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AN EVALUATION OF THE
POPULATION AND FAMILY PLANNING
SUPPORT PROJECT IN MOROCCO

A Report Prepared By:

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EXECUTIVE SUMMARY

Objective of the Evaluation

A team of three professionals in health care and family planning (FP) programs conducted a review of major support from the Agency for International Development (USAID) to population and family planning (POP/FP) in Morocco. The main objective of the mission was to evaluate the performance of the current assistance program and to assist the USAID and the Government of Morocco (GOM) in updating their assessment of the future needs of Morocco's population program.

Methodology

The team met in Rabat, Morocco, on November 30, 1981, and remained in the country for three weeks. The first week was devoted to discussion in Rabat with the personnel at the USAID mission, representatives of the United Nations Fund for Population Activity (UNFPA) and the United Nations Children's Fund (UNICEF), members of the National Committee of the Moroccan Family Planning Association (AMPF), and authoritative personnel of the Ministry of Public Health (MOPH) of Morocco. During the second week and for part of the third week, the team traveled extensively in the country, visiting six additional provinces and prefectures.* During these visits, the members of the team separated, forming three small groups to increase the number of contacts they could make with rural and urban facilities. The team visited 7 health centers, 14 dispensaries, and 4 family planning referral centers. During the field visits, discussions and fact-finding were focused on:

- the extension of the project known as "Visite à Domicile de Motivation Systematique" (VDMS) (the project's status, the preparatory work that has been completed, and the problems that have been identified);
- logistics (status and supplies of contraceptives, transportation problems, recordkeeping, and flow of information);

* These were El Jadida, Beni Mellal, and Meknes, the three provinces where the VDMS is due to begin in mid-January 1982; Marrakech and El Kelaa, a "non-VDMS" province; and Casablanca, the largest administrative and health prefecture of the country.

- training needs (knowledge of the paramedical personnel in contraceptive technology, including surgical procedures);
- delivery of FP services (availability, performance, acceptability, demand from the population program in information, education, and communication (IEC), etc.); and
- activity at the FP referral centers.

To ensure a reasonable degree of comparability among the smaller team groups, questionnaires were used to interview MOPH personnel and clients, and another kind of form was used to collect information on the logistics and supply system.

General Findings

A. Population Policy and FP

Despite encouraging statements by individual political leaders, who, traditionally, are opposed to FP, family planning is not mentioned among the major points of the 1981-1985 National Development Plan. However, it is becoming an essential instrument of the MOPH, which is using it increasingly to reach its major objective, namely, the decrease of infant mortality and the improvement of the health of mothers and children. The MOPH's goal is to increase to 24 percent by 1985 the number of women 15-44 currently protected by a modern contraceptive method. The MOPH is taking steps now to increase the availability and improve the quality of FP services. It has begun to use paramedical personnel to deliver FP services; it plans to extend FP services by door-to-door delivery (the VDMS project); and it is providing FP services in the most rural areas by operating mobile units.

Demand for female sterilization is increasing, not only in the major cities, but also in the smaller towns and rural areas. Although sterilization is not part of the national FP program, tubal ligation is available in urban hospitals, and the MOPH is ready to take further action to better meet demand. Discrete but sustained assistance from the USAID to extend sterilization services would be welcomed.

Abortion is not so openly discussed as sterilization. Yet, between 20 percent and 50 percent of hospital beds in obstetrical wards are reported to be occupied by women seeking treatment of incomplete abortions and dilatation and curettage (D&C).

The subsidized commercial sale of contraceptives is not a primary concern of the MOPH, and another sponsor (perhaps the AMPF) should be sought so that this subproject can begin.

B. Family Planning Logistics

The stated goal of improving family planning services by increasing the availability of contraceptive commodities is well-founded. This aspect of Morocco's FP program is sound and must be continued. The logistics system for contraceptive supply is working well in most of the areas visited. Sufficient quantities of supplies are available at the service delivery points which the team visited, and there has been no reported breakdown in the supply line in the past several years. Nationally, there is a two-year supply of oral contraceptives (OCs) on hand; the supply of condoms is sufficient for almost four years; but the supply of intrauterine devices (IUDs) will last less than four months*. The physical infrastructure, the administrative procedures, and the personnel responsible for managing the distribution of commodities are of high quality. Only minor managerial problems were found at the provincial level and the circonscription level, and all of these can be corrected easily with in-service training in the administration of the logistics system.

The evaluation team feels that the impact of the effort to provide contraceptives could be increased by improving logistics procedures in some areas of the country and in some facilities. The evaluators recommend that the MOPH be supported in its efforts to study and improve logistics and supervision. The USAID should continue to consider the introduction of new contraceptive methods. Also, oral contraceptives supplied by the USAID should be made available to private family planning services so that clients can avoid the side effects commonly experienced when a new provider switches them from one formulation to another.

C. Service Statistics

Two forms are used to record FP data. One, an individual form for new acceptors (PF/1), has just been improved to provide better information on the number of new acceptors. The other, a monthly record form (PF/2), provides information on the total number of FP clients (new acceptors and users) at the circonscription and provincial levels.

As the VDMS project expands, data on the FP activities of the VDMS program will be needed from the circonscriptions. These data should be interpreted and the results published in the format of the FP monthly report from static health facilities.

* The quantity is low because a large shipment of IUDs was sent recently to the provinces in anticipation of the initiation of the VDMS project.

At this time, FP forms only provide data on the number and characteristics of FP users and acceptors. The prevalence of contraceptive use cannot be estimated.

Comments on Project Paper Line Items

From fiscal year (FY) 1971 to fiscal year 1976, the USAID contributed the following support for family planning under Project Number 608-0112:

	<u>Support (\$000s)</u>
Technical Services	98
Participant Training	36
Commodities	1,539
National Family Planning Center	300
FP Referral Centers	325
Seminar Support	<u>26</u>
TOTAL	<u><u>2,323</u></u>

These items, representing the principal activities of the project, laid the groundwork for later efforts, but the project did not emphasize service delivery, except for the provision of contraceptive commodities.

As the Project Paper (PP) illustrates, Project Number 608-0155 (FY 1978-FY 1982) took a radical step toward service delivery and was much more ambitious in its coverage. The breakdown of funding for the current project (including that for FY 1977; Interim Project Number 608-0112) is:

	<u>Amount (\$000s)</u>
Household Distribution, Pilot Project	552
VDMS Expansion to 10 Provinces	4,750
10 FP Referral Centers	1,155
Manpower Development	640
Commodities	7,830
Commercial Distribution of Contraceptives	350
Information, Education, and Communication	280
World Fertility Survey and Contraceptive Prevalence Survey	275
Consultants, Evaluation, and Contingency	<u>150</u>
TOTAL	<u><u>15,952</u></u>

Most of the various subprojects are discussed in depth in the attached report. The following sections address the team's major findings on outputs, as envisioned in the Project Paper; the status, deviations, and levels of attainment achieved; and the implications for future revisions.

A. VDMS-Marrakech

It was envisioned that implementation of the VDMS project in Marrakech would "determine cost-effectiveness" and "establish prevalence statistics." Of major importance was the project's use of the existing health structure, because this meant it could be adapted easily to other provinces. Although the project was completed within a year of the targeted completion date, appropriate follow-up surveys were never done in the rural area and subsequent usage has not been verified; thus, the usefulness of the data that were produced is limited. Nonetheless, this was the first major MOPH program to deliver family planning services and, consequently, was extremely important.

B. Visite à Domicile de Motivation Systematique (VDMS)

Although the VDMS extension to other provinces originates from the VDMS experience in Marrakech, the project was given a new structure to emphasize development of basic health services and infrastructure. A number of changes have been made, principal among which was the addition of four other activities* that were to be conducted simultaneously with dissemination of FP information and delivery of services. Although, in future programming, one might hope for a more appropriate balance of population output per population dollar, it appears that the VDMS project will bring family planning to households in a more systematic way than ever before. It is this feature that makes the project notable. Yet, the Marrakech experiment did not test the possibility and the efficiency of using one visit to provide several family planning and health interventions.** Therefore, the VDMS extension is somewhat experimental, and thus calls for close supervision and monitoring of day-to-day project activities and careful planning and programming of the future extension of the project to seven other provinces.

The preliminary activities for the extension of the VDMS project to three new provinces are under way. A training session for 55 trainers was held in Rabat for a week while the team was in-country. A guide has been prepared which will be given to the trainers to help them train the itinerant nurses in their respective provinces. The VDMS forms were finalized at the last minute so that they could be presented at the Rabat training session.

In the field, the preparation for the VDMS project is ongoing, and the project is expected to begin by mid-January.*** A major problem is the lack of a sufficient number of motorbikes.

* These activities are:

- refer persons for vaccination;
- provide a nutrition supplement for malnourished children;
- provide iron and vitamins for pregnant women; and
- provide oral rehydration salts (ORS) for diarrhetic children.

** The itinerant nurse has been responsible for delivering health care at the doorstep. Services have consisted primarily of malaria control and treatment for tuberculosis (TB). An evaluation has not been made of the impact of these household visits on health parameters.

*** As of May 1982, the field project had not gotten fully under way.

C. FP Referral Centers

Family planning referral centers were not envisioned in the PP as the major source of family planning services, but they do have potential as centers of excellence for training personnel to conduct studies of the effectiveness of supervision and to solve the problems of outreach service delivery. All the centers which the team visited had conducted FP training sessions for paramedical personnel; the number of trainers and the quality of the training varied considerably from center to center.

More important than the construction of the centers is their use. The USAID might consider developing an in-country capability to strengthen the centers' capacities to train and supervise paramedical personnel and deliver outreach services by, for example, funding a one- or two-week consultancy each year at each center to develop individualized training and operational programs.

Although ten additional FP referral centers are envisioned in the PP, only two are currently under construction.

D. Training

The MOPH gives considerable attention to both basic and inservice training. The content of the formal training courses at the three levels of paramedical schools is being completely revised and will be made more practical and task-oriented. Inservice training seminars and workshops, with special emphasis on population IEC, have been conducted with the assistance of the World Health Organization (WHO), the University of Chicago, and International Training in Health (INTRAH).

The major objective of the USAID-supported "special training program" was to train high-level personnel for manpower development in both administration and technical skills. With the new National Training Center for Reproductive Health, which is to open in early 1982, it is felt that increased emphasis should be given to in-country training. There is a need for a systematic, country-wide, decentralized inservice training program that can be adapted to the needs of various categories of health personnel (e.g., supervisors, itinerant nurses of VDiS, and itinerant nurses of mobile units) and that deals with various topics (e.g., logistics, IEC in population and FP, contraceptive technology, etc.).

One of the recommendations of the evaluation team is that the USAID support secondary and tertiary training so that personnel at the provincial and lower levels can acquire special training skills. The team also strongly recommends that JHPIEGO* training in sterilization procedures be

* Johns Hopkins Program for International Education in Gynecology and Obstetrics.

reinstated outside Morocco, if the National Training Center does not begin training and certification in early 1982.

In addition, the USAID should consider providing support to improve the training capabilities in FP, and especially sterilization procedures, of medical students at the University Medical School of Casablanca.

The evaluation team feels that decisions about long-term training are also part of the purview of the Health Management Improvement Project, which will begin soon under a USAID contract.

E. Commodities

The provision of commodities in an expanding family planning program is vital and should be continued. However, assurances should be made that capability in logistics management is equal to the task of expanding commodity delivery, a requirement of the new VDMS program.

F. Commercial Sale of Subsidized Contraceptives

In spite of initial enthusiasm and a commitment to begin a program in 1978, the MOPH has made it clear that it is not interested at this time in the commercial sale of subsidized contraceptives. The USAID might choose to approach the private sector directly or use the available funds for small-scale marketing studies, including studies of current use in the private sector, and an assessment of contraceptive sales.

G. Population Information, Education, and Communication with the AMPF

Ambitious support of a facility to produce IEC materials is well-placed in a family planning association (FPA). The effort undertaken with the Moroccan Family Planning Association is not on schedule, but it is progressing well in an organization that has shown itself to be goal-oriented.

The evaluators would encourage the USAID to continue its support to the AMPF. The Agency also should consider extending its assistance to the FP service delivery activities of the AMPF and encouraging the organization of active AMPF committees in additional provinces.

H. Moroccan World Fertility Survey and Other Population and FP Studies

The use of contractors for population and family planning studies has been beneficial, leading to program success and the exchange of ideas. The team recommends that technical collaboration that involves contractors be continued. Although they are not in line with original scheduling, survey work and analysis are continuing at a slowed but steady pace.

I. RAPID

Delivery to the MOPH of the RAPID* program and accompanying hardware was completed in 1980; however, the RAPID presentation has not received widespread exposure.

Summary and Recommendations

Project Number 608-0155 is an ambitious and strongly service-oriented program. Because the MOPH is the only governmental department that is dedicated to delivering, and is in fact providing, substantial FP services, USAID inputs for population and FP activities are appropriately located in the MOPH. However, USAID support should not be concentrated exclusively in this ministry. The AMPF should continue to receive assistance, and the USAID should explore the feasibility of introducing population and FP components in collaborative projects with other appropriate ministries.

The MOPH has not always been able to maintain the schedule for many of the subprojects supported under the project. For this reason, implementation plans should reflect more closely Morocco's ability to absorb proposed inputs. However, the forward momentum in programming gained in the last five years should not be allowed to dissipate. Flexibility should be maintained.

In-country or short-term contractors should be used liberally to ensure continuity between conception and implementation of a program. Specifically, the team recommends:

- That the position once occupied by Mr. Wornum, the VDMS contractor, be filled as soon as possible with a new technical contractor, because a full-time VDMS contractor is needed to collaborate with

* Resources for Awareness of Population Impact on Development.

MOPH personnel in future planning of the VDMS extension, and to ensure close supervision of day-to-day program implementation and monitoring.

- That collaboration be continued with organizations and individuals who can provide short-term in-country consultant services. These persons must be familiar with the Moroccan health sector, and the development of USAID projects in particular, and they must be available for multiple visits to ensure consistency in advice and programming. Ongoing, on-site contact is necessary to ensure that the FP component of programming continues to grow in relation to other activities now supported with population funds.
- That continuity among similar tasks be established. To date, at least four different contractors (the National Council on Health Statistics [NCHS], the World Fertility Survey [WFS], Westinghouse, and the International Fertility Research Program [IFRP]) have been engaged for large-scale survey work. An attempt should be made to develop ongoing relationships to facilitate future work.

