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PROJECT ASSISTANCE COMPLETION REPORT

FOR

MAURITANIA RURAL HEALTH SERVICES PROJECT

(682-0230)

Date of Report: July 1993

PACD: December 31, 1992

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I. INTRODUCTION

The Mauritania Rural Health Services Project (RHS) was a follow-on to a program previously supported by USAID called the Expanded Program of Immunization (EPI), which terminated in December 1983. The RHS project was authorized in July 1983 for \$5 million to be implemented over a five-year period. It was extended three times, making the final PACD December 31, 1992.

The total project cost was estimated at \$7.5 million, and contributions were made by the Government of the Islamic Republic of Mauritania (GIRM), the United Nations Children Fund (UNICEF), and the World Health Organization (WHO).

The Ministry of Health and Social Affairs, the GIRM agency that oversaw the project, established a separate functional entity to manage implementation of the project. USAID handled overseas procurement of all commodities except vaccines and locally-available items. John Snow, Inc. (JSI) was contracted to provide long and short-term technical assistance.

The project purpose included six components: Developing a PHC program including administration, training, and supervision in three of the 11 regions of Mauritania - Trarza, Guidimaka and Assaba; expanding basic health services, including preventative ones, to the rural population of the three regions; integrating PHC at national, regional departmental and village levels, and EPI in the three selected regions; performing epidemiological and social baseline studies and operational research in Trarza, Guidimaka, and Assaba on subjects relevant to the project such as pharmaceutical marketing, nutrition and cost recovery; developing an operating Health Information System (HIS) throughout the nation to promote national management; and, formalizing a national policy and program for coordinating Primary Health Care (PHC).

The ambitious project did experience difficulty fulfilling all of its originally planned outputs. Implementation was found to be exceptionally challenging due to the project's diversity and complexity. It aspired to provide training, expand health services, perform studies, formalize a national policy, and integrate PHC and EPI at all levels. Following the project's mid-term evaluation in June 1986, the project outputs were reassessed and scaled-down. Fewer studies were performed and the vast component in EPI extension was curtailed due to transportation constraints.

The mid-term evaluation noted that the demands of implementation exceeded the capabilities of the parties involved (the contractor, USAID, and the Ministry of Health). JSI's final report echoed these conclusions and stated that the original project design had set competing goals in attempting to deverticalize and integrate all programs simultaneously. The report also observed that technical assistance problems were not rectified expeditiously. However, a revolving operating fund was instituted and alleviated cash flow problems.

To assist course direction, seven evaluation reports were submitted following the midterm one. These included a formal final report in April 1989, and one by JSI in June 1989.

By the cessation of project operations, project evaluators found the program had been successful in achieving most of its goals. Basic health services were significantly expanded in the three targeted regions, hundreds of health care workers received training, some studies were performed, and PHC had been accepted by the Ministry of Health and Social Affairs (MOHSA) as the preferred way to provide rural health care at all levels.

II. CONTRIBUTIONS OF THE PARTIES

The total project cost was estimated at \$7.5 million. Sixty percent of the budget was expended for operating costs, commodities, local transportation and personnel; 36.5 percent was devoted to technical assistance, and the remaining 3.5 percent to information activities.

USAID, the Government of the Islamic Republic of Mauritania (GIRM), United Nations Children Fund (UNICEF) and World Health Organization (WHO) funded the project with the following inputs:

GIRM

The Mauritanian government's inputs consisted of salaries, facilities, rent, utilities and community contributions. The salaries translated into personnel and the government facilities translated into office space provided by the government for use by the Rural Health Services Project. The total GIRM contribution was estimated at \$2.5 million in local funding, which constituted over 25 percent of total project costs. The community contribution consisted of support given by the local communities to the Community Health Workers (CHW) and Traditional Birth Attendants (TBA) primarily to ensure a resupply of medical kits.

USAID

The \$5 million USAID input covered foreign exchange and local currency costs for project technical assistance, training, commodities, evaluation, audits and contingencies. A separate local currency bank account was opened for receiving advances and reporting disbursements for project aid funds. This occurred on a monthly and quarterly basis. Subsequent reimbursements were made based on financial reports, bank reconciliations, SF-1034 forms, and bank statements.

Other Donors

UNICEF and USAID jointly supported the EPI segments and WHO provided some technical support and training during the project implementation. The dollar value of this assistance is not cited in any project documents.

