Country Cooperation Strategy
OF THE WORLD HEALTH ORGANIZATION WITH MAURITANIA 2018–2022
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## Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>CAMEC</td>
<td>Central distributor of medicines and medical supplies</td>
</tr>
<tr>
<td>CCM</td>
<td>Country coordination mechanism</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Committee on Elimination of Discrimination against Women</td>
</tr>
<tr>
<td>CHN</td>
<td>National hospital centre</td>
</tr>
<tr>
<td>CNC</td>
<td>National cardiology centre</td>
</tr>
<tr>
<td>CNO</td>
<td>National oncology centre</td>
</tr>
<tr>
<td>CNS</td>
<td>National health statistics office</td>
</tr>
<tr>
<td>CPDD</td>
<td>Partnership Framework for Sustainable Development</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and health surveillance survey</td>
</tr>
<tr>
<td>DPCIS</td>
<td>Directorate of Planning, Cooperation and Statistical Information</td>
</tr>
<tr>
<td>DPL</td>
<td>Department of pharmacies and laboratories</td>
</tr>
<tr>
<td>EPCV</td>
<td>Periodic household health surveillance survey</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FAO</td>
<td>United Nations Food and Agriculture Organization</td>
</tr>
<tr>
<td>FTP</td>
<td>Financial and technical partners</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
</tr>
<tr>
<td>GATS</td>
<td>General Agreement on Trade in Services</td>
</tr>
<tr>
<td>GPSE</td>
<td>Group programme for monitoring and evaluation</td>
</tr>
<tr>
<td>GPW</td>
<td>General programme of work</td>
</tr>
<tr>
<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
</tr>
<tr>
<td>HCT</td>
<td>Humanitarian country team</td>
</tr>
<tr>
<td>HDI</td>
<td>Human development index</td>
</tr>
<tr>
<td>HHA</td>
<td>Harmonization for Health in Africa</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
</tr>
<tr>
<td>HRH</td>
<td>Human resources for health</td>
</tr>
<tr>
<td>IHP+</td>
<td>International Health Partnership and related initiatives</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated management of childhood illness</td>
</tr>
<tr>
<td>INRSP</td>
<td>National Public Health Research Institute (of Mauritania)</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>LNCQM</td>
<td>National laboratory for drug quality control</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple-indicator Cluster Survey</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, newborn and child health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
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</tr>
<tr>
<td>NCD</td>
<td>Noncommunicable disease</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
</tr>
<tr>
<td>NHIS</td>
<td>National health information system</td>
</tr>
<tr>
<td>OHCHR</td>
<td>Office of the UN High Commissioner for Refugees</td>
</tr>
<tr>
<td>ONS</td>
<td>National statistics office</td>
</tr>
<tr>
<td>PNDS</td>
<td>National Health Development Plan</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>RGPH</td>
<td>General Census of Population and Housing</td>
</tr>
<tr>
<td>RHS</td>
<td>Reinforcement of health systems</td>
</tr>
<tr>
<td>SARA</td>
<td>Service Availability and Readiness Assessment</td>
</tr>
<tr>
<td>SCAPP</td>
<td>Strategy for Accelerated Growth and Shared Prosperity</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable development goal</td>
</tr>
<tr>
<td>SMART</td>
<td>Standardized monitoring and assessment of relief and transition</td>
</tr>
<tr>
<td>SMIR</td>
<td>Integrated disease surveillance and response</td>
</tr>
<tr>
<td>SMT</td>
<td>Security management team</td>
</tr>
<tr>
<td>SNIS</td>
<td>National health information system</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal health coverage</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNCT</td>
<td>United Nations country team</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Note: Acronyms have been listed in the manner most frequently used in practice. Some are based on French titles; in these cases, the English text describes the meaning.
Preface

“...I call on all WHO staff, and WHO Representatives in particular, to redouble their efforts to ensure effective implementation of the programmatic guidance provided in this document, with a view to achieving better health outcomes that can contribute to health and development in Africa.”

Dr Matshidiso MOETI
The third-generation WHO Country Cooperation Strategies (CCSs) integrate the reform agenda adopted by the World Health Assembly to strengthen WHO’s capacity and ensure that its services better respond to the needs of the country. It operationalizes the WHO’s Twelfth General Programme of Work, “Not Merely the Absence of Disease” at the country level, aims to ensure greater relevance of WHO’s technical cooperation with Member States and places an emphasis on identification of priorities and measures of efficiency for the implementation of WHO reforms and the regional transformation agenda. The goal of the transformation agenda is to make the regional health organization into a forward-looking, proactive, responsive, results-oriented, transparent and accountable institution. This generation of country cooperation strategies takes into account the roles of different partners, including non-state actors, in providing support to governments and communities.

The third generation of CCSs builds on lessons learned from the implementation of first- and second-generation CCSs, on national strategy (including policies, plans, strategies and priorities) and on the United Nations Development Assistance Framework (UNDAF). CCSs also align with the global health context and the move towards universal health coverage (UHC), as they incorporate the principles of alignment, harmonization and effectiveness articulated in the Rome (2003), Paris (2005), Accra (2008) and Busan (2011) declarations on aid effectiveness. The third generation of CCSs also takes into account the principles underlying the Harmonization for Health in Africa (HHA) and the International Health Partnerships and related initiatives (IHP+), reflecting a policy of decentralization and strengthening government decision-making capacity to improve the quality of public health programs and interventions.

Developed in consultation with key stakeholders working in the health domain at the country level, the CCS highlights expected results of the WHO Secretariat. In line with the WHO’s renewed emphasis on countries, the CCS should serve as a platform for communicating WHO’s work in country; formulating the WHO country work plan; undertaking advocacy, mobilizing resources and coordinating with partners; and shaping the health component of UNDAF and other country-level health partnership platforms.

I commend the efficient and effective role of the government in leading this important CCS development exercise. I also call on all WHO staff, and WHO Representatives in particular, to redouble their efforts to ensure effective implementation of the programmatic guidance provided in this document, with a view to achieving better health outcomes that can contribute to health and development in Africa.

— Dr Matshidiso MOETI
Regional Director of WHO for Africa
Preamble

“The third-generation strategy for cooperation between WHO and Mauritania centres on four strategic priorities: health system strengthening with a view to universal health coverage, health security and emergencies, reduction of maternal and infant-child mortality and disease control.”

Dr Abdou Salam GUEYE
Since 2012, WHO has initiated a wide range of reforms to enable it to more effectively fulfil its constitutional mandate as the “directing and coordinating authority on international health work.” In May 2013, as part of these reforms, the 66th World Health Assembly approved the Twelfth General Programme of Work for 2014–2019 to guide WHO actions worldwide and orient country cooperation strategies.

Inspired by the WHO leadership priorities, the Africa Health Transformation Programme 2015–2020 and the country’s programmatic priorities, the WHO Mauritania office has updated its country cooperation strategy for the period 2018–2022. This document provides a succinct summary of the strategic priorities and action areas on which WHO will focus its support over the next five years.

The third-generation strategy for cooperation between WHO and Mauritania centres on four strategic priorities: i) health system strengthening with a view to universal health coverage; ii) health security and emergencies; iii) reduction of maternal and infant-child mortality; and iv) disease control. It seeks to increase the relevance of WHO technical cooperation with the country. It is the culmination of a process involving in-depth analysis of the situation, joint identification of priorities, and bottom-up planning, focusing on accountability in the implementation of WHO’s programme budget.

The CCS 2018-2022 is inspired by lessons learned in the implementation of the first- and second-generation CCSs and the UNDAF. It builds on the conclusions of the final Millennium Development Goals (MDG) implementation report, evaluations of the national health development plan (PNDS) and strategic framework on poverty reduction (CSLP), and findings of multiple surveys (e.g. Service Availability and Readiness Assessment (SARA), Periodic Household Living Conditions Survey (EPCV), Multi-indicator Cluster Survey (MICS) and the Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey), all of which informed identification of priority health development actions in line with Mauritania’s national Strategy for Accelerated Growth and Shared Prosperity (SCAPP). The CCS also aligns with global health frameworks and the Sustainable Development Goals’ focus on universal health coverage. It will be implemented in accordance with the principles inscribed in the Rome (2003), Paris (2005), Accra (2008) and Busan (2011) Declarations on Aid Effectiveness, and with international health partnerships and related initiatives (e.g. IHP+, H6, and HHA).

In short, this document constitutes the first-line guide to cooperation between WHO and the Islamic Republic of Mauritania. I thank the Government of Mauritania, partners and civil society for their exemplary contributions to the development of this strategy.

— Dr Abdou Salam GUEYE
WHO Representative in Mauritania
Executive summary
At the close of the implementation period for the Country Cooperation Strategy (CCS) II (2009–2015),\textsuperscript{1} which reflected the WHO Mauritania Office’s medium-term strategic vision for supporting the national health development strategy, WHO and the Ministry of Health (MOH) agreed on a collaborative process for updating the CCS that would take into account ongoing national reforms and the need to better align CCS interventions with current challenges facing the country.