ABBREVIATIONS

AMPF	Moroccan Family Planning Association
CBD	Community-Based Distribution
CDC	Centers for Disease Control
CMO	Chief Medical Officer (Médecin Chef de la Préfecture)
CNSS	Caisse Nationale de la Sécurité Sociale
CPS	Contraceptive Prevalence Survey
D&C	Dilatation and Curretage
DH	Dirham (Monetary Unit of Morocco)
FIFO	First In-First Out
FP	Family Planning
FPA	Family Planning Association
FY	Fiscal Year
GOM	Government of Morocco
HQ	Headquarters
IEC	Information, Education, and Communication
IFRP	International Fertility Research Program
INTRAH	International Training in Health
IPAVS	International Program of the Association for Voluntary Sterilization
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KAP	Knowledge, Attitude, and Practice
MCH	Maternal and Child Health

MNEP	Moroccan National Education Program
MOPH	Ministry of Public Health (Ministère de la Santé Publique)
MSP	Ministère de la Santé Publique
NCHS	National Council on Health Statistics
OB/GYN	Obstetrics and Gynecology
OC	Oral Contraceptive
ORS	Oral Rehydration Salt
POP	Population
POP/FP	Population and Family Planning
PP	Project Paper
PSME	Maternal and Child Health Division
RAPID	Resources for Awareness of Population Impact on Development
SIAPP	Itinerant Health Worker System
SPF	Service de Planification Familiale
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDMS	Visite à Domicile de Motivation Systematique
WFS	World Fertility Survey
WHO	World Health Organization

I. HEALTH POLICY AND POPULATION IN MOROCCO

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The Ministry of Public Health (MOPH), like all other ministries of the Government of Morocco (GOM), will have to meet the service needs of Morocco's rapidly increasing population. At this time, the MOPH is pressed to meet the actual needs for health services. As of January 1, 1980, the MOPH reported a need for an additional 73 urban health centers, 143 rural health centers, 287 urban dispensaries, and 178 rural dispensaries. In addition, because of personnel vacancies, 331 specialist nurses and 1,279 registered nurses are needed. Auxiliary-level nurses, although sufficient in number, are maldistributed.

Between 1980 and 1990, the population will increase by more than seven million, according to a conservative estimate. What does this mean for the MOPH infrastructure? With the new découpage* (the ratio of health workers to population) planned by the MOPH, 2,859 auxiliary nurses, 476.5 dispensaries, and 159 health centers will be needed. Adding these figures to those calculated above, the MOPH will have to produce, place, and facilitate 24 new auxiliary nurses, 4 new dispensaries, and 1.3 new health centers *every month* during the next 10 years, 1980-1990.

Unfortunately, even if all the infrastructure is in place by 1990, the number to be served will continue to grow. Even if the rate of reproduction begins to decline today, the number of women in the fertile age group will continue to grow for at least 15 years, until 1997. Hence, even if the reproductive rate per woman is lowered, the increasing number of women in their reproductive years will continue to produce a sufficient number of children so that the national growth rate may continue at its current high level. Improved basic health care will lower mortality rates. Unfortunately, this positive effect of better health care also adds to the growth rate.

Yet, despite all these population pressures in the health sector, the MOPH has been able to make some significant progress in the analysis and recognition of its institutional and structural problems. Proceeding from these diagnoses, the MOPH has identified a set of corrective measures. The principal steps are:

1. Define objectives.
2. Formulate a strategy to:

* Geographical reapportionment that yields an increased number of health workers for a given population and decreases the area covered by each health worker.

- strengthen administrative, programming, and planning capabilities;
- improve the collection and processing of information;
- improve accessibility to health services;
- improve training of paramedics at all levels; and
- strengthen the potential for action in information, education, and communication (IEC) in matters of health.

3. Initiate effectively certain programs of action required by this strategy (e.g., the project "Visite à Domicile de Motivation Systematique" (VDMS), basic health care, itinerant family health units, new courses of paramedical study, etc.).

Of major importance is the MOPH's recognition of the need for an improved management system. With support from the United States Agency for International Development (USAID), the MOPH is undertaking a study of, and revising, as necessary, MOPH management systems and procedures. The MOPH is committed to the slogan, "Health for All by the Year 2000," and is attempting to bolster its outreach program by all available means. This effort is being supported in Project Number 608-0155.

Having considered the broad political orientation of the MOPH, the team attempted to undertake this evaluation with an eye to the anticipated follow-on Project Paper (a new USAID and MOPH project document written within the framework of the national health policy and aspiring to support those actions prioritized by the MOPH).

In orienting its policy and development, the MOPH has given priority to:

- research into alternative health care;
- improvement in the health of expectant mothers; and
- reduction of infant mortality.

All are sustained through education, information, communication, decentralization of training, permanent retraining of personnel, strengthening of the infrastructure, and environmental sanitation.

Research into Alternative Health Care

Research into alternative health care has resulted in:

- the creation, at the central level, of an Infrastructure Division, charged essentially with planning and program management;
- the collection and study of fundamental demographic, sociological, economic, and epidemiological data; and
- operational actions, including implementation of basic health care projects in two pilot provinces, Agadir and Settat, to study, among other things, methods for introducing the traditional midwife into the health care delivery system, for better integrating the itinerant into the community, and for using community agents to reach the estimated 20 percent of the population that falls outside the formal health care system. The development of a new level of health worker for field work also is being considered.

Health Protection of Mothers

Three principal activities should be undertaken concurrently to improve the health of mothers. These are

- family planning (FP);
- monitoring of pregnancies; and
- increasing the percentage of deliveries performed under the supervision of medical or paramedical personnel.

Reduction of Infant Mortality

A package of integrated actions has been defined and adopted by the MOPH to achieve by 1985 the objective of reducing infant mortality from the current estimated rate of 130 per 1,000 population to less than 100 per 1,000 population. The package includes:

- family planning;
- increased vaccination coverage of infants to a level exceeding 80 percent;

- efforts to treat infantile diarrhea;
- intensification of programs to combat malnutrition; and
- provision of iron supplements and vitamins to pregnant women.

The major constraints which the MOPH must overcome to properly implement its policy involve manpower, in both qualitative and quantitative terms, and, most important, the organization and management of available resources.

II. FAMILY PLANNING WITHIN HEALTH POLICY

II. FAMILY PLANNING WITHIN HEALTH POLICY

Of special interest to this evaluation are the changes in health policy that have been made since the 1976 evaluation of the Moroccan Family Planning Program.

Family Planning as Part of Basic Health

In 1976, evaluators found no reference to family planning in basic statements of health policy. Today, the MOPH clearly espouses acceptance of family planning as a necessary part of a basic health program. This new emphasis on family planning is evident in the commitment to VDMS; the inclusion of family planning on new basic health forms; the conduct of both the World Fertility Survey (WFS) and contraceptive prevalence surveys (CPS); and the completion of a pilot family planning service delivery system in Marrakech (VDMS).

Some of the changes, undertaken in a less than completely supportive political climate, illustrate the courage and commitment of certain personnel within the MOPH and in the provinces. All the efforts were supported directly or indirectly by the USAID under Project Number 508-0155, Population and Family Planning Support.

Family planning is fully recognized by the MOPH as essential to the realization of its priority objectives, the reduction of infant mortality and the improvement of the health of mothers. For the first time, a specific FP target has been spelled out in the MOPH's plan of action: By 1985, 24 percent of women 15-44 will be using a modern method of contraception provided by the public sector. In the view of MOPH authorities, some demographic effects that the Ministry is eager to measure should become evident if this goal is achieved.

From a strategic point of view, the Ministry must use its structural and human capabilities to promote, in a politically acceptable way, the acceptability, accessibility, and availability of contraceptives. It must make haste while being careful to avoid any cultural, psychological, political, or religious error which would prejudice development of the program. Because the MOPH has established certain objectives and must face certain constraints in the national context, the FP strategy it has adopted depends on those elements that made the VDMS project in Marrakech a success. Two features of the Marrakech project--the use of paramedical personnel to deliver FP services and the availability of contraceptive methods to couples at home--can, and will, be retained. For example, the itinerant will deliver pills and condoms while visiting homes, and intra-uterine devices (IUDs) gradually will be made available not only in health

centers, but also in rural dispensaries designed and equipped for this purpose. Some trained paramedics already are qualified to insert IUDs. Eventually, several thousand agents and nearly 1,200 health units will be delivering continuous, modern contraceptive services throughout the country.

The demand for family planning is great, as is indicated by the first results achieved by the mobile family health units, initiated in June 1981. In the past six months, these units, traveling through the remotest areas, have recorded 1,928 acceptors of IUDs, 5,183 acceptors of the pill, 479 acceptors of condoms, and 193 acceptors of spermicides--a total of 7,783 new acceptors.

Sterilization

The demand for female sterilization is increasing and is clearly spreading from the urban centers to the most rural provinces. Because this method is not part of the national family planning program, no aggregate statistics are available, and only those figures which the evaluation team collected indicate the extent to which this method is used. Compared to demand in neighboring countries, demand in Morocco for female sterilization is modest, but it nevertheless signifies a change in popular attitudes.

The word "sterilization" does not appear among service statistics or in survey questionnaires, and workers are taught to list it under the category "Other." Physicians openly talk about the number of procedures they perform, and they seem to be able to gather such data easily. It is likely that with increased demand, more open discussion, and the opening of the new National Training Center, which will offer training in sterilization procedures, access to sterilization will improve considerably in the near future.

In the six provinces visited by the team, excluding Rabat, the number of tubal ligations is estimated at 2,000-2,500 per year; of this number, 1,800 tubal ligations are performed in Casablanca. The MOPH's position on this method is unequivocal. Although it has agreed to respond to expressed needs, the MOPH does not envisage the adoption of sterilization, which is unacceptable politically, culturally, and religiously, as an official method of the FP program. Tubal ligation is available, however, and it is performed in all hospitals, and especially by gynecological services, for medical reasons (e.g., for mothers with several children or reproductive problems)--an approach that avoids controversy. The training of surgeons and gynecologists in the surgical techniques of sterilization should be pursued, and hospitals should be adequately equipped to continue and to expand sterilization services, for which demand is likely to continue to increase. In this sensitive area, the continuation of assistance from the USAID (training and equipment) is eminently desirable.

Abortion

If few figures on sterilization are available, even fewer on abortion exist. Abortion is a sensitive subject in Morocco, and difficult to discuss, but it is believed to be practiced widely. For example, in El Kelaa, it is estimated that 20 percent of beds in the obstetrical ward are occupied by abortion cases (both induced and spontaneous); at Meknes, the figure approaches 50 percent; and in Casablanca, the Obstetrics and Gynecology (OB/GYN) Service at the maternity hospital receives each day a dozen patients who have suffered miscarriages. Although induction may occur outside the hospital, the public health system provides the necessary follow-up care. The introduction and increasing acceptance of family planning should help to eliminate this problem.

Commercial Sale of Subsidized Contraceptives

The commercial sale of subsidized contraceptive products is not compatible with the present wishes of the MOPH. A large variety of oral contraceptives (OCs) is available and, because of the liberal economic system of Morocco, the MOPH views competition with the private sector as premature. The Ministry needs to clarify its policy on the importation and manufacture of medications before it develops a strategy for the sale of subsidized contraceptives.

Acceptability of Family Planning

The 1976 team noted that women receive a poor welcome when they arrive for family planning. The team also noted that it was not acceptable for male itinerants (the vast majority is male) to discuss family planning with a woman. A large number of the personnel with whom the 1981 team spoke use contraceptives, which may indicate that these workers, a large percentage of whom graduated in the last five years, have adopted a new attitude toward family planning. The experience in Marrakech points to resolution of the question of using male workers rather than female workers, in that male itinerants have been accepted at the same rate as females. However, a new concern has arisen that a man may have trouble discussing his wife's health with another man. Sensitivity to cultural acceptability is imperative, and adjustments must be made whenever necessary.

Availability of Family Planning

In 1976, the availability of family planning was reported to be minimal, and the evaluators concluded that much hinged on the opening of the

National Family Planning Center. This facility, which now houses the Population Division of the MOPH, has not performed the functions envisioned at the time the center was designed. But, more important, the MOPH has committed itself to making family planning available at all health outlets. In many areas, the availability of family planning probably is not yet a reality, but in those provinces where family planning services have been available for 15 years, the effects of availability are probably apparent.

It took quite a long time--and the experience of the VDMS-Marrakech project was crucial--for the MOPH to accept officially the use of paramedical personnel to deliver FP services. It is probable that much less time will be needed to demedicalize FP services so that they are acceptable. Certain social and other non-medical institutions ("Jeunesse et Sport" and "Promotion Féminine") already furnish FP services with support from the Moroccan Family Planning Association (AMPF). The MOPH is not overtly opposed to FP activities, but it is anxious to see them performed by personnel who are duly trained and prepared for the task.

III. VDMS-MARRAKECH

III. VDMS-MARRAKECH

The VDMS-Marrakech project, conceived in late 1976, was implemented in late 1977 as a large but simplified operations research project. The objective was to study the feasibility of delivering to households family planning information and services. Built on the existing MOPH system of itinerant nurses, the project included two visits to each accessible household in urban and rural Marrakech. The purposes of the visits were to complete questionnaires for baseline data, continuation data, and eligibility for the pill; to distribute contraceptives to eligible clients; to resupply contraceptives, either at the second visit or upon presentation of a specially supplied card, which would allow any member of the family to obtain a resupply; and to refer clients with a medical problem and clients who wanted an IUD.

The project tested the following hypotheses:

- A visit by an itinerant worker to a household to deliver family planning information and services is acceptable in Morocco.
- With proper training, an itinerant worker can safely supply and resupply oral contraceptives.
- Both male and female workers may be used in this work.
- Oral contraceptives may safely be supplied in lots of four to six cycles, without significant wastage.
- Such activity will enhance the availability and use of family planning services.

All the hypotheses were shown to be valid during the project. A formal report on the effort is available that contains most of the data and results. Several additional findings from subsequent evaluations and data analysis should be carefully considered before the delivery of FP services is extended to other areas.

