, reporting, maintenance, repair) required to ensure institutionalization of this service as an effective prevention program of the Ministry of Health?

HEALTH INFORMATION SYSTEMS

The health information system (HIS) is still in a rudimentary stage of development, but various pieces are in place. A new VHW reporting form has been developed and will be introduced in workshops for 38 VHW's this year. A new village supervisory form has been developed and is in use. The EPI reporting system has been set up and has been operating at a high standard of performance, in part due to the development and use of clear, comprehensive reporting forms. On the other hand, there is no overall accepted conceptual framework of what the goals of the HIS should be, what kind of data should be obtained, how the data should be analysed, how the resulting information should be used, or for that matter, who the various users should be.

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The HIS has for the most part been approached as a series of studies, with some data collection activities at various points. In general, the emphasis has been on gathering health information, rather that on the systems component, which brings together data producers, processors, and users. Some of the outstanding and unresolved issues with regard to the contractor-proposed Longitudinal Epidemiological Study reflect the absence of any consensus, let alone agreement, on the role and function of HIS and on its key components.

PROBLEMS

During the evaluation, persons interviewed drew attention to a series of problems which have affected implementation of the Project. These problems are occasionally implicit in the reviews of project achievements to date. They need to be explicitly discussed in order to understand some of the underlying concerns which led to postponement of decisions on PHC activities and technical assistance.

A. MOH and AID Commitment

There has been a continuing uncertainty about the MOH commitment to the program because of inaction on key institutional expectations such as the National Commission of PHC, and the perceived lack of interest in the statutory Comite Inter Service. The uncertainty has been aggravated by the feeling that the MOH is not providing the minimum operational staff. These feelings have persisted despite the fact that requisite staff have been posted, and every staffing crisis has been overcome. Uncertainty, anxiety, delays in decision-making, and inaccessability to key MOH personnel invariably create attitudes about viability of the Project and capacity of the MOH.

B. Technical Assistance

By the same token, questions have been raised about USAID commitment to this project, because of its unilateral action in suspending activities. The latter include suspension of the base-line data survey in 1985, PHC activities in 1986, and replacement of the current technical assistance team. There is a perception that such unilateral actions create adversarial relationships rather than good will among all parties needed to implement the project. The concerns of USAID to ensure that the program does not over tax the resources and capabilities of the Ministry of Health is being misinterpreted as a lack of willingness to collaborate as an equal partner. Meanwhile, problems in procurement have aggravated the situation.

The competence of several of the consultants provided by the technical assistance contractor has been questioned. Two short-term consultants were not able to carry out their assignments, and the long-term PHC consultant found it very difficult to carry out his duties. An analysis of the situation which he prepared to

explain the lack of progress in the PHC component of the project was ill-received. Apparently, the lack of success was interpreted as a lack of competence. In addition, his counterparts felt that his contribution was not significant. The situation with regard to this consultant is difficult to unravel, as several of the key actors are gone. What is important is that this episode has engendered strong feelings that raise questions about the general role of technical assistance in the project and the competences which are needed.

C. Pace of Progress

A third cause of discontent, which reflects the questions of MOH commitment and contractor performance, is the slow pace at which the PHC component of the Project seems to be moving. The problem herein is that the schedule for the first Project year was so overcrowded with activities that it was unlikely to effect accomplishments without the existance of a full scale, experienced, and highly skilled project staff. The fact that responsibilities were fragmented did not help; nor did the absence of the technical assistance which was expected to play a vital role in implementation.

The expectation that one could start off at full speed was naive. There was no consideration of the effort needed to overcome the inertia of a new program which required amalgamation of two totally different kinds of activities. The project nonetheless did have its natural start-up year. The second year inevitably turned out to be another start-up year in relation to the integration of the contractor chief of party and technical advisor for PHC. Two "start-up years" inevitably led to perceptions that no progress was being made.

GENERAL ASSESSMENT

In spite of perceptions that little progress is being made, there has been a respectable level of activity in EPI and in PHC. The two programs cannot and should not be compared. EPI is a highly operational-oriented program; PHC is a highly organizational- and sociological-oriented one. The EPI had to develop efficient systems. PHC had to figure out how to merge with the EPI system. That has been carried out to a certain degree of success at the regional level, but with much less success at the central level, because of the managerial fragmentation of functions and roles. The EPI in future must contend with the relative balance among different approaches to reaching the target population. PHC has to deal with how to maximize contact with target groups (VHW's, AT's, and Committees). In a sense, the EPI program may be in a more fragile status, if new strategies are introduced which require redirection of development efforts, where as PHC may be more stable in terms of the systems and method in place. In terms of the key infrastructural elements (cold chain and vehicles for EPI, and the

managerial supervisory system at regional and departmental level) both program components are well within the limits of reasonable expectations, given real time requirements for development.

VII. ASSESSMENT OF CURRENT STATUS OF INPUTS

The Inputs are divided into USAID funding and Mauritanian counterpart expenditures and responsibilies. The USAID input totals $5 million over five years and covers technical assistance, training, commod ties. The Mauritanian input covers salaries for local personnel, facilities, and community contribution. Each of these will be examined, following which the status of the overall input will be assessed.

USAID INPUTS

A. Technical Assistance

Short term technical assistance (TA) was to be provided in part through separate individual contracts in the first year of the Project, mainly to carry out preliminary studies and related HIS work. Long term technical assistance (4 years) was to start in year two. The contractor eventually chosen for the latter was John Snow, Inc., an American private sector firm based in Boston, Massachussetts. The contractor would henceforth provide short term technical assistance as well. The positions called for were health evaluator, training advisor and health management/EPI advisor. Job descriptions were detailed in the Project Paper. The first one was subsequently modified to emphasize primary health care management skills as well. The TAs arrived in October (EPI) and December (PHC) 1984. The PHC advisor resigned in March 1986. The EPI advisor is leaving in August 1986. Two short term (3 month) consultants were provided in January 1985, for curriculum development. They did not satisfactorily complete their assignments and were not invited backs. Replacements for all of these consultants was delayed until the evaluation results were in. Continuity in long term technical assistance has thus been disrupted, and questions of Project goals and technical needs have necessitated a review of the TA package.

The major issue in the provision of technical consultation is performance, although personality and interpersonal capability always play a role in arriving at a judgement of performance. There have been disappointments with the technical assistants on the part of USAID and the Mauritanian counterparts, particularly with regard to the PHC component. With respect to key actors who are no longer in place, assessments have to be made on the basis of performance as suggesl J by available documentation.

There is general satisfaction with the EPI advisor in his technical capacity. He can share in the credit for the achievements in EPI to date. The only major pieces of unfinished business are the development of health information system,

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although an EPI information system has been developed and has been providing complete and reliable information; and the preparation of several sections of a key EPI operational manual have been done. The momentum on developing a health information system was lost in arguments between the EPI advisor and the assistant USAID health officer regarding the Longitudinal Epidemiological Study.

Major issues regarding the TA package center around the PHC advisor. Herein personality and role conflict seem to have been more troublesome than professional competence. Unfortunately, this went beyond the usual limits of such conflict and the PHC advisor resigned. Judging from his reports, his level of activity, and his situation analyses, questions about his professional competence and technical suitability for the PHC program seem unjustifiable. The cause of doubt, in the case of the PHC technical assistance, may have arisen because of the difference in professional qualifications between the consultant and his Mauritanian counterpart.

When mutual expectations are clear cut, as they generally are in EPI, roles are easily definable. Competence can be clearly focused and any conflict resolved by good will. When mutual expectations are cloudy as in PHC, there is likely to be tension and conflict, and the latter are likely to persist particularly when the job does not seem to be getting done.

The project director has indicated that any new PHC technical assistant should have a medical background and specific areas of expertise within PHC which are complementary to locally available expertise. AID's position is that the Project should determine the composition of the T.A. package. Neither party indicated exactly what those needs are. The question of performance is clearly secondary to that of roles and expectations.

B. Commodities

USAID was primarily responsible for procurement of all commodities except vaccines which are supplied by UNICEF, and off-the-shelf items available locally which could be procured directly through the local operating budget of the Project. USAID has come in for occasional criticism from the national counterparts and the contractor TA in the procurement of commodities.

There have been snafus and dissatisfaction with major commodities such as vehicles (the wrong Land Rover model, notable for its problems in Africa, was purchased); purchasing cold chain equipment via UNICEF turned into a 19 month headache; spare parts for vehicles and back-up batteries have not matched specifications. The management of the commodities has suffered from the usual batch of problems associated with tele-procurement, particularly when orders have to go through multilayered bureaucratic processes.

In other instances, procurement has proceeded without problem, as in the case of equipment of the MCH centers. In some cases, delays have been serendipitous as they have allowed the EPI to take advantage of some new technical developments in the installation of cold chain equipment in Land Rovers. In general, while the delays and errors have been influenced the progression of activities, their impact has not been catastrophic, and both EPI and PHC components have advanced.

The major issues in commodity procurement relate to spare parts and replacements needed over the long term. The expectations with regard to the USAID input in meeting this need are unclear except for the line item obligations. There is a question as to whether or not funds should be used to build up stocks of spare parts, etc. in order to avoid any disruptive non-availability crises, and to permit preventive maintenance of to be instituted.

There is also a question of purchasing systems to be used over the long run, on the supposition that the EPI will ultimately take over all responsibility. It does not appear that purchasing systems have been developed and used in a way that would permit assumption of this management responsibility.

Vaccines, some cold chain equipment, and report forms are procured directly through UNICEF. Orders are placed directly by the Preventive Medicine Service, without any USAID mediation. This system is working well.

A list of items procured until July 1986 is included in the appendices.

C. Training

The major input here was funds for per diems, travel and scholarships for Mauritanians for local training, third country training in Africa, and long-term training in the U.S. The management of this input, whether from the local operating budget, the Project, or USAID foreign currency account, does not seem to be an issue. Funding of training in WHO centers such as Lome and Cotonou has been free of any problems. The issues in regard to this input relate to support levels for participants and trainers taking part in in-country training activities. The problem arises from the fact that the MOH has no standard per diem rate. All workshops are funded by donor agencies, and per diems vary with AID's being the lowest. It is argued that this discrepancy acts as a disincentive to participants. This may have colored attitudes of MOH personnel with regard to the desirability of joining or staying with the Project.

D. Fuel and Vehicle Maintenance

This is covered by AID. Petrol is supplied via a voucher system, and maintenance is provided for by a contract between USAID and a central garage of the Food Security Commission.

Delays and irregularities have been reported in delivery of vouchers for petrol. Serious questions of competence about the garage have been raised. The latter complaints raise issues as to how autonomous or dependent EPI (and for that matter PHC activities) should be on outside sources for mairterance, since vehicles are the essential limiting factor in both activities.

E. Special Studies

Only two studies have been funded, pharmaceutical and medical-anthropological. The pharmaceutical study was reviewed, but no action has been taken or recommendations made. The anthropological study was to have contributed to the adaptation of the training program to the Guidimaka region, which was suspended pending the evaluation. Funding has been managed by USAID, according to regulations in contracting technical assistance.

F. Financial Input

With respect to the overall $5 million budget, expenditures through 31 March 86 are as follows:

Technical Assistance:	536,371.80
Training	35,678.71
Commodities	19,935.13
Fuel and Maintenance	136,128.20
Local Salaries/Per Diem	2,062.38
Local Currency Account	197,582.42
TOTAL:	1,172,442.40

The Project has spent just over $1 million dollars or about 23% of its budget including contingency.

In conclusion, the inputs have to be assessed in terms of how well they have been managed, how important they are, and how useful they have been. For the most part the inputs have been managed satisfactorily. Nothing inherent in the problems related to TA package, commodity procurement, etc. has kept the Project from proceeding. The slow and extended start-up was unavoidable: the catch-up rate has been creditable. The general control and administrative records on commodity procurement are in excellent shape. The control of fuel and maintenance, as far as expenditures go, is also complete and clearly presented. The control of use, however, can be and must be improved.

COUNTERPART INPUT

The Mauritanian input consists of salaries and facilities (rent and utility), and community contribution.

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A. Salaries

The salary input translates into personnel, and the real issues that has to be addressed is the quality and quantity of personnel that have be assigned to the Project and the manner in which these assignments have been made. There have been some significent grievances on the part of USAID and the technical assistance consultants with respect to this input, throwing into relief the larger issue of local committment to PHC. Major issues have concerned performance of the RHS Project's first director; the assignment and replacement of Project office personnel; the assignment of field staff, principally regional and departmental supervisors; and non-assignment of experienced personnel to Project areas. The problem is aggravated by the placement of personnel trained by Project funds in services that bear little relation to PHC and thus do not make use of the training investment in any visible and measurable way.

At present this question arises once again vis-a-vis the replacement of the Project training coordinator, the Regional Medical Officer and Regional trainer in Trarza, and the reassignment of personnel with experience to the Guidimaka region. This is particularly important because valuable experience and knowledge about PHC are at a premium. Unless personnel receive training abroad, they are unlikely to be prepared for PHC. Learning becomes an on-the-job process with consequent programmatic backsliding until the learning process is completed and the person begins to perform at professional standards.

A second aspect of this problem is the rapid turnover of personnel or the loss of key experienced personnel to other disciplines. The general feeling is that the exodus of personnel can be attributed to the lack of incentive to remain in jobs associated with PHC because there is no future. If one stays too long, one is barred from any career advancement. If there are no rewards for persons working in PHC, obviously, incentives will diminish even faster.

There have been three crises in personnel i) the sudden outflux of field personnel at the end of the RMA Project, ii) the loss of personnel and the PRSSR Office in 1984 and iii) the upcoming one to replace key personnel in the central office and in the Trarza Regional Commission for PHC. Each crisis has been overcome, and although one is hopeful that the new crisis will be as well, the persistence of these problems eventually erodes confidence in the national willingness and ability to commit needed manpower to PHC.

The slow resolutions of the crises may have obscured the positive side of the Mauritanian commitment. There has been a high calibre of performance from several key technicians in the Project, performance characterized by dedication and competence. The quality of regional supervisors has been impressive, and the motivation of departmental supervisors is equally impressive in

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face of the difficult job without immediate or tangible rewards. It is important to point out as well that a Regional PHC Commission and departmental supervisors have been waiting in the wings for a long while for the program to start up in Guidimaka.

Thus on balance, the local inputs have been forthcoming and generally of a high quality. Can the crises stop? As long as the Project remains confined to one region, it is unlikely that there will be any great urgency to do any kind of long term planning to ensure the availability of personnel needed.

B. Facilities

The Government provides an office for the PRSSR which seems quite satisfactory and well located.