Updates to the CCS were carried out by a joint MOH-WHO team chaired by the WHO Representative and the Director of Programming, Cooperation and Health Information (DPCIS) of MOH. The entire WHO country office team contributed to the process, which consisted of:

- multiple stakeholder briefings on the CCS update process with a view to ensuring effective stakeholder participation;
- establishment of a road map;
- formation of six sub-committees corresponding to WHO leadership priorities.

Work by the sub-committees was utilized to carry out a comprehensive analysis of the health sector situation in Mauritania as well as an assessment of results achieved under CCS II. These activities were reinforced by a study of partner perceptions of WHO cooperation.

Based on the findings of the situation analysis and the CCS II review and partner perception study, WHO hosted a workshop to identify the strategic axes and priorities for the CCS III (2018–2022). The selection of strategic priorities was strongly influenced by the 2030 Agenda for Sustainable Development, which offers WHO an excellent opportunity to support member states in achieving universal health coverage (UHC) in furtherance of the sustainable development goals (SDGs) and SDG 3 in particular.

The present document details the four strategic priorities and priority action areas that will guide WHO’s cooperation with Mauritania for the next five years, as follows.

1. **Health system strengthening with a view to UHC:** This will involve ensuring universal access to quality health services and protecting all people against risks related to public health and disease-induced impoverishment. It will also require systematic evaluation and application of lessons learned in order to effectively manage challenges, adapt approaches to improving coverage and support progress towards UHC.

2. **Health security and emergencies:** WHO possesses a strong comparative advantage in this area, which will focus on continuously reinforcing the country’s capacity to prevent and detect public health emergencies and put in place adequate response frameworks that build health system resilience.
3. **Reduction of maternal and infant-child mortality:** This strategic priority will seek to increase access to high-impact interventions and to disseminate results of studies and research in the area of maternal, newborn and child health (MNCH).

4. **Disease control:** Controlling disease will mean reducing the burden of communicable diseases (HIV/AIDS, tuberculosis (TB), malaria, hepatitis, neglected tropical diseases (NTDs) and vaccine-preventable diseases) while simultaneously addressing the impacts of climate change. It will also require identification of pathways and strategies for addressing noncommunicable diseases (NCDs), both to prevent and control these diseases and to improve and protect the overall health and well being of the population.

Special attention will be granted to advocacy efforts aimed at expanding, diversifying and coordinating interventions by different health system actors including public, parastatal and private-sector entities, bilateral and multilateral partners, UN agencies and national and international civil society organizations. WHO will work to strengthen alignment with national strategies and to mobilize additional resources. Achievement of the SDGs as a whole will require robust action on the social determinants of health through sustained intersectoral collaboration.

Thus, the CCS for 2018–2022 will be implemented in a spirit of national ownership, alignment with national priorities, harmonization with other partners, achievement of results and mutual accountability according to the principles of the Paris Declaration on Aid Effectiveness. This will involve strengthening the leadership of the MOH in the definition, steering and monitoring and evaluation (M&E) of national health policy. The M&E process for the CCS will ensure rigorous documentation of results achieved vis-a-vis biennial work plans.

In brief, the Mauritania CCS for 2018–2022 is in line with the needs of the country. A concerted effort will be made to ensure the strategy’s internal consistency through regular review and updating of tools for measurement, monitoring and evaluation of progress.
Introduction
In order to render its cooperation with Mauritania more effective, WHO has since 2002 periodically developed multi-year cooperation strategies with the country. The first generation CCS covered the period 2002–2008. The second, initially planned to cover the period 2009–2013, was ultimately extended until 2015, given a favourable environment for such an extension.

Having reached the end of the extended deadline, the WHO Mauritania office, in collaboration with the other health sector actors, including MOH, financial and technical partners (FTP) and civil society organizations, updated the CCS for 2018–2022, resulting in the “third generation” strategy. The CCS for 2018–2022 is WHO’s response to Mauritania’s national priorities as set forth in the Accelerated Growth and Shared Prosperity Strategy (SCAPP), the National Health Policy and the National Health Development Plan for 2017–2020 (PNDS II).

The CCS development process unfolded in a favourable programmatic context marked by the evaluation of the Poverty Reduction Strategy Paper for 2011–2015; the elaboration of the national post-2015 development strategy; the SCAPP for 2016–2030; the PNDS mid-term review; and the release of data from several national surveys, including Periodic Household Living Conditions Survey (EPCV) 2014, General Census of Population and Housing (RGPH) 2013, Multi-indicator Cluster Survey (MICS) 2015 and Service Availability and Readiness Assessment (SARA) 2016.

The third-generation CCS also comes at a time when the international health community is facing major health security challenges with the emergence of health events that quickly become international in scope. In the case of Mauritania, food insecurity driven by drought in the Sahel, a refugee crisis born of political and religious conflicts in the Saharo-Sahelian belt, and recurring nutritional crises are phenomena that have a sharp impact on health planning.

WHO’s CCS with Mauritania has benefited from extensive consultation with stakeholders and partners in the health sector. It is the result of joint work by the WHO country team and the MOH. This process, based on data and encompassing aspects of human rights, gender, sustainability, peace and security, has allowed the identification of relevant and synergistic strategic axes based on the mandate of WHO and its comparative advantage. The CCS reflects medium-term vision that underpins and facilitates WHO’s technical cooperation with the country to improve health outcomes for the people of Mauritania.
Health and development challenges

Photo © Chris Brown 2014
2.1. KEY SOCIAL DETERMINANTS OF HEALTH

The average annual population growth rate calculated by the National Statistics Office (ONS) on the basis of the results of the last census from 2013 is 2.77%, which suggests a doubling of the population in 25 years. In 2015, more than one third of births (34.4%) were not registered with the state, which negatively affects the school enrolment rate.

Mauritania’s Human Development Index (HDI) has grown significantly over the past three decades, from 0.347 in 1980 to 0.506 in 2014, an increase of 159 points over the period and a gain of 4.54 points per year. Mauritania ranks 156th out of 187 countries and remains classified as a low-HDI country.

2013 RGPH data show that the illiteracy rate declined to 36.3% from 46.9% in 2000, a change of more than ten percentage points. Illiteracy remains higher among women (41%) than men (31.3%).

Another factor influencing health is the microbiological quality of drinking water at home, estimated at 52% in 2010 by the Ministry of Hydraulics and Sanitation. The same entity reported in 2011 that only 53% of households...
had access to improved sources of water, compared to 50.5% in 2007. The treatment of home water with bleach was practiced by 28% of households in 2011 compared with 21.8% in 2007, while use of improved sanitation and hand washing facilities and devices remains quite low.\textsuperscript{16}

With regard to environmental challenges, there is a weak mechanism for responding to and controlling climate risks and natural disasters.\textsuperscript{17} Mauritania, mostly desert, is experiencing drought in its northern two thirds, with recurring floods in the southern third. The territorial waters that cover a coastline of more than eight hundred kilometres, are frantically exploited by fishermen from all walks of life and are sometimes covered with oil slicks from the high seas, threatening aquatic fauna and flora along the coast.

The status of women has improved in terms of rights, economic empowerment and participation in decision-making power.

A significant increase in the country’s automotive fleet has exacerbated the unsatisfactory state of the roads; the behaviour of the drivers of vehicles threatens safety and causes accidents on public roads. On average, 20 patients are admitted to the national hospital for emergency care every day as a result of road accidents.\textsuperscript{18}

Despite progress in some areas, this situation creates an unfavourable environment for health and requires additional effort in the areas of health promotion and prevention.

2.2. HEALTH SITUATION

The epidemiological profile of the country is still characterized primarily by infectious and parasitic diseases, although NCDs, particularly cardiovascular diseases and diabetes, are becoming a serious public health problem.

The top ten reasons for health consultations are fairly typical for a developing country in a tropical environment. According to the 2015 Health Statistical Yearbook, they are (in decreasing order of frequency): acute respiratory infections (29.94% of all consultations), malaria (16.93%), simple diarrhoea (13.23%), wounds (4.99%), conjunctivitis (4.82%), ear infections (4.16%), bloody diarrhoea (4.05%), and high blood pressure (3.22%).\textsuperscript{18}
### Population

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013</th>
<th>2017</th>
</tr>
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<tbody>
<tr>
<td>Total population‡ (projection, 2017)</td>
<td>3,357,368</td>
<td>3,893,775</td>
</tr>
<tr>
<td>% population under 15 years‡</td>
<td>44.2</td>
<td></td>
</tr>
<tr>
<td>% population over 60 years‡</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth‡</td>
<td>60.3 (all)</td>
<td>58.3 (men)</td>
</tr>
</tbody>
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### Maternal and child health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Total fertility rate‡</td>
<td>4.3</td>
</tr>
<tr>
<td>Neonatal mortality per 1,000 live births‡</td>
<td>29 (both genders)</td>
</tr>
<tr>
<td>Child mortality per 1,000 children under five years of age‡</td>
<td>115 (both genders)</td>
</tr>
<tr>
<td>Maternal mortality ratio per 100,000 live births‡</td>
<td>582</td>
</tr>
<tr>
<td>% Births assisted by skilled birth attendant</td>
<td>69</td>
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### Immunization