Logistics and Supervision

Logistics for commodity control and supervision of day-to-day work are mandatory components of an outreach-type service delivery program. In the past, the chief of the dispensary provided supervision, making daily field checks and each month considering the data that had been

collected. Although well-conceived, this approach was not flawless. For example, supervision could not be provided under the following conditions:

- There is no transport for the chief.
- The chief is generally an auxiliary-level nurse and has not been trained in logistics or supervision.
- The data are complex, or the forms are unclear or misunderstood.
- The chief's direct superior emphasizes other aspects of the chief's work, and not supervision and commodity control.
- There is poor communication of problems up and down the chain of command.

A lesson of the Marrakech study was that the flow of information must move rapidly in both directions on the hierarchical ladder to avoid stockouts and delivery failures. Recognition of this fact is evident in the results of the questionnaires administered by the evaluation team. If supervision of commodity flow and personnel is well-established, a facility will run on its own impetus. If the chief is not well-informed in these areas, the facility will not run well, no matter what support or other training is given.

Retraining

The itinerant workers who were trained and retrained, and who gained practical experience in the use of the VDMS form, seem to have retained excellent levels of knowledge of family planning. Conversely, in provinces where this training has not been available, the level of knowledge of the personnel who distribute FP commodities varies considerably. The FP referral center tends to be the major locus of competence, with knowledge decreasing in the peripheral health centers, *where the majority of service delivery occurs*. One auxiliary nurse noted that she has not taken part in a retraining course in the 14 years she has worked in the health service. Hence, although the major thrust of service delivery is peripheral, the major base of knowledge is central.

To bolster family planning knowledge and motivation, personnel at all levels, but especially those who received basic training before the formal health training curriculum was revised in 1981, need to be retrained. Retraining should encompass:

- health and other reasons for birth-spacing and limitation of births;
- proper use of the pill;
- contraindications to the pill;
- proper surveillance of IUDs;
- contraindications to the IUD;
- proper use of spermicides and condoms;
- true side effects of contraceptive methods, as opposed to unrelated patient complaints;
- orientation to female sterilization as a medically indicated procedure for women who are multiparous or who have health-compromising illnesses;
- stock maintenance to guard against stockouts at dispensaries; and
- importance of providing sufficient quantities of contraceptives to avoid stockouts in households (e.g., a three- to six-month supply of pills, condoms, or spermicide).

Practical Guide

A probable reason for the high level of knowledge of the itinerants in Marrakech is the workers' experience in administering a brief questionnaire on medical history and in teaching clients how to use the pill according to a prewritten guide. A guide for brevete-level nurses is planned, but this does not obviate the need for a guide for the itinerants now at work. Simple but complete, practical knowledge of all family planning methods could be condensed on a single sheet or card which the workers could carry until they integrate the information completely into their routine.

Project Support

To facilitate the operations research project in Marrakech, it was decided that support would be provided for transportation, field work (per diem), and outreach (personnel based in one sector were to be employed part-time in outreach in another sector). Long-term support of any of these three activities is difficult to provide.

Because the effort in Marrakech was a demonstration project, this kind of project support was justifiable, but it was recognized that it would not be readily continued as long-term support. Therefore, continued resupply in Marrakech was planned to come from the dispensary (the major source) or the itinerant workers (the minor source). Clients were given a card that could be presented by any member of the family to receive supplies.

The temporary supplementation of transport, salaries, and staff is difficult and expensive, and it should not be the basis of donor support for a national program.

Male Workers Versus Female Workers

The use of female workers for outreach and male workers for family planning was tested by the Marrakech project. Although concerns about using males and females were alleviated, the evaluation team observed that discussions of family planning among males are problematical. It is acceptable for both male nurses and female nurses to discuss family planning with a woman, but it is not acceptable for a male to discuss family planning with another male, because the subject focuses on the wife's health and personal problems.

To illustrate: When the male itinerant VDMS worker arrived at a distant dispensary two years ago, he explained to the population there the concept of family planning, which seems to have been accepted and understood. The men of the area requested that a woman come back to speak with them in detail about the contraindications. This female worker never arrived; consequently, family planning has not been accepted in the area. Although anecdotal, this story seems plausible to all other personnel with whom it was discussed. What this implies is that in areas where all workers are of one sex, an occasional (but scheduled) visit by a trained member of the opposite sex may aid in increasing knowledge, fostering favorable attitudes, and encouraging the practice of family planning in remote areas.

Number of Cycles of Oral Contraceptives

A major hypothesis of the Marrakech project was that several cycles of pill could be given on each visit, with little loss or misuse. At the time of the second visit (two months to four months later), more than 95 percent of clients was judged by the itinerant worker to be using the pills correctly. Clearly, this surprisingly high level of correct usage justifies confidence in the capability of acceptors to properly use several cycles in the interim preceding resupply visits.

A second hypothesis tested in this study was that easy access to FP information and commodities would increase utilization. This proved to be correct. During the project, the level of usage was high and the number of new acceptors who visited static clinics increased, as did demand for IUDs. It is also possible that the level of usage following the project continued to be high (this has not been documented).

The following is an estimate of the woman-years of coverage distributed in 1976-1977 and 1980-1981:

Assumptions:

An average of one and one-half cycles per visit was given before the VDMS project began, and an average of two and one-half cycles is given once the project begins. This assumption is conservative; the vast majority of clients received only one cycle per visit in 1976-1977 and, theoretically, all now receive at least three cycles per visit. Also, because data for December 1981 are not available, December 1980 is counted twice.

Formula:

$$(\text{No. of Visits} \times \text{No. of Cycles per Visit} \div 13) + (\text{No. of IUDs} \times 2.5)$$

$$1976-1977: (93,046 \times 1.5 \div 13) + (1,700 \times 2.5)$$

$$10,736 + 4,250 = 14,986 \text{ Woman-Years Protection}$$

$$1980-1981: (83,897 \times 2.5 \div 13) + (3,748 \times 2.5)$$

$$16,134 + 9,370 = 25,504 \text{ Woman-Years Protection}$$

This conservative estimate reflects a 70 percent increase in woman-years of coverage.

It is not certain that these changes would not have occurred without the project, but the data reflect positively on household outreach for family planning and the distribution of multiple cycles of pills at each visit.

Recommendations

The evaluation team recommends that the following steps be taken to evaluate the impact of the VDMS project in Marrakech:

1. *Conduct service-oriented research to determine why a plateau was reached in Marrakech. Whereas the gross estimate of woman-years of coverage distributed in 1976-1977 is approximately 15,000, and that for 1980-1981 is approximately 25,000, the figure is approximately 48,000 for 1978-1979, including VDMS distribution. The decline between 1978-1979 and 1980-1981 and the stabilization of usage at a level higher than that recorded for 1976-1977 merit careful consideration.*
2. *With only one intervention, family planning, to perform, the itinerants were able to master their task completely. However, the project did not test the efficacy of many interventions during one visit. Therefore, the VDMS project in Marrakech should not be cited as proof that VDMS expansion will necessarily be successful.*
3. *Conduct a small survey on usage. This kind of survey was not administered in the rural areas and, because records on stock are not available, it is not possible to evaluate the impact of the project on changes in prevalence. The recommended survey could be a part of the research effort described in the first recommendation. Consultants who are members of the Johns Hopkins Operations Research group might be appropriate for this task.*
4. *Ensure proper training in logistics and development of materials for field workers before replicating this effort. Ensure also that culturally-specific requirements (e.g., an occasional visit by a female itinerant) are fulfilled.*

IV. EXPANSION OF VDMS: STATUS OF DEVELOPMENT

IV. EXPANSION OF VDMS: STATUS OF DEVELOPMENT

A number of conditions must be met before the new VDMS project can be launched in three additional provinces in mid-January. Steps have been or are being taken to fulfill these requirements. There are, however, some problems that must be solved to ensure successful initiation of activities and expansion. These problems are described below.

Preparations in Progress

Training for instructors began on December 14, in Rabat. In one week, 55 instructors (16 from El Jadida, 17 from Beni Mellal, and 22 from Meknes) were trained to teach VDMS concepts and practices to itinerant workers and supervisors when they returned to their respective provinces.

Chief medical officers (CMOs) have shown a lively interest in the successful realization of the training program. All the chief medical officers who met with the team are realistic (this is evidence of their experience with field personnel). Conscious of the problems and difficulties in launching the new program, each chief medical officer has defined an area where the VDMS can be initiated and followed up, and where problems can be identified and solutions found before the program is expanded throughout the respective province. In El Jadida, five of the nine districts comprising the province have been identified for the first phase of the training effort. In Beni Mellal, the chief medical officer has decided to concentrate the initial effort in the central region of the province, while in Meknes one district will be disregarded in the first phase of the project. This may be done also in three other districts, if a sufficient number of motorbikes is not made available.

In the field, geographical reapportionment (découpage) is under way in some areas. The boundaries of subsectors are being redefined to reduce, to the extent possible, the number of households a single itinerant must contact during his rounds. A list of the itinerant workers who have been assigned to each new subsector has been prepared, and action is being taken to meet the increased demand for itinerants that is a result of reapportionment. For example, personnel are being transferred within a province to ensure coverage of the areas that will be affected when the VDMS project is initiated. Permanent hospital staff, the number of which is excessive in some hospitals and health centers, are being assigned jobs as VDMS itinerant workers. Women itinerants are being assigned, at least in urban areas, and perhaps also in suburban areas. Students at the breveté level who will graduate in June, 1982, are targeted for priority assignment in VDMS areas.

The specifics of training programs for itinerant and supervisory personnel in the provinces have not been finalized, but organization of the programs is well under way. In El Jadida, the 16 instructors who were sent to Rabat will be responsible for training 138 itinerants and 23 sector chiefs. Two one-week training sessions for 75 persons who will be divided into three groups are planned. The first session is planned for personnel from Bir Jdid, Ouled Frej, and Sidi Smail. In Beni Mellal, the personnel who will be retrained will be divided into three groups of 50 each, and each group will be trained in a region of the province. Four training sessions are planned for Meknes. One session in Azrou will involve 83 persons; another in Moulay Idriss will be for 43 persons; a third in El Hajeb will train 78 persons; and the fourth in Meknes will include 81 persons. To solve the problem of attrition of itinerants, non-itinerant personnel who are not initially involved in the VDMS project will also participate in the training sessions.

Training will consist of role-playing and home visits in the field. Training will begin in the designated provinces upon return of the instructors from Rabat. Local authorities will be invited to the opening of the training sessions, which will last from one week to two weeks. By mid-January, all field personnel will be ready to begin their initial rounds of home visits.

Problems of Expansion

The replication of the VDMS project in other provinces entails organizational and other problems. To better understand these problems, one should keep in mind three points.

One, the success of the Marrakech experience, which no one questions, can be attributed to an investment of human and financial resources which the MOPH cannot be expected to make again in the other provinces. The effort in Marrakech involved operational research, limited in scope and conducted in a limited time period, which has been completed.

Two, the positive results of the experience have stimulated the USAID and the Government of Morocco to study ways to extend VDMS; a plan has been prepared that incorporates certain aspects of the VDMS-Marrakech project, some of which will be retained as they were designed originally and some of which will be modified. In the first stage, VDMS will be extended to three provinces; in the second phase, it will be initiated in seven additional provinces. Two features of the project in Marrakech will be retained: the use of paramedical personnel to conduct FP activities and the emphasis on FP during rounds. Several activities conducted in Marrakech will be modified. For example, other activities will be added to FP (e.g., vaccinations, referrals, use of oral rehydration salts, and provision of Actamine 5, iron, and vitamins to pregnant women).

Data collection will be simplified. Rounds will be continued "indefinitely," at the rate of two per year.

Three, in addition to negotiating with the USAID to expand VDMS, the MOPH has studied ways to use and improve the health surveillance system and has defined the objectives of and tasks to be accomplished by the system. The objective of the health surveillance system is to make an itinerant health agent permanently and regularly responsible for a known and recorded population. The worker should provide to the population a package of integrated health skills that are designed to achieve the two principal objectives of the MOPH, namely, reduction of infant mortality and improvement of the health of mothers.

To attain these objectives, a series of steps has been specified. These steps are:

- To develop two basic forms, the family form and the locality form. The latter is to be used to record fundamental information that is needed to better understand the characteristics of the community (demographic, sociological, economic, and epidemiological data). Some of this information is available at this time from the sub-sectors and needs to be transcribed. The collection of the data needs to be rationalized. Certain useless or unexploited data will be excluded from the new form and other items that have not been collected in the past, but which are now deemed to be necessary, will be added. Also, the information needs to be validated once a year. By remodeling the format and contents of data bases, a data bank can be built up that, theoretically, will facilitate the daily tasks of the itinerant worker, help supervisors to ensure the provision of high-quality services, and aid in the evaluation of the impact of the services on the health of the population.
- To assign to an itinerant nurse (as human resources gradually become available) responsibility for a population of 1,500-4,500, depending on local factors.
- To develop a health surveillance system in which the itinerant nurse accomplishes a set number of tasks, depending on local conditions. The tasks would include:
 - family planning;
 - provision of oral rehydration salts;
 - vaccination;
 - provision of Actamine;

- provision of iron supplements and vitamins to pregnant women;
- research and orientation of tuberculous (TB) patients;
- research and treatment of malaria;
- application of ophthalmic pomade;
- investigation of schistosomiasis; and
- other minor tasks.

VDMS Versus the Health Surveillance System

Changes have been made in the VDMS project to increase both the number of activities and the number of rounds. The authorities do not consider VDMS to be an isolated project; rather, they view it as an effort to furnish material, financial, and logistical support to a program of integrated actions centered around family planning. Their approach raises two questions:

- Is this new orientation compatible with the spirit in which the project was conceived? (I.e., will such a project reduce infant mortality and improve the health of mothers?)
- Is the place reserved for FP sufficiently prioritized?

The answer to the first question depends on a global understanding of the MOPH's health care strategy and the flexibility of the USAID in adapting its assistance to actual needs rather than maintaining "to the letter of the law" support for a strategy which appears to be too limited, given the health policy defined in the 1981-1985 Five-Year Plan.

The "new formula" for the VDMS was designed originally as a package of five interventions. Despite the explicit agreement which both the MOPH and the USAID signed, VDMS includes additional tasks, which vary from province to province. Members of the evaluation team were told repeatedly that "there is no fundamental difference between the services rendered to the population by VDMS and those of the health surveillance system." Indeed, it would be difficult for the MOPH to launch a nationwide outreach health program that includes family planning which is limited, "strictu sensu," to five activities, regardless of the specific problems of specific regions (e.g., malaria and bilharziasis) or the problems of individuals (e.g., TB and minor ailments).

