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MID-TERM EVALUATION OF THE
POPULATION AND FAMILY PLANNING
SUPPORT PROJECT,
PHASE III (608-0171)
MOROCCO

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GLOSSARY

A.I.D.	Agency for International Development
AMPF	Moroccan Family Planning Association
CHELCO	Societe Industrielle Chelia Confection
DHS	Demographic and Health Survey(s)
ENPS	National Survey on Family Planning, Fertility, and Health of the Population in Morocco--Enquete Nationale sur la Planification Familiale, la Fecondite, et la Sante de la Population au Maroc
GOM	Government of Morocco
IEC	Information, education, and communication
IMR	Infant mortality rate
IPAVS	International Project of the Association for Voluntary Sterilization
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JNV	National Immunization Days
MCH	Maternal and child health
MOPH	Ministry of Public Health
NTCRH	National Training Center for Reproductive Health
OCP	Groupe Office Cherifien des Phosphates
OPG	Operating Project Grant
OR	Operations research
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
PNI	Immunization Office of the MOPH
PRITECH	Primary Health Care Technology (project)
PVO	Private voluntary organization

RTM Morocco national television agency

SOMARC Social Marketing for Change (project)

SSB Primary health care--Soins de Sante de Base

STD Sexually transmitted disease

VDMS Integrated outreach FP/MCH service delivery program--Visite a Domicile de Motivation Systematique

USAID United States Agency for International Development (overseas Mission)

EXECUTIVE SUMMARY

The Population and Family Planning Support Project has been successful notably in meeting Project goals for increased availability and accessibility of family planning services and supplies and for increasing contraceptive prevalence in Morocco. The Project has also helped bring about significant policy and program changes in the population and health sector since its inception in 1971, and particularly during the current Phase III (1984-1989).

A fully operational outreach capacity for family planning and other preventive health services is now established in 31 of the 48 provinces of the country. The process of building that capacity over the past 10 years has played a major role in changing the perspectives of both health personnel and the population with respect to the acceptability of family planning services. A mobile strategy of outreach based on systematic planning of coverage areas in zones surrounding rural dispensaries and health centers is now the cornerstone of Ministry of Public Health (MOPH) policy for extending health services to the Moroccan population. MOPH officials now speak of a national family planning program.

The very success of the current Project has helped to bring about a transition period which requires more than usually careful management of activities through the end of Phase III and planning for subsequent family planning and health activities. Morocco's economic situation has also experienced major changes in recent years, making government budgetary constraints a major factor in current program operation and in future program planning and development. The Mission recognizes that these economic, policy, and program changes have significant implications for the future direction of USAID assistance for family planning and health services.

This mid-term Evaluation reviews and analyzes the progress of activities under Phase III of the Project, identifies some of the major transitional issues, and makes recommendations for strengthening several aspects of the program in the remaining life of the Project and in designing the next phase. Discussion with MOPH officials indicates that all major recommendations the Team has made are consistent with current Ministry policy and priorities.

Overview of Findings and Conclusions

Most of the 13 subproject activities are on target and three of the four main objectives for the end of the Project have already been reached. 1) Regular availability of a full range of

family planning information and services has been increased: At least 70 percent of the population has access to services, thanks to the extension of the outreach service delivery program (VDMS) to a total of 31 rural provinces and urban prefectures and to the establishment of reproductive health services at 30 provincial hospitals. 2) The 1987 Demographic and Health Survey (DHS) indicates that the Project's objective of achieving a nationwide contraceptive prevalence of 35 percent has been achieved. 3) Awareness has increased of problems of high population growth rates as policy development activities have resulted in the incorporation of specific population and demographic planning and sectoral models in the Government's development planning process.

The fourth Project objective is to improve maternal and child health (MCH) status. Availability of integrated outreach and facility-based family planning and preventive MCH services in the VDMS provinces obviously helps achieve this goal. Direct indicators for the effectiveness of the MCH services are not available, however. The Mission plans to conduct a separate, in-depth Evaluation of the Phase III Child Survival components for immunization and for control of childhood diarrheal disease. At this stage, however, it is recognized that the recent immunization campaign, assisted under the Project's Child Survival component, has vaccinated virtually all children under 5.

Most of the subproject activities are operating with no major apparent problems. Several initiatives are under way to support and expand the involvement of ministries in addition to Health in family planning activities. The recent immunization campaign demonstrated a major and successful inter-ministerial collaboration between the MOPH and numerous other ministries at the central, provincial and local levels. The capacity for providing clinic-based family planning services has been improved and expanded; comprehensive reproductive health and voluntary sterilization services have been established in 30 provincial hospitals, and the National Training Center for Reproductive Health has become a model regional training center. The extensive in-service, short-term training conducted under the Project has generally been appropriate to the needs to date. Problems with logistics of commodity supply appear to be under control.

The USAID Mission has expanded the scope of its private sector strategy for family planning services and supplies beyond that originally planned for Phase III of the Project. The Ministry's reluctance to support these activities has eased in recent years, and the Mission has taken advantage of the opportunity to move forward with plans for consumer and market research and development of several specific private sector subprojects. These activities now include expanded commercial retail contraceptive sales and company-based family planning

service delivery, as well as the originally planned community-based contraceptive sales activity through the Moroccan Family Planning Association (AMPF). A major portion of the Project's activities in family planning information, education, and communication (IEC) is also implemented through the AMPF.

Two of the subproject activities, both related to IEC and to information systems, have made less progress and have presented significant problems to date. The Mission has made repeated efforts to provide assistance to the Ministry to develop and implement an appropriate IEC strategy, but none yet exists. IEC activities have produced many mass media messages, but pre-testing is inadequate, quality is uncertain, and the impact is unknown. Printed material for educational use is inappropriate, confusing, out-of-date in terms of people's current needs for information, and unused by most health workers. The MOPH Education Office has had difficulty for years and remains unable to provide appropriate leadership.

The second activity that has experienced major problems is development and use of appropriate family planning program information. The information system remains plagued by an overabundance of data that is unused or unusable for decision-making and program monitoring purposes.

Transitional Policy and Program Issues

In spite of the apparent success in meeting most of the quantitative objectives established for Phase III, certain weaknesses exist in the quality of these activities, particularly in service delivery, which pose major policy issues for the Ministry and USAID. The contraceptive prevalence goal has been met, but with substantial reliance on oral contraceptives as the method practiced by 80 percent of current users. The VDMS outreach program has contributed to current acceptability of family planning, and particularly of oral contraceptives. A variety of evidence suggests that the family planning portion of the program focuses predominantly on promotion and supply of oral contraceptives and does not include adequate attention to the full range of available contraceptive methods.

A strategy of mobile outreach is now a cornerstone of the Ministry's strategy for extending coverage, and it has begun efforts to expand the range of services this way. Specifically, the strategy calls for extending a broad range of curative primary health care services, preventive family planning, and MCH services through mobile units. In addition, MOPH central and provincial level planning and management ideas for service coverage and related resource utilization has become more sophisticated than the VDMS approach. Plans for increased availability of a full range of primary health care services

through a mobile strategy, however, may include services not appropriate for periodic outreach. Further, plans to extend more health services to the Moroccan population are being developed during the most severe economic and budgetary constraints in a decade. The Ministry is currently having difficulty in assuming transportation and field worker allowance (indemnity) costs of the VDMS program. It will certainly have greater difficulty assuming the far higher costs of the family planning and MCH supplies and commodities that USAID now provides.

These trends in MOPH policy and planning have overtaken the VDMS program, and both the Ministry and USAID need to make appropriate and careful adjustments to meet requirements of changing circumstances. They need to do this in a way that assures that investments and progress to date in family planning and preventive MCH service delivery are not lost.

USAID has traditionally maintained that a large umbrella population and health Project provides necessary flexibility for the Moroccan situation. The scope of activities now managed by a limited number of Mission staff suggests, however, that this situation has now reached a point at which quantity and process are in danger of overriding quality.

Major Recommendations

The major recommendations are to take immediate steps to 1) broaden the contraceptive method mix beyond the pill by strengthening clinical methods of contraception; 2) revise and target the IEC strategy at all levels; 3) redesign the family planning information system; 4) assure that the MOPH can assume recurrent costs of the VDMS program; and 5) expand Mission resources for Project management and consolidate future Project activities.

INTRODUCTION

Project Background

The overall goal of the Population and Family Planning Support Project is to reduce Morocco's rapid rate of population growth and thereby diminish a key constraint to achievement of the country's economic and social development objectives. To accomplish this goal, the Project provides assistance to the Government of Morocco (GOM) in population policy development and in a range of health sector activities, with concentration on family planning services and supplies and related maternal and child health (MCH) preventive services and supplies.

The Project has existed since 1971, Phase I from 1971-1977 and Phase II from 1978-1984. The current Phase III (1984-1989) is a large umbrella activity with 13 subprojects. These subprojects comprise both activities begun in Phase I and new components, including Child Survival activities added in 1986 and 1987. The subprojects under Phase III were designed, individually and collectively, to achieve four main objectives: promote awareness of the problems of high population growth rates; increase the availability and acceptability of family planning services and supplies; achieve higher contraceptive prevalence rates; and improve MCH status.