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Penta3 vaccine coverage in one-year-old children*</td>
<td>86</td>
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### Human resources for health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Density of physicians per 1,000 people (physicians practicing in health care facilities, 2015)</td>
<td>0.034</td>
</tr>
<tr>
<td>Density of nurses and midwives per 1,000 people (2015)</td>
<td>0.7</td>
</tr>
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</table>

### Socio-economic

<table>
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<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure as % of gross domestic product (2015)</td>
<td>5</td>
</tr>
<tr>
<td>Government expenditures on health as a % of total expenditures††</td>
<td>6</td>
</tr>
<tr>
<td>Private health expenditure as % of total health expenditure††</td>
<td>42</td>
</tr>
<tr>
<td>% of the population living below the poverty threshold◊</td>
<td>31</td>
</tr>
</tbody>
</table>

### Literacy

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Literacy in adults (+ 15 years)◊</td>
<td>69 %</td>
</tr>
</tbody>
</table>

### Water, hygiene and sanitation

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% population with access to improved sources of water**</td>
<td>62 (total)</td>
</tr>
<tr>
<td>% population using improved sanitation facilities**</td>
<td>41 (total)</td>
</tr>
</tbody>
</table>

### Indices

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
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<td>Rank on the Gender Development Index of 188 countries 2015* (and Report on Human Development in Africa, 2016)</td>
<td>156</td>
</tr>
<tr>
<td>Rank on the IDH of 185 countries 2016* (and the 2016 World Report on Human Development)</td>
<td>157</td>
</tr>
</tbody>
</table>

Sources:

- ‡ RGPH (2013)
- † EPCV (2014)
- * Administrative data of EPI (2016)
- †† MICS (2015)
- Other data sources:
2.3. NATIONAL RESPONSE TO MAJOR CHALLENGES

The national response is tied to the implementation of national policies and strategies.

2.3.1. National development policies and processes

Mauritania’s 2001–2015 Poverty Reduction Strategy Paper (PRSP) was prepared in the context of the Enhanced Debt Initiative for heavily indebted poor countries. It was drafted in 2000 and is considered under the law on poverty reduction (n° 050/2001 of July 25, 2001) the reference for medium- and long-term economic and social development (through 2015). Its implementation has been achieved through three generations of action plans: the first covered the period 2001–2004, the second covered the period 2006–2010 and the third was implemented from 2011–2015.5

The PRSP was, from its conception, a tool for guiding the alignment of public policies with the Millennium Development Goals (MDGs), the deadline for which was reached in 2015.

As a result, the first-generation PRSP (for 2001–2005) initially selected four strategic axes: i) accelerating economic growth and stabilizing the macroeconomic framework; ii) anchoring growth in the economic sphere of the poor; iii) human resource development and expansion of basic services; and iv) improving governance and capacity building. A fifth axis was added to the 2006–2010 and 2011–2015 action plans, aimed at strengthening leadership, monitoring, evaluation and coordination.5

After the international adoption of the SDGs, the UN system in Mauritania carried out an awareness campaign with development actors in the country (spanning government authorities, partners, civil society and the private sector). This campaign has had the positive effect of including consideration of SDGs in the new national development strategy (SCAPP) for 2016–2030.3

2.3.2. National health policies, strategies and plans

Mauritania joined the International Partnership for Health (IHP+) initiative by signing the Global Compact on May 17, 2010 in Geneva.19 Mauritania’s national compact for IHP+ is based on its PNDS for the period 2012–2020. The PNDS, in turn, is aligned with the country’s MDGs, third-generation PRSP (for 2011–2015), National Health Policy (2006–2015) and UNDAF plan (2012–2016).20 It is the result of a long participatory process involving all stakeholders in the sector (government, private, civil society and FTPs).

The PNDS 2012–2020 is structured around five strategic axes aimed at: i) reducing maternal and neonatal mortality; ii) reducing infant and child mortality; iii) controlling major communicable diseases, including NTDs; iv) the fight against NCDs, including road accidents; and v) a cross-cutting axis aimed at strengthening the health system to support the four above-mentioned priorities and promote universal access to essential health services.4

These axes are broadly in line with WHO’s leadership priorities as set out in the 12th Global Programme of Work (GPW) and the Regional Transformation Agenda.

In January 2016, the country launched a mid-term review process of the PNDS 2012–2020. Drawing on the SCAPP, the health sector determined to make the SDGs, in particular SDG 3, the guiding reference for updates to the PNDS 2017–2020. WHO and other partners are working with national counterparts to adapt health-related SDG targets to the national context.
2.3.3. Health system structure

Administratively, Mauritania’s health sector is divided into three levels with central and decentralized services.

Actors at the central level include the MOH, namely the minister’s office, the general secretariat, the central directorates and their subdivisions, the coordinating bodies of programmes and related services, and support structures. The central level has a strategic role in defining policies, strategies and strategic plans.21

At the intermediate level, the regional health directorates and their regional teams are responsible for coordinating and monitoring health structures located in their areas.

At the level of the department (moughataa), district health management teams are responsible for operationalizing, implementing and monitoring national health policy.

In terms of its operations, the health care system is pyramidal, with three levels of service:

1. The primary level (moughataa) includes two types of health structures, one dependent on the other: health posts (numbering 621) and health centres (numbering 105) (DPCIS 2014).

2. The intermediate level is made up of two types of hospitals: i) moughataa hospitals, still limited in number; are targeted to the most populated or enclosed moughataas, and ii) regional hospitals, numbering 15, in all the wilayas excepting those of Nouakchott.18,21

3. The tertiary level is essentially concentrated in Nouakchott; it includes two types of reference hospitals: general hospitals, including the National Hospital Centre, the Cheikh Zayed Hospital (HCZ), the Hospital of Friendship (HA) and the Military Hospital; and specialized hospital centres, including the Hospital Centre for Specialties, the National Cardiology Centre (CNC), the National Oncology Centre (CNO), the Mother-Child Centre, the National Orthopaedics and Functional Rehabilitation Centre, and the and the specialities centre in the wilaya of Nouadhibou.18,21

In addition, five specialized centres provide referral and support services in certain domains; these include the National Centre for Blood Transfusion, the National Institute for Research in Public Health (INRSP), the Hepato-Virology Institute of the national laboratory for drug quality control (Laboratoire National de contrôle de la qualité des médicaments, or LNCQM) and the primary distributor of medicines and medical supplies (Centrale d’Achat des Médicaments et Consommables, or CAMEC). Five educational institutions—the National Schools of Public Health

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1 There are still only two moughataa hospitals, at Boutlimit and Chinguiti; it is planned to build five more, including one in Boghé.
of Nouakchott, Kiffa, Nema, Rosso and Sélibaby—provide training for paramedical staff. Finally, there are a number of military health and occupational health structures that are quite developed, especially those facilities supported by major mining companies.

Alongside the public system, the private health care system is developing rapidly, particularly in Nouakchott and other big cities. Although this trend is increasing health care availability, private health services remain unregulated; as such, rates are uncontrolled and highly variable and little information is available regarding the quantity and quality of these services.

2.3.4. Service delivery and quality of care

In 2015, Mauritania’s health care system consisted of approximately 904 public and private health facilities, including 634 health posts (led by nurses), 105 health centres (led by doctors) and 25 hospitals. The percentage of the population living within 5km of a health facility ranges from 51% in Tagant to more than 99% in Nouakchott; on average, it is 79%. Findings of the SARA 2013 and 2016 surveys indicate that the General Service Operational Capacity Index (the percentage of health facilities with the required elements for service delivery) has improved significantly, from 28% in 2013 to 55% in 2016. For 2016, there is a significant disparity in operational capacity between hospitals (73%), health centres (59%) and health posts (43%); this disparity is most marked in the areas of diagnostics and drugs.

Primary health care at health centres and health posts—even if delivered in an integrated fashion—is incomplete and inconsistent because of i) insufficient numbers of health care workers with the required skills; ii) irregular availability of essential drugs and consumables; iii) outdated...
equipment and buildings and ineffective maintenance systems; and iv) lack of standards and procedures, continuous training and supervision.

By contrast, hospital structures offer a relatively complete and continuous complement of activities—a result of recent efforts and reforms that have significantly increased hospital resources while granting them greater managerial autonomy. Increases in service availability, however, have not always been accompanied by improvements in service quality. Table 2 presents the coverage of certain services provided by the health system.

2.3.5. Human resources for health

In terms of human resources, the country has strengthened its production capacity through the creation of a medical school in 2010 and the extension and decentralization of the national training system for paramedical personnel (nurses and midwives) via the creation of four new schools of public health (in Kiffa, Nema, Sélibaby and Rosso). Enrollment has increased significantly across almost all categories of health personnel.

The major challenges in this area are, on the one hand, staff competency and preparedness—as training quality is hampered by insufficient supervisory staff—and on the other hand, inequitable distribution of staff between urban centres and rural areas. More than 75% of staff throughout the country are concentrated in the two largest cities (Nouakchott and Nouadhibou); 42% of the total workforce is based in Nouakchott alone.22

Some motivation and retention strategies for health personnel (including zone premiums for personnel in rural areas) have been implemented, but their impact is not conclusively known due to the limited scope of these measures.

