Mauritania

FACTFILE

Title Expanding Access to Quality Sexual and Reproductive Health Services

IPPF Member Association L'Association Mauritanienne pour la Promotion de la Famille (AMPF)

Set up in 1989, AMPF is the country's leading non-governmental organization promoting and providing sexual and reproductive health services.

Aim To improve access to sexual and reproductive health services in six urban localities and 50 rural zones, and to create awareness of key sexual and reproductive health issues in the target populations.

Duration Five years: 2003–2007

KEY ACHIEVEMENTS

- The project offered a full range of sexual and reproductive health services within locations previously not reached by any service (in the urban areas of Kif Fa, Rosso, Noudhibou, Kaédi and Nouakchott and four mobile services to the peri-urban surroundings of Kif Fa, Rosso, Noudhibou and Kaédi).
- The project attracted 76,917 new users of modern contraceptive methods and 68,337 individual counselling sessions took place.
- The capacity of clinic staff was built to develop and implement a quality of care system in each centre and mobile unit system.

PROJECT OVERVIEW

Strategies to expand services with good service mix

The project established four mobile clinics to cover 100 rural communities. These clinics provided a range of contraceptives as well as antenatal care, gynaecological examinations, immunizations and services for sexually transmitted infections. In addition, the mobile clinics provided some paediatric and general medical services.

> "We are happy working with AMPF even though our salaries are slightly lower than if we were working with other services. AMPF offers a good environment and organizational structure to develop our skills."
>
> Midwives from project centres

Collaboration with communities resulted in wider reach into rural areas

The introduction of the mobile unit into the regions and the planning of the unit's timetables and service points took place in consultation with the Regional Director of Health, communities in the areas, local non-governmental organizations, and community leaders and elders. This ensured that the units were stationed at times and locations that were convenient to people and resulted in a deep and wide reach into the community (33 per cent of new users of contraception came from these four units).

Clear organizational structure focused on quality of care

AMPF was specifically concerned with improving the quality of services that it provided. This was achieved through a combination of training staff in quality of care and developing a quality system across the organization. An example of its innovative approach was to provide a play space for children accompanying their mothers to the clinics.

> Given that over half the population believed that sexual and reproductive health should not be discussed outside the home, the project's strategy of engaging people one-to-one as well as in a group forum proved to be very successful.

KEY PROJECT STATISTICS

There were 36,929 prenatal visits and 3,753 paediatric visits for children aged 0–1.

17,334 community information, education and communication activities were held including 9,200 home visits.

42 health professionals and 18 other staff were all trained and employed in the six urban centres and 66 community-based volunteers were trained.

66 community liaison officers and 93 community leaders were sensitized and trained in sexual and reproductive health and rights.

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Home visits and individual counselling contributed to real change in attitudes and knowledge

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The project baseline survey in 2002 showed that only 65.3 per cent of the population had some knowledge of modern contraceptive methods in the centre locations. However, a national survey in 2007 put national awareness of modern contraception at 70.6 per cent. In three of the five areas in which the project was active this level was much higher (88.7, 83.7 and 90 per cent).

Networks of men, women and young people, headed by a community leader, were formed in each project zone and trained by the project.

Working through networks to target project beneficiaries

Meetings with community networks and leaders showed that they were well organized and engaged with their communities. Their ability to mobilize local populations meant that they formed a good link between service delivery points, mobile teams and the local communities. Networks of men, women and young people, headed by a community leader, were formed in each project zone and trained by the project. These groups worked with the project staff to promote sexual rights in their local communities and encourage service uptake.

Collaboration and joint planning activities with government

AMPF centres worked together with the government regional health services to plan joint activities and service provision for vaccinations, family planning and prenatal services. In addition, the regional health service played a strong role in agreeing the coverage for the mobile units.

The centre's service statistics were also centralized at the Regional Directorate for Health and Social Action and contributed to the government's targets for sexual and reproductive health.

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IPPF and UNFPA working together in-country

UNFPA is an important advocacy partner for AMPF and assisted in providing technical support for the project, especially for the final evaluation. As the goals of both IPPF and UNFPA focus on expanding access to the wider population, the project met a number of joint goals for both organizations.

Effects of poverty on project continuation

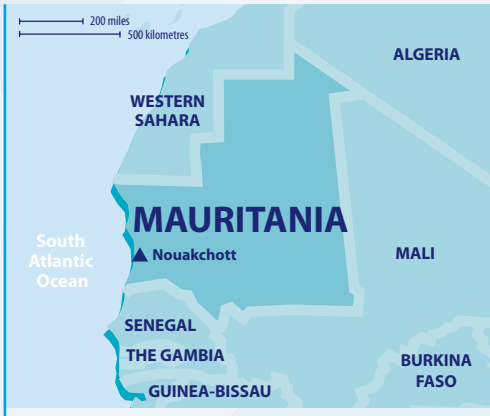
AMPF has found funding to continue with some aspects of the project. However, further funds are needed to allow the continuation of the full project.

LESSONS LEARNED

Five per cent of the population is nomadic and providing continual support to this key group proved difficult as they were not always able to access the same mobile unit.

Providing services in such poor locations means that it is not possible to charge client fees, resulting in the need for full funding for the project to continue.

Continuous professional training is needed as some staff have gained experience through years of service and are more familiar with the relevant issues than other staff.



COUNTRY STATS

Population is 3.2 million, with 40 per cent under the age of 15. (2008, Population Reference Bureau)

31 per cent of population is aged between 10 and 24. (2006, Population Reference Bureau)

Human Development Index ranking: 137 out of 177 countries. (2005, UNDP Human Development Report 2007/2008)

Average life expectancy at birth is 63.2 years. (2005, UNDP Human Development Report 2007/2008)

The infant mortality rate is 77 per thousand live births. (2008, Population Reference Bureau)

The total fertility rate is 4.8 (2000–2005) **with only 8 per cent of married women aged 15–49 practising family planning.** (1997–2005, UNDP Human Development Report 2007/2008)

71 per cent of all girls have been subject to female genital mutilation. (Update on FGM/C, Global Consultation on Female Genital Mutilation/Female Genital Cutting (FGM/FGC) 30 July–3 August 2007, Addis Ababa, Ethiopia)

Population living with HIV/AIDS (aged 15–49) is 0.7 per cent. (2005, UNDP Human Development Report 2007/2008)

Only 57 per cent of births are attended by trained personnel. (1997–2005, UNDP Human Development Report 2007/2008)

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