The population's acceptance of the itinerant and, consequently, of family planning, depends on the availability of appropriate resources to

meet concrete demand. The evaluation team does not object in principle to expansion of VDMS, but it questions whether or not a field worker can perform, and a woman absorb, many interventions at a single visit. The amount of knowledge that is to be transferred will be overwhelming if the itinerant has as many as 15 services to deliver. The impact of each service will be dubious and the likelihood will increase that the woman will misuse the medication. Misuse of drugs has serious implications. Misuse of contraceptives, for example, will result in an unwanted pregnancy which will alienate an acceptor, and probably her neighbors and friends.

The second question, which concerns the emphasis of FP over certain other services, cannot be answered definitively. An examination of field experience, training, supervision, and quantitative and qualitative evaluation is necessary to address this question. There are indicators, however, that point to an answer. These are:

- the repeated assurance of officials to make family planning the key objective of home visits;
- the emphasis placed on FP in the training of instructors and itinerants;
- the use of only the VDMS form in the three provinces designated for VDMS;*
- the conjecture about eventual activities associated with home visits, which implies that family planning retains priority; and
- the multiplicity of rounds leading, ipso facto, to ongoing motivation and follow-up of acceptors, which is indispensable to the continuing use of the methods (seven monthly cycles of pills are planned for each round).

Despite reassurances from the MOPH, the relationship of family planning to other health interventions must remain a concern of the Agency for International Development. Operational research has shown that most FP projects to which additional services are attached do not improve prevalence. To the contrary, these programs are less successful than community-based programs that distribute contraceptives only. The evolution of the VDMS project in Marrakech from a uni-purpose effort to an expanded "new formula" has been accepted as a political necessity, and the selection of health interventions to incorporate into the program has been a lengthy

* In discussions with the team, MOPH officials gave assurances that only this form will be used. The MOPH authorities consider the VDMS project to be oriented to service delivery, the quality of which will suffer if the project is burdened with additional and cumbersome data collection activities.

political process. One could conclude from this that the best, most practical choice of interventions to meet the needs of the population has not been made. To illustrate, a nutritionist-epidemiologist from the Centers for Disease Control (CDC) has determined that the provision of weaning food, iron pills, and vitamins has a negligible impact on the target population, and field tests have demonstrated the strong reluctance of rural mothers to allow their children to be "hanged" in a diaper-type sling to be weighed.

No one would argue that other health services must be delivered with family planning, but the choice of interventions must be balanced so that the needs of the population are met, so that clients (who usually are illiterate) can assimilate the information they receive, and so that the itinerant health worker can cover the population in his sector within a reasonable period of time.

The USAID must be vigilant in its continuous evaluation of the impact of services on the health of mothers and children, the acceptance and use of family planning methods, and the ability of the MOPH to assume gradually financial responsibility for a program.

Practical Problems of Reapportionment

Reapportionment (découpage géographique) would reduce the number of persons for which an itinerant is responsible, but, in many cases, the desirable figure of 1,500-4,500 persons per itinerant cannot be achieved with present resources. A reasonable estimate is that the project can effectively reach the greater part of the subsector population, given 10 household visits per day, with only two rounds per year. Reapportionment does not immediately pose major problems in human resources, but it does present a very real short-term problem in the numerical sufficiency of itinerant nurses. In El Jadida, 11 itinerants are available to expand VDMS to the districts designated for the second phase; 95 are needed. In Beni Mellal, 45 itinerants are available, but 72 are needed to cover the entire province. In Meknes, there is no personnel problem in the urban areas, but there is an insufficient number of staff in the rural areas (the number [92] assigned to the rural areas is insufficient to cover Ain Jemaa district). MOPH officials are cognizant of this problem, which can be solved only by gradually reapportioning the areas, considering factors in the field (e.g., population density and accessibility) and assigning, by priority, new graduates to the VDMS provinces. The reassignment of personnel in stationary posts, particularly in urban areas, to itinerant posts is also envisioned.

The assignment of new itinerants raises a question about housing. The Ministry expects that the local population will help to lodge itinerants. The cost of constructing several hundred lodgings for nurses would tax the financial capabilities of the MOPH. In certain regions,

the population has already offered to help construct lodgings for nurses. The MOPH needs to follow through and encourage this initiative, which can only facilitate the integration of the itinerants into the rural population with which they will work.

The number of motorbikes required by the project was estimated before geographic reapportionment began. Consequently, there will be a lack of transportation in the three designated provinces. In El Jadida, there are 85 motorbikes; 9 additional bikes for itinerants and 23 bikes for supervisors are needed. In Beni Mellal, only 45 motorbikes for 72 subsectors are available. In Meknes, there are 45 new bikes, 14 old bikes in running order, and 22 bikes which are repairable, making a total of 81 bikes, excluding those required by supervisors, for 92 subsectors. The increase in the number of itinerants needed to cover the new subsectors created by reapportionment poses a problem because the allowances and per diem proposed in the budget are insufficient.

Cost Considerations

As part of the evaluation of VDMS expansion, the evaluators considered the financial input of the USAID to support the VDMS project in Marrakech. VDMS-Marrakech was considered to be a pilot or operations research project. Certain components were bolstered by additional financial input, including:

- personnel (VDMS-Marrakech included special salary funding for a director's support and for secretarial help);
- transport (because transportation in Morocco is lacking, the USAID set aside funds for the rental and maintenance of motorbikes and the GOM put aside funds for cars and trucks to transport the motorbikes to outlying areas or to transport documents);
- administration (because a research-oriented service project is administratively complex, additional USAID money was supplied);
and
- training and IEC (extra funds were provided to develop an IEC program in souks [markets], but because this was not accomplished, the funds were used to support evaluation and retraining activities).

It was assumed that most of these would be one-time costs (incurred because the project was intensive) which would not recur should expansion take place. In addition to this support, the United Nations Fund for Population Activities (UNFPA) contributed motorbikes to facilitate expansion, thus obviating the need for excessive input in this category.

Graphs IV-1 and IV-2 present funding inputs for the two projects in dirhams (DHs). Graph IV-1 shows total input; Graph IV-2 presents per capita input.

Graph IV-1 shows the breakdown of funds by contribution and by budget category. Clearly, personnel costs comprise the majority of project costs. It is noteworthy that although the UNFPA has donated motorbikes, transportation has consumed a significant portion of the USAID's contribution. In part, this may be because the cost of petrol, which is a part of this support, has increased.

Graph IV-2 presents both the per capita input for the projects and percentage support by contributor. Based on the input, in dirhams, for household visits only,* the cost per capita in the provinces where expansion is taking place is double that in the other provinces; the percentage contribution from the USAID is approximately the same. Additional data for the two graphs are presented in Table IV-1.

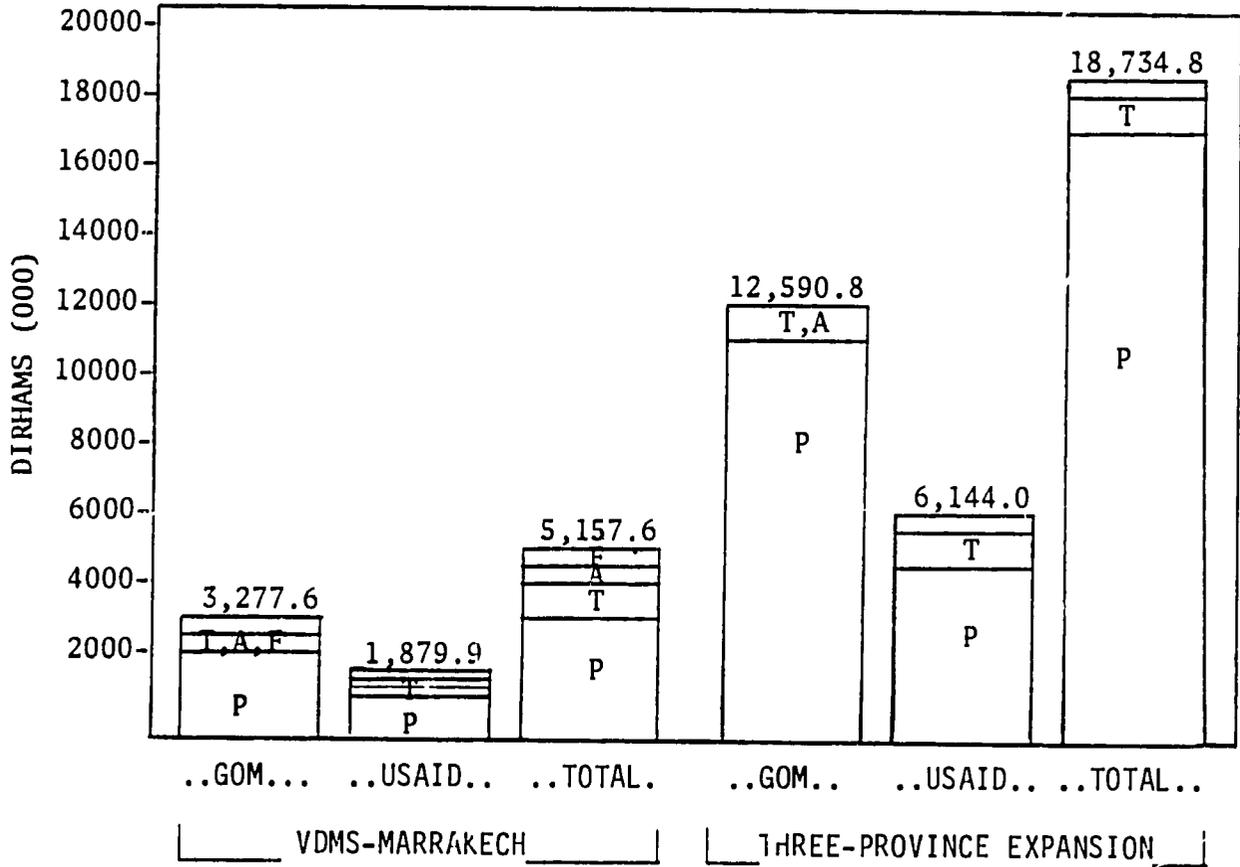
The graphs illustrate several significant points:

- Because the percentage of the USAID input in each budget category is similar, it appears that the MOPH assumes no additional responsibility for running costs in the expansion.
- The USAID's percentage of the total cost is about the same, even though expansion entails many non-family planning activities.
- If, in the next phase, the effort is continued or expanded to another seven provinces, the USAID should support fewer of the carrying costs of the project and limit itself as much as possible to one-time start-up costs. With this approach, the MOPH should be able to assume ongoing costs gradually and introduce these costs into national budgeting plans.
- Because programming has become more diffuse, the USAID's input of dollars for population activity should be adjusted, as is appropriate. In Marrakech, where the project involved family planning only (i.e., 100 percent), the USAID supported 36 percent of the project. The expansion effort involves a significant number of non-family planning activities, but the USAID's contribution is approximately the same, 32 percent. Although it is recognized that flexibility is necessary in all programming, efforts should be made to maintain a level of family planning funding that is appropriate to the effort.

* Both projects have additional input for data analysis and evaluation: Marrakech, approximately \$77,000; the three provinces, approximately \$150,000.

Graph IV-1

GOM AND USAID INPUT FOR THE
VDMS-MARRAKECH AND VDMS-EXPANSION PROJECTS



Code: P = PERSONNEL T = TRANSPORT A = ADMIN F = IEC/TRAINING

Graph IV-2

GOM AND USAID PER CAPITA INPUT FOR THE
VDMS-MARRAKECH AND THE VDMS-EXPANSION PROJECTS

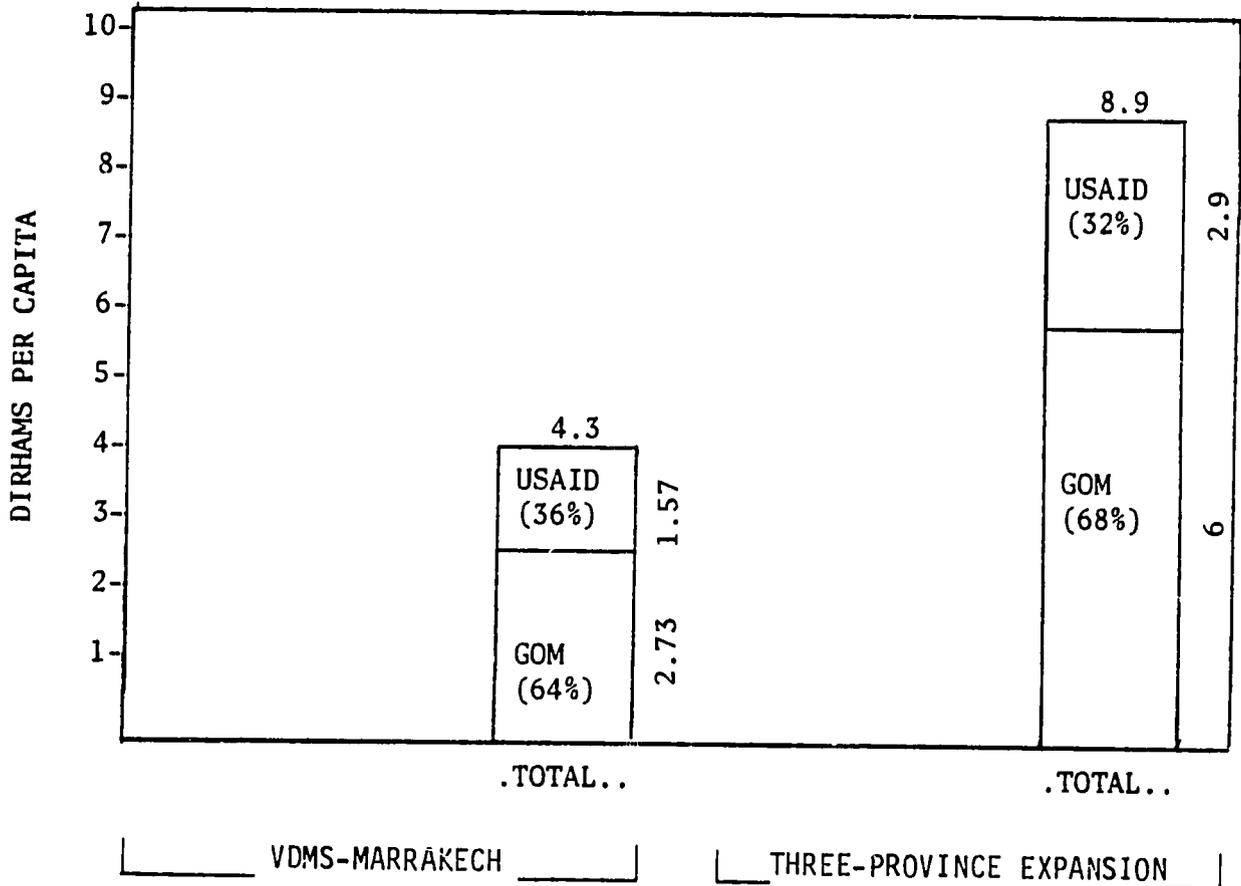


Table IV-1

VDMS COSTS IN DH (\$000s AND %)