Mauritania developed a Human Resources for Health (HRH) Development Plan for 2011–2015 that was not fully implemented due to lack of resources and follow-through. The process of updating this plan was initiated in 2017 with support from WHO and other FTPs.
2.3.6. Health products and medical technologies

Improving access to quality essential medical products is one of the goals included in the PNDS. To accomplish this, Mauritania developed a national drug policy and established a national list of essential medicines that is updated regularly. The Government has undertaken legislative efforts to regulate the pharmaceutical sector. The Department of Pharmacies and Laboratories (DPL) acts as a standardization and regulatory body, while the LNCQM was set up to ensure the quality of the products introduced in the country.23

Despite this framework, however, the availability of essential drugs in the country is in a critical state. The average availability of the 24 WHO standard tracer medicines was 28% in 201324 and decreased by two points in 2016 to 26%.11 Both in 2013 and in 2016, stockouts of key products such as antibiotics were fairly frequent in most health facilities. Supply security for drugs, consumables and medical devices is weak due to the limited capabilities of CAMEC, the main importer, and the vast expanse of Mauritania’s territory makes health products more expensive and exposes people to the risk of falsified, counterfeit, or low-quality medicines. Neither the inspection directorate, DPL nor LNCQM possess the full range of legal tools and technical capacity needed to ensure rigorous and effective control of medical commodities, which opens the door to these difficulties. However, it is notable that the phenomenon of “street drugs”, which is so common in other West African sub-regions, is virtually non-existent in Mauritania.

Finally, coordination among key players in the pharmaceutical subsector is a challenge that could be addressed through effective implementation of the recommendations from the 2011 external evaluation of Mauritania’s pharmaceutical sector.25

It should also be noted that Mauritania has a strategy neither for acquisition of biomedical equipment, nor for its maintenance. Strategies for these functions can bring greater efficiency to the country’s health investments.

Traditional medicine serves as a recourse for a large portion of the population and could be a complementary subsystem of the formal health care system (public or private). Despite the existence of a decree creating a National Programme of Traditional Medicine in 2012 and a dynamic association of traditional healers, traditional medicine suffers from the lack of a framework and corresponding legislation26 that would help foster a harmonious connection with the modern health system, as is recommended by WHO.

2.3.7. Health information management

The march towards UHC presupposes the monitoring of a standard list of health indicators, and thus a solid and reliable health information system. The Mauritanian national health information system (SNIS) is managed by a national programme that reports to the to the Directorate of Planning, Cooperation and Health Information. Despite recent reforms, weaknesses persist—such as the existence of multiple subsystems (i.e. from vertical programmes) that do not communicate with each other, low timeliness and completeness in data transmission, lack of disaggregated analysis and feedback, and omission of hospital and private-sector data from national data syntheses.27,28 In order to address these shortcomings, MOH has developed a large-scale campaign to enrol hospitals in the SNIS electronically and, with the assistance of WHO, has initiated the development of a promising data collection and analysis software: DHIS2.28

In addition, the country is gradually investing in operational research through the Medical School, INRSP, and several specialized centres established in recent years (including the cardiology, oncology, orthopaedics and hepato-virology centres).

The available evidence base with which to ground health decision-making is reinforced by the regular completion of large-scale surveys, including the RGPH, EPCV, SARA, MICS and veterinary investigations.

Beyond efforts to make information available, it is important to improve the capacity of the health workforce at the intermediate and peripheral levels to process, analyse and use the data they generate.
CHAPTER 2  HEALTH AND DEVELOPMENT CHALLENGES
2.3.8. Health finance

The health system in Mauritania is financed by public sources, private sources (cost recovery and benefit payments, employer funds, health mutuals, nongovernmental organizations (NGOs)) and external sources (bilateral and multilateral).

The share of the state budget allocated to health has increased from 3.9% in 2012 to 4.6% in 2015. This level is well below the objectives set by the PNDS 2012–2020 (8.5%) and by the Abuja Declaration (15%).

According to 2011 and 2013 national health statistics (CNS) measurements, more than 40% total health expenditure is borne by households, which is a sizable share and constitutes a barrier to health care access—despite government efforts in the area of health financing (which nearly doubled public expenditure on health from 12.814 million MRO in 2011 to 24.211 million MRO in 2013). The contribution of FTPs to health sector financing was 7% in 2012 and 12% in 2013.

2.4. DEVELOPMENT COOPERATION, PARTNERSHIPS AND CONTRIBUTIONS OF MAURITANIA TO GLOBAL HEALTH WORK

2.4.1. Development cooperation and partnerships

Mauritania has joined the IHP+ initiative and, as part of PNDS implementation, has signed a national Compact with other actors in the sector. The Compact aims to improve the economic and social effectiveness of aid and promote sustainable health development by strengthening the leadership of MOH in defining, managing, monitoring and evaluating national health policy.

Different development partners operate in a variety of areas in accordance with their mandates and national priorities. In view of resource limitations, synergistic action and comparative advantage are key principles for MOH coordination of partner interventions.

The Global Fund is the main partner in financing activities and purchasing inputs for the fight against malaria, TB and HIV/AIDS with a still-tentative effect on health system strengthening.

Bilateral and multilateral cooperation agencies (World Bank, Islamic Development Bank, European Union (EU), United States Agency for International Development (USAID), Japan International Cooperation Agency, Saudi Fund, Qatar, China) provide financial support for cross-cutting areas of health system strengthening, including supply chain management, health information systems and performance-based financing.
Nutritional surveillance and response to different food and nutrition crises have long been areas of focus for UNICEF, the World Food Programme (WFP), the UN Food and Agriculture Organization (FAO), and some NGOs. The UN Population Fund (UNFPA) is working in the area of reproductive health, Global Alliance for Vaccines and Immunization (GAVI) is supporting the strengthening of the country’s Expanded Immunization Programme (EPI), and the Joint UN Programme on HIV/AIDS (UNAIDS) is supporting coordination of the HIV/AIDS response.

In addition to the above-mentioned areas, WHO has a comparative advantage in providing technical support for the development of standards, strategies and policies, as well as in disease surveillance and emergency preparedness and response. Civil society organizations and NGOs are particularly active in the fight against HIV/AIDS, malaria, TB, NCDs, and in the promotion of human rights and good governance, family planning and environmental protection.

The coordination of external assistance is one of the main priorities of the country’s development strategies. To address this concern, the Government, in consultation with the partners, created a state-FTP committee to coordinate development assistance and monitor resource mobilization. This committee, chaired by the Minister of Finance, meets quarterly.

In parallel with this body, FTPs have set up an internal consultation framework comprising two levels, global and sectoral. The FTP/Health Group, of which WHO is the linchpin, meets regularly at the technical level. This mechanism facilitates exchange, coordination and harmonization among partners, while at the same time helping to strengthen and better structure the dialogue with the MOH.

Following the principles set out in the national compact, all partners in theory refer to the PNDS in their interventions and promote national leadership. However, ownership by the national party still needs to assert itself more. In addition, the low level of aid considerably affects the opportunities for support from which the country might have benefited.

The advent of the SDGs has led to a reorientation of global health partnerships, with the transformation of the IHP+ into an “international health partnership for UHC 2030”.32 This shift will help focus stakeholder attention on UHC and enhanced support for country coordination, advocacy and accountability efforts related to health systems strengthening.

2.4.2. Collaboration with the UN system at the country level

Mauritania’s UNDAF is the framework of reference for interventions by UN agencies in Mauritania. It covers the 2012–2016 period in four intervention areas, mutually defined by the Mauritanian government and the country team:20

- **Axis 1**: reduction of poverty and food insecurity;
- **Axis 2**: access to basic social services and maintenance of HIV seroprevalence at <1%;
- **Axis 3**: improvement of environmental governance and the rational use of natural resources;
- **Axis 4**: improvement of governance (economic, democratic, territorial and local, citizen control of public action) and capacity building of actors.

WHO plays a leading role in coordinating the health subcomponent of Axis 2. This involvement is evident throughout the planning and monitoring and evaluation process and in the coordination frameworks and mechanisms (e.g. UN country team (UNCT), security management team (SMT), humanitarian country team (HCT), group programme for monitoring and evaluation (GPSE), Operations Committee). WHO works in close coordination with all other agencies, particularly with UNICEF, UNFPA, UNAIDS, the World Bank, WFP, FAO, IOM and the Office of the UN High Commissioner for Human Rights (OHCHR) to drive the agenda of health in the country.

With a view to formulating the new 2018–2022 master plan, a road map has been drawn up with the aim of promoting a harmonious and transparent planning process, ensuring optimal connection between the SCAPP and the UNDAF and guaranteeing alignment of the fourth axis with national priorities.
2.4.3. Contributions of Mauritania to global health action

Mauritania is committed to respecting and promoting each of the international conventions it has ratified. The SCAPP 2016–2030 and its reference documents are based on the findings of a comprehensive evaluation of the PRSP. The SCAPP is also grounded in national consultations on the post-2015 agenda, the SDGs, recommendations from the Committee on Elimination of Discrimination Against Women (CEDAW), the 2015 Universal Periodic Review, and the Roadmap to Eradicate the Aftermath of Slavery. The Sendai Framework for Disaster Risk Reduction and the country’s international and regional commitments are also reference documents for the SCAPP.