C. Community Contribution

This component of the Mauritanian input relates to support given by the community to the VHWs and TBAs, primarily to ensure a resupply of the medical kits. A survey is currently underway, the results of which should provide interesting perspectives on the ability and willingness of communities to take responsibility for their own health care. Anecdotal evidence suggests that there is a wide variety of methods to finance drug supply and that by and large most communities involved in the program in Trarza have worked out a formula to tailored to their and means.

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VIII. PROJECT ISSUES

This section addresses several key issues project-related which have direct bearing on the design of the remainder of the Project. These issues have been brought up in the terms of reference and in many interviews in one form or another. Since many of them are interrelated, for the purpose of simplicity, they have been reduced to three key concerns that seem to reverberate in all aspects of the project. They are policies and strategies, technical assistance composition and role, and the mechanisms and desirability of integrating PHC and EPI.

(1) POLICIES AND STRATEGIES:

a) EXPANDED PROGRAM OF IMMUNIZATION

The impressive success of the EPI has of course carried some major issues in its wake. At present the backbone of EPI is the mobile team, a very expensive logistical system to operate because of fuel and maintenance requirements of the vehicles. The other component of EPI activities is based in MCH centers which provide vaccine coverage and which have received cold chain equipment. In addition to these routine activities, several National Vaccination Day were organized in 1985. Following a mass publicity campaign, they succeeded in attracting a substantial portion of the target population and thereby contributed to the improvement of vaccine coverage in urban areas.

These three strategies are very different in terms of their costs and effectiveness. In addition, the potential to improve their outputs is unequal. The mobile teams have attained a relative level stability while the performance of the MCH centers can be greatly improved.

As for MCH outreach activities, they should keep pace with the opening of the rural maternities. Besides the benefits that the EPI will receive from the maternities' inclusion in the vaccination network, these periodic outreach visits will serve as a general supervisory mechanism for MCH personnel.

Are the current strategies for EPI properly prioritized and relevant to their target population?

Fixed Facilities: There are 219 health facilities of all kinds throughout the country; however only thirty-one of them, MCH centers, have been equiped with refrigerators and deliver vaccination services. These 31 facilities serve 62% of the EPI target population. However, their activity accounts for only 20.6% of the group of children fully immunized in 1985, including those vaccinated during National Vaccination Days and representing 37.4% of EPI's routine activities. As compared with 1984, the increase is something between 10% and 15%, depending upon the type of vaccine. This improvement reflects well on the

MCH Service of the Ministry of Health, which has taken an active role in motivating MCH personnel with regard to EPI activities. The relatively low level of coverage indicates, however, that the MCH could function at much higher levels, perhaps by mass education activities and by collaboration with feeding centers and rural maternities.

PMI's do not conduct outreach activities. This type of activity is not required in most of the towns since there is virtually no inhabitant living far from the town. Nevertheless, in the major urban centers, MCH outreach activities could be used to cover a radius of around ten kilometers, areas not presently covered by the mobile teams. In addition, such outreach activities could provide a useful link with the rural maternities planned for the near future. In fact, it is estimated that approximately 70% of the population lives within walking distance (less than two hours) from a fixed health facility. Although no precise demographic statistics are available, this estimation given by several persons interviewed is consistent with calculations of urban populations. Therefore, upgrading smaller health centers such as dispensaries, especially with cold chain equipment, would substantially improve the coverage of the EPI at less cost than using the mobile teams.

Mobile Teams: There are currently ten mobile teams in operation in the country (10 teams functioning in nine regions) which are being equiped with battery-operated refrigerators. There have been several problems in the functioning of these teams in the last two years: vehicles kept off the road for various reasons (breakdowns, shortage of gasoline), absence of personnel in the integrated teams, difficulties in planning and lack of direct means of communication. As an average, they have been operational no more than 50% of their planned schedule.

In spite of these drawbacks and of the difficulties inherent in the operation of mobile teams, their performance accounted for 35.1% of the group of children fully immunized in 1985. This result is comparable to 1984 figures. The level of effort and financial investment by the Project has attained its maximum level for maintaining the mobile teams. Keeping in mind their constraints, the results obtained in terms of vaccination coverage is more than respectable, and it is stable; the essential thing now is to reduce the external constraints to the teams' functioning (planning, fuel supply, condition of vehicles, communications) in order to increase effectiveness without increasing costs.

One of the major handicaps has been vehicle maintenance. The type of Land Rover (110s) furnished by AID - against the wishes of the Ministry of Health and the Project Director - is not in general use in Mauritania. Therefore, there are no locally available qualified mechanics or replacement parts. Moreover, the 110s have been more susceptible to breakdowns than other models.

The system of parts supply in use by AID is perceived by EPI staff as totally inadaquate. Vehicles are out of operation more and more often and for increasing periods of time. This state of affairs is unacceptable, counterproductive, and in the long run extemely costly: immobilization of the vehicles ruins the supervision which is indespensible to the development of primary health care services, and more important in direct monetary costs, cripples EPI operations. This problem must be solved immediately.

Three possible solutions were suggested and discussed:

A) AID could simplify ordering procedures considerably by contracting directly with Rover U.K. for immediate dispatch and to have all necessary parts on hand, to be ordered by telex. This solution would require revision of reference catalogs. Stock needs identification by a specialist.

Pros - simple, no heavy infrastructure

Cons - doesn't solve the mechanical problems of the vehicles and risks errors in filling orders; probably expensive in the long run; impossible to implement without arrival of the expert, adding to cost and delaying solution of the problem.

B) AID could establish a garage specializing in the 110s, under the direction of a technical assistant mechanic-trainer.

Pros - introduces a new technology; could serve the vehicle maintenance and repair needs of all projects in the country.

Cons - very expensive; doesn't permit repairs outside Nouakchott; doesn't guarentee availability of parts.

C) AID could immediately replace all Project Land Rover 110s with a model which is regularly imported to Mauritania and which can be repaired anywhere in the country;

Pros - permits repairs throughout the country; would renew the nearly three-year-old EPI fleet; probably the most cost-effective option

Cons - cost not budgeted (10 Land Rovers at approximately $10,000 each).

National Vaccination Days: Three rounds of immunization at one-month intervals have been organized country-wide (except in two regions), with the assistance of other donors. They accounted for 44.3% of fully immunized children in 1985. This remarkable result points out the good response of the population to information campaigns and to the present weakness of fixed facilities in mobilizing the population and effectively covering their catchment areas. EPI activity in general has proven to the

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an accurate indicator of the efficiency and effectiveness of the health delivery system; the relatively low rates obtained from routine activities indicate that MCH services.

RECOMMENDATIONS

1. The Project should give first priority to strengthening outreach and other activities of the MCHs and at least 13 additional fixed facilities, as indicated in the Project. These should be chosen according to the population living in their catchment area so as to develop a network covering 70% of the population. It is in fact by this development of infrastructures that the project stands its greatest change of attaining its objectives and leaving behind a functional system. It is therefore, recommended that the upgrading of new MCH centers by the Project be flexible enough to respond to the country's changing needs and to correspond to the MOH plans for expansion. This will require proper supervision, possibly as an activity of the mobile teams which will visit these centers during their rounds. Equiping of new centers should be planned in collaboration with other programs (e.g. UNICEF) about to start in Mauritania.

2. With regard to EPI activities, it should be clearly stated that the program target group is the 0 - 2 year old, although no child up to age five should ever be turned away.

3. The mobile teams remain an absolute necessity to cover the 20 - 25 % of the population beyond reach of fixed facilities. This requires that substantial effort be made to keep them permanently in working condition (supplies, parts, and maintenance).

4. As more fixed centers are developed, the mobile team will increase their supervisory role in general PHC activities. Given the difficult traveling conditions and the absence of a means for rapid communication, it is essential to link the mobile teams to EPI headquarters by means of radio communications. This would greatly improve the teams' performance by avoiding needless trips; by assuming that important messages are transmitted, e.g. requests for vaccines, spare parts, refrigerator and vehicle repairs; and by speeding exchange of report and instructions.

5. The National Vaccination Days should be the lowest priority. They should be seen as a means to increase public awareness and to cope with the backlog of unimmunized children. They should, therefore, focus on the 2 - 5 year old age group and be stopped at the end of the program.

B) PRIMARY HEALTH CARE

EPI represents one PHC strategy which can produce impressive results. However, it is a highly specialized strategy that requires a sophisticated complex, and efficient organization to operate smoothly. Results come quickly and when they are good

they are impressive. Other PHC strategies are less glamorous; quality control is not as easily imposed and results take longer to appear. For the most part these characteristics apply to that part of PHC which is "operated" by the Lay Village Health workers and their village health committees. Having entrusted these guardians of community health with so many tasks, most PHC planners become highly disappointed when some tasks are not being performed correctly, or when certain tasks are given more emphasis than other, (curative over preventive, for example) or when some task are not performed at all.

Very often the training program is blamed for poor performance. The runner up is supervision. The natural reaction to such disappointments is retrenchment: limit intervention to strategies which have proven technologies, which are simple to apply and which have definable, measurable results over the short term.

This to a great extent has been the case with VHW/VHC base of the PHC program. Unfortunately evidence to prove the efficacy or inefficacy of VHW, is not available other than anecdotally or impressionistically.

On the negative side, the most discouraging indicator is the frequent difficulties in replenishing medical kits. A large percentage (impression) of VHW sell their drugs by consultation, the fees of which are used to buy medicines. Very often they do not get enough cash as villagers cannot afford to pay immediately. Drugs are costly, and although in principle they can buy drugs at pharmarim at a 10% rebate, this is often not the case. Future privatization of pharmacies may aggravate the situation. Private pharmacies are not only unlikely to offer rebates, but also may raise prices. Preventive health measures seem to be of secondary concern to most VHWs, and for that matter to most village health committees, and supervisors place a lot of emphasis on that aspect. This may be attributed to the fact that they may be most comfortable with this subject because health education is part of the nursing school curriculum. Curative intervention may also be compromised by incorrect technique and confusion between methods. This may happen not only because the VHWs forget what they learn, but also because their supervisors reinforce their tasks with wrong instructions.

On the positive side, there is anecdotal evidence from the villagers that they have noticed a change in illness patterns since the VHWs started to provide health care. This evidence is often confirmed by others, but it is hard to distinguish fact from wishful thinking. On the other hand, there is almost a universal acknowledgement that some major change has been produced in attitudes of the people in the last 3 years, particularly in regard to EPI.

The presence of village health workers may have helped motivate villagers to vaccinate their children. The influence may also work in the other direction: more positive attitudes to

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preventive health care may motivate villagers to support their VHWs, stay in the PHC program, or want to join or rejoin the program.

Thus, one might suppose that (a) something appropriate and productive is going on. (b) that the VHW and village committees are viable, (c) that the VHWS have had some impact in lowering morbidity and mortality, and (d) that their methods are replicable elsewhere. The issue to be addressed with regard to the PHC component is therefore, to what extent is the model developed over the last several years in the Trarza region replicable in the other two regions planned for in the RHS Project. We have to examine the conditions under which replicability is possible. Replicability will depend on two factors: 1) adequate training for village health workers and traditional birth attendants, 2) adequate supervision through integrated mobile teams.

1) Training

Since training plays so fundamental a part in PHC programs, one obvious area of immediate concern is whether existing training programs can ensure the VHW health care interventions are appropriate and adequate. A source of contention in the RHS Project has been the question of training. The existing curriculum used in the previous RMA Project developed by the Mauritanian trainers has been criticised for emphasis on curative care and for not being competency-based.

The training question cannot be resolved until there is some resolution of the questions of effective or ineffective health care interventions which can be conducted by VHWs. This requires data. Unfortunately, data are not available, and a health information system is not in place to help us get the data to resolve this question. Therefore we have to turn to circumstantial evidence: 60% of villages have remained in the program over a five year period; there appears to be some level of satisfaction with health care provided by the VHWs as most villagers pay for these services; and there is recognition of a perceptible improvement of the health situation at the village level. It appears that presumptive judgements were made without much supporting evidence about the ineffectiveness of the curriculum. Thus the curriculum is addressing the kind of care do villagers want in so far as. They are willing to pay for the care, since this program is based on a self-financing system.

In the professional judgement of the evaluation team the existing curriculum for the village health workers which was developed in the RMA Project is competency-based not only in letter but also in spirit and the program content is appropriate. It may need to be modified for the Guidimaka region. However the training team of the RHS Project has demonstrated ample capability in developing training programs. They have developed a ten-day refresher course for VHW in the Trarza and a month-long course for TBAs which will be used in the national TBA training

program, which was started by the PMI service of the MOH in 1983. They have also developed training programs for village sensitization, village health committees, and training of trainers. The training team is therefore competent to make any revisions in the curriculum to be used in regions with different health conditions. The Guidimaka Regional Health Commission has had two training of trainers courses. A third course to reinforce their skills would prepare them for playing an active role in VHW and TBA training program for their region.

2) Supervision

The second limiting factor is supervision. This will to a great extent depend on the competence of supervisors and availability of human resources. The Guidimaka PHC Commission has a full complement of supervisory personnel at present. These supervisors have already received several training several times, and acquired experience in the village sensitization activities they have undertaken. The current team model is acceptable and has proved to be workable in the Trarza Region. The model team needs a regional training supervisor, MCH supervisor and PHC supervisor to work with the Region Chief Medical Officer. It also needs at least one departmental supervisor. Guidimaka meets this requirement at present. To what extent, however, can these resources be guaranteed over time to make sure that the PHC program can be sustained over the long-term? Personnel crises in the Trarza have raised doubts about the MOH ability to ensure adequate, acceptable supervision. At present, several key persons will be leaving the Regional PHC commission and they have not yet been replaced. If they are not replaced by competent personnel, the program in the Trarza will be jeopardised. If continuity in basic requirements for program implementation can not be guaranteed in the region where the PHC program began, can it be ensured in other regions? Assurances have been given by the Director of Health that the Trarza vacancies will be filled before the current personnel leave. These persons must be assigned to resolve any doubts about the long-term viability of the PHC component.

RECOMMENDATIONS

1. Given the current readiness of the Regional PHC commission in Guidimaka, the PHC component should be extended to this region according the planned schedule. The training program for VHWs and TBA needs to take place before November 1986 or it will have to be delayed again until the harvesting season is over. The program should start by training VHWs from the 36 villages already taking part in the sensitisation program. The second round of sensitisation for the remaining 14 villages should be carried out following the return of the VHW and TBA and the first supervisory visits. This will provide feedback as to any adjustments which need to be made in the training program as well as test the supervisory capability.