III. IMPLEMENTATION

The three target regions were strategically selected. Activities in Trarza represented a continuation and consolidation of those begun in two previous USAID health projects. Guidimaka, is located east of Trarza and had received assistance from other ongoing USAID agricultural projects. In Assaba, 60 percent of the population had already been exposed to EPI due to prior UNICEF undertakings.

These three regions encompass 31 percent of Mauritania's population, represent 51 percent of the nation's cultivated land area, and contribute a total of 38 percent of the nation's agricultural output. Also, they constitute an area of Mauritania where health problems are particularly pronounced.

The training component outlined in the project paper anticipated that a diverse mix of exercises would occur throughout the LOP. This included 16 types of in-country training: four for PHC personnel, five for EPI staff, and seven seminars and workshops on a variety of management and technical areas related to PHC. The plan budgeted four short-term and three long-term participant training programs in third countries.

The Ministry of Health and Social Affairs established a separate functional entity to handle project management. The office was directly related to the Office of the Director of Health, but was not part of the Ministry's normal bureaucratic structure and therefore, had no decision-making relationship to the other MOHSA services. To compensate for this chasm and to coordinate the EPI and PHC activities, a Comite Inter Service (CIS), composed of the heads of the three services, was set up. Project evaluations indicated that the group sustained a productive and effective working relationship within the Ministry.

The Director of the Division of Hygiene and Public Health was the Chairman of the CIS and was responsible for overall project development and management. Regional Chief Medical Officers represented various services of the Ministry of Health at each regional level.

Within the Office of the AID Representative in Nouakchott (OAR/Nouakchott), project management was handled by the Health Development Officer (HDO) who was supported by a local-hire U.S. citizen and one Mauritanian.

Technical Assistance

In the first year of project implementation, technical assistance was provided through separate, individual short-term contracts and chiefly involved conducting preliminary studies. In the second year, JSI was contracted to provide curriculum development, visual aids, cold chain management and maintenance, and mass media campaigns. JSI provided 95-person-months of service, comprised of three long-term advisors, a primary health care manager/evaluator, a training advisor, a health management/EPI advisor, and two short-term consultants hired to do curriculum development.

Two of the long-term advisors terminated their employment early and replacements were not sought until after the midterm evaluation in late 1987. These staffing losses disrupted and delayed project implementation. JSI's \$1.75 million contract with AID was closed-out June 31, 1989.

Commodities

OAR/Nouakchott was responsible for procuring all commodities except vaccines, which were supplied by UNICEF, and off-the-shelf items available locally that could be procured through the project's local operating budget.

Waivers were granted for items such as additional vehicles, spare parts, and medical equipment. Also, a special request was placed to obtain the pharmaceuticals from UNICEF.

Fuel and vehicle maintenance were covered by USAID funds. The petrol was supplied by a voucher system and vehicle maintenance was supplied through a contract with a central garage of the local Food Security Commission.

OAR/Nouakchott ordered three Land Rover station wagons, but they were never delivered. A ten percent advance had been paid to a company which went bankrupt, and these funds were never recovered.

Following the closeout of project, office equipment was returned to the Ministry of Health. A May 13, 1990, memo acknowledged that OAR/Nouakchott no longer held any project property.

USAID Financial Inputs

A summary of project financial reports as of June 30, 1993, indicated the following:

LOP funding	Oblig. to date	Expend. to date
5,000,000	4,422,147	4,422,147

Of the total project funds, \$4,422,147 was obligated and disbursed as of June 30, 1993. Unused project funds were deobligated.

IV. ACCOMPLISHMENTS OF PROJECT OBJECTIVES

Basic health services were significantly expanded in the three target regions which supported the GIRM's policy reforms aimed at stressing preventative medicine and facilitating active community participation. Prior to the RHS program, only 30 percent of the population benefitted from government health services, which were concentrated in urban areas.

Project results were accomplished during the extended life of the project. The PACD was extended three times: the first completion date, July 31, 1988, was deferred until July 31, 1989, due to the absence of critical project personnel. A second extension was granted until December 31, 1990, in order to ensure that all services financed under the Project Grant Agreement be delivered. Yet a third extension, lasting until December 31, 1992, allowed long-term participants in the U.S. to complete their training and permitted the delivery of commodities. All other USAID-supported project activities were terminated in December 1991.