Mauritania is developing efforts to build the capacity required by the International Health Regulations (IHRs). This includes collaboration with the International Civil Aviation Organization under the Collaborative Agreement for the Prevention and Management of Public Health Events in the Civil Aviation Sector, which contributes to global efforts to improve planning and response to public health events affecting the civil aviation sector.

To support the global response to the Ebola epidemic in 2014–2015 in Guinea, Sierra Leone and Liberia, Mauritania made a cash donation to the affected countries and at the same time invested in its own preparedness to curb the spread of the epidemic. In addition, Mauritania has established health cooperation agreements with a number of countries such as Chad (for the care of cancer patients) and Cuba (in the domain of health research). The country regularly participates in the meetings of WHO governing bodies, for instance, the World Health Assembly and the WHO Regional Committee for Africa.

2.5. SUMMARY OF KEY HEALTH SECTOR PROBLEMS AND CHALLENGES IN MAURITANIA

Awareness of the urgent need to intensify actions to achieve health-related MDGs and the SDGs in Mauritania is strong. The challenges are immense and complex and span several domains—namely leadership and governance, organizational and institutional aspects, strategic health information, finance, and human and material resources.

The primary problems and challenges of the health sector in Mauritania can be grouped into the following categories:

2.5.1. Key problems

- Persistently high mortality and morbidity rates, especially among the most vulnerable groups and mother-child pairs;
- High prevalence and incidence of communicable diseases (malaria, TB, hepatitis B and HIV/AIDS) with emergent epidemic-prone diseases;
- The growing scale of NCDs (diabetes, hypertension, cancers);
- An underperforming health care delivery system;
- An insufficient, undermotivated and poorly distributed health workforce;
- An inadequately financed health sector (4.6% of the state budget in 2013 versus 15% recommended by the Abuja Declaration) that requires strengthening in relation to the goal of UHC;
- Difficulties implementing the national drug policy;
- A fragmented and underperforming health information system;
- A lack of coordination and regulation within the health sector;
- Inadequate intersectoral collaboration to influence the social determinants of health (population, behaviour and environment).
2.5.2. Key challenges

Leadership and governance

- Define a strategic vision for the system as a whole and build consensus of all stakeholders, including the private sector, around the MOH;
- Establish efficient management in accordance with transparency requirements and the need to produce and report results;
- Raise awareness of the importance of organizational structure to establish it as a priority issue.

Service delivery

- Improve maternal-child health indicators;
- Achieve control of HIV/AIDS, TB, hepatitis B, and NTDs and eliminate malaria;
- Bring the country to an acceptable level of preparedness for response to public health emergencies and contribute to global health security;
- Ensure better monitoring of risk factors for NCDs and develop strategies for the prevention and appropriate management of these diseases;
- Strengthen the peripheral level of the health system to provide quality, integrated and person-centred care.

Health information

- Establish an integrated and inclusive framework for evaluating the performance of the national health information system and establish a continuous process of coordinated monitoring, evaluation and revision;
- Create a motivational work environment and promote a culture of evidence-based decision-making.

Health finance

- Increase public funding for health by respecting the commitments of heads of state at the Abuja Summit and mobilizing more external aid;
- Adopt an appropriate funding strategy geared towards UHC to better meet the requirements of equity and efficiency.

Human and material resources

- Increase the quantity and quality of the health workforce, ensure a more balanced geographic distribution of human resources for health and establish greater equity in the management of careers, assignments and motivation while ensuring optimal conditions of safety in the workplace;
- Improve the efficiency of mechanisms for supply, distribution and use of pharmaceutical products while developing local production of traditional medicine products;
- Establish a strategy for acquisition and maintenance of biomedical and mobile equipment.
Review of WHO cooperation during the last cycle (CCS2)
WHO is seen as the coordinator of technical and financial partners, and as the head of the health cluster. Its technical support for the process of developing policies and strategies, including the mobilization of resources for health, is appreciated.

The previous WHO cooperation strategy with Mauritania (CCS2) proposed the following seven strategic axes: i) prevention and control of NCDs; ii) prevention and control of communicable and epidemic-prone diseases; iii) reduction of maternal and infant-child mortality; iv) strengthening health system performance, including human resource development and implementation of pharmaceutical policy; v) management of environmental risks, as well as the health consequences of emergencies and disasters; vi) health promotion; and vii) building partnerships for health. These axes guided the development and implementation of the various programme budgets for the period 2009–2015.

3.1. CCS2 KEY ACHIEVEMENTS AND IMPLEMENTATION OUTPUTS

3.1.1. Axis 1: Prevention and control of NCDs

- 2009 Global Youth Tobacco Survey (GYTS)
- NTDs declined as a priority in the PNDS II
- National plan to fight tobacco developed
- National oral health plan developed
- National mental health policy developed
- Strengthening of oncology and cardiology technical platforms
- Sectoral Policy: National Strategy for Youth and Sport, National Strategy for the Development of Fruit and Vegetable Crops supported
- NCDs are taken into account in the various national policy documents such as the 2016–2030 SCAPP, the 2005–2015 National Health Policy, and the 2012–2020 PNDS II, which devotes its Axis 4 to the fight against NCDs and their risk factors.
- NCD service established within the MOH Directorate for Disease Control
- Cancer registry established
- 2016-2020 NTD Strategic Plan undergoing validation
- Ratification of the WHO Framework Convention on Tobacco Control by Mauritania
- Drafting of a 2012 Tobacco Control Bill in line with the provisions of the WHO Framework Convention on Tobacco Control, establishment of a National Tobacco Control Programme (NTP), adoption and validation of a national tobacco control policy and a multisectoral national strategic plan for tobacco control
Establishment of a multisectoral and multidisciplinary committee for the fight against tobacco

Introduction of tobacco substitutes in the list of essential medicines

Epidemiological surveys for the surveillance of risk factors have been carried out but are not regularly scheduled: STEPWISE survey, GYTS, General Agreement on Trade in Services (GATS), SMART.42,45

3.1.2. Axis 2: Prevention and control of epidemic-prone communicable diseases

Revision of the list of priority diseases with updating and adoption of the Integrated Disease Surveillance and Response (SMIR) guide46

Assessment of minimum capacities required under the IHR and adaptation of SMIR to the Mauritanian context through integration of maternal and neonatal deaths34,46

Rapid detection system for epidemics of cholera and meningitis for effective management

Mass vaccination with MenAfriVac vaccine, which allows better control of cerebrospinal meningitis

Country certified free from the transmission of dracunculiasis

Mapping of NTDs

Strategy and master plan for the control of NTDs

Regular updating of normative documents and technical tools for HIV/AIDS, tuberculosis and malaria with support for increased resource mobilization through the Global Fund ($32 million in 2015) with consequent support to the CCM and at the Secretariat against AIDS (principal beneficiary)

HIV portion of MDG 6 component achieved through perceptible control of TB47

Development of the national hepatitis strategy 2015-201748

Support to the country for the preparation and response to certain epidemics (Crimean Congo fever, Rift Valley fever, dengue fever, Ebola virus disease)

3.1.3. Axis 3: Reduction of maternal and infant child mortality

Support for the establishment of an MDG unit

Support for Acceleration Plan for MDGs 4 and 5, focused on MNCH services

Strategy to reduce maternal and neonatal mortality

Strategic plan for child survival

National guide, maternal and neonatal death audit training modules, guides and standards for safe abortion

Road map for accountability in reproductive health

Institutionalization of emergency obstetric and newborn care, audits of maternal, neonatal deaths and near misses

Development of the Action Plan for the Fight Against Cancer, including cervical cancer

Vaccine against pneumococcal infections introduced into routine EPI

Country participation in the polio eradication campaign (no case reported since 2010)

Support for reinforced EPI management

EPI routine support in collaboration with UNICEF

3.1.4. Axis 4: Strengthening health system performance, including human resource development and implementation of the pharmaceutical policy

Support for programming, planning, supervision, monitoring and evaluation of PNDS 2012–2020

Development of 2012–2015 compact, signed in 2012

Development of the Strategic Plan for Human Resources in Health

Human Resources Observatory

DHIS2 national health information system reinforcement plan
3.1.5. Axis 5: Management of environmental risks and the health consequences of emergencies and disasters

- Support to Malian refugees in M’Bera Camp
- Flood response support: surveillance of epidemic-prone diseases in flooded communes, development of an interagency contingency plan
- National action plan to adapt health to climate change (Libreville Declaration)

3.1.6. Axis 6: Health promotion

- National strategy paper for health promotion available
- Establishment of media/NGO/Parliamentary networks for health promotion
- Celebration days to raise awareness on various health topics and publication of newsletters (Bayane).