2. The training program for VHWs should be based on the existing curriculum with revisions made to ensure that the health conditions in this region are addressed. The preventive content of the curriculum should be strengthened to reinforce the VHWs ability to focus on areas, which the experience of Trarza suggests may not be priority concerns of the villagers, but which are none the less important. The curriculum should strengthen areas such as sanitation, oral rehydration, community participation, and include specific endemic diseases in the Guidimaka. The ethnomedical study carried out in 1985 should be used as a reference. The newly revised curriculum for TBAs should be used in the TBA training activity as well. The use of a curriculum for an existing national program is important to consolidate integration of PHC into the routine activities of the MOH.

3. The revision of the existing curriculum should be undertaken in the framework of a training of trainers curriculum development workshop. The Guidimaka Regional Health Commission team members should participate (including the EPI Chief) to ensure that curriculum and training methodologies are consistent with each other. This TOT course should be organised along the same lines as the TOT courses which have preceeded previous training programs.

INTEGRATION OF PHC INTO THE MOH STRUCTURE

The assessment of the Project in terms of outputs suggests that there are fundamentally two projects still in operation in Mauritania. Putting the EPI and RMA under one roof, as it were, has not forged a unitary project with common objectives. EPI operates independently with a fairly well defined technological and staff base. That, of course, is the advantage of a vertical program. PHC, on the other hand, is in a dependent relationship. It depends on the mobile team and on the MCH Service for its means of locomotion and personnel. Thus the burden of integration is on PHC. Moreover, the fact that PHC acts as cashier for the EPI (or is perceived as such) is a source of contention which further separates the components, at least at the central level. The burden will continue to weigh heavily on the RHS project until the relation of PHC to the whole of the MOH can be resolved.

Thus there is a major issue of integration that goes well beyond the problems of whether the PHC supervisors can cooperate with the EPI teams.

The question of integration was often expressed to evaluators as a problem in the management structure of the Project. That is its most tangible expression because of a) the dissatisfaction with the roles Project staff are confined to in relation to the other Services of the MOH; b) the sense of exclusion from the MOH in general, the unavailability of the MOH to the Project, and c) the overriding feeling that the Project Office as an activity does not belong anywhere. These feelings are most acute at the

central level because of the daily friction caused by seeking agreements between program and budget, trying to convene meetings of the Comite Inter Service, and trying to get commitments from the MOH.

The issue is perceived differently at the regional level. Here, it is one of trying to get the attention of the MOH. The question of who is in charge and where PHC fits is not perceived as terribly important because the program is integrated at the Regional level through the office of the Regional Chief Medical Officer. For him, EPI and the use of local health workers in the community are both components of PHC. On the other hand, the question of support from the MOH is important. Support means professional, administrative and clerical staff, quick responses to communications, and periodic physical presence to demonstrate backing.

At the departmental level the issue of integration is seen still differently. Here, it is one of getting support and active participation of the civil authorities. The prefet in charge of the department's civil administration, is the real link between the health infrastructure and the villages.

Both the civil authorities and the departmental Chief Medical Officer can influence the villages as to whether they want to establish a health committee and nominate a VHW, or ask for a dispensary. Clear written policies and a common understanding of PHC are required to ensure coordination and to provide a basis for securing additional support for supervisory activities, referral mechanism, etc.

From the preceding description, one can see that resolution of the issue of integration has to eliminate role conflicts at the central level, preserve active support to the regional level and provide a common set of principles to promote joint action by civil and medical personnel at the departmental level.

All parties interviewed at the central level agreed on the necessity of integrating PHC into the MOH structurally and functionally. Three approaches for accomplishing this were discussed during the evaluation.

The first is through establishing a new PHC Service which would give a PHC director visibility and decision-making authority. The PHC Service could be the result of an amalgamation of existing Services such as EPI and MCH, whose activities make up the greater part of PHC approach. A variation with this option is to establish a PHC Service which deals exclusively with the village-based infrastructure (health committees, village health workers,and traditional birth attendants) and coordinates with EPI and MCH for supervision and other operational requirements.

The second way of resolving the integration issue at the central level is to look at PHC as the sum of its eight component activities and to apportion them to the appropriate existing

Services. In this way, visibility may be lost, and the lay base may not be ensured unless there is a strong philosophical statement in the form of a national policy. Spreading the PHC activities through different Services would require some form of inter-service coordination and monitoring to ensure that each service's individual goals and objectives interrelate, particularly at the village and referral centers.

A third approach, which has been tried in Senegal, makes no attempt to coordinate PHC activities at the central level. Instead, each Regional Chief Medical Officer plans and implements an integrated PHC program at the regional level. They make use of resources from the various central services, but they report directly to the Minister of Health.

All three possibilities require policy and strategy statements from the highest level to ensure that all interests converge. Thus, the conduct of a national seminar/workshop on integration, as originally proposed in the RHS project, is still a valid concept. However, its purpose should be to find long-term solutions to the organizational changes required by PHC, rather than solutions to the particular problems created by the management structure of the RHS Project. Products should include a PHC policy statement objectives, a three-to-five year plan for accomplishing objectives, and a clear delineation of the responsibilities of each service.

It is also necessary to pursue the concept of integration at the regional level, by maintaining the Regional Health Commission structure as developed in the Trarza region and replicating it in Guidimaka and other regions. To function effectively the Regional Commission needs to be strengthened by logistical and administrative support, and by training for the Regional Chief Medical Officers in PHC management skills. Integration of services delivery through mobile teams would continue. Remote populations would receive comprehensive health services in one visit (vaccination, growth monitoring, ante- and post-natal care, health education, and first aid). Problems in functional integration of EPI and lay-service supervision might be reduced by preparing and training the teams to perform joint tasks, especially for the EPI members (e.g. hygiene surveillance, triage, first aid). This would give them more to do and would create an extended role in relation to the community, which might make them more aware of the importance of the PHC supervisor's work and thus less impatient leave for the next village.

Integration needs to be assured at the departmental level as well, so that the departments are operationally self-sufficient to supplement supervisory visits made with the regional mobile teams. The departments need to draw on all available resources. Therefore, it is crucial for the civil authority to be regularly informed about PHC activities and invited to participate in decisions related to PHC in his department.

It is interesting to note that PHC integration issues appear primarily at the central level. The evaluation team believes it would be presumptions to advocate any one approach to PHC integration at this level. However, it might be useful to pass along the opinion of several interviewees that creation of a PHC Service would do very little in the way of coordinating or integrating PHC into the other Services; rather, each existing Service must understand, and be committed to a PHC approach. In any event, the need for the formal integration of PHC into the MOH structure, planning, and policy is urgent and should be undertaken at the earliest possible time.

A second integration issue relates specifically to the structural location of the RHS Project Office outside the Ministry of Health. Because the Project is the largest PHC program in Mauritania, it is seen by some as synonymous with primary health care. The Project Office has never been accepted by the MOH as a tool for investigating and testing PHC approaches for Mauritania as a whole.

Instead it is perceived as a one-region project at best, and a foreign project, at worst. AID actions to restrict the project to one region only confirmed these presumptions. This misunderstanding of the Project Office's purpose has had two consequences:

First, while the Office is in fact well-situated for conducting pilot projects and studies, it has to justify itself as an instrument for implementing primary health care at a national level.

Second, the Comit(Inter Service (composed of directors of the MOH Services), which could have used the Office to develop a policy and a national program, has instead dealt mainly with burdensome administrative matters.

As a result, no single entity or person within the Ministry of Health represents primary health care in Mauritania and has the responsibility to operationalize it. There is no sense of urgency to respond to Project Office requests for support and no demonstration of commitment to the Project. It should be stressed that this in no way indicates a lack of commitment to PHC in general. The Comite Inter Service has worked together solve technical problems, as in the development of a national curriculum for traditional birth attendants.

RECOMMENDATIONS

1. Formal integration of primary health care into the Ministry of Health should be accomplished as quickly as possible, resolving the various issues discussed in the section above to this end.

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The national seminar called for in the Project Document should be held, but it should take the form of a working group to define PHC policy, plan strategies, and divide responsibilities. Participants could include the Director of Health, heads of each Service, Regional Chief Medical Officers, and possibly outside observers (e.g. WHO).

The success of such a working group depends upon the care with which the agenda is prepared; methods of work chosen; expected products and other outcomes; and the skill of the facilitator(s). Professional facilitator with experience in the Africa region might participate in designing and conducting the Working Group. There are a number of Francophone Africans who are qualified to serve in this capacity.

2. The Comit(Interservice, possibly augmented by the presence of the Regional Chief Medical Officers, should continue in its technical problem-solving capacity. In addition, it should meet periodically to coordinate PHC project activities and to review and adjust PHC strategies.

3. The Comit(should be freed from time-consuming administrative matters, either by dealing directly with donor administrative offices or by creating its own administrator staff position. This is important for the RHS Project because of audit requirements placed on the local operating budget of $600,000.

4. No one interviewed believed that the Project Office could or should continue in its position outside the Ministry of Helath. The evaluation team members are of the same opinion. Project training, supervisory, and administrative functions should be taken over by the appropriate services (eg. MCH for training and supervisions of village health works, Preventive Medicine for EPI activities).

5. Regional and departmental Chief Medical Officers should receive training in the principles and technique of PHC Management. Such a workshop should be held for at least the Trarza and Guidimaka regions, and then for all departmental and Regional Chief Medical Officers. Again, workshop organization and design should be contracted out to francophone management training specialists.

There is a wealth of experience in Trarza which needs to be documented, and one of the first tasks of the health information specialist and operations research officer should be to collaborate on the preparation of several case studies on critical aspects of the project. This would serve as a basic working document for identifying management problems, investigating solutions, and inculcating new or reinforcing existing skills.

6. Written task descriptions should be developed for each mobile team member. EPI team members' duties should be expanded as described above, to more evenly distribute workload.

(2) TECHNICAL ASSISTANCE

The problem of identifying appropriate technical assistance is to define the kinds of technological requirements which are essential but not available locally to achieve the objectives of the project. The problem is compounded by the different perceptions of the quality of indigenous skills. Donors may perceive them differently from nationals. To a great extent, a two year learning process about the need for technological support occurred. Unfortunately the process was painful and generated misunderstandings about competencies and roles. The dissatisfaction which appreared in 1985 and which ultimately led to the resignation of the long-term PHC Consultant may not have been inevitable but the conflict in the interpretation of technical roles by the different partners forced everyone concerned to think about the nature of technical assistance in this project rather than to take it for granted.

Although there may still be residual feelings about this episode, the technical assistance requirements should be in light of those needs which currently reflect the current status of the project and which are necessary to ensure that the objectives of the projects are met. There are three considerations with respect to project needs: 1) competency of Mauritanian counterparts 2) status of project's two components and 3) the technical areas in the project which need major attention over the next two years.

1) Competencies

a) EPI operations require competencies in cold chain management, logistics and supplies, statistics and documentation, supervision, and fleet maintenance. The eight-man team responsible for EPI in the Preventable Medicine Service possess these skills. The eight persons function as a team as well, which is an equally important element for successful operations. In addition, they have developed skills as trainers and have developed the training program in cold chain management for MCH personnel which occurred in July 86. Within the framework of the current mobile team-oriented EPI strategy, they can continue to function without additional technical support. New strategies, particularly those oriented to developing six centers, will require major changes in routine operations, although the technologies used remain the same.

b) The PHC component personnel possess adequate skills in training program development, village sensitization, supervision, and program organization to ensure the continuity and expansion of the PHC program as developed in the Trarza region. In addition, the project staff has involved personnel from WHO, the School of Public Health, to supplement expertise needed in developing training programs. The practice of holding workshops to develop skills needed for implementing new activities serves to strengthen the basic competencies need to manage the project

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at central and regional level. At present there is no need for technical support of a generalist nature. The PHC teams want specialized skills to complement what exists locally. However, these skills have not been specified.

2) Project Status

Both components of the RHS project have entered their operational phase. To a great extent the development phase of planning and organizing resources and getting systems working has been completed. Both programs function, and despite inevitable problems and crises, operation of both are becoming fairly routine. For the most part, the nature of the project has undergone a fundalmental change. The program now needs to focus on improving operational efficiency rather than on translating concepts into practice. There is enough evidence to demonstrate that these systems work in principle, but means of showing what has been accomplished is still in a rudimentary state.

3) Technical difficulties

An examination of the project outputs to date indicate several areas related to both components of the project which are in a rudimentary stage of development. These are the health information system and the patient referral system from primary care to secondary care levels. The first absence of an HIS has made it impossible to obtain more than circumstancial evidence about the effect of the project activities, particularly with respect to the PHC component. It has also made it difficult to judge the overall impact of EPI. The absence of a referral system tends to compromise the work of a village worker. If villagers do not have access to higher levels of care, they want higher levels of care brought to them. Thus, a demand to establish village based dispensaries run by a nurse persists. As programs enter the routine operations, questions of efficiency and cost begin to arise. The Regional PHC Commission had been trying to deal with the issue of the most cost efficient supervisory strategy to apply within the framework of an integrated mobile team. A second concern is to organize the tasks and activities of the members of the integrated mobile teams so that they complement each other. Many of the problems the EPI team face in logistics, supply, procurement and fleet maintenance are related to improving efficiency and lowering cost. The identification, study and solution of operational problems is thus becoming a major preoccupation for which there is no systematic means of addressing at present.

The evaluation team considered three options with regard to the composition of technical assistance: 1) maintain the same composition, 2) reduce or eliminate technical assistance, 3) change the composition of the technical assistance input. The first option was rejected because the PHC long-term consultant as originally conceived and subsequently modified was principally a generalist and would now duplicate existing skills. On the other hand, it was recognized that the EPI management skills still

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reflected project implementation support needs. The second option was also rejected as the major HIS deficiency in the project and as the needs to deal systematically with operational problems required long-term support. Thus, the third option was selected. An assessment of the support needs indicates support is needed in the following areas: EPI program development, Health information Systems development and operations research. The latter areas of support were noted for short term consulations in the original project document. The profile of the technical assistance is as follows:

An operation research advisor's primary function would be to investigate, test and promote cost effective approaches and methods in EPI and PHC to assure program continuation and extension after the RHS project ends, and to advise on and monitor current Project development. Operational Research skills have recently been recognized as critical links in the development of primary health programs. In general, operations research is essentially a problem solving technique that combines systematic research with decision-making skills. The operations research specialist would work with central, regional and departmental personnel in identifying problems, studying alternative solutions, and determining which solutions are acceptable and effective. These problems would include EPI logistics and maintenance, supervision, mobile team integration, drug supplies for VHWs, referral systems, etc. The advisor would train and supervise EPI and PHC staff in designing, implementing and analysing simple operational research studies.