<u>Province</u>	<u>GOM</u>	<u>USAID</u>	<u>TOTAL</u>
<u>MARRAKECH</u>			
Personnel	2,668.3 (66.8) (81.4)	1,141.1 (28.6) (60.7)	3,994.2 (100%) (77.4%)
Transport	514.5 (61.4) (15.7)	323.4 (38.6) (17.2)	937.9 (100%) (15.2%)
Administration	94.9 (33.3) (2.9)	189.8 (66.6) (10.0)	284.8 (100%) (5.5%)
Training IEC	0.0 (0.0) (0.0)	225.5 (100) (12.0)	225.5 (100%) (4.4%)
TOTAL	3,277.6 (64.0%) (100%)	1,879.9 (36.0%) (100%)	5,157.6 (100%) (100%)
<u>THREE-PROVINCE EXPANSION</u>			
Personnel	11,840.8 (70.8) (94.0)	4,863.8 (29.1) (79.2)	16,704.6 (100%) (89.2%)
Transport	440.0 (34.4) (3.5)	840.9 (65.6) (13.7)	1,280.9 (100%) (6.8%)
Administration	310.0 (48.9) (2.5)	324.2 (51.1) (5.3)	634.2 (100%) (3.4%)
Training IEC	0.0 (0.0) (0.0)	115.0 (100) (1.9)	115.0 (100%) (0.6%)
TOTAL	12,590.2 (67.6) (100%)	6,144.0 (32.4) (100%)	18,734.8 (100%) (100%)

Recommendations

In their discussions with the evaluators, the chief medical officers in the provinces were realistic in their assessment of expansion. As they recognize, the task is to launch a new and ambitious effort that will require time and labor. The first steps will be fundamental to the future orientation and expansion of the program as a whole. Thus, to ensure the success of the effort, careful, rigorous attention must be given to training, supervision, strategy, and evaluation.

If the CMOs decide to proceed cautiously by implementing the program in stages, this would be a correct approach. Given the multiplicity of factors that will certainly influence the development of the project, officials at the national level especially should proceed carefully.

Specifically, the evaluators recommend the following activities to ensure the successful replication of VDMS in other areas:

1. *The project should not be expanded to the other seven provinces until the experiences of the first phase are analyzed and the lessons understood. At least two rounds should be made in a sufficient number of districts before the project is expanded to the other provinces. The VDMS-Marrakech project tested the feasibility and efficiency of a home visit designed to accomplish a single objective. It is impossible to anticipate all the difficulties that are likely to arise when making a home visit that has more than one purpose.*
2. *During the first phase, particular attention should be given to the organization of operational field research. This research should examine especially:*
 - continuing quantitative and qualitative evaluation of the activities of itinerant workers and the benefits accruing to the population (e.g., coverage, services rendered, etc.);*
 - the impact of FP activities (e.g., acceptance and continuation);*
 - the identification of logistical problems, including supervision by sector chiefs, and the adequacy of proposed solutions;*
 - organizational, administrative, and financial management of the project; and*
 - the adequacy of training.*

During the same period, it will be important to plan all aspects of the expansion of the project to the other seven provinces. Care should be taken to:

- order and supply the means of transportation;*
- assign personnel;*
- reapportion subsectors;*
- conduct a budgetary study, possibly leading to the reallocation of unexpended budget items; and*
- establish a logistics system. Retraining in logistics and supervision should be provided to the chief nurses responsible for the dispensaries. The majority of these persons are auxiliary nurses who have never received such training. Provincial district medical officers and officials concerned with the supply system should also participate in the training. The USAID should offer to assist the MOPH in organizing the training and, perhaps, provide a short-term adviser. Logistics is also a problem for the Health Management Improvement Project, which might benefit from similar assistance.*

3. The most urgent problem is transportation. It is imperative that each itinerant worker have at his disposal a motorbike in good working condition. The ordering of new, supplementary bikes will not solve the problem, because of delays in delivery. The expenditure of project funds to repair unused motorbikes should be considered, and a reserve pool should be created to ensure that the schedule of home visits is completed on time. There are various ways to ensure that itinerants' bikes are maintained in good working order. These methods should be considered and tested during the first phase. They include:

- using project funds to assign a mechanic and supplying spare parts to a provincial garage;*
- providing as part of the itinerants' allowance a supplement for the maintenance and repair of the motorbikes; and*
- arranging easy repayment terms that would enable an itinerant worker to purchase a motorbike and, as its owner, assume the costs of maintenance and repair.*

4. During field trips, the members of the evaluation team noted the extreme diversity in the number of monthly cycles of pills that were being distributed, even within the same province.

The MOPH should specify how many cycles are to be distributed and communicate its decision to all provincial officials. Standardized distribution is imperative. A minimum of three monthly cycles, systematically distributed to all users at permanent health facilities, is recommended. Also, the itinerants should offer seven monthly cycles on each tour as planned. The MOPH should restate its decision at the next meeting of chief medical officers to further legitimize its policy and to ensure that the plan of distribution is understood.

5. *A program for the continuous retraining of VDMS itinerants should be planned. Furthermore, itinerants should be furnished with a brief list (in Arabic and French) of the indications, contraindications, and secondary effects of contraceptive methods.*
6. *The itinerants' satchels are too large for the luggage racks of their motorbikes and contain many items that are not needed for the VDMS project. The size of the satchels should be changed to fit the rack on the motorbike and unnecessary items should be eliminated.*
7. *To be successful, efforts to combat diarrhea should not be limited to an Oralyte demonstration for those families that present a sick child at the time of an itinerant's visit. The use of Oralyte as a preventive measure should be taught to all mothers, perhaps during group meetings. Once they have been instructed, the women could be given a standard number of packets of Oralyte (e.g., five).*

Retraining must be part of each visit, and each woman who is given packets must demonstrate capability in preparing Oralyte. In addition, she must pass an oral test that shows that she understands how to use the solution.

8. *All the provincial chief medical officers and their principal collaborators should be given a copy of the study on the VDMS project in Marrakech.*
9. *The MOPH should begin to examine ways to ensure continuation of the program after external aid is withdrawn. It should seek funding especially for allowances and transportation costs. The USAID should be vigilant in promoting this effort.*

V. TRAINING OF PARAMEDICAL PERSONNEL

V. TRAINING OF PARAMEDICAL PERSONNEL

There are three categories of paramedical personnel:

- auxiliary nurses (adjoints de santé breveté);
- registered nurses (adjoints de santé diplôme d'état); and
- specialist nurses (adjoints de santé spécialiste ou cadriste).

The distribution of these nurses among urban and rural health centers and dispensaries is given in Tables V-1 and V-2.

Both in urban and rural health facilities, there is a serious shortage of upper-level paramedical personnel. These persons are responsible for planning, monitoring, supervision, and evaluation of health programs. Registered nurses who have not been trained in these areas currently perform these tasks. Similarly, because of the lack of registered nurses, especially in rural health facilities, auxiliary nurses often perform the tasks that normally are the responsibility of registered nurses. As a consequence, there is a shortage of auxiliary nurses whose major function is outreach activities. In rural areas, the problem is even more acute, because it is difficult for a nurse, often of urban origin, to integrate himself or herself into the rural environment.

The MOPH has taken various actions to overcome the problem of a shortage of health personnel and to upgrade the quality of existing and future health manpower.

Central-Level Training

The Service of Professional Training has been upgraded to a Division of Training. Two departments recently were created within the Division: the "Formation Pédagogique," which is responsible for the planning and reorganization of formal training at the three levels of paramedical schools (écoles de breveté, écoles de diplômes d'état, and écoles des cadres) and the Department of Inservice Training, which is in charge of all programs for on-the-job training.

Table V-1
PARAMEDICAL PERSONNEL IN
URBAN HEALTH CENTERS AND DISPENSARIES,
1980

<u>Category</u>	<u>Existing Number</u>	<u>Required Number</u>	<u>Coverage (%)</u>
Auxiliary Nurses	2,655	1,969	135%
Registered Nurses	438	725	60%
Specialist Nurses	17	206	8%

Table V-2
PARAMEDICAL PERSONNEL IN
RURAL HEALTH CENTERS AND DISPENSARIES,
1980

<u>Category</u>	<u>Existing Number</u>	<u>Required Number</u>	<u>Coverage (%)</u>
Auxiliary Nurses	2,790	2,978	97%
Registered Nurses	249	1,241	20%
Specialist Nurses	7	149	5%

Decentralization of Formal Training

To solve the problem of recruiting and retraining candidates of urban origin who upon graduation will be assigned to rural areas, the MOPH has decentralized the training of both auxiliary nurses and registered nurses.

At this time, there are 28 schools of auxiliary nurses (nearly one in each province) from which approximately 2,000 students are graduated each year (70 percent female and 30 percent male in urban settings; 50 percent male and 50 percent female in rural areas). There are 8 schools of registered nurses which graduate approximately 500 nurses each year (50 percent of each sex). At this time, there is only one school of specialized nurses (cadristes), located in Rabat. A second school is expected to open in the period covered by the 1981-1985 Development Plan. Several years ago, approximately 20-25 persons were graduated each year. Today, 100 specialized nurses graduate each year from the school in Rabat. However, the students in the specialized nursing school come primarily from the ranks of the trained registered nurses, thereby depleting the number of registered nurses.

Other Alternatives

The MOPH is considering adding a fourth level to its array of paramedical personnel. This new category of worker would be lower than the level of auxiliary nurse. The new health workers would originate from and be assigned to rural areas.

The MOPH is also studying the feasibility of using traditional birth attendants (TBAs) and community health workers, both from the non-formal sector. These personnel would be part of the system to achieve the objective of the MOPH's national policy.

Revision of Curriculum

The courses of all three levels of paramedical schools are being revised at this time. The new course for the auxiliary nursing school has been part of the program since 1980-1981. The new course for registered nurses will be offered for the first time in 1982-1983, and that for specialist nurses will be included in the curriculum in 1983.

To revise the curriculum, the MOPH began with the different posts filled by nurses, identifying the tasks performed at each post and then specifying the theoretical knowledge and practical skills needed to accomplish those tasks. With this information, it designed a program and introduced it into the school of auxiliary nurses.

At the same time, a guide pédagogique was produced for the monitors of the schools to help them to teach the new training program. A module is planned to be given to the students as a reference document.

In the program for the auxiliary nurses, eight hours are devoted to population and ten hours to family planning.

Inservice Training

The Department of Inservice Training was incorporated recently into the Training Division of the MOPH and is still being organized. The primary objective of this department is to systematize inservice training for all categories of health personnel--a high priority of the MOPH. Inservice training both in-country and abroad is being considered. Already, several MOPH officials have been sent abroad, primarily to the United States, for short-term training in various disciplines (IEC, health planning and management, contraceptive technology, etc.). Language is a barrier, however, limiting both the benefit of and the number of prospective candidates for training. The MOPH is considering sending appropriate candidates to the "Centre Pédagogique" in Tunis and is looking into the possibility of sending trainees to French-speaking Canada with assistance from International Training in Health (INTRAH).

However, the emphasis is now on in-country inservice training. Over the past several years, many seminars have been organized in collaboration with INTRAH, the World Health Organization (WHO), and the University of Chicago. More are planned for the future.

Comments

There is growing awareness in the MOPH of the problem of the quality of health manpower and the ability of personnel to perform correctly the tasks and functions that will enable the Ministry to achieve its objectives. Considerable emphasis is being given to supervision, a task assigned primarily to registered nursing positions. At this time, these positions frequently are filled by auxiliary nurses.

Many steps have been taken and positive achievements have been made, but the process of developing health manpower needs to be strengthened. This is a long-term venture for which the MOPH will need further assistance.

Recommendations

Because of the importance of well-trained health manpower, without which sound health services, including family planning, cannot be

delivered, the MOPH needs to strengthen its training programs and capabilities. To facilitate this process, the evaluators recommend the following action:

1. *The USAID should support inservice training of MOPH personnel at all levels through both health and population funding.*
2. *The USAID should support and, when requested, assist the MOPH in its efforts to develop a strategy to establish a systematic and ongoing national program of inservice training in family planning.*
3. *The USAID should give special emphasis and attention to the support of in-country service training, especially at the provincial level (supervision, logistics, FP, and VDMS).*
4. *The USAID should assist the MOPH in strengthening the training capacity of the family planning referral centers.*

VI. EVALUATION OF FAMILY PLANNING LOGISTICS IN MOROCCO

VI. EVALUATION OF FAMILY PLANNING LOGISTICS IN MOROCCO

The primary objective of a family planning logistics system is to ensure that sufficient quantities of contraceptive supplies are available to actual and prospective users at the points of service delivery. Studies have shown that if contraceptives are unavailable or available in small quantities only, dropout rates increase dramatically. Therefore, if supplies are generally available in sufficient quantities, the logistics system is considered to be working well, even though there may be problems with certain individual features of the system or at certain geographic points in the country.

To summarize, in Morocco the system is working well; supplies at most of the service delivery points which the team visited are available in sufficient quantities. The physical and administrative structure of the family planning logistics system in Morocco is well-conceived and, if properly managed, it should operate efficiently at all program levels.

At the circonscription and provincial levels, there are some problems because certain individuals have not been adequately trained in supply management. These problems can be resolved easily by providing inservice training at the provincial level (stages de recyclage) in the administration of the Moroccan logistics system.

Additional minor administrative problems were traced to the method used to prepare the monthly stock reports at the provincial level; the method presents problems when supply shipments are calculated at the national level. These difficulties were discussed with the officials responsible for the reports (Mr. Mimous Boukhrissi and Mlle. Aicha Haiguech), each of whom agreed on the corrective actions that need to be taken at the provincial level.