3.1.7. Axis 7: Creation of partnerships for health

- Existence of several health platforms and groups, involvement of media/civil society/Parliamentary networks

- In-depth diagnosis of the pharmaceutical subsector
- Quality control laboratory standards
- Support for pharmaceutical regulation (essential medicines list, registration, best practices for pharmaceuticals, inspector general for health)
- Support to national public health research institute (INRSP)
- Support for the development of the eHealth Strategy
- Completion of National Health Accounts 2011–2015, catastrophic spending and national health financing strategy under development
- Technical support to different country submissions (GAVI, World Bank, Global Fund)
- Support for two surveys on the availability and operational capacity of health services (SARA).
3.2. PARTNER PERCEPTIONS OF CCS2 IMPLEMENTATION

To complement the results of the CCS2 review, the country office conducted a qualitative survey of government officials, FTPs, NGOs and country office technical staff.

The partner survey found that WHO’s priorities are aligned with those of the MOH and reflect the needs of the country. WHO is generally viewed as the lead FTP in the health domain, given its role as the leader of the health cluster. Its technical assistance for policy and strategy development and health resource mobilization is valued. Partner input revealed the following strengths, weaknesses, opportunities and threats with respect to WHO’s support.37

3.2.1. Strengths

- An effective presence, a strong knowledge of health realities of Mauritania and a strategy that is well-adapted to country needs and priorities;
- Improved identification and understanding of environmental, socio-economic and cultural factors, leading to increased attention to NCDs;
- Continuous institutional, technical and, to a lesser extent, financial support has produced positive results in key areas (e.g. definition of strategic directions, capacity building in planning, programs and operations).

3.2.2. Weaknesses

- Lack of attention to and/or marginal support for certain domains, including maternal and child mortality and NCDs;
- Insufficient (in number) and irregular surveys and studies;
- Large disparity between tertiary and basic health services;
- Monitoring and evaluation gaps and information system inadequacies.

3.2.3. Opportunities

- Development of a comprehensive framework, based on the SCAPP 2016–2030, to succeed the PRSP 2011–2015;
- Existence of a National Health Policy on the horizon for 2030 and National Health Development Plan 2017–2020;
- Consolidation of central operational structures and specific programs,
- The IHP+ Results initiative, establishment of the HHA mechanism, implementation of the national compact and signing of the IHRs.

3.2.4. Threats

- The mismatch between WHO approaches and methods and national health management and administration practices;
- Insufficient coordination between government structures involved in public health (especially livestock and health);
- The obvious shortage of quality national human resources;
- The reduced staffing levels of the office and country, given the volume of activities.
Strategic programme for WHO cooperation 2018–2022
The strategic priorities for technical cooperation in a country must be based on an in-depth analysis of the country’s health and development situation, taking into account the national strategy, national health policies or plans, and the six WHO leadership priorities. The strategic priorities identified in the WHO Mauritania CCS for 2018-2022 will serve as the basis for the development of WHO’s programme budgets and biennial work plans.

4.1. METHODOLOGY

Based on the situation analysis, the CCS2 scope and a rubric of selection criteria, MOH officials and WHO staff identified four strategic axes which will form the foundation of cooperation between the WHO country office and Mauritania for 2018–2022. For each strategic priority, action areas were identified, taking into account the results chain from the WHO 12th GPW and the comparative advantages of WHO.

The resulting CCS3 agenda is harmonized with the health development priorities set out in the PNDS 2017–2020.

4.2. CCS3 STRATEGIC PRIORITIES AND ACTION AREAS (2018–2022)

The third-generation CCS with Mauritania has been developed in line with the Government’s vision for achieving the SDGs set out in SCAPP. The strategic priorities identified in this CCS should enable WHO to make an optimal contribution to the achievement of health development priorities. The priority definition process took into consideration ongoing reforms within the organization, particularly the regional transformation agenda and upstream, an alignment with sectoral strategies of choice. These priorities will
constitute the framework of reference for WHO’s work with Mauritania and other partners.

The strategic priorities and action areas that will guide WHO’s cooperation with the country for the next five years are as follows.

Strategic Priority 1: Health system strengthening with a view to UHC. Ensure access to quality health services for all and protect all individuals from public health risks and disease-related impoverishment (either due to direct payments or loss of income when a member of the household falls ill). Apply lessons learned to improve the management of challenges and adapt the resulting approaches to increase coverage and support progress towards UHC.

Strategic Priority 2: Health security and emergency preparedness and response. Strengthen the country’s capacity for prevention, early detection and reporting of public health emergencies and put in place an appropriate response framework for health system resiliency in line with the requirements of the IHR 2005 and the Global Security Agenda.

Strategic Priority 3: Reduction of maternal and infant-juvenile mortality. Promote access to high-impact interventions and disseminate results of studies and research in the area of MNCH.

Strategic Priority 4. Disease control. Reduce the burden of communicable diseases (HIV/AIDS, TB, malaria, hepatitis B, NTDs and vaccine-preventable diseases), identify essential pathways and strategies for combatting NCDs and take into account the impact of climate change.

4.2.1. Strategic Priority 1: Health system strengthening toward UHC

■ Developing UHC-focused human resources aimed at meeting primary health care needs
   ◆ Provide technical support for development and equitable distribution of HRH in the health system.
   ◆ Regularly update the HRH country profile and support operations of the HRH Observatory.
   ◆ Develop HRH tools, norms and standards for Mauritania.
   ◆ Strengthen the capacities of community-level actors and harness their potential to revitalize primary health care implementation.
   ◆ Provide technical and financial support for the MOH primary health care revitalization plan.

■ Framing of health financing to facilitate progress toward UHC
   ◆ Develop a health financing strategy and monitor its implementation to support progress towards UHC.
   ◆ Undertake advocacy efforts to mobilize all stakeholders toward adequate health funding.
   ◆ Provide support for governance and monitoring of health sector financing.

■ Strengthening of the national health information system and eHealth development
   ◆ Support the implementation of the PNDS M&E plan.
   ◆ Strengthen the NHIS by supporting the implementation of paper and eHealth tools including DHIS2, telemedicine and eHealth.
   ◆ Support implementation of surveys, e.g. the demographic and health surveillance survey (DHS), SARA, National Health Accounts and Catastrophic Health Expenses.

■ Updating and implementation of the national drug policy to improve access to essential medicines and other quality health technologies
   ◆ Support the updating and implementation of the National Drug Policy and related documents.
   ◆ Support the updating of the national essential medicines list.
   ◆ Continue support for strengthening supply chain mechanisms to ensure availability of quality medicines and medical products.
Support strengthening of drug inspection and quality assurance systems.
Support the strengthening of legal and regulatory frameworks.
Promote rational use of medicines, including traditional medicine.

Factoring into planning social and economic determinants of health
Build capacity and promote cross-sectoral collaboration to address the socio-economic determinants of health through programme implementation.
Facilitate the monitoring of progress and improvements in accountability through the collection, analysis and dissemination of disaggregated socioeconomic health data.
Equip actors from health and allied sectors (especially those working in the environment) to know and apply the principles recommended by the IHRs (2005).

4.2.2. Strategic Priority 2: Health security and preparedness and emergency response

Improving country preparedness and response capacities by strengthening IHR-recommended competences and risk and disaster management capabilities according to the 2015–2030 Sandai Framework
Support Mauritania to build the minimum capacities required by the IHR (2005).

Support Mauritania to develop and update annual action plans to contain health events, in accordance with the IHR (2005).
Strengthen capacity for Vulnerability Risk Analysis and Mapping (VRAM) and Disaster Risk Management (DRM).
Support preparation for epidemic outbreaks and acute public health emergencies, as well as effective management of the health aspects of humanitarian crises, to contribute to national health security.
Support the development and implementation of a national plan for the detection and reporting of antibiotic-resistant strains.
Support the establishment of a surveillance system for infections caused by antimicrobial-resistant pathogens.

Managing and coordination of response and intervention to humanitarian crises, epidemics, and any other public health events
Support strengthening of epidemiological surveillance, including surveillance of zoonoses, according to the "One Health" approach.
Support the establishment and operation of a public health emergency operations centre.
Support the development and implementation of a public health emergency preparedness and response plan.

Support the publication of norms and standards on the management of epidemic- and pandemic-prone diseases and promote cross-sectoral collaboration for the prevent and control outbreaks according to the "One Health" approach.

Improving food safety and the management of hazardous and infectious products
Support the country in developing a national strategy for the management of hazardous and infectious products
Support the establishment of a surveillance mechanism for food safety-related events.

Reducing environmental health risks
Continue advocacy for the implementation of the Libreville Declaration on climate change.
Strengthen the capacity of environmental stakeholders to assess environmental health risk factors by referring to the evidence base, international recommendations and legislation currently in force in Mauritania.
4.2.3. Strategic Priority 3: Reduction of maternal and infant-child mortality

- Improving benefits and access to quality maternal and child health services, including emergency obstetric and neonatal care and family planning
  - Support implementation of the Reproductive Health Strategic Plan through the H6 Partnership.
  - Provide technical support for scaling up effective pregnancy monitoring, essential neonatal care and postpartum care within 24 hours of birth.
  - Support country actions to address unmet reproductive health and adolescent reproductive health needs.
  - Support Mauritania to build a strong national partnership for reproductive health and maternal, newborn, child and adolescent health.