The Project has two principal service delivery components. One is an outreach program, "Visite a Domicile de Motivation Systematique" (VDMS), which provides integrated family planning and MCH preventive services. Under this program, Ministry of Public Health (MOPH) nurses provide family planning counseling and supplies and six MCH services (promotion and supply of oral rehydration therapy [ORT], nutritional surveillance, breastfeeding promotion, immunization referral, and weaning food and iron supplements) on a house-to-house basis in communities surrounding rural dispensaries and in urban areas. The program began in 3 provinces in 1982, after a pilot Project in Marrakech, and had become operational in 13 provinces by the end of Phase II of the Project. The current Phase III of the Project has extended the VDMS program to a total of 31 of the 48 provinces in Morocco.

The other principal service delivery component is facility-based, with support for clinical family planning and MCH services in VDMS provinces. In addition, the Project provides national level support for reproductive health services, voluntary surgical contraception, immunization, and control of childhood diarrheal disease.

The Project also includes related activities in population policy development; information, education, and

communication (IEC); data collection, analysis, and information systems; logistics; training; collaboration with ministries other than Health; and work with private sector organizations, manufacturing and commercial firms, and health care providers and suppliers. Phase III is currently scheduled to be completed September 30, 1989. The Mission plans to begin design of a follow-on phase during 1989.

Evaluation Objectives, Methodology, and Team

Objectives. This was a mid-term Evaluation of Phase III of the Project, with primary objectives of 1) determining the extent to which the Project's goal and specific purposes are being or can be met within the life of the Project, and 2) providing recommendations for any changes in Project design or implementation procedures.

The scope of work, (see Appendix A), specified a set of 11 major questions, each with a series of subquestions, to be answered by the Evaluation. These questions cover all 13 subprojects of the Project. The scope of work also requested a review of cross-cutting issues and an assessment of the overall effectiveness of the Project. Since the scope of work had been written one year before the Evaluation Team's arrival, the Mission had already addressed some of the specific questions; other issues, not included in the scope of work, had arisen by the time of the Evaluation. The Team leader worked closely with Mission staff to assure that the Evaluation addressed major issues at this stage of Phase III.

Methodology. The International Science and Technology Institute (ISTI) conducted three days of planning with Team members in Washington, March 2, 3, and 4, 1988, before departure to Morocco on March 5. The Team conducted the Evaluation in Morocco from March 6 - April 7. Due to a variety of scheduling constraints, only two of the five Team members were present in Morocco for this whole period. Other Team members' tour of duty were 10-21 days in various segments throughout the month.

The Team's findings are based on an extensive review in Morocco of documents provided by the USAID Mission; data from national level surveys and provincial and central level Ministry information systems; interviews with MOPH and other government officials, as well as representatives of private sector health service providers, communications, commercial, and research firms; and site visits to 10 provinces and urban prefectures. The Team also held mid-tour and final debriefing meetings with USAID and MOPH officials.

Special comment is necessary about the methodology for evaluating the VDMS program. The Mission designed the mid-term

Evaluation of the VDMS program in two components. The first was an in-depth, extensive field survey of beneficiaries, health workers, and local government officials. This survey was carried out by a Moroccan university-based research group, EXPERDATA. The survey was designed to provide a variety of measures of effectiveness of services, health workers, and program operations, and of beneficiary impact (Appendix B provides the scope of work for the survey). EXPERDATA had completed the first phase of descriptive tabulations for all survey questions and interviews, contained in 12 volumes, in early March. The plan was to complete the final summary and analysis in the following month.

The second component of Evaluation of VDMS was to be carried out by the Evaluation Team. The Team was to use the field survey as the primary source of information for evaluating VDMS and provide a summary of the survey findings. The Team was able to review selected aspects of the field survey findings during its tour of duty in March, but the Team and the Mission agreed that interpretation, analysis, and summary of the extensive information and findings from the field survey was not possible at that time, along with completing all other aspects of the scope of work. Final summary and analysis of field survey findings will be provided separately by EXPERDATA.

The Team's Evaluation of VDMS thus concentrated on 1) assessing several aspects of the potential impact of the program, using available national and provincial level data, and 2) conducting a general review of field operations. Analyses of impact include an assessment of the effect the program has had on coverage and availability of family planning services and on contraceptive prevalence. These analyses also include an indirect assessment of the program's impact on child health status and a qualitative assessment of its impact on the primary health care system more broadly.

The general review of program operations in the field included site visits to six VDMS provinces and one urban VDMS prefecture, together with four non-VDMS provinces for comparative purposes. The VDMS provinces visited included a sample from the original group (begun in 1982), the second (begun in 1983), and the most recent (begun in 1986). This review also includes analysis of variation in levels of family planning service delivery activity, based on selected provincial level data in five of the provinces visited.

Team members. The Team was composed of five members. Moncef M. Bouhafa was responsible for Evaluation of the IEC component. Miriam Labbok was responsible for Evaluation of medical and other technical aspects of family planning and health service delivery. Charles Tilquin was responsible for Evaluation of data analysis, information systems, logistic support, and MOPH

management issues. William Trayfors was the A.I.D./Washington Representative on the team. He conducted the special data analysis of contraceptive prevalence, coverage, and VDMS impact. Charlotte Leighton was the Team leader. She was responsible for Evaluation of the remaining five areas in the scope of work.

The four Team members wrote individual reports in their areas of expertise. These are on file at the Mission. The Team leader prepared a draft of the full report of the Evaluation, which included contributions from each of the Team members' reports in relevant sections.

The following 10 sections present the Team's findings and conclusions on each of the principal sets of activities under the Project, as well as on issues that cut across individual subprojects. Recommendations follow the presentation of findings and conclusions at the end of each Section.

1. POPULATION POLICY DEVELOPMENT AND IMPLEMENTATION

1.1 Government Policy and Implementation Strategy

The GOM population policy has long been characterized by action in family planning service delivery, rather than by a set of explicit population policy statements. In line with this approach, the MOPH is the key ministry responsible for implementing the government's implicit support for reducing population growth. The Ministry's implementation strategy is to provide family planning services as an integral part of other primary health care services to improve maternal, child, and family health.

An official family planning program has existed since 1966. The Government's Development Plan set objectives in early years of the program in terms of modest numbers of "new acceptors" and more recently in terms of target rates of contraceptive prevalence among married women of reproductive age (15-45). The 1981-85 Plan called for a prevalence rate of 24 percent by 1985. This rate was achieved by 1983. The current 1988-1992 Plan calls for a target rate of 45 percent.

One of the frequent comments about the Moroccan situation is that lack of an explicit, national population policy has not necessarily inhibited implementation of relevant programs that help to reduce population growth, at least in the short run. This appears to be an accurate assessment: The Government's approach to population policy and the MOPH's implementation strategy have been entirely appropriate and relatively effective in the Moroccan context to date. Morocco's emphasis on an implementation strategy through the health sector has continued to help produce substantial gains in contraceptive prevalence and coverage (see Section 2).

These gains are at a transition point, however, and some aspects of Morocco's family planning program rest on a fragile base. Sustaining and improving contraceptive prevalence, and ultimately reducing the population growth rate, are soon likely to require a stronger public and private expression of commitment by relevant government officials, as well as increased GOM funding for family planning and other population activities.

1.2 USAID Policy Development Activities

Under Phase III of the Project, USAID has continued to provide assistance in population policy development for purposes of increasing awareness among high government officials of the problems rapid population growth poses for development. The specific purpose of policy development assistance during this

Phase was to incorporate population analyses in the Government's development planning process through use of population growth projections and impact analyses across various development sectors (see Appendix C for the log frame for Phase III).

This purpose has been achieved with the development and use by the Ministry of Plan of sector specific models in health, education, and employment in the 1988-92 Development Plan. The Ministry of Plan used initial results of these projection and impact models in organizing a national population seminar in 1985 and in preparation of the 1988-92 Development Plan. The Project has also funded participation of Moroccan officials in invitational travel, short-term training, and international conferences on population and development problems.

Top officials in the Ministry of Plan are very enthusiastic about the population impact and sectoral modeling exercises and consider impact on population growth a key criteria in developing priorities for development Projects. The conference reportedly produced a much stronger appreciation on the part of Ministry officials of the interaction of their programs, the relevance of population growth to their programs and budgets, and a need to develop solutions within their programs to help solve "the population problem."

Although these activities appear to be establishing a positive impact on at least part of the development planning process, they do not yet seem to have affected the Ministry of Finance's funding decisions for either the development plan or for operating budgets of relevant ongoing programs. For example, the Ministry of Finance cut the MOPH's overall request for the investment budget for the 1988-92 development plan by 80 percent (see Section 7 for further details).

USAID Mission personnel have gone beyond the formal Project plans to initiate frequent discussions with GOM officials in numerous ministries on formal and informal occasions. These persistent efforts are likely to have had as important an impact on developing and sustaining population policy, and especially health sector implementation efforts, as the formal Project activities carried out to date in policy development.

RECOMMENDATIONS FOR POLICY DEVELOPMENT AND IMPLEMENTATION

1. Project goals for incorporating population projections and modeling in the development planning process have been achieved. Further USAID assistance in this type of policy development and awareness, beyond limited action to reinforce these processes, does not seem necessary for the next phase of the Project.

2. USAID should concentrate future efforts at the central level of government on policy implementation, especially on practical budgetary issues with the Ministry of Finance, since funding is a key constraint to implementation of the Government's implicit policy for reducing population growth.

3. USAID should develop initiatives for the next phase of the Project that would assist the MOPH increase population and family planning awareness among Government officials and community leaders at the provincial and local levels. These efforts should be part of a larger move to mobilize other resources in support of family planning.