A management information system specialist: primary function would be to set up a relevant HIS, integrate surveys and other studies into the HIS, and train a national to take over full-time the statistical monitoring system for EPI set-up in the 1985-86 period. The health information specialist would deal with an area that has been included in the original project but which was lost sight of in the arguments between epidemilogical needs and local capacity to manage data collection and analysis. The original plan to bring in a short-term consultant to develop the HIS is unrealistic. HIS development is a long-term undertaking as it must take place in the context of management development. The HIS specialist will have to work with decision-makers at central, regional and departmental levels in determining information requirements, as much as he will with data producers and analysts.

The operations officer and management information specialist are complementary positions, as both deal with decision-making from two different but necessary perspectives. Both will be available to both the EPI and PHC components and consequently responsible to the MOH services which are involved in these programs. In short, the operations research and HIS advisors would work on problems which are common to both components of the RHS project and train project and MOH staff.

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The EPI long-term technical assistant will have essentially the same function as the current technical assistant except that he will not be responsible for HIS development. The consultant will continue to work with the national EPI team on designing new EPI strategies for mobile teams, fixed centers and furutre mass campaigns and developing the operational system for these strategies. He will work in close cooperation with the operations research and HIS advisors. This position was felt an absolute necessity by the Mauritanians and by the present EPI technical advisor in order to consolidate the results obtained so far and to ensure that they will be sustainable in the long run.

Short term technical assistance is often useful to deal with particular problems and there should be provision in the technical assistance package for the contractor to field short term specialists if the MOH, long-term TAs and USAID judge necessary. For example, despite the previous experience, a visual-aids specialist is still needed and desired to develop appropriate materials. The national seminar on PHC policy may require a facilitator with experience in running top level workshops.

RECOMMENDATIONS

During the second half of the RHS Project, long-term technical assistance should be expanded to three positions with the understanding that the roles of this position are technical and advisory rather than managerial. Program management will be handled by the MOH.

The operations research advisor should have extensive experience in public health in developing countries and be able to carry out operations research which will examine problems relating to cost, efficiency of various aspects of EPI and PHC systems which have been established.

The Health Information Systems specialist should have experience in setting up community based information systems, integration of data collection systems in organizational and management structures, and general procedures for simple data collection and analysis. The advisor should be able to train persons in using micro-computers and adapting existing software to project information needs.

The EPI consultant should have experience commensurate with the current technical assistant.

In a three person team, there will be a question of which person should serve as chief of party. As the operations research officer will interrelate with both EPI and PHC activities as well as with data collection and analysis, the evaluation team is of the opinion that this person should be the COP. The engagement of three long-term technical assistant advisors may necessitate some budgeting adjustments, particularly in relation to the

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technical assistance contractor. It is advisable that the budget be reviewed as soon as possible to see what adjustments should be made, so that Scopes of Work for the consultants can be prepared. The Scopes of Work should be prepared in collaboration with appropriate MOH personnel.

IX. CONCLUSIONS RELATED TO INDICATORS

This section presents conclusions which are directly related to outputs and inputs of the project. They are referenced to the indicators of the Project Document, and are presented under four headings: primary health care, EPI, integration and supervision, and health information systems.

Primary Health Care

Ind. 1. Community-based primary health care services available to a larger percentage of the rural population in three selected areas.

Ind. 3. Community level primary health care services providing selected interventions including treatment of diarrhea, immunization, first aid, maternal and child care, health education.

Ind. 9. Serious illnesses referred to next higher level of treatment.

The project has reached a steady state in one region. All evidence indicates that the VHWs are providing services ranging from curative to preventive, though actual performance is difficult to determine. Anecdotal evidence suggests that most VHWs can do what they have been taught, though errors creep in, and retraining and supervision will continue to be necessary.

The major deficiency in the VHW-based health care system is the absence of a workable referral system. The need for one was projected in the original project paper. The lack of such system is evident in the persistent demand by villages with health committees for dispensaries. The small fixed center which provides supervision and referrals, is the critical link in making a primary health care program viable. At present, people requiring care exceeding the competence of a VHW prefer to go to Nouakchott as the increased effort is more than compensated for by services available there.

PHC activities in Trarza represent what can be realistically expected to operate. Although, there is room for improvement, it functions at an acceptable level. The steady state can be maintained by supervision, periodic retraining and other incremental improvements. Any radical overhaul such as intervention strategies will catapult the project again into a pilot phase which will never be replicable elsewhere. There has to be a trade off between acceptability and replicability.

Action should therefore be taken initiate the project to Guidimaka. As only about 50 villages are expected to enter there, the one existing mobile team should be able to provide adequate supervisory coverage. As in the Trarza, a limiting factor will be referral, so the project should place emphasis on this aspect. Referral and extended EPI coverage through fixed centers are closely related, and the incorporation of smaller dispensary-type facilities should be a priority activity in the remaining two-year period. The Project outputs envisaged 13 centers of this type to be upgraded. The centers should be carefully selected in terms of their EPI catchment and referral potential. Planning for the use of these centers should, of course, be within the framework of an integrated EPI-PHC context.

Expanded Program of Immunization

Ind. 4. EPI reaches 60% of target population

Ind. 5. EPI cold chain being maintained

Ind. 8. EPI and drug distribution systems effectively functioning.

The EPI is very close to reaching its target, with data indicating that it has already attained a 55% coverage in urban areas. The issue facing EPI now is how to combine the three coverage strategies (mobile team, fixed center and National Vaccination Day campaigns) to increase coverage and to use resources most efficiently. The last has to be considered because the current cost to fully vaccinate a child is over $8, much higher than the acceptable upper limit set by WHO. The high cost burden is due to the heavy logistical requirements of the mobile teams. The distribution of the population and the proportion contributed by fixed centers suggests that the latter are being underutilized both as vaccination sites and as health service centers. In addition, the smaller dispensaries, which could extend the penetration of fixed center vaccination to 70% of the population, have not been used in any significant way. National Vaccination Days produce spectacular results, but they also run the risk of deflecting interest and energy away from the routine operations of covering the vulnerable population, and of habituating people to visit health centers only when there is a great fanfare. With the pending initiation of the new UNICEF/Italian EPI, an opportunity exists to combine resources and redirect the coverage strategy to fixed centers. It will be necessary to develop a general policy and strategy on the use of mobile teams, fixed centers and National Vaccination Days so that each complements the other and duplications of effort are avoided.

The cold chain is the key to any successful EPI. It requires special equipment, logistics monitoring, and efficient repair and maintenance. The Project has nearly completed installation of equipment for the various components: central storage, regional

storage and mobile teams. Outfitting the teams is still to be completed. Logistics, which includes repair and maintenance, is still a problem, and vehicles are often out of service for considerable periods of time. A reliable system for monitoring cold-chain efficacy are still in the process of being developed and tested. A quality control system for vaccines also must be instituted. In general, the basics are in place, but incremental improvements are still required. There is also a need to shore up some management aspects. The EPI management training program has been postponed several times, and the production of an operations manual is still unfinished. Data analysis and report generation skills have to be developed. There is, therefore a need for an EPI operations officer to consolidate the progress made so far. At the same time, the logistics problems, particularly those associated with vehicle maintenance and repair are priorities: they must be solved for both the delivery of services and supervision.

EPI supply requirements are vaccines, spare parts for vehicles, bottled gas for refrigerators, and replacements for parts for the cold chain such as cold boxes and vaccine containers. At present, except for vaccines, the supply system is dependent on USAID, which serves as the manager of commodity procurement. The Project needs to address the question of how the MOH will ultimately assume responsibility for this function. Setting up a supply system and training people to manage it shoud be part of the operation research officer's job description.

The drug supply system part of the Project is still in an embryonic stage. There are two dimensions of any such system which would have to be addressed: the village health worker/village health committee component, and the village health worker/pharmacy supply depot component. At present, the first dimension is under study. The second has been studied from the perspective of major institutions involved in pharmaceutical import and distribution. An operations research TA officer should make the study of bringing these dimensions together one of his priority activities.

Integration and Supervision

Ind. 2. EPI and community health worker teams functioning in collaborative activities in three selected regions.

Ind. 7. Supervision and village sensitization programs operational.

It has taken over a year to integrate the EPI staff and the VHW/VHC supervisor into a mobile team in Trarza. The personnel still do not function as a team in all respects, as work habits, objectives, and techniques differ radically. The major obstacle to overcome is the attitude of the EPI team members, who are in the majority and who are often impatient with the PHC supervisors' less well- defined and more time consuming tasks. On the other hand, given the lack of a cost-effective alternative to

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moving both members around vast distances concurrently, the team must be encouraged to function.

As long as the Regional Health Commission, which is also an integrated team, functions, gradual improvements can be introduced in work patterns and attitudes. The mobile teams should be involved in the village sensitization process so that all members begin to relate to the village as a whole and to the functions of the health committee and village health worker. The EPI members should supervise village health worker activities in relation to promoting vaccination and keeping track of vaccination, identifying targetable children, etc. That is, the success of their activities in the village should be functionally related to the performance of the village health worker. If the Regional Health Commission fails in its management capacity, the integration of the mobile team will be jeopardized. Thus, it is extremely important to ensure the viability and durability of this Commission by staffing it with qualified and motivated personnel and by ensuring that those leaving are immediately replaced in order to avoid disruption and discontinuity in the functioning of the commission.

There is a potential Regional Commission in the Guidimaka at present. Further delays in moving ahead with the PHC component will obviously frustrate the members. More important, they will kind cast doubt on the viability or importance of this institution and understandably lessen commitment on the part of national authorities to expend personnel resources in strengthening existing ones, as in the Trarza.

The problems of integration at the Regional level are simple when compared to the problems at the central level. Much of the disappointment in the PHC program at the regional level seem to be projections of frustrations in getting things done at the central level, particularly with respect to the Comité Inter Service, the National Commission on PHC, and the program/budget dichotomy which exists between the EPI activity and the Project Office. There is general dissatisfaction with the current set-up for bringing about PHC/EPI integration at the central level. The establishment of a Project Office external to the operational services has served to engenders feelings of enclusion and indifference. The hesitation to take action on a National Commission may partly be attributable to people's perceptions of a lack of harmony in this "integrated" effort.

The general feeling is that the ambiguous role of the Project Office must be resolved by somehow re-integrating it into the MOH. However, no action has been taken, and no concrete solutions have been proposed. This evaluation has examined several possibilities for the MOH to consider in effecting this re-integration.

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Health Information System

Ind. 6. Appropriate data on morbidity, treatments, immunization activities, and maternal and child health activities being collected and reported from all levels of the health system to Ministry of Health.

The only functioning part of the envisaged health information system is the EPI reporting system. This is complete, regular and accurate, and the information is distributed throughout the MOH. The information component of PHC is in a rudimentary form. A new VHW reporting form has been developed and will be introduced in refresher courses for 88 VHW's this year. A new supervisory form which could provide valuable information has recently been introduced as well. There does not appear to be any provision for analysing these data, though ideally the availability of a micro computer at the Project Office should have permitted the data collection and data processing needs to be developed concurrently. The proposed longitudinal epidemiological study should be seen as part of the HIS; otherwise by virtue of the time, effort and cost required, it will replace the concept of an HIS. Some kind of trade-off needs to be made between utility of having the data and the practicality of getting and actually using them on a routine basis.

The flow of information of another kind must also considered. The Project as a whole needs, a consistent, comprehensive reporting system distributed to all persons involved or interested in the project. At present, there are several reporting systems, each providing different kinds of information in different formats. One uniform system to which everyone contributes but whose production is the responsibility of one group is extremely important for giving necessary feedback to those involved in Project operations and management. Other contractual reports should be shared as a courtesy. If there is nothing inherently confidential, there is no reason not to include all program collaborators on the distribution list.

The information system component of the project is the weakest element so far. It is also critical for making decisions and formulating policy. It should be given high priority in the second half of the Project.

X. GENERAL CONCLUSIONS

This report so far has addressed the first three purposes of the mid-term evaluation. It has reviewed the status of the RHS Project in terms of its output, inputs and major project issues. The evaluation has found that the RHS Project, despite, delays has essentially adhered to the original lines of the

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implementation plan, and in principal could have progressed further in the PHC component if the planned extension to the second region of Guidimaka had not been suspended pending the results of the evaluation.

The evaluation has found that the RHS Project conforms to the original purposes of the Project as well. The major systems for the PHC and EPI have been established and are functioning, although many operational problems need to be solved. It has also been found that there are some major areas which have not been adequately addressed in both EPI and PHC. These include a long-term strategy for EPI vis-a-vis the appropriate use of vaccination coverage mechanisms, the maintenance and repair of vehicles to ensure the uninterrupted movement of all mobile teams, the development of a referral system between villages and health centers, and the institutionalization of an HIS which can monitor the operations and outputs of all the components of this project.

The next two years of the Project need to systematically address fundamental operational problems and two essential development issues. The aspects of the project which should become the focus of the next phase of the RHS Project do not alter the basic project design: the RHS Project is capable of adhering to its original intent of replicating the Trarza experience in two additional provinces.

The evaluation report has recognized and emphasized the limiting factors that will affect the replicability of the PHC component in other regions. One is that of personnel. The commitment of the MOH to provide resources to ensure the viability of the RHS Project is evident. On the other hand, it is important to recognize that a cadre of competent, qualified personnel is a scarce commodity at present and mobilization of such resources may present difficulties for the MOH. There may be delays in assigning personnel. The major issue that has to be addressed is that of providing incentives for health professionals to remain in PHC. The loss of personnel, especially those with training and experience, to other disiplines needs to be addressed as part of the general question of how PHC is to be integrated into the MOH health care delivery system.

The second limiting factor is transportation. This is the basis for supervision of both EPI and village level health activities. Without the availability of simple and ubiquitous maintenance facilities, the road-worthiness of the transportation system is seriously compromised. If the mobile teams cannot adhere to their supervisory and operational schedules, the systems which have been established will break down, and many of the accomplishments will be nullified.

In Part VIII of this report, various issues were examined which might affect the design of the Project. In general, the issue which has the greatest implication for design is PHC policy

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and strategies. The original concept in this regard appears to the evaluation team sustainable over the next phase of the project, so long as the two limiting factors are addressed. Modifications have been proposed in the composition of technical assistance, but the recommended revisions serve to reinforce the possibilities of adhering to the initial strategy of developing a sustainable project covering three regions. The modifications also serve the purpose of developing systems and addressing problems common to both components of the Project.