- Developing and implementing an integrated child survival plan by supporting implementation of a national nutrition development policy and the scale-up of integrated management of childhood illness (IMCI)
  - Strengthen capacity for scaling up quality care that improves child health and development, including integrated management of pneumonia, diarrhoea and malaria.
  - Continue support to the country to achieve the six global nutrition targets identified by the World Health Assembly and to be implemented by 2025 (resolution WHA65.6).
  - Strengthen intersectoral dialogue and multisectoral coordination to strengthen the nutritional surveillance system.
  - Provide technical support for policy development, strategic planning and establishment of standards for delivery of nutrition services to infants and young children.

4.2.4. Strategic Priority 4: Disease control

- Developing and supporting programmes for the control, elimination and eradication of malaria, tuberculosis, HIV/AIDS, hepatitis and NTDs
  - HIV: support implementation of the Global Health Sector Strategy on HIV 2016-2019 to end the epidemic as a threat to public health by 2030.
  - Hepatitis: help develop an integrated approach to prevent and fight viral hepatitis.
  - TB: support the implementation of the Stop TB Strategy with a view to its elimination in 2030 through the scaling up of tuberculosis care and control, particularly of TB/HIV coinfection, multidrug-resistant TB and extensively drug-resistant TB, screening of high-risk populations and integrated management of tuberculosis at the community level.

- Malaria: support the implementation of the global technical strategy for malaria elimination 2016-2030.

- Capacity building support for the prevention, diagnosis and treatment of HIV / AIDS, hepatitis, TB and malaria.

- Provide norms and standards for strengthening service delivery systems and integrated management of HIV/AIDS, hepatitis, TB and malaria.

- Support operational research on the management of HIV/AIDS, viral hepatitis, TB and malaria to promote new approaches to managing these four diseases.

- Provide technical support for the implementation of preventive chemotherapy and the management of target NTDs.

- Strengthen national capacity for monitoring, evaluation and reporting.

- Strengthen communication strategies.

- Strengthening the fight against vaccine-preventable diseases with a focus on poliomyelitis eradication, the elimination of neonatal and maternal tetanus and the introduction of new vaccines such as HPV

- Provide technical assistance to Mauritania in the development and implementation of immunization strengthening plans in all health zones with low immunization coverage.

- Support implementation of the "Reach Every District" strategy.
Support implementation of the Global Plan for the Decade of Vaccines.
Support capacity building of immunization actors in new vaccine introduction and new immunization technologies.
Provide technical assistance to accelerate control and elimination of vaccine-preventable diseases: measles, neonatal tetanus, yellow fever, hepatitis B.
Support planning, implementation and evaluation of polio mass immunization activities.
Provide technical and financial support to strengthen the surveillance of cases of acute flaccid paralysis, implementation of the vaccine response plan to any importation of wild poliovirus cases and emergence of circulating vaccine-derived polio virus.
Provide technical and financial support for development of a plan, guidelines and training on phase-out of oral polio vaccine and introduction of inactivated poliomyelitis vaccine (IPV).

Strengthening the prevention and care system for NCDs, including mental health, violence and trauma
Provide technical support to develop a multi-sectoral national plan of action in line with the WHO Global Plan of Action for Noncommunicable Disease Control 2013–2020.
Support establishment of a project to fight cancer and cardiovascular diseases.
Strengthen capacity to develop and implement national policies and plans in line with the Global Plan of Action for Mental Health 2013–2020.
Contribute to youth advocacy and sensitization to combat drug use.
Support the interdepartmental programme for integrated control of substance abuse and substance abuse-related mental illness and infectious disease.
Support anti-smoking initiatives.

Table 4, beginning on the next page, highlights the alignment of the CCS3 with the different frameworks guiding WHO’s action in Mauritania: the 2017–2020 phase of the PNDS, the 12th GPW and SDG 3. The CCS fits well with these ongoing initiatives, and special effort will be made to maintain the internal consistency of the strategy through regular review of instruments for measuring, monitoring and evaluating the organization’s progress.

Figure 5 illustrates how the timing of the CCS3 aligns with the timing of other major frameworks that influence or guide WHO planning in Mauritania.
### 4.3. RELEVANCE OF THE CCS3 STRATEGIC AGENDA

Table 4. Links between CCS3 priorities, PNDS II strategic orientations, 12th GPW targets and SDG targets.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>4.3.1.1. Support the development of UHC-focused human resources aimed at meeting primary health care needs</td>
<td>Human resource development</td>
<td>Necessary human resources</td>
<td>SDG 3: Health access (3.c)</td>
</tr>
<tr>
<td>4.3.1.2. Support framing of health financing to facilitate progress towards UHC</td>
<td>Financing of UHC demand</td>
<td>Policies and financing</td>
<td>SDG 3: Health access (3.8)</td>
</tr>
<tr>
<td>4.3.1.3. Contribute to strengthening the national health information system and eHealth development</td>
<td>M&amp;E and operations research</td>
<td>Health information system and evidence base</td>
<td>Objective 16. Justice and peace (16.10)</td>
</tr>
<tr>
<td>4.3.1.4. Support the updating and implementation of the national drug policy to improve access to essential medicines and other quality health technologies</td>
<td>Access to quality essential drugs and medical products</td>
<td>Access to safe, effective and quality medicines and health technologies</td>
<td>SDG 3: Health access (3.b)</td>
</tr>
<tr>
<td>4.3.1.5. Promote intersectoral collaboration to influence the social, economic and environmental determinants of health</td>
<td>Inter- and intra-sectoral coordination and partnerships</td>
<td>Health promotion in all policies</td>
<td>SDG 3.10</td>
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<tr>
<td></td>
<td></td>
<td>Reduction of health inequities</td>
<td>SDG 3.10</td>
</tr>
<tr>
<td>4.3.2.1. Improving country preparedness and response capacities by strengthening IHR-recommended competences and risk and disaster management capabilities according to the 2015–2030 Sandai Framework</td>
<td>Preparedness and response to health events</td>
<td>All countries have complete, up-to-date national health policies, strategies and plans</td>
<td>SDG 3: Health access (3.d)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Epidemic and pandemic response preparedness</td>
<td>SDG 3: Health access (3.d)</td>
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<tr>
<td></td>
<td></td>
<td>Influenza pandemic preparedness, global action plan on antimicrobial resistance</td>
<td>SDG 3: Health access (3.d)</td>
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<tr>
<td>4.3.2.2. Provide country support in the coordination of interventions for epidemic outbreak, humanitarian crises and natural disasters</td>
<td>Epidemic preparedness and response</td>
<td>Response to health crisis situations</td>
<td>SDG 3: Health access (3.d)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Response to natural disasters</td>
<td>SDG 3: Health access (3.d)</td>
</tr>
<tr>
<td>4.3.2.3. Support the development of a national strategy for the management of hazardous and infectious products and the implementation of food safety surveillance</td>
<td>Health event preparedness and response</td>
<td>Development of food safety policies, strategies and plans</td>
<td>SDG 6.1</td>
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<tr>
<td></td>
<td>Food control</td>
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<tr>
<td>4.3.2.4. Support the reduction of environmental health risks</td>
<td>Biomedical waste management and hygiene promotion</td>
<td>Environmental health risks, including water and sanitation</td>
<td>SDG 6</td>
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<tr>
<td></td>
<td>Promotion of good hygiene practices at the community level</td>
<td>Environmental risks related to climate change</td>
<td>SDG 13</td>
</tr>
<tr>
<td>4.3.3.1. Support improved delivery and access to high-quality maternal, newborn and infant health services, including emergency obstetric and neonatal care and family planning</td>
<td>Safe motherhood</td>
<td>Maternal, prenatal and post-partum health</td>
<td>SDG 3: Health access (3.1)</td>
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<tr>
<td></td>
<td>Newborn care</td>
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<td></td>
<td>Family planning and birth spacing</td>
<td>Sexual and reproductive health</td>
<td>SDG 3: Health access (3.7)</td>
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<tr>
<td>4.3.3.2. Support implementation of a National Nutrition Development Policy and the scale up of IMCI to strengthen integrated child survival efforts</td>
<td>Child nutrition</td>
<td>National nutrition guidelines, norms and standards</td>
<td>SDG 2.1</td>
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<tr>
<td></td>
<td>IMCI</td>
<td>Increased access to interventions for improving health of women, newborns, children and adolescents</td>
<td>SDG 3: Health access (3.1)</td>
</tr>
<tr>
<td>4.3.4.1. Support prevention, promotion and care programmes to accelerate efforts to eliminate malaria, tuberculosis, HIV/AIDS, hepatitis and NTDs by 2030</td>
<td>HIV/AIDS and hepatitis control</td>
<td>Prevention and control of HIV, viral hepatitis</td>
<td>SDG 3: Health access (3.3)</td>
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<td>TB control</td>
<td>TB prevention and control</td>
<td>SDG 3: Health access (3.3)</td>
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<tr>
<td></td>
<td>Malaria control</td>
<td>Elimination of malaria</td>
<td>SDG 3: Health access (3.3)</td>
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<td></td>
<td>Control of NTDs</td>
<td>Control of NTDs, Special Programme for Research and Training in Tropical Diseases (TDR)</td>
<td>SDG 3: Health access (3.3)</td>
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<tr>
<td>4.3.4.2. Strengthen the fight against vaccine-preventable diseases with the aim of eradicating polio, eliminating neonatal and maternal tetanus and introducing new vaccines such as HPV</td>
<td>Systematic strengthening of EPI through innovative approaches and active follow-up of immunization dropouts</td>
<td>Global Vaccine Action Plan, elimination of measles and rubella, new vaccines</td>
<td>SDG 3: Health access (3.2, 3.3)</td>
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<tr>
<td></td>
<td>Strengthening supplementary immunization and injection safety</td>
<td>Long-term management of poliomyelitis risk and surveillance</td>
<td>SDG 3: Health access (3.2, 3.3)</td>
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<tr>
<td>4.3.4.3. Support strengthening of prevention and management of NCDs including mental health, violence and trauma</td>
<td>Control of diseases with common risk factors (cardiovascular, respiratory, diabetes, cancers)</td>
<td>Prevention of risk factors, NCD management, multisectoral policies and plans</td>
<td>SDG 3: Health access (3.2)</td>
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<td>Mental and neurological health</td>
<td>Mental Health Action Plan, continuity of mental health services</td>
<td>SDG 3: Health access (3.4)</td>
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<td>Control of road accidents</td>
<td>Reducing risk factors for violence and trauma, with a focus on road safety</td>
<td>SDG 3: Health access (3.6)</td>
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Notes:
PNDS II Axes: 1: Improvement of the leadership and governance of the sector, 2: Acceleration of the reduction of maternal, neonatal and infant mortality morbidity and mortality, 3: Disease prevention and control and Public Health emergency management, 4: Health system strengthening with a view to UHC.