4. The MOPH should place a high priority on developing budget and program presentations that would help convince Finance to allocate scarce budget resources to ongoing programs in family planning and other related services; the presentations could make the point that these programs would produce longer range budget savings.

2. CONTRACEPTIVE PRACTICE AND COVERAGE

2.1 Prevalence and Practice

National surveys show that contraceptive prevalence among married women in Morocco has almost doubled in less than a decade, having risen from 20 percent in 1979 to 36 percent in 1987. Almost 70 percent of this increase has occurred since 1984, when Phase III of the Project began. One of the main purposes of Phase III of the Project, to attain a contraceptive prevalence of 35 percent among married women of reproductive age, has thus already been met.

Most contraceptive practice (81 percent) is currently based on modern methods, with use of the pill by 23 percent of married women representing the dominant method (80 percent of total contraceptive use). Virtually 100 percent of ever-married women are aware of at least one modern contraceptive method, as well as a source of supply. Over 50 percent have used at least one of these methods at one time, according to the recently completed national family planning and health survey, "Enquete Nationale sur la Planification Familiale, la Fecondite, et la Sante de la Population au Maroc, 1987" (ENPS) (see Charts T1-3 in Appendix D).

This survey also provides detailed information on socioeconomic and geographic variation in contraceptive prevalence in Morocco. In general, prevalence for married women is higher among urban, educated women over 30 with three or more children. Prevalence is also highest in the central, central south, and western regions, where many of the VDMS provinces are located. Specific comparison of prevalence rates in VDMS and non-VDMS provinces shows a much higher prevalence in VDMS provinces (40 percent) than in other provinces (25 percent) (see Charts T4 and 5 in Appendix D).

Although these descriptive data are suggestive of the impact of various factors on prevalence, analysis is not yet available that identifies the statistical significance or relative importance of these socioeconomic, geographic, or programmatic factors in contributing to contraceptive use.

Historically, contraceptive prevalence rates of 30-40 percent represent a critical point in demographic transition that can bring about a significant drop in fertility. Recent surveys in Morocco show, along with increasing contraceptive prevalence in the past decade, a drop from 5.9 to 4.9 in general fertility rates, as well as substantial proportions (42 percent) of married women who want no more children or who want to wait two years or

more before the next child (13 percent). Desired birthspacing is more common among married women under 30, whereas women over 30 are more likely to want no more children.

Data analysis is not yet complete for the ENPS survey on the likelihood that these wishes on the part of younger women will actually translate into significantly lower fertility rates in Morocco. Even with contraceptive prevalence rates similar to those that Morocco is approaching, however, substantial impact on population growth rates is not always automatic (see Chart T29).

2.2 Availability and Coverage

Morocco has made substantial gains over the past decade in making family planning services and supplies widely available. Family planning services and supplies are now available at all (approximately 1,200) MOPH facilities. With the extension of the VDMS program to 18 additional provinces and prefectures under Phase III of the Project, family planning outreach services are now operational in 31 provinces, which include almost 75 percent of the population. By this criterion, the Phase III objective of establishing regular availability of a full range of family planning information and services for at least 70 percent of eligible couples in Morocco has already been met.

The joint efforts of the MOPH with USAID to make family planning information, services and supplies extensively available have undoubtedly played a major role in increasing the contraceptive prevalence rates in Morocco. The public sector, represented by the MOPH, is currently the largest supplier of family planning services and supplies. Almost two-thirds (61 percent) of current users of contraception in the ENPS survey cited the MOPH system as their source of family planning services and supplies. Private sector physicians, clinics, and pharmacies provided family planning services and supplies to 21 percent of women currently practicing modern methods of contraception (ENPS 1987). The balance, 18 percent, did not cite a source (see Section 6 for additional discussion of the private sector).

Although the evidence is clear that availability of family planning services and supplies has increased during Phase III, key indicators of actual service coverage, such as number of people served, are not available at the central level. The current MOPH family planning information system is based on data about new acceptors, continuing users, and visits for re-supply, all of which are interpreted somewhat differently depending on the facility or outreach worker. Reliable numbers of people served, and the proportion of target populations reached and served, by either fixed facility or outreach health workers, cannot be calculated (see Sections 3 and 5 for additional detail).

2.3 Unmet Demand

Evidence exists of substantial, current unmet demand for family planning services in Morocco. Among married women aged 15-49, 43 percent want no more children and 13 percent want to wait at least two years before another child (Table 4, ENPS, 1987). These data mean that current contraceptive prevalence in Morocco could, in principle, be increased immediately by 50 percent, from 36 to 56 percent.

In addition, among married women not now practicing contraception, 37 percent want no more children, 11 percent want to wait two years or more before the next child, and 16 percent are undecided about when or whether they want another child (Table 8, ENPS, 1987). These data indicate that 64 percent of the married women not now practicing contraception are potential candidates for family planning services.

Finally, lower rates of use of modern contraception among uneducated or rural women are not necessarily indicative of a lower demand for contraception in this group. The ENPS survey shows that the proportion of uneducated (37 percent) or rural (35 percent) women wanting no more children is higher than or almost equal to the proportion of educated (31 percent) or urban (40 percent) women who want no more children.

A variety of constraints in the health service delivery system and in available information probably account for findings that about half the women in Morocco who want to limit or space births do not practice contraception. These constraints are likely to include factors related to continuing problems of accessibility, particularly in rural areas; inadequate or misleading information among current and potential contraceptive users about contraceptive methods; inadequate referral and follow-up procedures within the health system; restrictive MOPH policies and physician attitudes toward surgical contraception; and misinformation among health personnel about infections and side effects related to contraceptive methods.

RECOMMENDATIONS FOR CONTRACEPTIVE PRACTICE AND COVERAGE

Recommendations presented in the following sections are designed to address the constraints identified above, with a view toward maintaining current levels of contraceptive prevalence and creating a base for expanding availability of appropriate family planning services and information to meet demand.

3. SERVICE DELIVERY

3.1 Clinical Family Planning Services

In response to stated MOPH goals, the capacity for providing clinic-based family planning services for IUD insertion and tubal ligation has been improved and expanded under Phase III of the Project. The National Training Center for Reproductive Health (NTRH) has developed a model program for training medical and paramedical personnel in Morocco, as well as throughout Francophone and Arabic-speaking countries in Africa and the Middle East. Since 1984 it has trained 400 Moroccan and regional health personnel in reproductive health technology. The NTRH is also responsible for refresher training in clinical family planning services for MOPH physicians and nurses, monitoring the performance of hospital staff, and repairing laparoscopic equipment distributed to participating hospitals.

Phase III goals of establishing availability of comprehensive reproductive health service capabilities in 30 provincial hospitals throughout the country had been met by the end of 1987. These are staffed by physicians who have received certification from the NTRH. JHPIEGO¹ and IPAVS¹ have been providing the technical assistance and monitoring support for these efforts to expand and strengthen clinical family planning services.

The increased and improved capacity to deliver clinical family planning services is, however, not being used with maximum effectiveness to meet the potential demand (see Section 2). At the beginning of Phase III, the Mission estimated in the Project Paper that the proportion of total users who rely on oral contraceptives would decline from 75 percent in 1983 to about 65 percent in 1988, due to more women using the increased capacity to deliver IUD and tubal ligation services established during Phase III. Instead, the proportion has increased to 80 percent of all users relying on the pill.

The extensive use of oral contraceptives is not the most effective response to the expressed demand of women who want to limit births. There should be much greater use of clinical family planning services that provide more permanent and reliable protection, particularly for women who want no more children. Although 43 percent of Moroccan married women want no more children at all, only 3 percent of married women use the IUD and only 2 percent have had tubal ligation (ENPS, 1987).

¹See glossary for the full names of these and other organizations widely known by their acronyms.

The very low levels of use of IUDs and tubal ligations may reflect delivery constraints of those two methods, rather than the actual level of demand for them. Provider reluctance may be one factor. In the case of IUDs, the concern is related to what is presumed to be an extraordinarily high rate of sexually transmitted diseases (STD) in the country (doctors report the rate to range from 40-90 percent). Because it is medically unsound to insert IUDs in persons suffering from certain STDs, this is clearly a valid concern. Given Morocco's reportedly low sterility rate of 1.7 percent, however, it is highly unlikely that STDs are as prevalent as reported. The problem may be that doctors are making incorrect diagnoses. It is also probable that they are not providing the simple and appropriate treatments that are available to cure most of these patients. What is lacking is a scientifically based protocol that would make clear to doctors when IUDs can be inserted and when they should not.

Provider reluctance also inhibits provision of tubal ligation. Several physicians and other health personnel noted that permanent methods of contraception were not advisable unless a woman is over 30 and has four children, one of whom is a boy and 2 years old. These views reflect official policy. This problem was also noted earlier in the 1983 final Evaluation of Phase II of the Project.

A second problem relates to training for these procedures. Again, the 1983 final Evaluation had flagged a problem with respect to permanent methods, noting that minilap training was not being provided to enough physicians, particularly those in the private sector. Conversely, although many nurses have received training in IUD insertion, those trained have had so little practice in carrying out insertions that they are badly in need of refresher training.

A third concern relates to equipment and facilities. This is not a problem with respect to laparoscopy services; in fact, the considerable number of provincial hospitals equipped to provide these services are underutilized. On the other hand, many clinics do not have the equipment needed to provide IUDs (lighting, surgical equipment, sterilization facilities and use). In particular, the new maternities are not being routinely equipped to provide postpartum IUDs, although this is an excellent time to begin this method.