The major design question that could not be satisfactorily answered is how to effect the integration of PHC into the MOH structure. This is an issue which can only be solved by the MOH and national authorities. Meanwhile, lines of communication between the Project and the MOH can be clarified and strengthened to smooth the implementation of Project activities. The failure to resolve the issue of integration, however, will affect the long-term sustainability, replication, and development of PHC on a national scale. This issue needs to be addressed seriously and immediately.

Other aspects of the Project can be adjusted without affecting its design. All data-gathering studies should be treated as elements of a health information system rather than separate activities. These should be replanned by the EPI, PHC, and MOH personnel in collaboration with the HIS advisor within the framework of a general approach to developing health information systems that serve clearly defined needs.

The basic training programs for the RHS Project components have been established. For PHC, these include programs for VHWs, TBAs, and village committees. For EPI, training programs are mainly for cold chain management and operations. Training program development which is not directly associated with program operations should be eliminated. This includes all workshops and seminars of a general nature.

In conclusion, the evaluation team wishes to reiterate that the achievements of the Project to date conform to its original purposes. Several technical aspects of the Project which have not been addressed in the first phase can be tackled over the next two years. Several issues relating to the role of PHC in the Mauritanian health care system cannot be wholly addressed within the framework of the project, but the way they are ultimately resolved will influence the long-term replicability and sustainability of the operational systems developed by the project.

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LIST OF PERSONS CONTACTED

NOUAKCHOTT, Mauritania

MINISTRY OF HEALTH

- Comdnt. Dr. N'DIAYE KANE, Minister of Health
- Dr. Ba MOHAMED LEMINE, Director of Health
- Dr. Kelly NAZIROU, Chief Preventive Medicine
- Mrs. Ba KHADY SY. Chief Maternal and Child Health

USAID MISSION

- George T. EATON, Director
- Walter BOEHM, Deputy Director
- William JONES, Project Development Officer
- Joe GUARDIANO, Project Specialist
- Charles HABIS, Health Development Officer

AMERICAN EMBASSY

- Robert PUGH, Ambassador

PROJECT OFFICE

- Dr. Idrissa SOW, Director
- Mr. Moctar Ould MEMAH, Training Coordinator
- Mrs. Taguib (Caf)
- Mr. Kane Sidi BAIDI, Administrator

JSI TECHNICAL ASSISTANCE

- Dr. Pierre CLAQUIN, COP, EPI Technical Advisor

EPI TEAM

- Mr. Djibril SENGHOTT, Chief Communicable Diseases
- Mr. Koné BASSIROU, EPI
- Mr. Correra CHOUAIBOU, Statistician

UNICEF

- Mr. Sine MALICK, Representative
- Mr. Jan Van MANNEN, Project Officer

WHO

- Mr. Ahmed Cheich MOUCHTARE, Representative
- Dr. Leckie BOTTE, EPI Officer

TRARZA REGION

- Mr. Mohamed O. DEYDAT, Deputy Governor
- Mr. Sy M'BERA, Préfet Keur Macene
- Mr. Yahya O. Sidi MUSTAPHA, Préfet Boutilimit
- Dr. Traore HAMIDOU, Médecin Chef Rosso
- Dr. Abderhamane O. TOLBA, Médecin Chef Boutilimit

GUIDIMAKA REGION

- Mr. DIALLO, Governor
- Dr. Athie MAMADOU, Médecin Chef

FIELD OPERATION STAFF

In the regions visited, the team met with:

- The regional and departmental PHC supervisors and trainers.
- The members of the mobile team
- The PHC Committees, VHWs and TBAs in the visited villages.

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BOSTON, Ma (Team Leader)

- Joel LAMSTEIN, President - John Snow Inc.
- Logan BRENZEL, Project Desk Officer, John Snow Inc.

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PARTIAL LIST OF DOCUMENTS EXAMINED

Mauritania Project Paper
MSH Evaluation of the Rural Medical Assistance Project
Mauritania Project Proposal
Mauritania Project Agreement with the GIRM (contract)
Amendment to the contract + correspondence
    -with special reference to change in long-term advisor
Longitudinal Epidemiologic Survey + correspondance/critique
Proposed Reorientation of the PHC Component of the RHS Project
Official Cable to USAID/Washington from USAID/MTN
Letter from D. Miller to Joel Lamstein
Official Cable from JSI to USAID/MTN re JSI performance
Comments by the COP on 10 above (QIR Jan 86)
Minutes of meeting with Health Office
All Quarterly Reports
Appendix A, QIR July 1985 (C. Pervilhac)
Appendix B, QIR Jan 1986 (C. Pervilhac)
Trip Reports (Brenzel 11/85 + 2/86; Pyle 2/86)
PHC Advisor evaluation of consultants
Chronology of Events Memo
Memo on evaluation
Memo on handling of consultants
Trip Report Brenzel 5-6/86
Annual EPI Report 1985
EPI Coverage Survey
Cost-Effectiveness Analysis of Immunization Strategies
Various memos on PHC and EPI

EXECUTIVE SUMMARY

PURPOSE OF THE EVALUATION

The mid-term evaluation of the Mauritanian Rural Health Services Project has four objectives as defined in the Terms of Reference:

A) Review status of inputs, outputs, verifiable indicators, and Project issues

B) Determine their continuing validity and relevance

C) Determine reasons for changes from the Project Implementation plan

D) Recommend revisions in Project design and the Implementation Plan

MAJOR FINDINGS

Primary Health Care

The Project has been able to develop a model of a community-based Primary Health Care system in one region. This model is workable and replicable. Two rounds of sensitization have already been completed in 36 villages in a second region, and all relevant steps for program expansion have been taken. Program development was found to be satisfactory in spite of drawbacks that affected the program in 1985. A limiting factor in further development will be the capabilities for supervision and training. Supervision is currently at an acceptable level and will remain so if the Ministry of Health can mobilise human resources in a timely manner. A training curriculum has been developed and training program carried out at a commendable level.

Expanded Program For Immunization

EPI strategy relies on three components: fixed facilities, mobile teams, and National Vaccination Days. The combination of these has permitted exceptional performance and a rise in coverage from approximately 20% to 55% of the target population. The major limiting factor is logistics, mainly with regard to mobile teams' activities.

ISSUES AND RECOMMENDATIONS

The evaluation team identified three major issues: policies and strategies, integration, and technical assistance.

Issue One: Policies and Strategies

The question related to EPI is: How should the three approaches be prioritized?

The evaluation team recommends that:

- first priority be given to strengthening and expanding fixed facilities, in accordance with MOH plans, to attain coverage of 70% of the target population,
- mobile teams be kept in constant operating condition, with improved effectiveness and reduced costs,
- National Vaccination Days be seen as a means to cover the backlog of unimmunized children.

The question related to primary health care is: Given the current state of training and supervision, what should the next step be?

The team recommends that:

- the program be expanded to the second region,
- the training program for village health workers be based on the existing curriculum,
- curriculum revisions needed for training village health workers in the second region be made in a training-of-trainers workshop,
- the training of traditional birth attendants be based on the recently revised national curriculum.

Issue two: To what degree, and by what structural and operational mechanisms, can primary health care be integrated into the health care system?

The team recommends that:

- a working group be convened to define national policy, develop strategies, and assign responsibilities for PHC activities; this is an urgent need and should be done at the earliest possible date,

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- the Comité Inter Service continue in its technical problem-solving capacity and be freed from administrative matters,

- the Project Office not remain outside the Ministry of Health; Project training, supervision and administrative functions should be taken over by the appropriate Services,

- workshops be conducted at the regional level in PHC management, with lessons abstracted from the Trarza,

- a clear written task decription be developed for each mobile team member, to achieve true operational-level integration of comprehensive PHC services.

Issue three: In view of program needs and current status, what should be the composition of the technical assistance package for the remainder of the project?

The team recommends that:

- three long-term positions be created: an EPI technical advisor with experience commensurate with the current technical assistant; an operations research advisor to take the Project to its next level of development; a health information systems specialist to improve the decision-making process at all levels.

ANNEXES

PROJECT STATUS REPORT
(March 16 - June 23, 1986)

PROJECT NAME: Rural Health Services NUMBER: 682-0230

Host Country Implementing Agency : Ministry of Health

AID (grant)	: $5,000,000
Host Country	: $2,548,000
UNICEF	: $170,000
WHO	: $ 48,000
Total	: $7,766,000

Cumulative AID Allotments	: $5,000,000
Cumulative AID Obligations	: $5,000,000
Date Authorized	: 7/21/83
Date Agreement Signed	: 7/27/83
Project Activity Completion Date	: 6/31/88
Scheduled Dates for Completing Evaluations	: 6/86 and 7/88

SERVICES CONTRACTS:

Contractor	Date Signed	Type of Services	Actual Contract Price
John Snow Inc.	5/11/84	Technical Assistance	D
CSA	10/30/84	Repair/Maintenance of Project Vehicles	D

SUMMARY PROJECT DESCRIPTION:

The project's purpose is to improve the effectiveness of the national Expanded Program of Immunization (EPI) and to develop an expanded and integrated community - based Primary Health Care (PHC) system in Trarza, Guidimaka and a third region. The project will provide immunization and community-based PHC services to rural populations. Through the Ministry of Health (MOH), the project will assist the Islamic Republic of Mauritania to prepare a comprehensive PHC training curriculum and program at village, regional, and national levels; train and supervise approximately 200 village health worker teams; conduct selected research activities and studies; establish health education resource centers; and improve the immunization delivery, program management and cold chain and vaccine handling in the EPI component.

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PARTIAL LIST OF DOCUMENTS EXAMINED

Mauritania Project Paper
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Mauritania Project Proposal
Mauritania Project Agreement with the GIRM (contract)
Amendment to the contract + correspondence
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Trip Report Brenzel 5-6/86
Annual EPI Report 1985
EPI Coverage Survey
Cost-Effectiveness Analysis of Immunization Strategies
Various memos on PHC and EPI

February 25, 1986

SCOPE OF WORK: Health Management Consultant/Team Leader for Mid-Term Evaluation

1. As Evaluation Team Leader

This individual will serve as Evaluation team leader, and in this capacity he will be responsible for the following:

a. Coordination and supervision of evaluation team activities and assignments.

b. Review of all relevant project documents.

c. Scheduling and conduct of meetings and field trips.

d. Preparation of final report, including recommendations for future actions.

e. Insure that the final report reflect the evaluation team consensus, but should also indicate dissenting views, if any.

2. Management Consultant

a. The management consultant will review and evaluate all management aspects of the project including for example, project management of the USAID, the contractor, and MOH.

b. Functionally, the consultant should evaluate management and operating procedures of the following components at all levels of the project:

1. Expanded Program for Immunization (EPI)

a. Cold Chain
b. Vaccine
c. Logistics
d. Supervision
e. Programming of activities
f. Strategies
g. Budget

2. Primary Health Care (PHC)

a. Curriculum Development
b. Training: in-country and out of country
c. Health Information System
d. Supervision and Monitoring
e. PHC Commission
f. Institutional Building
e. Programming of activities

f. Strategies
g. Budget

c. In carrying the evaluation, a special attention should be given to the role and relevance of Central Project Organization and Structure (PRSSR).

d. The evaluator should develop specific recommendations that relates to project design, and suggestion for change. Priority attention should be given to:

1. Adequacy and relevance of central project organization (PRSSR).

2. Institutional linkages between Project and Ministry of Health.

3. <u>Qualification</u>

a. Previous overseas experience in EPI or PHC project, preferably, senior level consultant with a Health Planning/management education and experience. Alternatively, an equivalent experience which provides him with management knowledge and skills required to evaluate complex Health project, in Francophone Africa.

b. French language skills. Must have sufficient command of French/English (FSI 4) to conduct meetings and interview personnel fluently in French.

c. Previous experience as member of evaluation team of USAID-funded health project is highly desirable but not absolute requirement.

d. Combined Academic degrees in MBA/MPH.

February 25, 1986

RURAL HEALTH SERVICES PROJECT MID-TERM EVALUATION
SCOPE OF WORK FOR EPI TECHNICAL OFFICER

GENERAL: THIS INDIVIDUAL WILL SERVE AS PRIMARY RESOURCE FOR EVALUATION OF THE TECHNICAL ASPECTS OF THE EPI COMPONENT OF THE RHS PROJECT. HE WILL WORK CLOSELY WITH MANAGEMENT AND PRIMARY HEALTH CARE CONSULTANTS IN REVIEWING ALL RELEVANT PROJECT DOCUMENTS, REVIEWING THE RESULTS OF THE PRE-EVALUATION ASSESSMENT, ORGANIZING SPECIFIC TECHNICAL AGENDA FOR FIELD TRIPS, AND DRAFTING RECOMMENDATIONS RELATED TO TECHNICAL ASPECTS OF EPI PROGRAM FOR DISCUSSION AND APPROVAL OF EVALUATION TEAM.

(2) SPECIFIC RESPONSIBILITIES:

(A) REVIEW RECOMMENDATIONS OF 1983 EPI EVALUATION IN CATEGORIES OF COLD CHAIN, LOGISTICS, PROGRAMMING, AND DISEASE SURVEILLANCE;

(B) REVIEW RESULTS OF PRE-EVALUATION ASSESSMENT IN EACH OF ABOVE CATEGORIES AND DEVELOP WORK PLAN, BASED ON THIS PRELIMINARY ASSESSMENT, OF THOSE ASPECTS OF PROGRAM REQUIRING CLOSER SCRUTINY;

(C) PREPARE TECHNICAL AGENDA FOR, AND PARTICIPATE IN, FIELD TRIPS TO AT LEAST TWO REGIONAL OPERATION SITES, INCLUDING MOBILE AND FIXED TEAM OPERATIONS, TO OBSERVE AND EVALUATE FUNCTIONAL STATUS OF EPI OPERATIONS AT ALL LEVELS;

(D) MAKE ASSESSMENT OF RELIABILITY, CONSISTENCY, AND GENERAL QUALITY OF ONGOING HEALTH INFORMATION BEING COLLECTED BY MOH WHICH ARE RELATED TO EPI PROGRAM;

(E) REVIEW OBJECTIVES RELATED TO EPI COMPONENT OF THE PROJECT, CONFIRM THEIR CONTINUING VALIDITY, AS APPROPRIATE, AND RECOMMEND CHANGES AND ADDITIONS.

(F) DRAFT RECOMMENDATIONS FOR SPECIFIC ACTIONS WHICH MOH AND DONOR AGENCIES (WHO, USAID, UNICEF) SHOULD TAKE TO STRENGTHEN PROGRAM OPERATIONS OVER THE 1986-1988 PERIOD.