SDG3 Targets: Allow everyone to live in good health and promote the well-being of all people of all ages. 1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births, 2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births, 3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases, 4: By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being, 5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol, 6: By 2020, halve the number of deaths and injuries from road traffic accidents, 7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes, 8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all, 9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.
Implementation of the CCS3: Implications for the Secretariat
5.1. ROLE OF WHO REPRESENTATION IN THE IMPLEMENTATION OF THE STRATEGIC PROGRAMME

WHO’s third-generation CCS with Mauritania will be implemented through three biennial cycles. The four strategic priorities and their priority action areas will be the basis for allocating programme budget resources to ensure that country priorities are sufficiently addressed at all levels of the organization.

As the representative of the WHO in Mauritania, the country office will assume the role of political and technical adviser to the Government on health issues. It will lead political dialogue with all other development stakeholders to make the “Health in All Policies” directive a reality and will exercise the mandate of the organization with the support of the other WHO levels—multi-country teams, regional office and headquarters.

The WHO country office has a slight human resource shortfall, especially in the areas of administration and support to the pharmaceutical sector. WHO will address this shortfall by leveraging WHO’s global network of experts while strengthening staffing of the country office staff to make it more operational.

With Global Fund financing, the WHO country office is currently recruiting a national programme officer for the malaria, TB, HIV/AIDS and hepatitis programme for a period of 30 months. The effectiveness of the office will also be strengthened by refocusing clusters and making other appropriate adjustments to its structure.

In addition, the SWOT (Strengths | Weaknesses | Opportunities | Threats) analysis will be reviewed on a regular basis to translate weaknesses into strengths and, similarly, how to use opportunities to minimize threats.

Country office capacities will be strategically strengthened to produce better programme coordination and integration through a versatile, supportive and responsive team that can effectively collaborate and implement joint activities across different domains.

The concept of decent work in a secure space, with GSM-compliant computer equipment, regular implementation of risk assessments and internal controls including MOSS survey software will also be taken into consideration.

5.2. USE AND APPLICATION OF THE CCS

The CCS will be further integrated with the planning process so that country priorities and needs are better accounted for. It will be a tool for improving the quality of both the results framework and management practices.

The CCS, once signed by the Regional Director, will be widely disseminated within and outside of the country in order to inform other stakeholders about the focus of WHO’s interventions and support in Mauritania. The CCS will serve as a tool for promoting improved allocation of technical and financial assistance to the MOH.

The strategy will guide WHO’s contributions to UNDAF and its participation in multiple partnership platforms (e.g. IHP+, HHA, GF, GAVI, H6). It will also be used for advocacy and to mobilize additional resources for the achievement of WHO objectives at the local level.

Finally, the CCS will be used as a tool for developing health partnerships and facilitating collaboration with other development sectors and civil society. It will promote improved health governance through approaches such as "Health in All Policies” with a view to UHC.
Monitoring and evaluation of the CCS
The Mauritania CCS for 2018–2022 will ensure the strategy’s internal consistency through regular review and updating of tools for measurement, monitoring and evaluation of progress.
The evaluation of the poverty reduction strategy framework carried out in 2015 has shown that significant progress has been made in Mauritania over the last ten years and the WHO CCS2 has certainly contributed to this progress. Nevertheless, some health indicators have not met the MDG targets. Major challenges remain, as the analysis of the situation above shows, and the poor performance of the health system is a major handicap.

The CCS aims to support the country to substantially reduce these shortcomings during the second phase of the PNDS (2017–2020). To this end, the WHO Mauritania office will work to strengthen its staffing and structure, while making use of technical support at the regional and headquarters levels.

There are several opportunities for Mauritania today that can be seized on to strengthen health development and other sectors based on the values of equity and social justice. These include a peaceful social and political climate, a clear desire for good governance, a national development strategy focused on growth and shared prosperity that has strong partner backing and development of South-to-South cooperation within subregional and regional organizations.

This CCS will help WHO Mauritania promote strong partnerships, a framework for good governance and measurable milestones in the march to universal health coverage.
Annexes


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Annex 2. Key Performance Indicators (KPIs) of the WHO Mauritania office

A2.1. Specific Indicators

<table>
<thead>
<tr>
<th>Priority</th>
<th>Outputs</th>
<th>Person(s) responsible</th>
</tr>
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<tbody>
<tr>
<td>1. National action plans based on joint external evaluation</td>
<td>5.1.1 (old) or 12.2.1 (new)</td>
<td>NIANG, Saidou Doro BELIZAIRE, Marie Roseline Darnycka</td>
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<td>2. Malaria</td>
<td>1.3.2</td>
<td>ABDEL AZIZ, Mohamed Boubacar</td>
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<td>3. TB</td>
<td>1.2.1</td>
<td>ABDEL AZIZ, Mohamed Boubacar</td>
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<td>4. WHO guidelines implementation status</td>
<td>4.1.1</td>
<td>Kelly Aminata Sakho ZOMBRE, Daogo Sosthene</td>
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<tr>
<td>5. Health and environment</td>
<td>3.5.1</td>
<td>Baba Yarguate Lemlih</td>
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<td>6. National health accounts</td>
<td>4.1.2</td>
<td>Kelly Aminata Sakho ZOMBRE, Daogo Sosthene</td>
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<td>7. Health information (SARA)</td>
<td>4.4.1</td>
<td>ZOMBRE, Daogo Sosthene OULD BEBANA, Mohamed</td>
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### A2.2. Common Indicators (all countries)

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<tr>
<th>Priority</th>
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<th>Person(s) responsible</th>
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<tr>
<td>1. HIV treatment (90/90/90 rule)</td>
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<td>ABDEL AZIZ, Mohamed Boubacar</td>
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<tr>
<td>2. NCD prevention and control plan</td>
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<td>NIAWG, Saïdou Doro</td>
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<td>3. Reproductive, Maternal, Newborn, Children and Adolescent Health plan development</td>
<td>3.1</td>
<td>MOHAMMED CHEIKH, Mohamed OULDZEIDOUNE, Naceredine</td>
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<td>4. DTP3-containing vaccines coverage</td>
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<td>OULDZEIDOUNE, Naceredine</td>
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<td>5. Health workforce coverage</td>
<td>4.1</td>
<td>ZOMBRE, Daogo Sosthene</td>
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<tr>
<td>6. Integrated Disease Surveillance and Response</td>
<td>12.3</td>
<td>NIAWG, Saïdou Doro BELIZAIRE, Marie Roseline Darnycka</td>
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<td>7. International Health Regulations</td>
<td>12.2</td>
<td>NIAWG, Saïdou Doro BELIZAIRE, Marie Roseline Darnycka</td>
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<td>8. ARCC polio certification</td>
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<td>9. % of resource mobilization out of allocated budget</td>
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<td>WR / Programmes</td>
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<td>10. Utilization target achievement</td>
<td>6.4.1</td>
<td>WR / FALL, Oumou</td>
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<td>11. Communication strategy and output development</td>
<td>6.5</td>
<td>WR / HPR / BEBANA, Mohamed</td>
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<td>12. Staff satisfaction survey</td>
<td>6.4.2</td>
<td>WR / FALL, Oumou</td>
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<tr>
<td>13. Managerial KPI (overall score)</td>
<td>6.4.2</td>
<td>WR / FALL, Oumou Kalsome Faye ZOMBRE, Daogo Sosthene</td>
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</tbody>
</table>
Bibliography

19. Ministry of Health of Mauritania. Pacte National entre le Gouvernement de la République Islamique de Mauritanie et ses Partenaires pour le Soutien au Secteur de santé: le COMPACT
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