Description

The logistics system for public sector family planning and other medical supplies in Morocco is a "push" system (systeme d'allocation). In this kind of system, decisions about the timing and frequency of the delivery of supplies from higher-level facilities to lower-level facilities are made at the higher level. They are based on reports of consumption and supplies on hand which the lower levels send to the higher levels. It is a system best suited to situations in which lower-level personnel are not particularly knowledgeable about supply management. In fact, it is the most commonly used system in national family planning programs in developing countries.

In Morocco, the management of contraceptive supplies is based in the "Service de Planification Familiale" (SPF), in Rabat, which is under the direction of Mr. Boukhrissi, although actual day-to-day operation of the supply system is the responsibility of Mlle. Haiguech. The monthly circonscription-level reports of supplies received, supplies used, and supplies on hand at the end of each month (recorded on the last page of form PF/2a, Section 5, "Etat Mensuel du Stock des Produits Contraceptifs au Centre") are used to prepare periodic lists of the contraceptives that are to be allocated and shipped from the central-level warehouses to the various provinces. These allocation lists are prepared once every three months for any one province. A change to six-month intervals is envisaged.

IUDs and other contraceptive supplies which are supplied in small quantities are stored and packed for shipment in the SPF's offices. The SPF also keeps on hand a small quantity of pills and condoms for emergency shipments. Most pills and condoms, which are shipped in large quantities, are stored in the facilities of the "Dépôt Central," which is under the direction of Mr. B. Fahdi.

The Dépôt Central is responsible for physically organizing all shipments of IUDs and other supplies from the SPF to the provinces, as well as all shipments of pills and condoms from the two large warehouses in Rabat and Casablanca. It is also responsible for customs clearance and receipt of overseas shipments from the USAID and other donor agencies. When Mr. Fahdi receives allocation lists that specify the quantities of pills, condoms, and other supplies to be shipped from the SPF, he prepares for each province a list of items to be sent (bordereau d'expédition). The lists are then sent to the manager of the warehouse in either Rabat or Casablanca; the supplies are allocated, and the items are shipped in a truck belonging to the SPF.

The warehouse in Rabat stores a wide variety of medical supplies, and thus only a small percentage of the large quantities of pills and condoms used in Morocco. The warehouse in Casablanca is used to store most of the central-level stock of pills and condoms, although it is entirely under the administrative control of Mr. Fahdi's office in Rabat. Shipments are made from either one or the other warehouse, depending on quantities on hand in each facility.

Contraceptives are stored at the provincial level for distribution to health centers at the circonscription level. Administrative control of provincial-level stock varies from province to province. In the provinces visited by the evaluation team, the responsibility was divided as follows:

- In El Jadida, the animateur de planning familial was in charge.
- In El Kelaa, the warehouseman exercised administrative control.

- In Beni Mellal, the nurse in charge of the family planning referral center supervised distribution.
- In Marrakech, the animateur for health education was in charge.

Each month, the provincial-level office receives a monthly report, PF/2a, "Programme de Planification Familiale, Compte Rendu Mensuel d'Activités," from each health center and each referral center (circonscription level) in the province (see Exhibit VI-1). Section 5 of this report (see Exhibit VI-2) is a summary of the receipts, issues, and balance of IUDs, condoms, and pills on hand at the beginning and end of the month. The person responsible for management of the stock at the provincial level uses this report to determine the amount of each contraceptive that each health center and each referral center will need (this is done also at the national level). Supplies are then shipped on a vehicle belonging to the province or, in some cases, the circonscription. An identical system is used to supply dispensaries with pills and condoms (few dispensaries perform IUD insertions).

Evaluation and Recommendations

At all program levels, the physical infrastructure, the administrative procedures, and the personnel available to manage the distribution of commodities are of high quality.

All the warehouses and storage areas which the team visited are sound and dry, and, with the exception of Marrakech Province, the quantities of stock are recorded on stock cards. Most personnel seem to be aware of the first in-first out (FIFO) (premières entrées-premières sorties) method of stock management, which is in use in most areas, although a small number of pills dating back to 1977 was seen.

At the national level, and everywhere in Beni Mellal Province, physical inventories are regularly performed. The information on the stock cards is accurate. In El Jadida Province, physical inventories are not performed; the discrepancy between the amount of stock the evaluation team counted and the amount recorded on the stock cards was minor. However, in the provincial warehouse in El Kelaa, cartons are stocked so that an exact physical count is impossible and the FIFO system is difficult to administer. A rough count by the evaluation team showed that the amount of pills on hand is almost twice that recorded on the stock cards.

Recommendation: As a national policy, at least twice each year, physical counts should be made of all commodities in stock. In addition, use of the FIFO system should be encouraged strongly.

Exhibit VI-2

SUMMARY OF RECEIPTS, ISSUES, AND BALANCE OF STOCK

5. Etat Mensuel du stock des produits contraceptifs au centre .

FIGURE 2

Type de produit	Diaphragme en pièces	Pilules en boîte	Condoms en pièces
Mouvement du produit			
a - Stock au début du mois			
b - Quantité reçue durant le mois			
c - Quantité distribuée pendant le mois			
1. Dispensaire			
2. Itinérance VIMS			
d - Stock à la fin du mois			

MINISTÈRE DE LA SANTÉ PUBLIQUE

Mois _____
Année _____

PROGRAMME DE PLANIFICATION FAMILIALE

COMPTE RENDU MENSUEL D'ACTIVITES

6. Personnel responsable de la Consultation

Médecin _____
Sage-femme _____
Laborante _____

Province ou Préfecture _____

Centre ou Hôpital _____

Nom du Responsable _____

7. Observations

Visa de contrôle du Médecin Chef
des Services de Prévention

Signature du Responsable

Cartons should be stocked with space between them so that most are visible and the oldest lots can be distinguished and distributed first.

An analysis was done of the number of months' supply of contraceptives on hand at various program levels. This was done by calculating the average monthly amount of each method issued (sorties) from the storage facility that covered the country, province, circonscription, or dispensary for the past six months (the past 12 months, for the national level, to compensate for large amounts issued in early 1981). The average monthly amount for each method was then divided into the amount for each method on hand at the end of the past month; in this case, November 30, 1981. The result was the number of months' supply as of this date. At the national level, in a large family planning program such as Morocco's, a minimum of 12 months' supply and a maximum of three years' supply of each method should be on hand. As of December 11, 1981, the number of months' supply of each method on hand at the national-level storage facilities in Rabat and Casablanca was:

Pill	23	Months
Condom	45	Months
IUD	3.6	Months.

The amount of condoms is excessive and should be allowed to drop. Either fewer should be ordered from overseas or more should be shipped to lower-level facilities after similar analyses are completed in all the provinces. The consumption of condoms could increase dramatically when the new VDMS program is launched. Use of condoms should be monitored over the next year.

The stock of IUDs is extremely low, no doubt because of the large recent shipments to the provincial level in anticipation of the new VDMS program. New supplies must be received soon from overseas to avoid stock-outs at the national level.

At the provincial- and circonscription-level facilities, a similar analysis was done where there were sufficient statistical data on logistics. Mlle. Haiguech receives stock reports from the provinces and circonscriptions approximately three months after the end of each month.* Henceforth, provincial shipments will be made every six months; therefore, the provincial stocks should be relatively large. For a province in

* On December 14, 1981, none of the 39 provinces had submitted reports for November; 6 had turned in reports for October; 20 had submitted reports for September; and 31 had provided reports for August.

Morocco the team would recommend that a minimum of 12 months' supply and a maximum of 18 months' supply of each method be kept on hand. The monthly supply on hand in two provinces was as follows:

	<u>Pill</u>	<u>Condom</u>
El Jadida	10 Months	9.5 Months
Beni Mellal	22 Months	(Use Extremely Low)

As is evident, the amount of pills on hand in Beni Mellal is excessive, partly because of the large special shipment recently sent in anticipation of the VDMS program. To correct this situation, larger amounts of stock could be kept in the health centers in Beni Mellal, where, in one case, the team found that too few pills are regularly kept on hand.

At the circonscription and health center levels, analysis was done at Kasba Tadla Health Center, Beni Mellal Province. There, it was found that only a one-month supply of pills is kept on hand, although the majeur in charge of supply management at the health center has a good knowledge of logistics techniques and keeps four dispensaries, including one in a remote village, regularly supplied. A minimum supply of two months and a maximum supply of four months should probably be kept on hand in the circonscriptions.

In the provinces where the new VDMS program is being launched, large shipments of supplies have been made to all health centers and dispensaries. Itinerant house visitors will be distributing contraceptives from these facilities. There is some indication that personnel in these areas consider the stock to be "for the VDMS program"; that is, to be separate and apart from contraceptives distributed from static facilities. This misperception should be corrected; an analysis of the monthly consumption of contraceptives in a health facility engaged in VDMS activities should indicate consumption levels for both VDMS and static activities. The minimum and maximum number of months' supply to be kept on hand should be based on this total consumption. The new forms for the monthly reports from provinces and circonscriptions should include a monthly count of supplies distributed, broken down by clinic and VDMS activities.

Recommendation: As national policy, analysis of stock on hand should be a regular part of the system of supply management. At each level of health facility, the number of months' supply on hand in the storage facility covering the area and the number of months' supply on hand in all the lower-level facilities should be added together. The number of months' supply in the lower-level facilities should, in the aggregate, fall somewhere between the recommended minimum amount and the recommended maximum amount for a single lower-level facility. Contraceptive supplies for

VDMS activities should not be treated separately, either physically or administratively. Quantities consumed and quantities kept on hand will merely be increased where VDMS activities are under way.

Decisions about the quantities of contraceptive supplies to be shipped to lower-level facilities should be based on the maximum and minimum number of months' supply on hand in these facilities. If a lower-level facility does not have on hand the maximum number of months' supply, the amount of the next shipment should be equivalent to the additional number of months' supply needed to bring the stock up to the maximum level. When the lower-level facility has more than the maximum number of months' supply on hand, the next shipment can be postponed. If the stock in a family planning facility falls below the minimum number of months' supply, an emergency shipment may be required.

This kind of analysis helps to ensure that lower-level facilities do not run out of stock, that facilities are not over-supplied, and that the logistics system functions as efficiently as possible. The analysis should be done at the national, provincial, circonscription, and dispensary levels in Morocco after personnel are trained to use the formulas to calculate the levels of stock and the quantities of supplies needed.

At the SPF's office in Rabat, all monthly reports from provinces are collated. The reports include form PF/2a, "Compte Rendu Mensuel d'Activités" (see Exhibits VI-1 and VI-2), which is submitted for each circonscription in the province. They also include a report on family planning activities, by number of initial visits and re-visits, as well as a report on stock levels and use.

Most provinces also submit a report which is a summary of all family planning activities in the province, by circonscription. This summary is in the same format as the circonscriptions' reports on family planning activities. Reports are not on a pre-printed SPF form, such as the PF/2a, but on forms produced ad hoc. The forms differ from province to province. (For an example, see Exhibit VI-3.) More important, only a small number of the 37 provinces include data for stock levels and use based on information from the provincial-level storage facility. As a result, Mlle. Haiguech does not have the data she needs to determine the quantities of each contraceptive method for each province. Mlle. Haiguech can only estimate roughly the amount of stock each province actually needs based on the total levels of stock in circonscriptions; she collates this information on the "Bilan Mensuel d'Activités" (see Exhibits VI-4 and VI-5). Because supplies are shipped from the national-level warehouses to the provincial-level warehouses, and not to circonscriptions, data on the stock in the provinces are needed to enable the "push" system to function properly.

Exhibit VI-3

SAMPLE OF SUMMARY REPORT ON PROVINCIAL FAMILY PLANNING ACTIVITIES

ROYAUME DU MAROC
 MINISTRE DE LA SANTE PUBLIQUE
 PROVINCE MEDICALE D'AL-JADIDA

MOS DE _____

RECAPITULATIF PROVINCIAL DE LA PLANIFICATION FAMILIALE

Circonscriptions ACTIVITES	Centre de Reference	C.S. El Jadida	C.S. Azemour	SIDI Benmour	C.S. Zemamra	BIR Jdid	C.S. Oualidia	SIDI Smail	CS Ouled Fredj	TOTAL
Nombre de visites initiales pour toutes raisons										
Appareils intra-utérins										
a) Insertions initiales										
b) Reinsertions										
c) Retraits										
d) Expulsions										
e) Grossesses										
f) Autres visites de contrôle										
Nombre de consultantes ayant reçu pour la 1ere fois :										
a) Pilules										
b) Condoms										
Nombre de consultantes revenues pour :										
a) PILULES										
b) CONDOMS										

Etat de stock à la date du :

- Pilule
- Condoms
- Appareil intra utérin

Le Medecin Chef du S.I.A.A.P.

Recommendation: Provinces should be required to submit a monthly report which includes stock levels and use in the provincial-level storage facility. The information should be provided in the same format as the data included in the circonscriptions' reports. The data can be recorded on the new form, PF/3, "Récapitulatif Provincial des Activités de Planification Familiale." The section on family planning activities could be identical to the form used in El Jadida (see Exhibit VI-3), and the report on stock could be identical to Section 5 on form PF/2a (see Exhibit VI-2), except that it should be retitled "Etat Mensuel du Stock dans le Dépôt Provincial." In addition, data on the number of pills and condoms distributed by VDMS itinérants should be submitted. The information could be recorded in the section labeled "Stock Provincial" on the "Bilan Mensuel d'Activités," which Mlle. Haiguech needs to accurately determine quantities of contraceptive supplies to be shipped from the national level to the provincial levels (see Exhibit VI-5).

In addition, the "Bilan Mensuel d'Activités" should be modified slightly. At the bottom of the second page ("Total"), the amount distributed (line "D") and the amount in stock (line "S") are listed as the total of the amount distributed from health centers, as well as the amount distributed from the Itinerant Health Worker System (SIAAP) or the provincial warehouses. However, the amount distributed from the SIAAP, or the provincial warehouses, is the amount distributed to the lower-level facilities; thus, when the two figures are added together, the distributed items are counted twice. The form should be modified to include a line for "Total Centers" above the line for "Stock SIAAP" and "Stock Provincial," which should remain separate (see Exhibit VI-6).

There seems to be a considerable variation in the knowledge and skills of provincial personnel involved in logistics and supply management. In the provinces the team visited, the quality of management ranged from poor in one province, because of a lack of specific logistics training, to excellent in another (Beni Mellal). It is likely that similar variations would be found in comparisons of other provinces.