(3) QUALIFICATIONS:

(A) FIELD EXPERIENCE IN DEVELOPING COUNTRIES IN ALL ASPECTS OF EPI OPERATIONS, INCLUDING DISEASE SURVEILLANCE, COLD CHAIN MAINTENANCE, LOGISTICS, AND HEALTH INFORMATION SYSTEMS.

(B) FLUENCY IN FRENCH AT FSI 3 LEVEL.

(C) PREFERENCE WILL BE GIVEN TO CDC TRAINED OFFICER.

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SCOPE OF WORK: CONSULTANT IN PRIMARY HEALTH CARE

THIS INDIVIDUAL WILL SERVE AS ASSISTANT TEAM LEADER AND WILL BE RESPONSIBLE FOR THE FOLLOWING:

(A) ASSIST TEAM LEADER IN COORDINATION OF EVALUATION TEAM ACTIVITIES AND ASSIGNMENTS;

(B) REVIEW ALL RELEVANT PROJECT DOCUMENTS; INCLUDING PRE-EVALUATION ASSESSMENT;

(C) ASSIST TEAM LEADER IN SCHEDULING AND CONDUCTING MEETINGS AND FIELD TRIPS;

(D) ASSIST TEAM LEADER IN DRAFTING FINAL REPORT, INCLUDING OPERATIONAL RECOMMENDATIONS AND IN COLLABORATION WITH THE EVALUATION TEAM.

SPECIFIC RESPONSIBILITIES AS PRIMARY HEALTH CARE CONSULTANT:

(A) ANALYZE AND EVALUATE THE PROGRESS AND STATUS OF THE VARIOUS COMPONENTS OF THE PHC SYSTEM SUCH AS:

(1) COMMITMENT BY THE GOVERNMENT TO PHC, INCLUDING THE DEVELOPMENT OF THE NATIONAL PHC COMMISSION.

(2) PHC COVERAGE OF THE POPULATION IN AREAS CONCERNED BY THE PROJECT.

(3) DEGREE OF INTEGRATION OF THE PHC PROGRAMS OF THE PROJECT WITH THE CENTRAL LEVEL ACTIVITIES IN (SMP) PREVENTIVE MEDECINE, (SMI) MOTHER AND CHILD CARE AND THE (SEP) STUDIES AND PLANNING.

(4) INTEGRATION AND EFFECTIVENESS OF PH ACTIVITIES AT THE REGIONAL LEVEL.

(5) INTEGRATION AND EFFECTIVENESS OF INTEGRATED MOBILE TEAMS ACTIVITIES.

(6) QUANTITY AND QUALITY OF CURATIVE AND PREVENTIVE ACTIVITIES CONDUCTED BY CHW'S AND TBA'S IN VILLAGES CONCERNED BY THE PROJECT.

(7) QUALITY OF TRAINING CURRICULA FOR CHW, TBA, VILLAGE HEALTH COMMITTEES AND THEIR SUPERVISORS AT DEPARTMENTAL AND REGIONAL LEVELS. CRITIQUE THE MATERIALS ACCORDING TO COMPENTENCY-BASED CRITERIA.

(8) THE AUDIO-VISUAL AND GRAPHIC MATERIALS FOR VARIOUS CURRICULA, INCLUDING ASSESSMENT OF HEALTH EDUCATION AND RHS PROJECT ACTIVITIES FOCUSED ON VISUAL MATERIALS FOR PHC RELATED WORK.

(9) QUALITY AND QUANTITY OF SUPERVISION AT CENTRAL, REGIONAL AND DEPARTMENTAL LEVELS.

(10) STATUS OF HEALTH INFORMATION SYSTEM INCLUDING STUDIES THAT WERE TO BE DEVELOPED WITHIN THE FRAMEWORK OF THE PROJECT.

(11) QUALITY OF SUPPORT SYSTEM TO PHC PROVIDED BY THE CENTRAL TEAM OF THE PROJECT.

(B) REVIEW AND EVALUATE STATUS OF IMPLEMENTATION OF TRAINING PLAN RELATED TO ALL THIRD COUNTRY TRAINING, THROUGH DISCUSSIONS WITH PROJECT STAFF, PLANNING DEPARTMENT, USAID PERSONNEL AND W.H.O. COUNTRY REPRESENTATIVE.

(C) CONSULTANT WILL EVALUATE ALL ASPECTS OF THE PHC COMPONENT INDICATING PROGRESS AND DIFFICULTIES, POSITIVE AND NEGATIVE ASPECTS. THIS EVALUATION WILL BE MADE THROUGH CONTACTS WITH PERSONS CONCERNED. VISITS TO PROJECT SITES, AND A REVIEW OF ALL PROJECT DOCUMENTS, SUCH AS:

- PROJECT PAPER (GREEN DOCUMENT)
- PROJECT AGREEMENT
- JSI CONTRACT
- EVALUATION OF MSH
- NOV. 84 REVISED PROJECT IMPLEMENTATION PLAN
- OTHER DOCUMENTS AS DEEMED NECESSARY BY THE TEAM

(D) EVALUATE THE REASONS FOR PROGRESS OR LACK THEREOF AND ASSESS THE CONTINUING VALIDITY AND RELEVANCE OF THE SEPARATE PROJECT COMPONENTS.

(E) DEVELOP SPECIFIC RECOMMENDATIONS ON PROJECT DESIGN, MODIFICATIONS AND IMPLEMENTATION PLANS. THESE RECOMMENDATIONS SHOULD REFLECT, AS MUCH AS POSSIBLE, THE EVALUATION TEAM CONSENSUS BUT SHOULD ALSO INDICATE DISSENTING VIEWS, IF ANY. THE TEAM REPORT SHOULD EVENTUATE IN A SPECIFIC SET OF ACTION DECISIONS TO BE APPROVED BY GOVERNMENT OF MAURITANIA AND MISSION DIRECTOR AS THE BASIS FOR SUBSEQUENT PROJECT IMPLEMENTATION.

3. QUALIFICATIONS
- REQUIRED:

- (A) PREVIOUS OVERSEAS EXPERIENCE, PREFERABLY AFRICAN, IN A PRIMARY HEALTH CARE ACTIVITY OF SUFFICIENT DURATION, AND IN A CAPACITY ADEQUATELY TO ASSURE THOROUGH FAMILIARITY WITH ALL ASPECTS OF PHC IMPLEMENTATION.

- (B) KNOWLEDGE AND EXPERIENCE IN APPLICATION OF COMPETENCY-BASED TRAINING METHODS IN HEALTH CARE.

- (C) SUFFICIENT COMMAND OF FRENCH AND ENGLISH TO CONDUCT MEETINGS AND TO INTERVIEW PERSONNEL FLUENTLY IN EITHER LANGUAGE (FSI 4 OR BETTER).

- DESIRABLE: PREVIOUS EXPERIENCE AS MEMBER OF EVALUATION TEAM OF

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USAID-FUNDED HEALTH PROJECT.

C. ALL CONSULTANTS MUST HAVE SUFFICIENT STAMINA TO CARRY OUT FIELD WORK INVOLVING EXTENDED TRAVEL BY LANDROVER AND CAMPING OUTDOORS UNDER HOT DUSTY CONDITIONS.

D. CONSULTANTS WILL BE RESPONSIBLE FOR PREPARATION OF FINAL REPORT. MISSION WILL ARRANGE FOR TRANSLATION.

E. WASHINGTON ACTION REQUESTED. PLEASE, IDENTIFY FROM EXISTING IQC'S, PASA'S, IPA'S, SUITABLE CANDIDATES FOR HEALTH MANAGEMENT/TEAM LEADER AND PRIMARY HEALTH CARE CONSULTANTS. MISSION WOULD LIKE TO BEGIN EVALUATION IN MARCH. AS NOTED IN REF (C) PARA 4, EVALUATION MAY LAST AS LONG AS FIVE WEEKS.

F. MISSION DISCUSSED WITH DR. MOCTAR, WORLD HEALTH COUNTRY REP ON WHO'S PARTICIPATION IN THE EVALUATION. IT IS POSSIBLE WHO WILL PROVIDE AND/OR FINANCE EITHER THE EPI SPECIALIST OR THE PRIMARY HEALTH CARE CONSULTANT. WILL ADVISE AS SOON AS WHO MAKES DETERMINATION OF WHETHER FUNDING OR PERSONNEL IS AVAILABLE.

1985	REMISSION				PID/C OR PIL								P. O.					ACCUSE DE RECEPTION				REMARKS
																		A. REPORT 6ID		B. REPORT 6IRH		
REG. NO	DATE	ITEMS DESCRIPTION	TOTAL VALUE	PID/C OR PIL	DATE	ITEMS DESCRIPTION	TOTAL VALUE	CONTRACT DATE	NO. OF AMEND.	NEW TOTAL VALUE	PO NO.	DATE	ITEMS DESCRIPTION	TOTAL VALUE	NO. OF AMEND.	NEW TOTAL VALUE	NO.	DATE	NO.	DATE	REMARKS
00010.	11/8/85	Carburant		682-6230-14-50010	Jan. 85	Diesel = 46240 L	24.642.00	11/8/85 11/13/85	682-6230-14-50010 A1	27.593.05	PR85-043	11/21/85	Kerosene-4500 L Benzol=11560 L	UM 102.928 UM 304.462		UM 102.928 UM 304.462	0314 0313	11/21/85 11/21/85	0314 0313	11/21/85 11/21/85	
						Essence = 4500 L			682-6230-14-50010 A2	29.235.85	PR85-042	11/21/85	Essence=28580 L Diesel=34680 L	UM 913.386		UM 913.386	0315	11/23/85	0315	11/23/85	
						Petrol = 18320 L					PR85-041	11/17/85	Petrol= 7740 L								
00045 00042	11/15/85	120 Barrels 140 Barrels	298.860 UM 28.000	682-6230-14-50011	11/20/85	Barrels for transporta- tion of fuel for Equines Mobiles	423.471	Jan. 15. 1985	682-6230-14-50011 A1	631.70	PR85-044	11/20/85	Barrels for mobile units	UM 28.000	85-044 (A1)	UM 42.000					Cash Payment BV 682-85-126 Barils were received Bv 6IRH
00113	13/08/85	Spare Parts									PR85-149	19/3/85	Spare Parts Mercedes LR-110	CFA 919.647		CFA 919.647	00406	18/16/85	00406	18/16/85	
Lettre 5331. 05/85	13/31/85	Pince detachee Spare 2 LR	UM 212.533								PR85-073	14/28/85	Pince detachee Spare 2 LR IC 370 IC 387	UM 212.533		UM 212.533					Certificat de travail Fronche 16/4/85
00114	14/25/85	Carburant	UM 360.009								PR85-076	14/25/85	Carburant	UM 360.009		UM 360.009	00345 00344	15/12/85 15/8/85	00345 00344	15/12/85 15/8/85	
00120	12/31/85	Gaz liquefiable Le interieur des pays pour les an 1360 charges	UM478.800	PIL 12 682-230 14-50064	16/11/85 15/85	1360 Bouteilles de gaz pour les mois de 85 an 131 mois 86 the twelve EPI mobile	6.290.89	de 19/1/85 les 18/31/86		6.290.89	PR85-110	16/23/85	Gaz bottles 450 Bout. Garantie 450 x 2053 Charge 350 x 450	UM1.081.350		UM1.081.350	00381	17/18/85	00381	17/18/85	

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1984 REQUISITION				PID/C OR PIL								P. O.						ACCUSE DE RECEPTION				REMARKS
REQ. NO	DATE	ITEMS DESCRIPTION	TOTAL VALUE	PID/C OR PIL	DATE	ITEMS DESCRIPTION	TOTAL VALUE	CONTRACT DATE	NO. OF AMEND.	NEW TOTAL VALUE	PO NO.	DATE	ITEMS DESCRIPTION	TOTAL VALUE	NO. OF AMEND.	NEW TOTAL VALUE	R. REPORT AID NO.	R. REPORT AID DATE	R. REPORT BIRN NO.	R. REPORT BIRN DATE	REMARKS
Lettre No. 12	16/11/85	Transport cold deliver and distribute cold chain equipment	36.000	PIL 12	16/11/85	The cost of installation of EPI equipment in the operation region and the twelve EPI mobile	36.000			36.000	PR85-109	16/17/85	Transport to deliver and distribute cold chain equipment	UM 600.000		UM 600.000					BV 682-85-616. 18/1/85 Action Completed cold chain equip. del and dist. to 30 part 1810 regio.
00118	16/25/85	Inst. B. Electrogene & construction Edifice & supp. B.	UM 270.000 270.200	PIL 12	16/11/85		36.000			36.000	PR85-122	16/27/85	Inst. B. Electrogene & construction Edifice & supp. B.	UM 214.400 (AI)	85-122	UM 239.900	0001	10/21/85	0001	10/21/85	
											85-126	17/7/85	Supports houlez.gaz	UM 53.000		UM 53.000	1398	12/2/85			
00119	12/1/85	Carburant	UM 495.000								PR85-128	17/15/85	Carburant	UM 495.031		UM 495.031	00382	17/21/85	00382	17/21/85	
000120	17/31/85	Gaz	UM 52.500								PR85-146	18/11/85	Gaz	UM 52.500		UM 52.500	00438	12/1/85	0002	12/1/85	
00127	19/26/85	Carburant	UM 765.000	682-0230-14-50010	11/9/85	Carburant	19 24.642.00	1/8/85 (to 11/13/85)	682-0230-14-50010 (681) 682-0230-14-50010 (682)	27.593.05 29.235.05	PR86-16	11/4/85	Carburant	UM 990.014		UM 990.014	00438 (bis)	12/1/85	0003 009 0015	12/2/85 12/2/86 14/8/86	

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1984 REQUISITION				PID/C OR PIL							P. O.						ACCUSE DE RECEPTION				REMARKS
																	R. REPORT AID		R. REPORT BIRM		
REQ. NO	DATE	ITEMS DESCRIPTION	TOTAL VALUE	PID/C OR PIL	DATE	ITEMS DESCRIPTION	TOTAL VALUE	CONTRACT DATE	NO. OF AMEND.	NEW TOTAL VALUE	PO NO.	DATE	ITEMS DESCRIPTION	TOTAL VALUE	NO. OF AMEND.	NEW TOTAL VALUE	NO.	DATE	NO.	DATE	REMARKS
04130	10/24/85	Pompe Immersible Jet sam Installation	TUN 11.400								PN86-25	11/14/85	Pompe Immersible Jet sam Installation	TUN 11.400		TUN 11.400	0004	12/15/85	0004	12/15/85	
				1682-0230-150021	13/11/85	Consolidation. Incoming Items for the day to day Operation of the project	10 5.500.00	13/11/85 13/15/85		10 5.000.00											
RB4-092 DOL	13/29/84	Electric Typewriter		1682-0230-14-40026	18/84	Office Supplies	10 17.250.00	18/28/84 12/28/85		10 17.250.00							00277	11/21/84	00277	11/21/84	
				1682-0230-14-40017	14/24/85	Material Divers	10 99.000.00	14/24/84 19/31/85		10 99.000.00							00309	11/8/85	00309	11/8/85	
				1682-0230-160003	NOV.-85	Material de Canaux	10 11.000.00	NOV 85 19/30/86	1682-0230 14-60003	10 912.500.00											Bons le circuit