A fourth problem relates to referrals. At present, there is no recognition for the itinerant worker who follows up a referral to see whether the woman referred actually received the sterilization or IUD recommended. Thus, women who decide against the procedure after receiving counsel may remain undetected. It is believed that a large number of acceptors may be lost this way: Counseling time is very brief and concerns such as cost, lack of transport, or inconvenience may offset the initial motivation to undergo the procedure.

The Ministry recognizes that the family planning program is currently relying too much on oral contraceptives, and current policy calls for broadening the method mix. Preliminary estimates² indicate a need for 8-10 times the current number of IUD and sterilization procedures to meet current demand within an appropriate method mix.

The following provides recommendations for reinforcing appropriate delivery and use of clinical family planning services in order to broaden the mix of contraceptive methods.

RECOMMENDATIONS TO REINFORCE CLINICAL FAMILY PLANNING SERVICES

IUD Services

1. A revised protocol for IUD insertion should be developed that will reinforce proper care and correct current inappropriate practice. It should include specification of minimal equipment and space needs. It should be based on a special study of current problem areas, including but not limited to

Vaginal infections in various areas of Morocco and the handling of IUD insertion when infection is present;

Proper diagnosis of infection;

Appropriate and inexpensive treatment modalities for infection that does exist; and

Needs for adequate equipment, heating, and lighting in maternity centers and IUD service sites.

2. An assessment should be conducted of in-service training needs for nurses in IUD insertion and sterilization techniques and for itinerant workers in IUD and sterilization promotion and referral. The findings of this assessment should be included in the next scheduled in-service ("recyclage") training sessions. The IUD training could be carried out on a regional basis with second level training carried out by midwives, nurses or physicians in a one-week session.

²Estimates of necessary increases in all services, highlighting IUD and sterilization services needed to meet current demand were made by the Team and are on file at the Mission. The estimates are based on surveyed demand. Alternative estimates based on steady growth appear in the MOPH Five-Year Plan.

3. Postpartum IUD insertion should be encouraged and included in training sessions for nurses based in maternities, as well as training for outreach workers in how to explain and promote this option.

4. Maternities should be provided with necessary inexpensive equipment.

Tubal Ligation

5. The NTCRH should continue and increase training in quality female sterilization procedures, including mini-laparotomy.

6. Consideration should be given to opening additional training center(s) that specialize in mini-lap with laparoscopy as a secondary method. These centers could be located at universities with medical faculties in coordination with the National Center. Additional training centers would also facilitate training for private health care providers.

Referral Services

7. Management of the referral and follow-up system for IUDs and sterilization should be strengthened. A small-scale operations research effort could help identify efficient and effective methods to manage referrals and generate necessary follow-up action.

Coordination of Training and Service Delivery

8. The MOPH should play a stronger role in coordinating the IUD and sterilization training and service delivery efforts of the University Ob-Gyn departments, the NTCRH, and the centers of reference and maternities. The Ministry could also support these efforts by assuring that trained personnel remain at a center offering sterilization until replacement personnel are trained.

Other Contraceptive Methods

9. Support might be provided, perhaps at a lower level of effort, for other reliable contraceptive methods, including spermicides, natural (e.g., sympto-thermal) methods, and injectables, especially through private sector efforts.

Information, Education, Communication

10. The IEC strategy should be revised and targeted to support and promote broadening of the contraceptive method mix (see Section 4, Recommendation 7).

Implementation Priorities. Studies, training needs assessments, protocol development, and equipment supply for strengthening IUD services and the related referral system should begin within the remaining life of Phase III of the Project. Other recommendations may be approached as part of a three-to-five year plan to strengthen clinical family planning services and to broaden the mix of contraceptive methods in use.

3.2 VDMS Outreach Services

3.2.1 Impact of the VDMS Program

3.2.1.1 Impact on Coverage and Prevalence. Although accurate data on family planning service coverage in terms of number of people or percent of target population served are not available (see Section 2), the role of the VDMS program in increasing the availability and accessibility of family planning services and supplies can be inferred from available data. These data provide mixed evidence.

Although the program is operational in provinces with 75 percent of Morocco's population, VDMS outreach plays a notable but not a dominant role in overall coverage for family planning services and supplies. According to the ENPS survey, only 17 percent of women using modern contraception cited VDMS outreach as their source. More than twice that proportion, 41 percent, cited the Ministry's fixed facilities as their source. Other Ministry mobile teams accounted for only 4 percent. Slightly more than one-third, 35 percent, of women using pills received them from MCPH facilities, whereas 21 percent received them from the Ministry's VDMS outreach workers.

VDMS appears to play a major role in extending coverage to populations who would otherwise be unlikely to receive family planning services because of inaccessibility to fixed health facilities. The ENPS survey shows that contraceptive prevalence in urban areas is virtually identical in VDMS and non-VDMS urban prefectures (45 vs. 44 percent). Prevalence in VDMS rural areas is 40 percent higher than in non-VDMS rural areas (25 vs. 18 percent. See Chart T-4 in Appendix D). Higher prevalence rates reported for VDMS provinces nationwide are thus due primarily to its strong role in rural provinces.

The program appears to help increase overall contraceptive prevalence through its extension of services to underserved populations and through its apparent success in recruiting new acceptors. Under this interpretation, the population served by VDMS represents a sizeable net addition to the total number of women practicing contraception in Morocco today.

Data based on new acceptor rates from the MOPH information system in VDMS compared with non-VDMS provinces support this interpretation. (Although there are serious definitional problems with data on new acceptors and on all users collected by the MOPH, these data do provide indications of an order of magnitude of differences among provinces, if not precise calculations.) Charts T6-11 in Appendix D show that VDMS provinces account for 70 - 80 percent of new acceptors and of users of contraception in Morocco since 1983, and for about 70 percent of new acceptors of oral contraceptives over the period 1981-1987. These proportions of "coverage" correspond well to the percentage of total population living in VDMS provinces and prefectures (75 percent). One would expect, if the program is working properly, that the majority of new acceptors and users of contraception would be in areas where the majority of the population lives.

These data also show the strong role that VDMS outreach has played in increasing the availability and use of oral contraceptives. On a cumulative basis, VDMS provinces accounted for more than twice as many new acceptors of pills as did non-VDMS provinces over the period 1981-1987. VDMS and non-VDMS provinces are equal, however, in new acceptors for facility-based family planning services over this period (Chart T-9). Charts T12-25 in Appendix D also show that VDMS outreach activities are far more responsible for recruiting new acceptors of oral contraceptives than are the fixed facilities in VDMS provinces.

3.2.1.2 Impact on Child Health Status. Both the family planning and other preventive health services included in VDMS outreach services could be expected to have a positive impact on child survival and child health status in general. A reliable in-depth analysis of these potential impacts is, however, a quite complicated undertaking and is beyond the scope of this Evaluation.

A preliminary analysis³ of historical trends in infant mortality rates (IMR) in VDMS compared with other provinces from 1972-1987 (i.e., before and after the introduction of the VDMS

³This analysis carried out by the Evaluation Team uses a provincial breakdown of the ENPS national survey data. A note on the validity of these data is in order to ensure appropriate interpretation of the findings. Because of sample size on the provincial level, data on IMRs for several individual provinces are not reliable. The aggregated estimates of IMRs for all VDMS and all other provinces are based on a large enough number, however, to provide sufficiently reliable indications of the order of magnitude of differences between these two groups of provinces.

program) show that IMR was at a lower rate (102) in 1972 in provinces that later were selected for VDMS, than in other provinces (111). Infant mortality began declining at a faster rate in VDMS than in other provinces during the 1970s before VDMS began and has continued to decline at somewhat faster rates than in other provinces since 1981. By 1987 estimated infant mortality in VDMS provinces (67) was substantially lower than in other provinces (91) (see Chart T28 in Appendix D).

While these data indicate relative differences in infant mortality trends between the two types of provinces, they do not show that service delivery by VDMS is responsible for these declines in infant mortality. A different type of analysis would be necessary to verify the statistical significance of these differences and, more important, to separate the relative contribution of health service delivery from the many other factors related to socioeconomic and environmental conditions that also strongly affect infant mortality.

These findings are, however, useful in highlighting some of the positive changes in child health status that have been and are occurring in provinces where VDMS is located. Continued reinforcement of the MOPH's family planning and MCH services in these provinces can help to strengthen and perhaps accelerate this trend.

Recent evidence of longer birth intervals in Morocco also lends credence to the idea that improvements have occurred in child health status. The ENPS survey found that in 1987, 65 percent of all births (excluding first order births) occurred at greater than 24 month intervals, compared with 58 percent in 1980. Presumably increased availability of family planning services is helping women to increase birth spacing.

3.2.1.3 Impact on the Primary Health Care System.
VDMS has helped to strengthen the entire primary health care system in provinces where it is located. Most of this effect derives from the decision to integrate family planning and other preventive health care services. These effects were also already apparent by the end of Phase II of the Project, but have now been extended to an additional 18 provinces.

One of the strongest aspects of VDMS has been an emphasis on developing a capability among provincial and local level health personnel to identify the population to be served, plan coverage areas, and allocate staff resources to achieve objectives of extending service availability through outreach services. Some of these concepts existed before VDMS and have since been applied in more elaborate form in other provinces and with particular success in one province, Agadir, a pilot primary health care (SSB--Soins de Sante de Base) province. The VDMS

program has consistently stressed these principles, directed training toward these skills, and made them operational on a regular basis. In so doing, VDMS has helped increase knowledge of health needs of populations living near health facilities and introduced and established public health concepts of orientation toward the people to be served.