Recommendations: After SPF staff finalize the logistics procedures, a course in supply management should be arranged and made part of inservice training. Mr. Boukhrissi has suggested that national-level personnel visit each province in turn to provide this training. If this approach is not feasible, a training-of-trainers course should be held in Rabat that includes the administrateur-économe and the person directly responsible for the distribution of stock in each province. In either case, the SPF may want to request a USAID consultant to help develop the training course and assist in finalizing some of the logistics procedures.

VII. RECORDKEEPING AND SERVICE STATISTICS

VII. RECORDKEEPING AND SERVICE STATISTICS

Current Forms

The basic forms for the recordkeeping and service statistics system for ongoing family planning activities in static health facilities in Morocco are the PF/1, "Fiche Individuelle," and the PF/2a, "Compte Rendu Mensuel d'Activités." The information recorded on the PF/2a at referral centers and health centers is summarized on ad hoc forms at the provincial level.

A. PF/1

The "Fiche Individuelle" (see Exhibit VII-1) is used to record data on clients. Standard information on a person's personal, demographic, and gynecological history and on the kind of method prescribed for the new acceptor is listed. The Ministry of Public Health recently decided to change the format of the PF/1 (see Exhibit VII-2). The draft shown to the evaluation team now includes computer codes to facilitate record surveys and the collection of information on breastfeeding. On the reverse side of the new form (see Exhibit VII-3) subsequent visits, including the quantity of contraceptive methods distributed, are recorded. During the initial visit, the front side of the form is completed in two copies; a paper copy is sent to the Ministry of Public Health and a cardboard copy, which includes the reverse side, is kept on file in the health facility.

The "Fiche Individuelle" is well-conceived, and the recent improvements will facilitate surveys on the characteristics of new acceptors. These data will aid in targeting IEC activities.

The PF/1 is filed in health facilities by either name or number, depending on the preference of the centers' personnel. One health center requires that the client's photograph be attached to the form to ensure that only the client herself is resupplied. However, the service statistics of health centers that file only by name or number include only initial visits and subsequent visits, by method.

Recommendation: A system for filing the "Fiche Individuelle" should be developed which would permit staff to count the number of active family planning clients; that is, the number of clients using a center's family planning services who possess and, it is presumed, are using a contraceptive method. This number would be the prevalence,

Exhibit VII-1

SAMPLE CLIENT RECORD

MINISTERE DE LA SANTE PUBLIQUE
PLANIFICATION FAMILIALE
FICHE INDIVIDUELLE PF/La

- 1. N° D'Enregistrement
2. Circonscription sanitaire.
3. Date de la première visite.

- 4. Centre ou hôpital de.
5. Nom de la femme (Prénom, nom du père, nom de la mère)
6. Adresse détaillée (Cercle ou ville, Prov, ou préf., profession du Mari)
7. Nom du Mari
8. La femme travaille-t-elle en dehors de la maison? (Oui/Non)
9. Si oui, en quoi consiste son travail

- 10. Age de la femme
11. Age du mari
12. Nbre de garçons vivants
13. Nbre de filles vivants
14. Nbre d'enfants décédés
15. Nbre de fausses couches
16. Mois écoulés depuis la dernière Grossesse
17. Date des dernières règles (Jour, Mois, Année)
18. La consultante désire-t-elle d'autre enfants? (OUI/NON/Ne sait pas)
19. La consultante a été informée de l'existence de centre de PF Par: Mari, Parents, Amies, Personnel de la santé, Radio, Cinéma, journal, Autres (précisez)
20. LA Consultante sait-elle lire et écrire? (OUI/NON)
21. Nombre d'années passées à l'école
22. La femme a-t-elle essayé d'autres méthodes contraceptives dans le passé (OUI/NON) Si oui, lesquelles
23. Examen gynécologiques: Normal (Oui/Non) Si non, précisez
24. La consultante est-elle enceinte? (OUI/NON) Si oui, âge de la grossesse en semaines
25. L'appareil intra-Utérin a-t-il été inséré? (OUI/NON) Si non, expliquez
26. Taille de l'appareil inséré (B, C, D)
27. Autre méthode prescrite: Condom, Pilule, Aucune, Autres (Précisez)
Signature du Médecin

Exhibit VII-2

SAMPLE OF MODIFIED PF/1 FORM (Front)

NOME
 SERE DE LA SANTE PUBLIQUE
 PLANIFICATION FAMILIALE
 FICHE INDIVIDUELLE P.F/12

1 - NO. LA REGISTREMENT
 2 - PREV. DE PREVENTION DE
 3 - FORMATION SANITAIRE DE
 4 - DATE DE LA 1^{ERE} VISITE

5-1 NOM ET PRENOM DE LA FEMME
 6- LA FEMME TRAVAILLE-T-ELLE? OUI NON
 7-1 NOM ET PRENOM DU MARI 7-2 AGE (EN ANNEES)
 7-3 PROFESSION DU MARI
 8-1 NOMBRE D'ENFANTS VIVANTS 8-2 NOMBRE DE GARCONS VIVANTS 8-3 NOMBRE DE FILLES VIVANTES
 9-1 NOMBRE D'ENFANTS DECEDES 9-2 NOMBRE DE MORTS 9-3 NOMBRE DE FETUS MORTS
 10- TEMPS ECOULES DEPUIS LA DERNIERE GROSSESSE (EN MOIS) (EN ANNEES)

11- ALLAITEMENT ACTUEL: OUI NON
 11-4 EN AMENORRHEE REGLER
 11-2 DATE DES DERNIERES REGLES:

12- LA FEMME A-T-ELLE UTILISE D'AUTRES METHODES CONTRACEPTIVES DANS LE PAYS? OUI NON
 12-1 LESQUELLES?
 - D.I.U.
 - PILULES
 - CONDOM
 - AUTRES:
 12-2 DUREE UTILISATION: MOIS
 12-3 POURQUOI?

13- LA FEMME DESIRE-T-ELLE D'AUTRES GROSSESSES? OUI NON

14- L'EXAMEN GYNECOLOGIQUE EST-IL NORMAL? OUI NON
 PRECISER:

15- METHODE ACCEPTEE: D.I.U. PILULE CONDOM MOUSSE TABLETT. AUTRE
 15-1 DATE D'ACCEPTATION:

15-2 LE D.I.U. A-T-IL ETE INSERE? OUI NON
 TYPE:
 DATE: J M A
 POURQUOI?

Explotation fiche par la recipitulation.

and not the incidence, of use. It is a much more accurate measure of program progress than the recorded number of initial and subsequent visits.

The simplest and easiest method would be to file the PF/1 by month of next appointment. At the end of each month a count could be made, by method, of the cards remaining in a file separator for the month just ended. This number would represent clients who have not kept their appointments in the previous month, who are now "inactive" and must be followed up. In this group would be pill users who have missed their appointment for resupply and who presumably have no more pills in their possession. If no follow-up is done, the cards could be filed in a separate section for "inactive" cases and the cards retrieved if and when the clients decide to resume their use of a contraceptive. A count also would be made of "active" clients whose record forms would be filed behind file separators for appointments in the subsequent months; presumably, these persons would have a contraceptive method in their possession and would be using it. This number would be totaled in the monthly report under a new category, "Nombre de Consultantes Actives." (Exhibit VII-4 is an example of monthly file separators.)

B. PF/2a

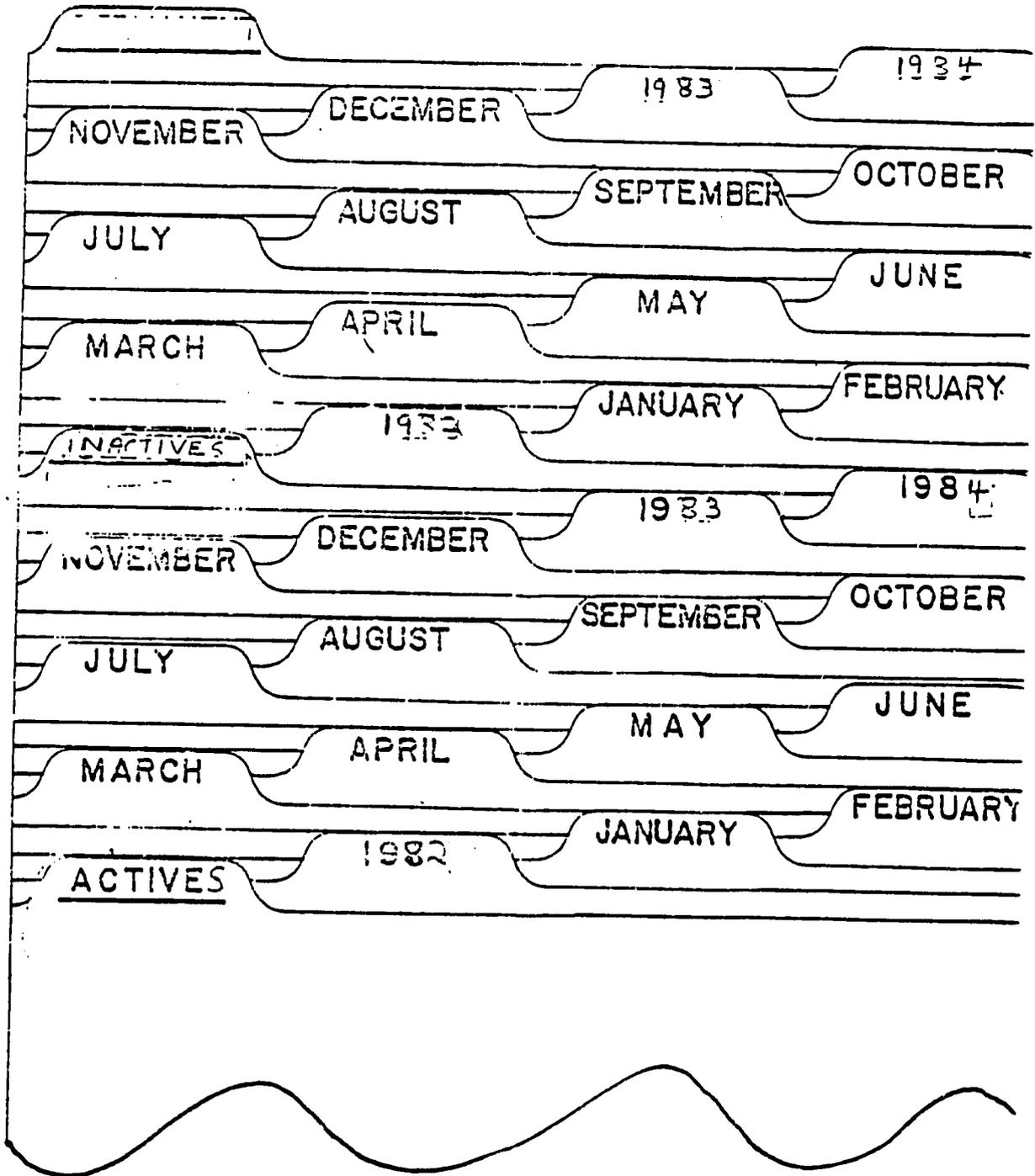
Form PF/2a provides information on the total number of initial users for all reasons; details on the first IUD insertion and subsequent IUD visits; and the number of initial and subsequent users of the pill and condom in health centers, referral centers, and dispensaries that offer family planning services. The "Compte Rendu" is used as a daily tally sheet; numbers are totaled at the end of each month and sent to the provincial level. (Information on the receipts, issues, and balances of stock on hand, which is also recorded on this form, is provided in the chapter on logistics.)

The PF/2a only lists information from the Ministry of Public Health's static health facilities. As the VDMS program expands, data on the numbers and characteristics of family planning clients served by itinerant house visitors will have to be collected from the circonscription and provincial levels.

Recommendation: The data should be presented in a single monthly report from the dispensaries, circonscriptions, and provinces; the report should contain data from static facilities, information on house visits by itinerants, and supply management data on commodities distributed for both activities. The PF/2a will have to be redesigned, as will the compatible lower-level data collection forms

Exhibit VII-4

CARD DIVIDERS



used by the VDMS itinerant house visitors. VDMS family planning data should not be kept separately nor recorded in a format different from that used to collect data from static health facilities. Definitions should be uniform.

The PF/2a also should include space for the category "Nombre de Consultantes Actives."

Proposed Form: The PF/3

A new form, the "Récapitulatif Provincial d'Activités de Planification Familiale," has been proposed, but it does not yet exist. At this time, most, but not all, the provinces provide information to the SPF on ad hoc summary sheets on which are collated the family planning service statistics recorded on the PF/2a by the referral centers and circonscriptions. The format of the summary sheets is similar to the PF/2a, with vertical columns dividing the information by lower-level facility rather than by day of month. A similar summary is made at the national level after this information is made available.

Recommendation: The form proposed as PF/3 should be designed and put into use. It should include space to record the following items:

- family planning service statistics, including number of active clients, for both static facilities and VDMS activities;*
- stock information on the provincial warehouse and all lower-level facilities taken as a whole; and*
- the number of tubal ligations performed, preferably by age and parity (to facilitate planning for the training of gynecologists and surgeons in tubal ligation and to evaluate the impact of sterilizations on the country's demography).*

A form similar to the PF/3 could be used at the national level.

Estimation of Active FP Users

National-level statistics are recorded in formats similar to the format of the PF/2a (see Exhibits VII-5 and VII-6). The forms provide information on the number of visits, or the "incidence" level of family planning activities.