1986	REQUISITION			PO/C OR PO						P. O.				ACCUSE DE RECEPTION				REMARKS
ER. NO	DATE	ITEMS DESCRIPTION	TOTAL VALUE	PO/C OR PO	DATE	ITEMS DESCRIPTION	TOTAL VALUE	CONTRACT DATE	NO. OF AMEND.	NEW TOTAL VALUE	PO NO.	DATE	ITEMS DESCRIPTION	TOTAL VALUE	NO. OF AMEND.	NEW TOTAL VALUE	R. REPORT AID NO.	R. REPORT AID DATE	R. REPORT BIRD NO.	R. REPORT BIRD DATE	REMARKS
0034	11/21/85	124 batteries hour ch. de Fluid 12V - 150 AH																			
0037	12/7/85	16 batteries hour ch. de Fluid 12V - 150 AH									PV86-3611	09/86	Does cycle batteries 12V (50)	2,777.00		2,777.00	86-5171	6/22/86	0027	6/22/86	
0039	12/4/86	1140 bouteilles de gaz									PV86-4712	5/86	Gas in bottles 140x250GR	DM 49,000		DM 49,000					Received by PEV
0035	12/8/85	1800 Gas bottles		1682-8230 14-30048	12an. '86	1800 Bouteilles de gaz	30,000.00	02/01/86 04/01/86	-	30,000.00	PV86-561		Commercial butane gas bottles (1800)	FF 217.432			85-5181	6/22/86	0028	6/22/86	
38	11/21/86	Spare parts 16 materials for the Scold chain Investment Ile the Mobil Trans Vehicles									PV86-5812	25/86	Spare parts 16 materials for the Installation of c. chain Investment in the mobil Trans Vehicles	DM 140.426		DM 140.426	00467	05/2/86	00467	05/2/86	
39	11/21/86	Spare parts 16 materials for the Scold chain Investment Ile the Mobil Trans Vehicles		1682-8230 15-40010							PV86-6513	3/86	Spare parts 16 materials for the Installation of c. chain Investment in the mobil Trans Vehicles	DM 225.335		DM 225.335	00471	13/12/86	00471	13/12/86	

1984	REQUISITION			PID/C OR PIL								P. O.					ACCUSE DE RECEPTION				REMARKS
																	R. REPORT AID		R. REPORT GIRM		
EB. NO	DATE	ITEMS DESCRIPTION	TOTAL VALUE	PID/C OR PIL	DATE	ITEMS DESCRIPTION	TOTAL VALUE	CONTRACT DATE	NO. OF AMEND.	NEW TOTAL VALUE	PO NO.	DATE	ITEMS DESCRIPTION	TOTAL VALUE	NO. OF AMEND.	NEW TOTAL VALUE	NO.	DATE	NO.	DATE	REMARKS
40155	14/29/86	1150 charges de gaz	UM 67.500	PIL 13							86-93	14/30/86	150 charges de gaz	UM 67.500	-	UM 67.500	0491	15/5/86	016/86	15/5/86	
40151	12/4/86	Pieces détachees pour Mercedes IC 955 TT		482-0230-14-40043	Nov 86	Pieces détachees pour Mercedes	10 1.700.00	15/1/86 to 17/1/86	-	10 1.700.00	86-95	14/29/86							023	16/12/86	
40152	12/4/86	Pieces détachees pour LR 110									86-97		Pieces détachees pour LR 110	10 410.05	-	10 410.05					
40153	12/4/86	Materiel complémentaire pour l'entretien des vehicules du PEV									86-67	14/27/86	Spare parts and material for the installation of c. chain equipment in the mobil teams vehicles	UM 190.270		UM 190.270	00469	10/3/86	00469	10/3/86	
30156	15/26/86	1150 charges de gaz									86-104	15/27/86	150 charges de gaz	UM 67.500	-	UM 67.500	0509	14/6/86	0026	10/6/86	
30157	16/30/86	130 Bottles																			
30158	107/86	1450 charges de gaz	UM 202.500																		

1984	REQUISITION			PIO/C OR PIL						P. O.					ACCUSE DE RECEPTION				REMARKS
REQ. NO	DATE	ITEMS DESCRIPTION	TOTAL VALUE	PIO/C OR PIL	DATE	ITEMS DESCRIPTION	TOTAL VALUE	CONTRACT DATE	NO. OF AMEND.	NEW TOTAL VALUE	PO NO.	DATE	ITEMS DESCRIPTION	TOTAL VALUE	NO. OF AMEND.	NEW TOTAL VALUE	R. REPORT RID NO.	R. REPORT RID DATE	R. REPORT GIRM NO.	R. REPORT GIRM DATE	REMARKS
	Dec. 83	Super Gasoline + Bluleurs & Pneus									84-031	12/15/83	Super Gasoline 16840 L	UM 678.032		UM 678.032	000113	1/8/84	000113	1/8/84	
	Dec. 83	120 Bridges-tion Tires									84-032	12/26/83	26 Bridges-tion	UM 220.000		UM 220.000	000114	1/9/84	000114	1/9/84	
				682-0230-14-40004	Dec. 83	Land-Rover Spare Parts	6 244.056.40	Issuance 682-0230-14-40004 (A)		6 260.868.00	84-045	12/26/84	Land-Rover	144.000 Pounds Sterling		144.000 Pounds Sterling	00287	11/7/84	00287	11/7/84	
001	Apr 84	Reconditionies of 11 cold storage	UM 68.362								84-111	4/17/84	Reconditioning of 11 cold storage	UM 68.362		UM 68.362					B.V 682-14-1095 June 7/84
R84-043-002	4/16/84	Carburant (12.000 L)									84-090	4/18/84	Carburant 12000 L.	UM 327.000		UM 327.000	84-108-1007	4/16/84	84-108-1007	4/16/84	
				682-0230-14-40004	Dec. 83	Land Rover Spare Parts	6 244.056.40	Issuance 682-0230-14-40004 (A1)		6 260.868.00	84-105	5/6/84	Spare Parts for LR 110	93 7.033.16		93 7.033.16	00235	8/27/84	00235	8/27/84	
											84-039	1/4/84	Coupteur Lk 122 Cable couteurs 22	UM 172.612		UM 172.612					
R84-145-001	5/16/84	Off. furniture and cleaning supplies	UM 543,333	PIL 9	5/17/85	Office Supplies - Office Equipments- Cleaning Supplies - Vehicule	6 100.000.00			6 100.000.00	84-104	5/20/84	Office furniture & cleaning supplies	UM 492.423		UM 492.423	Sans Numero	5/20/84	Sans Numero	5/20/84	

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1984	REQUISITION				PIO/C OR PIL							P. O.					ACCUSE DE RECEPTION				REMARKS
REQ. NO	DATE	ITEMS DESCRIPTION	TOTAL VALUE	PIO/C OR PIL	DATE	ITEMS DESCRIPTION	TOTAL VALUE	CONTRACT DATE	NO. OF AMEND.	NEW TOTAL VALUE	PO NO.	DATE	ITEMS DESCRIPTION	TOTAL VALUE	NO. OF AMEND.	NEW TOTAL VALUE	R. REPORT AID NO.	R. REPORT AID DATE	R. REPORT GIRM NO.	R. REPORT GIRM DATE	REMARKS
004	16/6/84	Carburant	UM 442.260								84-112	16/7/84	Carburant 16200 L.	UM 442.260		UM 442.260	00200 00201	16/20/84 16/20/84	00200 00201	16/20/84 16/20/84	
005	16/6/84	Carburant	540.540								84-113	16/7/84	Carburant 19800 L.	UM 540,540		UM 540.540	00199	16/20/84	00199	16/20/84	
	17/2/84	Brulours & Roches									84-033	12/15/84	Brulours (20) Roches (80)	UM 164.000		UM 164.000	000111	1/15/85	000111	1/15/85	
006	17/4/84	Extension of of Insurance Policy for vehicles IC 654 TT IC 955 TT IBO 339 TT									84-160	19/5/84	Extension of Insurance Police for Renault 654. Fiat 131 - From 7/20/84 to 7/22/85	UM 32.392		UM 32.392					Facture No 1340 dated 19/3/84
007	17/9/84	Carburant	UM 644.400								84-124	17/15/84	Carburant 18000 L.	UM 491.000	84-124 (A1)	UM 509.000	00231	19/7/84	00231	19/7/84	
008	17/9/84	Carburant	UM 491.000								84-125	17/15/84	Carburant 18000 L. M.I.	UM 491.000	84-125 (A1)	UM 509.000	00230	19/7/84	00230	19/7/84	
009	17/23/84	Spare Parts for LR IC3807T	UM 48.682								84-127	17/25/84	Spare Parts for LR IC3807T	UM 48.682		UM 48.682	00234	18/13/84	00234	18/13/84	
0010	17/23/84	Furniture of Reparation vehicule IC3871T	UM 61.459								84-126	17/25/84	Furniture en Reparation ILR C3871T	UM 61.459		UM 61.459					INV 682-84-1400 15/16/84
0011	17/30/84	Reparation vehicule	UM 40.000								84-145	18/9/84	Reparation vehicule IC3807T	UM 40.000		UM 40.000					Certification de service Rendu 18/15/84

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REQUISITION				PID/C OR PIL							P. O.						ACCUSE DE RECEPTION				REMARKS
NO	DATE	ITEMS DESCRIPTION	TOTAL VALUE	PID/C OR PIL	DATE	ITEMS DESCRIPTION	TOTAL VALUE	CONTRACT DATE	NO. OF AMEND.	NEW TOTAL VALUE	PO NO.	DATE	ITEMS DESCRIPTION	TOTAL VALUE	NO. OF AMEND.	NEW TOTAL VALUE	R. REPORT AID NO.	R. REPORT AID DATE	R. REPORT GIRM NO.	R. REPORT GIRM DATE	REMARKS
17/30/84	Reparation vehicule medecin Chef BI	UM 108.386									PR85-036	12/17/84	Reparation vehicule medecin Chef BI 50 3150	UM 108.386		UM 108.386					BS 682-85-1239 Pave __ le couple local
18/15/84	Reparation Machines	UM 46.547									PR84-159	8/16/84	Reparation machines	UM 46.517		UM 46.517					BL No. 000130 - 8/22/84 BS 682-84-017
19/16/84	Carburant	UM 115.200										10/10/84	Carburant	UM 875.600		UM 875.600					Sans Accuse de Reception
			682-0230 15-40010	Feb '84	Chaine de Froid	$ 144.307.24	5/30/84 to 7/31/84	-	$ 144.307.24								100304	12/30/84	100304	12/30/84	

:ALTHREP

QUESTIONNAIRE POUR LE GOUVERNEUR / PREFET :

REGION DE : DEPARTEMENT DE :

DATE :

1. QUELLE EST VOTRE OPINION SUR LES ACTIVITES DE SSP DE VOTRE REGION/DEPARTEMENT TELLES QU'ELLES SE DEROULENT ACTUELLEMENT ?

2. PENSEZ VOUS QU'IL EXISTE UNE POLITIQUE CLAIRE DE SSP QUI DEFINISSE LES BUTS A ATTEINDRE PAR LES SSP ? QUE FAUT/FAUDRAIT-IL COMME POLITIQUE POUR VOTRE REGION/ DEPARTEMENT ?

3. QUELLES ONT ETE LES REALISATIONS DES SSP DANS VOTRE REGION/DEPARTEMENT ?

4. QUE FAUT-IL FAIRE POUR REALISER LES BUTS DES SSP DANS VOTRE REGION/DEPARTEMENT ?

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5. QUEL EST LE ROLE DU GOUVERNEUR/ PREFET DANS LA GESTION ET LA REALISATION DES SSP AU NIVEAU REGIONAL/DEPARTEMENTAL ?

6. PENSEZ VOUS POUVOIR JOUER UN ROLE ENCORE PLUS IMPORTANT DANS LA REALISATION DES SSP ? COMMENT ?

7. SI C'ETAIT A VOUS DE DEFINIR L'EQUIPE DIRIGEANTE DES SSP (AU NIVEAU REGIONAL OU DEPARTEMENTAL) , QUEL PROFIL SOUHAITERIEZ VOUS LUI DONNER ?

8- SI C'ETAIT A VOUS D'ETENDRE LES ACTIVITES DE SSP DANS LA REGION/DEPARTEMENT QUEL PLAN D'ACTION PROPOSERIEZ VOUS ET PAR OU COMMENCERIEZ VOUS ?

QUESTIONNAIRE POUR LE MEDECIN CHEF OU RESPONSABLE DE :

REGION DE : DEPARTEMENT DE :

DATE :

1. QUELLE EST VOTRE OPINION SUR LES ACTIVITES DE SSP DE VOTRE REGION/DEPARTEMENT TELLES QU'ELLES SE DEROULENT ACTUELLEMENT ?

2. PENSEZ VOUS QU'IL EXISTE UNE POLITIQUE CLAIRE DE SSP QUI DEFINISSE LES BUTS A ATTEINDRE PAR LES SSP ? QUE FAUT/FAUDRAIT-IL COMME POLITIQUE POUR VOTRE REGION/ DEPARTEMENT ?

3. COMMENT FAUDRAIT-IL LA FORMULER ?

4. QUELLES SONT LES CONDITIONS NECESSAIRES POUR LA REALISER ?

5. ON PARLE SOUVENT DE LA NECESSITE D'"INTEGRATION " POUR REALISER LES BUTS DES SSP . COMMENT CETTE INTEGRATION EST-ELLE REALISEE DANS VOTRE REGION/ DEPARTEMENT ? EST-ELLE SATISFAISANTE? POURQUOI ?

6. QUE FAUDRAIT-IL FAIRE POUR REALISER UNE INTEGRATION ACCEPTABLE ?

7. QUELS SONT LES PROBLEMES DE GESTION/ADMINISTRATION/ LOGISTIQUE AUXQUELS VOUS DEVEZ FAIRE FACE DANS LA MISE EN OEUVRE DES SSP ?