It has also emphasized and established capabilities to administer logistics, personnel, and vehicle support at the central and local levels. Further, transportation support for VDMS outreach and supervision allows itinerant nurses to carry out other health activities in their coverage area (e.g., malaria control, water control) and provides the means for supervision of all activities at the health center and dispensary level.

All these capabilities and processes can be easily generalized and applied beyond family planning and other preventive health outreach service delivery. The approach of indirectly strengthening the broader system through the outreach component cannot be relied on much further, however, if continued or additional gains in health status are to be expected. Similar efforts are now necessary to strengthen directly the back-up referral, supervisory, and management systems of the primary health care system if family planning and other preventive health services are to continue to be effective.

3.2.2 Program Operations at the Field Level

3.2.2.1 Service Delivery. Technical aspects of outreach service delivery in all provinces visited appear to be generally good. The basic knowledge of VDMS outreach workers and supervisors is quite high when measured by the important points in their training guide. Itinerant workers in particular are well versed on the basic set of rules outlined in the guide for family planning, diarrhea, and immunization. This finding is supported by the knowledge test given to VDMS workers in the field effectiveness survey.

Although training to date appears to have been effective in providing basically sound technical skills, problem solving skills to meet requirements of daily situations that go beyond the rules do not appear to be well developed. In addition, worker knowledge on supplementation of breastfed infants does not appear uniformly adequate. At least some workers have been promoting the idea that all infants should receive supplements by four months, an idea that has harmed breastfeeding practices in many countries.

The practice of providing at least three cycles of oral contraceptives at each resupply visit seems now to be well established. This practice has probably increased acceptance of

the method as a long-term preventive health measure, rather than as curative medicine that must be carefully controlled and stopped as soon as possible. (The practice of providing one cycle at a time continued to exist in one of the non-VDMS provinces visited.)

The current package of supplies carried by VDMS outreach workers includes oral contraceptives, oral rehydration salts, condoms, actamine, iron/folic acid tablets, aspirin, gauze, mercurochrome, and a scale for baby weighing. The family planning and other preventive health services currently delivered by VDMS workers represent an excellent choice for periodic visits. One of the main advantages of the VDMS outreach service package is that it comprises a simple set of preventive health care services that address principal maternal and child health problems, as well as a select few curative and first aid services.

Problems included the notable variation in VDMS outreach worker motivation and in quality of supervision. These may pose an important constraint to adequate outreach service delivery.

3.2.2.2 Support Systems. The family planning commodity logistics system seems to be working well. All sites visited had ample supplies of contraceptives, though some supplies of condoms are approaching expiration. Data collection for VDMS activities seems to present no major problems. All provincial and service delivery personnel appear to collect the required data diligently and complete required reporting on time (see Section 5).

Information from five provinces visited (Agadir, Marrakech, Safi, El Jadida, and Casablanca-Anfa) shows considerable variation among them. Provinces vary substantially in past and current recruitment of new acceptors of family planning services. Condom use is growing more rapidly in some provinces than others, but all show the concentration of VDMS outreach on promotion of oral contraceptives. Evidence of the impact of VDMS outreach on use of fixed facilities for family planning services, especially on increasing referrals for clinic based contraceptive services (IUD insertions), is inconclusive in this data set, but all provinces show that fixed facilities have a substantially lower level of family planning activity than does VDMS outreach.

These variations suggest that, despite a good performance in the aggregate, the VDMS program has weaknesses at the local level that should be addressed by day-to-day program managers. These questions will be best resolved once the Ministry establishes specific program goals (e.g., increase total

contraceptive rates vs. recruitment of new acceptors vs. numbers of people served vs. relative use of pills and IUDs) against which to monitor and measure progress and designs the information system to produce the related, appropriate indicators (see Section 5).

3.2.3 USAID Assistance

USAID's assistance to VDMS program operations at the field level has included financial and technical support for 1) transportation and allowances (per diem and incentive payments) for outreach workers and supervisors; 2) training in technical, communications, administrative, and data collection activities for outreach workers and supervisors; and 3) contraceptive commodities and supplies, as well as selected maternal and child health medical supplies. The principal VDMS activity that USAID has supported in Phase III of the Project has been to extend the VDMS program to 16 additional provinces, following the basic model already tested and established for the first 15.

The extension gives every indication of proceeding as planned. The remaining, scheduled training activities for the new provinces, as well as scheduled refresher training for pre-existing provinces, appear to be on track. Major variations in quality of services, management, data analysis, and other matters did not appear to vary by length of time VDMS had been operational.

The only major problem observed was in conjunction with the planned Phase III phase-down of USAID funding support for allowances and gasoline for VDMS provinces in the first and second phases. Under this plan, the Mission had stopped providing these funds for 13 of the provinces as of January 1988 and will discontinue funds for the new provinces under Phase III by January 1989. Due to severe financial constraints, the MOPH maintains it is unable to assume responsibility for these payments at present (see Section 7). This presents a dilemma.

It is apparent that immediate withdrawal of funding support for transport and allowances--that is, withdrawal of USAID funding without the Ministry covering the costs--would have a major negative impact that would likely negate much of the investment effort that has been made in the program. Transportation is obviously critical to outreach services and supervision. Even if there are valid objections to allowances for outreach workers, evidence of problems with outreach worker motivation and difficult working conditions in Morocco suggest that incentives are essential to most of these personnel if they are to maintain their current level of activity.

RECOMMENDATIONS FOR VDMS OUTREACH SERVICES

Funding Support for Field Worker Allowance and Transportation

1. USAID should not withdraw funding support for allowances and transportation costs before the end of Phase III unless means are in place to cover these costs and sustain progress achieved in the VDMS provinces. The Ministry and USAID should jointly take action to assure that means are in place within the remaining life of Phase III.

Although this issue is best understood as part of a larger recurrent cost and budgetary problem facing the MOPH (see Section 7), the following set of complementary actions are suggested for implementation within the remaining life of Phase III:

The Ministry and USAID should not rely on amounts included in the Ministry's budget request or authorization as assurance that funding is actually available. Direct negotiations with the Ministry of Finance are necessary to assure that budget allocations are made in the current situation of government budget constraints.

The Ministry should make every effort to assure adequate funding in its operating budget for transportation costs to cover the basic level of outreach service delivery it wants to assure nationwide. Worldwide experience shows that local community contributions to fund this kind of operating cost is generally unreliable and can increase inequalities in service delivery capabilities.

Steps to reduce the costs of allowances should be considered, perhaps by providing selective payments, instead of providing allowances to all outreach workers and supervisors and to principal provincial level personnel.

Supervision as a means of motivation should be improved. A special study should be conducted to determine other non-financial means of worker motivation.

VDMS Training

2. VDMS worker training should be upgraded and reinforced in the areas of IUDs and sterilization, referral processes, and conditions under which these methods are advisable (see also recommendations in Section 3.1).

3. VDMS worker training needs upgrading and reinforcement to encourage problem solving. Basic rules should be set forth in as simple a manner as possible, and training should reflect questions that actually arise in the field.

VDMS workers should know what to tell a woman when she switches from one brand of oral contraceptives to another, how to respond if a woman has been given contradictory information by a doctor, how to respond to common rumors about contraception. Some rules can be stated simply, such as indicating that all types of oral contraceptives can begin on day 1 of the menstrual cycle and condoms need not be associated with other methods, but use of spermicide with them increases efficacy considerably. The guide could be made more useful by setting out basic messages in boxes, providing illustrations that workers could use with women during discussion, and developing a small notebook, to which pages could be added, with major information only on each item or task the worker must do.

4. In-service training ("recyclage") should be conducted for VDMS itinerant workers at least annually. Periodic meetings for VDMS itinerant workers should be scheduled to share technical information, solve problems, and provide worker motivation.

5. Video could be used for training and problem solving, particularly to show difficult worker-client situations and to promote discussion for possible solutions, as well as to allow workers to share experiences in a productive manner. This method can also assure quality and consistency throughout all training sites.

6. Training in food supplementation for breastfed infants for VDMS workers should be reinforced and upgraded. Training should include information that a breastfed child may grow at a slightly different rate from a bottlefed baby, creating a different growth curve than is illustrated in the present growth chart based on data collected on bottlefed U.S. children. It should also reinforce information that too early supplementation can shorten breastfeeding and threaten child health. Workers should be well trained that supplementation need not begin until month 6, and for infants growing well, not until even later. When introduced, it should only be given after a breastfeed, so that milk supply will be maintained. No supplements or teas should be given in the early months.

Supervision

7. Training of VDMS supervisors should include more skills in problem solving and worker motivation.

Additional Services

8. Consideration should be given to adding one or two additional services or supplies to the VDMS outreach program. These must be chosen carefully for their suitability for a periodic visit and should be selected according to specific health needs in each province.

The kind of service and/or supply must be governed by this consideration: Periodic outreach is appropriate in the provision of preventive care, but is not useful or effective for cure or treatment of disease which can occur at any time before or after a health worker's visit. Similarly, medicines for periodic outreach must be chosen quite differently from medicines and essential drug lists for fixed facilities. Treatment modalities, such as oral rehydration salts (ORS) or ophthalmic treatments, if included in outreach worker activities, should be left with people who need them since recurring problems will arise between visits. The concept of leaving a small stock with an interested, well-informed community representative is one way to provide a bridge between visits.

Implementation priorities

Recommendations 1, 2, 3, 6, and 7 should be implemented during the remaining life of the Project. Recommendations 4, 5, and 8, should be considered for a follow-on Phase of the Project.