Project accomplishments included:

EPI

One of the project's greatest achievements was in the facilitation of the EPI program. Substantial EPI operations were begun in Trarza and Guidimaka and operations were maintained in the Assaba Region. More than 200 villages in the three regions received PHC services. The project instituted mobile teams capable of delivering vaccine to rural areas and fixed facilities, reaching 60 percent of its target population; and, EPI area community health worker teams were collaborating in activities in the three regions, providing supervision and referrals. This resulted in strong vaccination coverage throughout the country. In addition, the EPI Documentation and Statistical Unit is now capable of producing annual reports on the EPI activities.

Under the project, 25 mobile team nurses were retrained, 30 EPI fixed centers were re-equipped and made functional; 10 regional EPI and central EPI depots with cold chain equipment were established; and 13 dispensaries in the three regions were re-equipped.

PHC

The functional PHC systems in the three target regions demonstrated that this strategy was feasible and technically acceptable in Mauritania. The project produced the following outputs: some 600 village health workers were trained or given refresher courses; central, regional and departmental supervisors and trainers were trained; 60 fixed center nurses were re-trained and their skills periodically upgraded; and over 300 new community health workers (CHW) and traditional birth attendants (TBA) were trained and in-service training given to existing personnel. As a result of the RHS project and the efforts of other donors, particularly UNICEF, the Bamako Initiative and PHC have been accepted by MOHSA as the preferred way to provide rural health services. PHC is now well-integrated in the MOHSA, and the Ministry's acceptance of this approach was expected to ensure its sustainability.

Supervision and village sensitization programs also were made operational, and The National Commission for Primary Health Care was formed and was instrumental in integrating the various levels of the PHC network. Selected PHC interventions were delivered by CHW teams who had their appropriate medical kits replenished through funds raised by the Community Health Committee or by sale of medicines; and most received a salary from the same source.

Training

Ministry personnel benefitted as well from training programs in management, epidemiology, computers, health information, training, supervision, and service delivery.

Studies and Data Collection

Project-funded studies and data collection activities yielded information on topics such as the national rate of morbidity, treatment, immunization and pharmaceuticals. Results were supplied to the Ministry of Health for use in developing future programs. A data collection system was designed to monitor program activities.

V. LESSONS LEARNED

According to the final evaluation report, most of the difficulties pertaining to project management and implementation were attributed to the original PP's design. However, these areas were identified and rectified following the midterm evaluation. Some of the lessons learned that may assist future endeavors include the following.

1. Project designs must reflect more accurately the required resources needed and time required to accomplish its purpose. The original PP outlined extremely complex goals, which were later redesigned to reflect a more scaled-down approach.
2. Problems with personnel in key technical assistance roles delayed project implementation and instigated the first PACD extension. A contract technical assistance team was absent for six months, the Chief of Party position was open for one year, there was a change of Project Directors in the Ministry of Health, and the rotation of the OAR/Nouakchott Health Officer caused a four-month hiatus awaiting his replacement. Technicians to the EPI and Health Information Systems (HIS) programs departed at the end of their contracts; however, their expertise was still needed. Project evaluators noted that these two programs would have benefitted from extending these contracts.
3. The EPI program did not establish a reliable transportation system for the EPI teams. Evaluators found that the program could have been executed more efficiently with an improved transportation network.

4. OAR/Nouakchott Project Officers needed to have ultimate responsibility for project management, including monitoring contract performance. The decision by OAR/Nouakchott to allow the Contract Chief of Party to bypass the USAID Health Development Officer exacerbated managerial difficulties in the RHS project and impeded its progress. Lack of coordination among MOSHA representatives, participating donors, and the outside project director was also a major stumbling block in project implementation. This situation was improved following the formation of the CIS.

5. Funding for program expenditures and technical assistance needed greater pre-planning than originally foreseen. An improved system for cash advances for RHS project operations was developed during project implementation to provide project personnel more rapid access to funds. OAR/Nouakchott established a revolving operating fund using an average monthly expenditure figure, \$53,000, which provided money for regular project activities.

6. The long-term sustainability of this staff-intensive project by the GIRM was not outlined in the PP. Evaluators recommended including a cost recovery component in future project designs, which would allow the host government to obtain funding adequate to support and even expand these programs.