- ACTIVITES DES CENTRES DE PLANIFICATION FAMILIALE I.R PROVINCES ET DISTRICTS
 ETAT COMPARATIF (ANNEE 1979 / 1980)

Prov. et Prefec.	Années	Adrar	Al-Hocima	Assila	Beni-Hellal	Boulevard	Chicoune	El-Jadida	El-Kelâj	Er-Rachidia	Senouira	Pis	Pignis	Kénitra	Rhamsset	Rhénifra	Rh. uriga	Marrakech	N. dimes	Medor	Guarasante	Oujda	Saïf	Serrat	Tanger	Tzoumate	Tarfaya	Taza	Tiaret	Tlemcen	Comblance	Alger-ville	TOTAL
I-Nbre de dev int.	1979	174	962	1665	30576	230	8569	1079	16770	5002	626	19222	2348	9190	9679	1905	856	1726	43459	9373	2109	1527	2763	12369	824	991	632	1171	1562	2170	31994	23215	571302
	1980	212	1037	1810	31301	247	9092	2729	17321	4410	1576	3906	2066	50643	3530	2702	652	21035	16020	5767	534	1185	2217	2020	660	514	1621	1915	1693	1506	4221	27100	719251
II-A.I.U.	1979	109	64	271	770	0	5	231	1570	96	36	1151	0	101	79	18	297	2065	1400	60	125	400	293	42	275	2	0	269	337	15	1620	1176	14219
	1980	297	124	319	636	0	5	761	1200	116	37	929	12	112	99	273	300	2192	1667	71	139	601	192	02	261	5	3	370	235	17	3147	1259	15647
b-Mén.	1979	0	4	6	20	0	0	3	107	0	0	25	0	1	3	2	2	44	159	0	2	12	20	0	2	0	0	5	20	0	195	161	097
	1980	22	6	25	39	0	0	1	225	0	1	74	1	2	3	3	1	47	165	0	4	1	14	1	7	0	0	11	21	0	101	190	1053
c-Retr.	1979	76	5	14	113	0	1	29	160	2	6	130	0	110	5	7	12	175	160	4	32	100	160	3	31	0	0	39	101	0	611	206	2393
	1980	101	15	42	160	0	1	11	213	6	9	230	3	22	3	10	51	235	230	9	25	131	45	1	45	0	1	62	70	4	700	126	2936
d-Exp.	1979	3	2	10	14	0	0	2	79	0	1	20	0	0	1	5	1	45	41	5	4	14	2	0	7	2	0	2	20	4	139	36	467
	1980	0	2	0	27	0	0	1	100	5	2	36	0	2	0	0	0	49	69	4	6	26	4	0	10	0	0	10	14	0	137	105	636
e-Gros	1979	0	0	3	16	0	0	1	15	0	0	7	0	1	0	0	0	15	1	3	2	7	4	0	2	0	0	3	0	0	29	30	177
	1980	1	2	10	5	0	0	1	11	1	0	15	0	0	0	0	0	10	0	0	6	9	1	0	1	0	0	0	5	0	32	30	172
F-V.C.	1979	156	3	934	749	7	0	1412	8453	172	164	1066	0	963	216	201	230	9467	14162	3260	137	1306	1010	0	1070	7	0	1020	4732	35	15430	3554	73902
	1980	199	52	109	694	0	13	1930	6007	575	224	6907	14	1350	730	500	302	9526	16173	3609	1410	1773	1019	0	1612	6	0	1793	1772	3	15529	4123	81255
III-1° Foie	1979	960	1160	2431	8712	630	904	2421	202	1200	1065	6239	331	1661	8871	3131	3137	3350	9776	2034	1007	3300	3141	3597	1268	1000	395	1614	2716	506	12300	3902	106035
	1980	1370	1067	206	8079	677	901	3530	3529	2196	2015	5355	100	5106	3662	3700	270	4054	10102	2303	3103	6001	3479	3153	1363	1356	419	1204	2375	871	12660	3022	117407
b-Condos.	1979	80	59	712	50	13	199	279	115	92	31	2703	0	116	140	75	260	560	464	27	7	1021	134	37	167	130	0	190	135	7	2500	1190	13561
	1980	0	109	627	20	1	111	160	117	205	65	1067	0	1539	467	61	697	540	770	39	57	230	599	469	0	392	11	310	67	193	240	1301	15926
IV-2° Foie a-Pilul. (1)	1979	319	93	152	2016	641	53	1271	1131	112	1391	1535	135	5349	301	2127	474	2247	7102	420	113	1200	1250	606	1441	157	54	1506	1174	675	15192	5102	87306
	1980	200	15	141	172	41	50	1100	111	194	1010	130	210	692	653	1023	141	2929	8651	1060	100	1015	1000	1250	144	297	47	1910	190	110	17291	5261	101630
b-Condos. (1)	1979	0	0	150	33	4	2	2	15	71	1	210	0	3	0	7	225	120	120	22	0	15	170	5	25	2	0	0	51	0	197	109	1900
	1980	0	10	0	20	0	13	0	21	109	0	370	0	99	15	3	61	145	124	6	59	11	12	603	0	102	0	69	40	120	16	120	2206

N.B : (1) Situation de décembre.

SAMPLE FORM FOR COLLECTION OF NATIONAL STATISTICS

Exhibit VII-5

EVOLUTION DE L'ACTIVITE DES CENTRES DE
PLANIFICATION FAMILIALE DURANT LE 1ER SEMESTRE 1981

ACTIVITES	M O I S							Jt.	A	S	O	N	D	T O T A L
	J	F	M	A	M	J								
I) Nbre. de visites initiales pour toutes raisons	67559	69915	66682	74905	74932	76270								430 263
II- Appareils Intrautérins														
a- Insertions	1425	1966	1995	2262	2566	2344								12 658
b- Réinsertions	139	130	160	159	174	167								958
c- Retraits	292	312	322	358	330	391								20005
d- Expulsions	76	75	71	81	65	78								446
e- Grossesses	24	13	12	23	14	15								101
f- Autres visites de contrôle	6811	8250	7666	8024	8449	8253								47 453
III- Nbre. de cons. ayant reçu pour la 1 ^{re} fois :														
a- Pilules	110751	13236	12522	13574	13547	13902								77 532
b- Condome	1523	2344	2119	2183	3194	1888								13 251
IV- Nbre. de consul. revenues pour :														
a- Pilules	101166	104230	106362	113974	11970	116884								
b- Condome	4108	4224	3592	3814	3901	3005								

SAMPLE FORM FOR COLLECTION OF NATIONAL STATISTICS

Exhibit VII-6

Exhibit VII-6 presents national-level activities for 1979 and 1980, broken down by province. Also shown are the percentage increases in all activities from 1979 to 1980; for example:

	<u>Percentage Increase 1979-1980</u>
Initial Visits, All Reasons	25.9%
IUD Insertions	10.0%
First Visits: Pill	11.1%
Condom	12.4%
Revisits: Pill	19.2%
Condom	40.0%

The figures show increased use of family planning services, but little else; they cannot be used to estimate even roughly the prevalence of use because no standard amount of pills is given for initial visits and revisits. The figures for the first semester of 1981 cannot be compared as percentage increases because an error seems to have been made in the tabulation for revisits for pills and condoms.

Recommendations: To be a more valid tool for measuring the effectiveness of the family planning program in Morocco, service statistics must include information to estimate prevalence, as well as to count visits. Data are needed especially to measure the prevalence of pill use as compared to IUD use.

One or more of the following methods can be used to measure prevalence:

- *The recordkeeping system can be modified to count the number of active users.*
- *Small-scale surveys on the use of contraceptives in the public sector can be conducted in one or more small areas, such as a province. These surveys can be either household-based surveys or record surveys based on the "Fiches Individuelles" on file in the facilities that provide family planning services.*
- *Data from the new PF/3 provincial-level monthly report, which should include information on the amount of supplies distributed from the provincial stock, in addition to information gathered by the circonscriptions, can be used to make a rough estimate of contraceptive prevalence in each*

circumscription or province, or in the entire country. In this approach, monthly issues (sorties) of each method supplied from the warehouse would be added for a period of one year. This resulting number would be divided by the average number of units of each method used during that year. (This would be 13 for pills, 100 for condoms, and 0.4 for IUDs, which stay in place an average of 2.5 years.) The result would be a rough estimate of the number of public sector users of each method for one year. By taking 20 percent of the population of the area as the total number of women 15-44 in the area, it is possible to calculate the percentage of those women who are public sector users. This figure can be compared with the results of contraceptive prevalence surveys and data on the number of active users. As an example, this calculation was done for Morocco as a whole:

1. ISSUES FROM DEPOT CENTRAL, PAST 12 MONTHS:

<u>Pill</u>	<u>IUD</u>	<u>Condom</u>
4,351,105 Cycles	61,946 Units	618,782 Units

2. DIVIDED BY:

13 Cycles/Year	0.4 Units/Year	100 Units/Year
----------------	----------------	----------------

3. EQUALS NUMBER OF USERS:

334,700	154,865	6,188
---------	---------	-------

4. OR, 459,753 TOTAL USERS.

5. POPULATION MOROCCO: 20,000,000

6. 20% WOMEN 15-44: 4,000,000

7. $\frac{459,753}{4,000,000} = 12.4\%$ Estimated Contraceptive Prevalence.

If pill and condom use alone is calculated, the estimated prevalence would be:

$$\frac{334,700 + 6,188}{4,000,000} = 8.5 \text{ percent.}$$

By doubling this percentage to 17 percent to account for purchases in the private sector, and adding the rate of prevalence for IUDs in the public sector (3.9 percent), total estimated prevalence, approximately 21 percent, can be calculated. This figure is a rough estimate only, but it is interesting, because the stated goal of the MOPH is to increase to 24 percent by 1985 the rate of prevalence in the public sector. It may be possible to obtain a more precise figure of private sector sales from drug companies in Morocco which can then be used to calculate a more accurate overall figure. The calculations should be compared with the results of the CPS in Beni Mellal, El Jadida, and Meknes.

- *Larger-scale household surveys, such as contraceptive prevalence surveys for baseline data, can be compared with surveys conducted at a later time, or with surveys on continuation rates (e.g., the 1972 survey) to obtain data on active users in both the public and private sectors, as well as other program evaluation data on users and non-users. A major advantage of a well-managed CPS is that data can be available within six months. In contrast, the results of the larger-scale World Fertility Survey take longer to process.*
- *To make service statistics complete and valid for the public and semi-public sectors as a whole, the service statistics of the AMPF can be, in fact, must be, integrated with those of the Ministry of Public Health at the national level. Integration will result in more efficient use of family planning services in Morocco.*

USAID/Morocco and the Ministry of Public Health may want to request the services of a consultant to implement the recommendations on service statistics and the design and administration of surveys.

VDMS Form

USAID/Morocco developed a form which will be used by VDMS itinerant house visitors during their two annual rounds (see Exhibit VII-7). The form, which was approved for use in the VDMS project, has since been revised and incorporates certain of the team's recommendations.

Recommendations: The revised form should be adopted by the Ministry of Public Health for use in the VDMS program. It should be given a name and number (e.g., VDMS-1, "Fiche Individuelle a l'Usage des Agents Itinerants du Programme VDMS").

VIII. MOROCCAN NATIONAL TRAINING CENTER FOR REPRODUCTIVE HEALTH

VIII. MOROCCAN NATIONAL TRAINING CENTER FOR REPRODUCTIVE HEALTH

History

Professor Moulay Tahar Alaoui, the new director of the Technical Committee of the Ministry of Public Health, has brought a new sense of direction and a new set of skills to his position. Dr. Alaoui, an internationally known obstetrician-gynecologist, was once active in and served as vice president of the AMPF in the Rabat region. Trained in laparoscopy and other methods of surgical contraception, he was named an expert consultant to the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). He immediately proposed the idea of training in surgical contraception for physicians and related personnel in Morocco.

Consultation was sought with JHPIEGO and the International Program of the Association for Voluntary Sterilization (IPAVS). It was decided that Morocco's needs might be better served if the practice of transporting trainees to Tunis or other JHPIEGO locations were discontinued and a new training center built. It was felt that a new francophone center would increase the number of training spaces available to candidates from other countries in francophone Africa. Discussions begun in 1978 led eventually to a signed agreement in 1980. At that time, eight additional physicians were trained in laparoscopy (six in Tunis and two in Baltimore, Maryland); five laparoscopes and laproscators were placed in Morocco. (One scope is used to perform approximately 60-80 procedures per month; a second is known to be used rarely; a third is said to have considerable usage.) In addition, approximately 16 physicians were sent to Baltimore for the training course for administrators, and two physicians were sent to the course in infertility.

The National Training Center, the Moroccan National Educational Program (MNEP) in Reproductive Health, Endoscopy and Laparoscopy, was to open in 1980. However, because of delays in renovation and in the designation of center staff, the center is not expected to open until January 1982.* The MNEP is intended to provide to Moroccan physicians, nurses, and nurse-midwives, as well as personnel from other francophone and Middle Eastern countries, training in the techniques related to reproductive health. The training will include two or three weeks of didactic and practical training in endoscopy for 50 physicians (the emphasis will be on management of fertility and infertility); one week of didactic and practical training in physician-assistance and care of equipment for 50 nurses or nurse-midwives; and three weeks of didactic and practical training in

* As of May 1982, the center had not opened.

family planning health care services for 40 nurses. After the participants have been certified, their home institutions will be given laparoscopes, laproscators, and minilap kits so that the trainees may use their new skills and train their associates.

Current Status

At the time of this report (December 1981), the center was not open, although one training session had been held in December 1980, for 11 nurses who learned how to develop a curriculum for training nurses in the future. The physical plant, which Dr. Alaoui has said will cost almost three times the projected renovation costs (the updating of the elevator accounts for approximately 50 percent of the additional cost), has been expanded to include a large maternity center with two operating theatres, six to eight labor areas, and three rooms of ten beds each located at the main entrance.

The gynecology ward, including two operating theatres, is to be located on the second story at the rear of the building. It, too, will have three rooms of ten beds each. It will be located, appropriately, just above the outpatient and emergency gynecology area. This will facilitate logistics for both patients and personnel. An intensive care area, a physicians' lounge, quarters, offices, and consultation rooms will be part of the ward. In addition, an unknown number of private rooms will be available which, Professor Alaoui reports, will be used by functionaries of the government.

The outpatient family planning facility will be conveniently located, with a separate entrance at the front of the building. It will be small, compared to other areas, but the patient flow should be rapid. Unfortunately, the room for IUD insertions and other medical exams will be small, but the training plan includes practical rotations in other public health facilities. This area of the building is still being renovated.

The classroom for didactic training will accommodate 120 people and will be equipped with appropriate IEC materials. It seems that equipment for all sections of the center is limited, but sufficient to open the facility. Apparently, all the equipment provided by the two donor agencies is being carefully stored until the facility opens.

The MNEP will be used to educate all levels of MOPH personnel. In addition to the JHPIEGO training, three months of training at this facility will be required of fourth-year medical students. Residents in OB/GYN will be in attendance and nurses will be trained in all aspects of female reproductive health care.

Training has been delayed several times but is expected to begin in February. It has not been determined when training will be scheduled, what the curricula will be, whether and when evaluation will be done,