4. DEMAND GENERATION THROUGH INFORMATION, EDUCATION, AND COMMUNICATION

4.1 IEC Activities and Strategy

4.1.1 Overview

Although the Project has undoubtedly played a role in increasing the level of awareness in Morocco of family planning methods (see Section 2), the precise role of Project activities is difficult to determine. Project activities have included making family planning information available nationwide through the mass media, the Ministry's Health Education office, and, intensively, through the VDMS outreach program. No in-depth evaluations of any of those strategies has been carried out; what pre-testing is carried out is not usually conducted with groups representative of most of the population. IEC objectives have been unclear and the Five-Year Plan identifies only very general goals. The 1983 Evaluation of Phase II of the Project noted these same deficiencies.

The Ministry has just recently completed a preliminary communications strategy, with assistance from USAID and RONCO. This will be developed further in the coming months. There is a question, however, whether adequate capability exists to implement an effective strategy.

Available information provides some indication of the impact of current IEC activities. It is clear that men are less favorably disposed to contraception than women, but that they do appear very responsive to child health messages. A study of the recent immunization campaign showed that, in 8 out of 10 cases, the husband was a key factor in encouraging mothers to take their children to be vaccinated. Discussions with VDMS workers suggest that religious beliefs and family problems are important constraints to family planning and that negative rumors about contraceptive methods are prevalent. The recent consumer research study carried out by IMS (a research firm) also points out the existence of negative rumors and misleading information. For example, apparently most private sector physicians think that IUDs have a higher failure rate than oral contraceptives.

The VDMS Field Effectiveness Survey also provides preliminary evidence of the relative importance of different sources for family planning information in VDMS provinces. Findings from this survey show that VDMS outreach visits are the most important source in rural areas for first knowledge about, and for information on specific methods of, contraception. In urban areas, mass media is the most important source of both of these kinds of information, and is twice as important as VDMS outreach for first knowledge. Friends and neighbors and health

personnel at the MOPH facilities play an equal role in urban areas for first knowledge, but friends and neighbors have almost no role, in either urban or rural areas, in providing information about specific methods.

4.1.2 VDMS Information Activities

Approximately 2,000 VDMS outreach workers and 450 physicians have been trained in communications techniques under Phase III. The field effectiveness Survey should provide some information on the effectiveness of VDMS workers in providing family planning and other health information and education. A preliminary review of Survey findings suggests that the average amount of time spent in a VDMS household visit (15 minutes) is insufficient to communicate adequately all the required information and to motivate people to adopt contraception, unless they are already disposed to do so.

Discussion with VDMS workers in the field strongly suggests that they find it easiest to provide information about the pill and that they are reluctant to discuss more controversial methods, such as the condom. Further, the typical translations they use for IUDs, "the small operation," and tubal ligation, "the big operation," are not likely to help promote either method. Use of these terms also confuses clients about the difference between permanent and non-permanent methods (see Sections 2 and 3).

VDMS workers vary in the extent and manner they use posters and pamphlets. In many instances, numerous copies of the same poster were lined up next to each other on facility walls, and the entire, though limited, quantity of pamphlets were lined up on the nurse's work table. These same posters were not displayed in other nearby public places, nor did VDMS workers report using the supply of pamphlets in house visits. The VDMS guide has provided theoretical, rather than practical, information on how to use these materials. A 1985 Evaluation of communications training in five provinces showed that only 57 percent of those receiving training thought it was useful for their work; 83 percent requested further training in communications. Efforts are now under way to revise the communications curriculum toward more practical applications.

4.1.3 Mass Media Activities

Mass media activities under the Project have been carried out through the Moroccan Family Planning Association (AMPF). The AMPF is responsible under Phase III for developing national IEC activities to promote family planning through print, cinema, television and traditional folk media. USAID has

provided AMPF with excellent and extensive video production equipment for television and additional equipment (a time base corrector, chromo key, and special effects generator) is scheduled for delivery soon. AMPF has negotiated a co-production agreement with the national television agency (RTM) and produced and aired three two-minute family planning educational messages and an eight-part family planning soap opera.

The 1983 Evaluation recommended that USAID withhold funding for production equipment unless the MOPH and AMPF develop clear IEC objectives and develop and implement a plan for field-testing materials with representative populations prior to production. The Project Paper for Phase III indicates that carrying out these actions would be a condition precedent to USAID funding of production costs for AMPF IEC materials. So far as it could be determined, any pre-testing that has been carried out has been inadequate, no evaluation of AMPF message impact has been done, and a target audience has not been defined.

The television spots AMPF has produced for family planning do not carry a clear message and potentially transmit negative images about family planning. Systematic testing is necessary to evaluate the precise impact of these spots, particularly since the mass media appears, according to the Field Effectiveness Survey, to have a relatively important role as the current source of information about contraception generally, and also about specific contraceptive methods. Competence and talent in media communication clearly exists at AMPF, but it has not been directed toward a systematic and reliable family planning communications strategy.

Morocco has an estimated 23 television sets per thousand population, with an increase of about 2.5 percent in the number of sets each year. About 50 percent of the television sets are in four major urban areas, Rabat-Sale, Casablanca, Marrakech, and Fes. In spite of the predominance of sets in large urban areas, all towns and settlements appear to have some access to television. Excess television production capacity currently exists in Rabat, and television currently represents the lowest cost advertising media per thousand persons reached, with an estimated potential audience of 18 million during prime evening time.

It is currently difficult for AMPF to increase its access to television time slots on the RTM, because of the network's restrictions on the number of soap operas and the approval process for advertising on television. A new, semi-private television channel is scheduled to open in 1989. Competition for access to that channel will further increase the need for quality television spots for family planning.

Television has been successfully used in Morocco for public service messages on immunization, hygiene, and water conservation. In these cases, focus group research was conducted in advance, and private sector agencies have played the key role in developing messages.

Several private sector organizations and associations have begun to specialize in market research in public health and other social sector issues. These firms appear to be highly professional in their approach, though they could benefit from updated knowledge on current social marketing techniques. They also need more technical information and background on family planning and public health issues to make the best use of their potential for social marketing in these areas.

The use of radio for family planning information may be the most cost-effective way to reach people in Morocco. There are over three times as many radios as television sets in the country, or 77 per thousand population. In rural areas, particularly, radios far outnumber television sets. AMPF routinely produces and airs family planning radio messages (over 30 broadcasts during 1986 and 1987). Both radio and television are particularly important for the country's illiterate population.

4.2 Social Mobilization for Immunization

The MOPH's most successful promotional activity to date was its recent immunization campaign. Virtually all children under five were vaccinated in 1987 at 11,000 sites throughout the country. The MOPH used a well-managed, targeted and systematic communications and mobilization strategy to do this. The tactics included using focus group research to develop specific materials in local dialects to describe the diseases that vaccination protects against; developing national logos, slogans, and theme songs and interviews for television spots; distributing printed promotional materials through the official newspaper delivery system; distributing widely immunization posters, which are still found everywhere in the country; establishing mobilization committees at the national and provincial and local levels; and coordinating MOPH resources with those of other ministries.

A separate evaluation is scheduled of the impact of these activities. It is already clear, however, that the strong public support of the King for the immunization campaign provided a unique and important incentive to all social mobilization activities. It is also likely that the social mobilization activities played a stronger role in the success of the immunization campaign than did the specific communications and educational messages and materials.

For example, one survey of the communications aspect conducted after the first round of the campaign found that about half the people interviewed recognized the logo and 40 percent were able to associate it with immunization. Given the intensity with which the logo was communicated, (up to 130 minutes of television time and appearance in all MOPH facilities), a higher recognition rate was to be expected. Special surveys remain necessary to determine the reason for low recognition rates. For example, it may be that greater exposure is necessary and/or that logos in general, or the immunization logo specifically, are not a particularly effective communication mode for the Moroccan population.

4.3 Health Education in the MOPH

In principle, the Health Education office of the MOPH should be the lead actor in developing, coordinating, and implementing an IEC strategy for family planning and other health services. This office has long had difficulty playing this role, however, and presently does not provide competent leadership or support family planning and other health service divisions at the central or the provincial level.

The Health Education office does not involve the relevant health service program offices in developing the content of educational and promotional materials. To fill this gap, temporary, parallel education or communication structures have been created for special efforts. This approach was used for the immunization campaign and may well be employed for the upcoming ORT campaign. These are short-term measures, however, that compound rather than solve the basic problem.

The content of family planning, ORT, and nutrition informational materials in the field appears to be largely inappropriate and confusing. One poster, for example, a series of pictures demonstrating that ORT will make a sick child well, was presented in the European manner (left to right), rather than the Arabic. When read from right to left (the Arabic way), the pictures began with a well child and ended with a sick child who had just received water with oral rehydration solution (ORS).

Family planning posters are also out of date. They apparently are addressed to increasing awareness of the broad concept of family planning, but that has already been achieved for nearly 100 percent of the Moroccan population. Most family planning posters have been used for nearly a decade. None appear to have been designed with a particular audience in mind, and most health workers reported that the posters were not useful or appropriate in motivating or informing people.

The distribution process for educational materials is also inadequate. The Health Education office seldom produces enough materials for target audiences, does not seem to have an idea of how many pamphlets or posters are adequate for each level of the health system, and uses a distribution system separate from the one for family planning and other health commodities and supplies. A small pamphlet developed for the immunization campaign was rarely available in any health facilities: Only 5,000 copies had been produced and these were destined for distribution primarily to educational institutions and students. The only poster that had been well distributed was the poster developed separately through the immunization office (PNI) for the recent campaign.