8. QUELS SONT LES PROBLEMES SPECIFIQUES A VOTRE REGION/DEPARTEMENT POUR LA REALISATION DES SSP ?

9. COMMENT VOYEZ VOUS LE ROLE ET LE FONCTIONNEMENT DE LA COMMISSION REGIONALE DE SSP ET DE CHACUN DE SES MEMBRES ? PENSEZ VOUS QUE SES MEMBRES SOIENT A LA HAUTEUR DE LEURS TACHES ? COMMENT POURRAIT-ON LES RENDRE PLUS PERFORMANTS SI NECESSAIRE ?

10. QUELS SONT VOS RELATIONS AVEC LE PRSSR : INSTITUTIONNELLES ? PROFESSIONELLES ? PERSONNELLES ?

11. QUEL ROLE LE PRSSR JOUE-T-IL DANS L'IMPLANTATION DES SSP DANS VOTRE REGION ?

FAUT-IL AVOIR UN PROJET SPECIAL COMME LE PRSSR POUR PROMOUVOIR LES SSP ?

Y A-T-IL DES PROBLEMES DANS LE FONCTIONNEMENT DU PRRSR ? QUELS SONT-ILS ?

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QUELLES SOLUTIONS DEVRAIENT ETRE APPORTEES A CES PROBLEMES ?

12. LE PRSSR SERAIT-IL PLUS EFFICACE S'IL ETAIT INTEGRE AU SEIN DU MINISTERE DE LA SANTE ?
SI OUI, OU DEVRAIT-IL ETRE IMPLANTE ? POURQUOI ?

13. SI VOUS DEVIEZ QUITTER DEMAIN VOTRE POSTE ACTUEL QUEL PROFIL DEVRAIT AVOIR VOTRE REMPLACANT POUR LA MISE EN OEUVRE DES SSP ?

EXISTE-T-IL ACTUELLEMENT EN R.I.M. DES PERSONNES REPONDANT A CES CONDITIONS ?

14. QUELS SONT LES PRINCIPAUX PROBLEMES QUE VOUS SOUHAITERIEZ VOIR RESOLUS PAR CETTE EVALUATION ?

15. QUEL PLAN D'ACTION PROPOSERIEZ VOUS POUR ASSURER LA REALISATION DES BUTS DES SRP DANS LES TROIS PROCHAINES ANNEES ?

QUESTIONNAIRE [illegible] LES FORMATEURS

REGION [illegible] : DEPARTEMENT DE:

1. DE QUAND DATE VOTRE FORMATION ? OU ? CONTENU ?

2. PARMI LES SUJETS QUE VOUS ENSEIGNEZ QUELS SONT CEUX POUR LESQUELS VOUS PENSEZ QU'UNE FORMATION COMPLEMENTAIRE VOUS SERAIT NECESSAIRE ?

3. Y A-T-IL D'AUTRES SUJETS DE SANTE ADDITIONNELS QUE VOUS DESIRERIEZ ENSEIGNER ? DE QUELLE FORMATION SUPPLEMENTAIRE AURIEZ VOUS BESOIN POUR LE FAIRE ?

4. DEPUIS VOTRE REPRISE DE FORMATION - COMBIEN DE SEMINAIRES-RELIERS AVEZ VOUS PARTICIPE ? DE QUELLE NATURE ? QUAND ? DE QUELLE DUREE ? EN TANT QUE ?

5. COMMENT FAITES VOUS LA PLANIFICATION DES PROGRAMMES DE FORMATION ? CONTENU, MATERIEL, DUREE, OBJECTIFS ECRITS, CALENDRIER ,ETC....

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6. QUELLES SONT LES DIFFICULTES QUE VOUS AVEZ RENCONTRES AU COURS DE LA PLANIFICATION ET DE LA MISE EN OEUVRE DES SEMINAIRES OU DES STAGES ?

7. LESQUELLES AVEZ VOUS PU LES RESOUDRE ET COMMENT ?

8. DE QUELLES FACONS EVALUEZ VOUS LES CONNAISSANCES ACQUISES AU COURS DES STAGES ?

9. COMMENT EVALUEZ VOUS L'IMPACT A LONG TERME DES FORMATIONS SUR LA PRATIQUE DES PARTICIPANTS ? QUEL EST VOTRE JUGEMENT SUR CET IMPACT ?

10. QU'EST CE QUI RENDRAIT VOTRE TRAVAIL DE FORMATEUR PLUS EFFICACE, PLUS AGREABLE ET PLUS FACILE ?

11. QUELLES AUTRES SUGGESTIONS OU COMMENTAIRES VOUDRIEZ-VOUS FAIRE ?

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QUESTIONNAIRE PMI ET DISPENSAIRE

1. QUELLES SONT LES ACTIVITES DE SANTE QUE VOUS PRATIQUEZ ?

2. QUELLES SONT LES 5 PRINCIPALES CAUSES DE CONSULTATION ?

1-

2-

3-

4-

5-

3. REMPLISSEZ VOUS UN RAPPORT D'ACTIVITE MENSUEL ?
QUI LE FAIT ?
EST CE DIFFICILE ?
COMBIEN CELA PREND-IL DE TEMPS ?
A QUOI CELA VOUS SERT IL ?

SI VOUS N'EN REMPLISSEZ PAS POURQUOI ?

4. AVEZ VOUS RECU UNE FORMATION OU UN RECYCLAGE ?
QUAND ? OU ? PAR QUI ? COMBIEN DE TEMPS ?
QUEL ETAIT SON CONTENU ?

5. PENSEZ VOUS QUE LE TYPE DE FORMATION QUE VOUS AVEZ RECU CORRESPONDE AUX BESOINS DE VOTRE TRAVAIL QUOTIDIEN ?

SI NON, QUELS SONT LES DOMAINES DANS LESQUELS VOUS AIMERIEZ RECEVOIR UNE FORMATION ?

6. PAR QUI ETES VOUS SUPERVISEE ?

COMMENT ?

COMBIEN DE FOIS EN 1985 ?

7. QUEL TYPE DE RELATION PROFESSIONNELLE AVEZ VOUS AVEC :

-- LE SUPERVISEUR DEPARTEMENTAL DE SSP ? NOMMEZ LE

-- LE SUPERVISEUR REGIONAL ? NOMMEZ LE/LA

TRAVAILLEZ VOUS EN COLLABORATION ? SUR QUEL TYPE D'ACTIVITES ?

8. QUAND ETES VOUS ALLE/E AVEC L'EQUIPE MOBILE SUR LE TERRAIN POUR LA DERNIERE FOIS ?

QU' Y AVEZ VOUS FAIT ?

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9. QUAND A EU LIEU LA DERNIERE REUNION AVEC L'EQUIPE MOBILE ?

DE QUOI AVEZ VOUS PARLE ?

10. QUELS RELATIONS DE TRAVAIL AVEZ VOUS AVEC LES ASCs ?

VIENNENT ILS VOUS VOIR ?

VOUS ADRESSENT ILS DES MALADES ? POURQUOI ?

LES INFORMEZ VOUS DES RESULTATS DE LA CONSULTATION POUR LES MALADES QU'ILS VOUS ONT ADRESSES ?

11. COMMENT ETES VOUS APPROVISIONNE/E EN VACCINS ?

TOUS LES COMBIEN ?

12. AVEZ VOUS EU DES RUPTURES DE STOCK EN 1985 ? PENDANT COMBIEN DE TEMPS ? POUR QUELLES RAISONS ?

13. AVEZ VOUS EU DES PANNES DE REFRIGERATEUR EN 1985 ? COMBIEN DE TEMPS CELA A-T-IL DURE ? NATURE DE LA PANNE ?

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QU'AVEZ VOUS FAIT : 1) POUR SAUVER LES VACCINS ? AVEZ VOUS DES CONSIGNES SUR LA CONDUITE A TENIR DANS CE CAS ?

2) POUR REMETTRE EN ROUTE LA CHAINE DE FROID ?

14. COMBIEN DE SESSIONS DE VACCINATION ORGANISEZ VOUS PAR SEMAINE, DE QUELLE HEURE A QUELLE HEURE ?

15. COMBIEN D'ENFANTS VACCINEZ VOUS PAR SESSION ? VIENNENT-ILS DE LOIN ? [HEURES DE MARCHE]

16. COMMENT FAITES VOUS POUR IDENTIFIER LES ENFANTS EN RETARD POUR LEURS VACCINATIONS ? COMMENT VOUS Y PRENEZ VOUS POUR LES VACCINER ?

17. DANS VOTRE LOCALITE A COMBIEN ESTIMEZ VOUS LE POURCENTAGE D'ENFANTS DE MOINS DE 1 AN ENTIEREMENT VACCINES [OU DE MOINS DE 5 ANS SI CELA EST PLUS FACILE].

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18. PENSEZ VOUS QU'IL SOIT POSSIBLE DE VACCINER TOUS LES JOURS QUELLE QUE SOIT LA RAISON POUR LAQUELLE UN ENFANT SE PRESENTE A LA PMI ? POURQUOI ?

QUESTIONNAIRE POUR LES COMITES DE SANTE COMMUNAUTAIRE

REGION DE : DEPARTEMENT DE :

VILLAGE : DATE :

1. DEPUIS QUAND FONCTIONNE LE COMITE ?

2. POURQUOI CE VILLAGE A-T-IL DECIDE DE FORMER UN CSC ? COMMENT SES MEMBRES ONT-ILS ETE CHOISIS ?

3. QUELLES SONT LES ATTRIBUTIONS ET LES TACHES DE CE COMITE ?

4. QUEL EST LE CONTENU QUE CE COMITE DONNE AUX SSP ?

5. LE VILLAGE A-T-IL UN ASC ET UNE AVT ?

A) COMMENT SE SONT-ILS ETE CHOISIS ?

B) QUELLES SONT LEURS RESPONSABILITES VIS A LA COLLECTIVITE ?

C) DE QUELLE FACON SONT-ILS INDEMNISES ?

D) LA COMMUNAUTE EST-ELLE SATISFAITE DE LEURS SERVICES ? POURQUOI ?

E) DES DIFFICULTES ET/OU DES CONFLITS SONT-ILS SURVENUS DEPUIS LA CREATION DU COMITE SOIT AVEC LES ASC/AT SOIT AU SEIN DU COMITE LUI-MEME ? QUELLE ETAIT LEUR NATURE ET COMMENT ONT-ILS ETE RESOLUS ?

6. QUELS SONT LES PROBLEMES AUXQUELS VOUS FAITES FACE ACTUELLEMENT DANS LA REALISATION DES SSP ? QUELS SONT LES SOLUTIONS QUE VOUS ENVISAGEZ POUR LES RESOUDRE ?

7. RECEVEZ VOUS UN SOUTIEN DE LA PART DES SERVICES DE SANTE DEPARTEMENTAUX, REGIONAUX ET CENTRAUX ? DE QUELLE NATURE ? CE SOUTIEN REPOND-IL A VOS BESOINS ? POURQUOI ?

8- DE QUOI VOTRE COMITE AURAIT-IL BESOIN POUR FONCTIONNER PLUS EFFICACEMENT ? DE LA PART DE QUI ?

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9- AVEZ VOUS D'AUTRES COMMENTAIRES ET SUGGESTIONS ?

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QUESTIONNAIRE ACS

1. QUELLES SONT LES ACTIVITES DE SOINS DE SANTE PRIMAIRES QUE VOUS PRATIQUEZ ?
Cochez SANS LES SUGGERER les activites enumerees

---- HYGIENE DES PUITS ------ EAU POTABLE
---- TROUS A ORDURES ------ LATRINES
---- MOUCHES ------ DIARRHEES
---- VACCINATIONS ------ SURVEILLANCE NUTRITIONNELLE
---- PREMIERS SOINS ------ ADRESSE/REFERENCE DES PATIENTS
---- EDUCATION POUR LA SANTE

2. AVEZ VOUS RECU UNE FORMATION EN SSP ?
QUAND ? OU ? PAR QUI ? COMBIEN DE TEMPS ?

3. QUELLES SONT LES 5 PRINCIPALES CAUSES DE CONSULTATION DES MALADES QUE VOUS SOIGNEZ ?

1- 4-

2- 5-

3-

4. REMPLISSEZ VOUS DES FICHES D'ACTIVITE ?
SI OUI, AVEC QUELLE PERIODICITE ?
SI NON : JAMAIS FAIT ?
POURQUOI AVEZ VOUS CESSE ?

5. COMMENT ETES VOUS SUPERVISE ?

PAR QUI ?
COMBIEN DE FOIS AU COURS DE 1985 ? 1. 2. 3. 4. 5.

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6. A QUOI VOUS A SERVI LA SUPERVISION ?

7. QUELLES SONT LES PRINCIPALES DIFFICULTES QUE VOUS RENCONTREZ DANS VOTRE TRAVAIL ?

COMMENT POURRAIENT ELLES ETRE RESOLUES ?

8. AVEZ VOUS DES CONTACTS AVEC LA PMI DEPARTEMENTALE ?

COMMENT ?
A QUEL PROPOS ?
COMBIEN DE FOIS EN 1985 ?

9. CONNAISSEZ VOUS LE CALENDRIER DE VACCINATION ?

BCG : ROUGEOLE :

DTC 1 : POLIO 1 :
DTC 2 : POLIO 2 :
DTC 3 : POLIO 3 :

TT 1 : TT 2 :

10. COMBIEN DE FAMILLES AVEZ VOUS DANS VOTRE VILLAGE ?
COMBIEN D'ENFANTS, A VOTRE AVIS, N'ONT PAS RECU LE BCG ? :
POUR QUELLES RAISONS :

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11. QUELLE EST LA DATE DU DERNIER PASSAGE DE L'EQUIPE MOBILE ?

12. MOHAMED EST UN PETIT GARCON DE 4 ANS. IL A LA DIARRHEE DEPUIS 2 JOURS ET UN PEU DE FIEVRE. QUE FAITES VOUS LORSQUE SA MAMAN VOUS L'AMENE ?

COMMENT LE TRAITEZ VOUS ?

13. INSPECTION DE LA BOITE A PHARMACIE.

ETAT / PROPRETE :

PRESENCE DES PRODUITS SUIVANTS ET EN QUELLE QUANTITE ?

-- ORS :
-- ASPIRINE :
-- PENICILLINE :
-- GANIDAN :

CHLOROQUINE :
TETRACYCLINE :
DESINFECTANT :
PANSEMENT :

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