RECOMMENDATIONS FOR IEC

MOPH Education Office and IEC Strategy for Family Planning

1. The Ministry should take immediate steps to find lasting solutions to 1) the Health Education office's lack of effectiveness, and 2) its overall organizational inability to develop a well-designed, coordinated, and targeted IEC strategy for family planning. Failure to do this is probably one of the reasons that contraceptive use is currently almost exclusively based on the pill and that only half of the women wanting to limit or space births are currently using modern methods of contraception.

The Ministry does not have to be the lead actor in implementing all components of the IEC strategy. Neither should a non-governmental organization, such as the AMPF, necessarily have primary responsibility for developing the Ministry's national mass media communications strategy and content for family planning. The Ministry should identify areas for its own personnel to implement based on its current competence, personnel capabilities, and resource constraints. A clear policy must be developed with specific goals, criteria, and monitoring mechanisms. Activities must be identified that other public or private organizations might implement most effectively.

2. For a follow-on Phase of the Project, a broader range of private sector media organizations and associations might be used to help implement an IEC strategy.

Media activities

3. An in-depth, systematic Evaluation should be conducted of the impact of media (television and radio spots) and written materials (pamphlets and posters) that have been used for family planning. This should be done before the final Evaluation of Phase III and before any further development of a

communications strategy for these IEC methods to ensure that a valid, objective basis exists for reaching conclusions about the effectiveness of IEC activities. The Evaluation should identify which of these methods has the most impact, for which population groups, and for what kinds of messages (e.g., motivation, promotion, general vs. specific information).

4. A fact-finding study should be carried out in representative urban and rural areas of Morocco to identify rumors that are prevalent among men and women about contraception and about different contraceptive methods. The findings of this study should be used to help develop new strategies and content for media and health worker messages.

5. No further video production equipment should be provided to AMPF until it has developed a clear strategy based on a systematic approach and in harmony with whatever themes the Ministry decides are priorities. Any excess capacity that now exists should be used to develop video training materials (e.g., self-teaching, exchange of experiences) for health personnel.

6. Consideration should be given to including a component in a new media strategy that would promote the role of health personnel as providers of family planning. This would enhance their prestige, facilitate their work, and serve to motivate them. This approach would not provide specific information about contraceptives, which is not appropriate for mass media.

Activities of VDMS and other health personnel.

7. The family planning information and education strategy for health personnel, both those who conduct outreach and those who provide clinical family planning services, should be redesigned. The new strategy should correct over-reliance on oral contraceptives and diversify the method mix. New materials, new verbal messages, and a new communication training component will have to be designed. Experienced fieldworkers who have had the most contact with the population should be involved in creating these new materials. This activity should be carried out within the remaining life of Phase III (see Recommendation 10 in Section 3.1).

8. For the follow-on Phase of the Project, a component in outreach worker training should be considered that would increase their skills in community mobilization.

5. MOPH PLANNING, MANAGEMENT, AND ADMINISTRATIVE SUPPORT

5.1 MOPH Planning and Management of the Family Planning Program

5.1.1 Planning and Management Capabilities

One of the strongest aspects of the Project has been its emphasis on developing a capability through the VDMS program to identify the population to be served, plan coverage areas, and allocate staff resources to achieve program objectives. This kind of planning certainly existed in Morocco prior to the VDMS program. The design of the VDMS approach, however, calling for phased implementation of activities throughout a majority of provinces and provision of resources needed to do so, allowed Ministry personnel at all levels of the system to carry out these activities more effectively than they had in the past.

The example of the VDMS program has served as a basis for subsequent major program efforts, such as the Ministry's Primary Health Care (SSB) Project and for the National Immunization Campaign in 1987. Thus, when the time came to prepare for the 1988-1992 development plan for the MOPH, all provinces were able to participate in conducting inventories of their resources and designing new coverage and related resource allocation plans. With the successful completion of the first year of the immunization campaign and development of the Five-Year Plan, the Ministry had begun to establish a reputation for strong and capable program planning, development, and implementation.

Much of the success of implementing program plans, whether for VDMS or other efforts, however, has depended on a relatively small number of capable, energetic people at the central level and in the provinces. Management capabilities at the province, circumscription, and sector levels vary widely in terms of the degree of delegation, team-work, program analysis, and effective coordination of family planning, other preventive, and curative care services.

The use of health personnel time also varied in its degree of effectiveness and efficiency, especially at the dispensary and health center levels. Most people visit fixed health facilities in the mornings or early evenings. Often, health workers have virtually nothing to do in the afternoons. Facilities may have four or five health personnel providing services to about 20 people, many of whom must wait for substantial periods of time. Preliminary findings from the Field Effectiveness Survey suggest that one VDMS outreach worker generally provides services to at least as many people in a single visit to an outreach site. This seemed true as well for outreach workers providing preventive and curative care in SSB provinces.

Time requirements and organization of service delivery are naturally different, depending on the nature and location of the health services provided. The large discrepancies observed, however, suggest that a more in-depth review of use of existing health personnel and management of service delivery at dispensaries and health centers is warranted.

Although certain basic planning and administrative processes appear to be established in the VDMS program, broader management capabilities are necessary to help the program sustain and extend its current coverage level. For example, routine administrative, supervisory and data gathering functions do not appear to present major problems, but supervision is not effectively used for problem solving or motivation. Further, nearly all dispensaries visited had displays of tables and graphs on the walls, but neither the nurses nor the supervisors appeared to use these data to track program progress in relation to goals or to identify problems, strengths and weakness, or as a means of using available resources more effectively.

The office at the central level responsible for the family planning and VDMS program has a total of four personnel, most of lower grade level, plus the director. This number is almost identical to the number assigned to the program in 1982, when the VDMS program existed in only three VDMS provinces. The current staffing level is clearly insufficient to carry out responsibilities for planning, managing, monitoring, and support for 31 provinces and prefectures, as well as necessary coordination with other health services in the central office.

Central office personnel are forced to concentrate on daily administrative matters that must be accomplished, rather than on managing the VDMS and family planning program. For example, the provinces aggregate and send a great deal of program data to the central level. The VDMS office has neither the staff nor the computer capacity, however, to summarize and analyze the data routinely, in a form useful to decision making and program monitoring.

Dependence of the Ministry's family planning services, as well as of other preventive and primary health care services, on a few individuals means that achievements to date are fragile. This is particularly true as under the Ministry's decentralization policy, reliance increases on provincial level staff to design solutions to major resource problems and to devise implementation strategies for the Ministry's national policy goals. The capacity the Ministry demonstrated in the recent immunization campaign to manage and mobilize resources needs to be strengthened, extended beyond campaign efforts, and institutionalized in a solid management system.

It is thus important to provide a larger number of personnel at the central and provincial levels with broader planning, Evaluation, and management capabilities. Although the need for reinforced management capability is broader than the family planning program, the success of an integrated preventive health care strategy will continue to depend on management skills throughout the Ministry's primary health care system.

5.1.2 Management Training Activities

The Ministry recognizes a need for more extensive training in management skills for all levels of personnel. The 1988-92 Plan includes proposals for a five-year effort to provide this training, using three principal structures: the newly established office in the central Ministry for in-service training (Service de Formation Continu); the health training school for all levels of nursing (Ecole des Cadres); and a planned, graduate level Institute for public health training and research (see Appendix E).

Since 1981 a great deal of training activity has occurred throughout the MOPH system. Until recently, however, there was no office at the central level responsible for coordinating these activities. The recently established office to manage in-service training (Service de Formation Continu) has conducted a training needs inventory in preparation for developing a rational and targeted plan for future training. This office is particularly interested in developing the capacity of its staff at the central and provincial levels to provide in-service management and organization skills training to Ministry personnel.

An estimated three-fourths of all in-service training to date has been technical training in various medical service delivery skills and about one-fourth in administrative or management skills. Physicians currently receive no management or administrative training in the course of their medical studies, yet it is physicians who hold the key planning and management posts at the central and provincial levels. The Ministry's current priority for the new Institute is to provide initial short-term intensive management training sessions to the Provincial Chief Medical Officers.

Training assistance provided by USAID to date to strengthen management in the context of the Project has concentrated on training in data collection and program administration in the VDMS program. The Mission also more recently commissioned a study of the organizational structure and related management needs at the provincial level. In addition, plans are under way to provide longer term training at institutions outside of Morocco to MOPH personnel specifically in

planning and managing family planning and primary health care programs. Six people will be chosen soon for this training, with a total of 20 to participate over the next several years.

Planning and administrative training under VDMS, along with training provided under the auspices of the Primary Health Care Project and for the National Immunization Days (JNV), have all contributed to a base for developing broader management skills. These efforts, along with the current Minister's emphasis on management, have also developed a strong appreciation among Ministry personnel of a need to increase their skills in organizing and allocating scarce resources.

RECOMMENDATIONS FOR MOPH MANAGEMENT OF THE FAMILY PLANNING PROGRAM

Central Level Staffing

1. The Ministry should make every effort possible to assign more personnel to the family planning office at the central level. The small staff size of the central office is a major constraint to effective program management and planning the future direction of family planning services in Morocco.

Management Training

2. The Ministry's current emphasis and general direction of the plans under way to improve management skills are appropriate. In line with these plans, Appendix E provides suggestions for specific management training actions that could be undertaken over the next five years for and by each of the Ministry's three principal training structures.

For the remaining life of Phase III of the Project, USAID should work closely with the Ministry to identify the most appropriate technical assistance in management that USAID could provide in a follow-on Phase of the Project. Priorities for improving management capabilities of the MOPH are to

Develop institutionalized capacity of the in-service training unit and the Institute to provide ongoing management training;

Concentrate at the provincial level on developing skills in planning, management, Evaluation, and efficient and effective use of resources;

Assure that "management training" is practical, action-oriented, directly relevant to daily problems and decisions that Moroccan health personnel face, and directed toward providing the skills and motivation to

accomplish key Ministry objectives for family planning and other MCH preventive services.

USAID has an advantage, compared with other donors, in its ability to identify this type of assistance and should make it a high priority for any further training assistance under Phase III or a follow-on phase of the Project.

Management Information System

3. Steps should be taken immediately to redesign the family planning information system. This action is needed to improve management of the program and planning for future options (see Recommendations in Section 5.2).

5.2 Data Collection, Analysis, and Information Systems

The major data collection activity under Phase III of the Project involves carrying out two contraceptive prevalence surveys, with a primary purpose of filling information gaps in the Ministry's service delivery statistics. The first scheduled survey has been successfully carried out by the Ministry with assistance under the A.I.D.-funded Westinghouse Demographic and Health Surveys (DHS) Project (ENPS 1987). This provides the best available data on contraceptive prevalence, practice, demand, and availability and coverage of family planning services and supplies.

The other major data-related objective under Phase III is to strengthen the Ministry's information system for the collection, processing, analysis and presentation of family planning and preventive child health services data. By all accounts the family planning information system has been consistently plagued by an abundance of data and an inability to use it for decision making, planning, and monitoring purposes. One of the main recommendations of the 1983 final Evaluation of Phase II of the Project was to simplify the family planning information system and develop a standard form for family planning activities provided at fixed facilities and through VDMS outreach.

With USAID assistance, efforts began in 1985 to computerize the system at the central level. This effort experienced numerous problems related to computer hardware, software, and data quality control. A consultant review in 1987 reported that the computer in the family planning central office was overloaded and data produced were largely unused or unusable. A recent revision developed by the Ministry and now being field-tested takes steps to simplify the system, but it is unlikely to solve the fundamental problems in use of data collected and system design (see Appendix F for further detail).

The current information system includes several separate components to track logistics, transport, allowances, and other administrative matters, as well as service delivery. Most of the problems in design and definition exist in connection with service delivery indicators, however. In addition, the process of data collection for the amount of information currently involved does not pose as much of a problem as does analysis and appropriate use.

"New acceptors" and other indicators are enumerated at all levels in both the VDMS and the fixed facilities. Staff diligently aggregate this data by circumscription, province, month, and year and submit the reports to the central office, but neither the central, provincial, nor the dispensary level VDMS workers routinely analyze or use this data for program planning, monitoring, or Evaluation (see Section 5.1.1). The major constraints to their doing so are 1) lack of skills in family planning program analysis and monitoring, and 2) lack of microcomputer capacity to facilitate the task.

Problems with definitions and design of the current family planning information system also mean that some of the data currently collected is misleading and other key indicators are not available (see Section 2). For example, the system does not produce a reliable count or estimate of number of women scheduled to be visited, number provided with pills, condoms or IUDs, or number of women referred for an IUD insertion or tubal ligation. The lack of consistent definition and application of the terms "new acceptor," "continuing user," and "visits for resupply" mean that facility-based and VDMS outreach data are not comparable, many women are counted numerous times, and others who use contraception may be counted only if a VDMS worker makes a visit in a given month.

Periodic surveys, such as the 1987 ENPS, can help correct this problem, but do not provide necessary information on the routine basis necessary for effective program management. It is important to distinguish between data that are essential for collection and processing on a routine basis and data that are useful but not critical for continuous monitoring. A carefully targeted data system, coupled with a flexible plan for periodic surveys to collect less essential data, is the approach most likely to produce the best results.

Technical assistance to the MOPH in redesigning the system to meet important decision-making needs can help correct the definitional problems and identify which information is appropriate for routine data collection. The history of design and application of a family planning information system in Morocco, however, should alert people that this will not be an easy or necessarily successful process, unless steps are taken to address past constraints.

Most notably, the expectation is that there will be controversy and debate among key Ministry officials and among consultants about what the service delivery indicators should be (e.g., new acceptors vs. couple years of protection vs. users vs. continuing users) and which ones are necessary for what level of decision making (central office vs. province vs. service delivery site). The most controversial issue is the number and type of service indicators needed at the central level. Ministry personnel at all levels of the system tend to want to collect, process, and graph too much data on a routine basis. The 1983 Evaluation Team also noted this tendency.

It is very important that any further assistance be specifically tailored to provide the information necessary to enable Ministry officials to make essential planning and management decisions, as well as to sustain and promote the family planning program in discussions with other ministries (e.g., Finance) and in public. The latter groups are particularly important, given the current budgetary constraints and the continuing political sensitivity of family planning.

In short, consensus among Ministry officials about the number and type of key service delivery indicators is more important than consensus among family planning and computer experts. The Ministry has to be clear and specific about its objectives for family planning so that suitable indicators can be identified to track and evaluate progress. Finally, along with technically necessary indicators that are to be used by family planning and health experts in the Ministry, several key indicators have to be identified that are easy to explain and quickly understood by people who are not family planning or health experts.

RECOMMENDATIONS FOR THE FAMILY PLANNING INFORMATION SYSTEM

1. The family planning information system should be redesigned to identify the minimum number of appropriate program and service indicators needed for routine collection and processing. The new system should undergo pilot testing in several (e.g., eight) provinces. The redesign can be accomplished within the remaining life of the Project and should not be postponed until other health information systems are fully operational.⁴

⁴The team left on file at the Mission a proposed plan that identifies the principal, phased actions to accomplish redesign of the family planning information. See report of Charles Tilquin.

2. Microcomputers, related software, and on-site training should be provided to the central family planning office and the pilot provinces.⁵

3. A technical assistance team should be selected that includes an appropriate family planning program specialist and an information systems specialist with a strong practical orientation and extensive field experience in developing information systems for ministries' use in decision-making.⁶

5.3 Logistics Support for Commodities

The largest portion of Project costs is for principal commodities related to family planning and child survival service delivery: oral contraceptives, condoms, IUDs, medical supplies and equipment for IUD insertion and tubal ligation, Actamine 5 (a locally-produced weaning food), vaccines, packets of ORS, and scales for growth monitoring. The Mission has also provided support for commodity warehousing, distribution, and logistics management. Most problems with logistics support appear to be under control, and actions are planned with the assistance of the Family Planning Logistics Management Project to address supply projections, warehouse needs at the central level, and retraining for logistics management personnel at the central and local levels.

Several problems were noted with respect to commodities. The A.I.D. logo currently appears only on contraceptive supplies, not on boxes of other health service commodities A.I.D. provides. Many stocks of condoms are, or soon will be, older than their expiration date. Moreover, the VDMS guide is not totally reliable in this matter: it suggests that commodities such as condoms or IUDs that have passed the printed expiration date can still be used if they do not show signs of deterioration. Actamine 5 cartons frequently break, resulting in contamination of that and other products they are placed next to. The single piece of leather luggage designed for VDMS worker use to carry supplies for outreach visits is heavy and not easily carried on a motorcycle. The central warehouse for family planning supplies holds only one month's supply.

⁵The Team left on file at the Mission suggested specifications of hardware, software, and estimated costs. See report of William Trayfors.

⁶At the request of the Mission's population office, the Team left a proposed plan with scopes of work and timetables for a technical assistance team. See memo from Charles Tilquin, to Carl Abdou Rahman, March 25, 1988.

RECOMMENDATIONS FOR COMMODITIES LOGISTICS SUPPORT

1. The A.I.D. logo should be on all health service commodities to reflect the breadth of A.I.D. support for primary health care in Morocco.

2. USAID and the MOPH should continue their efforts to assure that commodity condition is monitored periodically and the first in, first out principle is applied. The Ministry should review the current guide on these commodity management principles to assure they are clear and being used appropriately.

3. Steps should be taken to develop a different packaging system for Actamine 5.

4. A lighter weight container is needed for VDMS workers.

5. USAID should assure that plans for a new central warehouse are implemented in time to meet the anticipated need for substantially more space. The Ministry should provide assurance that sufficient numbers of trained personnel will be in place to manage the central warehouse and related supply, inventory, and distribution.

6. MOBILIZATION OF NON-MOPH RESOURCES

Extensive efforts are under way to encourage the use of resources in addition to those of the MOPH to help extend the availability and use of family planning and other health services. Principally involved are the private sector, other Government ministries, and local governments and communities.

6.1 Private Sector Activities and Strategy

The USAID Mission has expanded the scope of its private sector strategy for family planning services and supplies beyond that originally planned for Phase III of the Project. These activities now include expanded commercial retail contraceptive sales and company-based family planning service delivery, as well as the originally planned community-based contraceptive sales activity and IEC component, both being carried out by AMPF (see Section 4). The Mission is implementing the family planning private sector strategy through a large, umbrella Operating Project Grant (OPG) to the AMPF.

The current strategy is designed to increase substantially the availability and distribution of oral contraceptives and condoms and to develop alternative sources of family planning services over and above the 20 percent of married women who now use private sector sources for family planning services (see Section 2).

At the beginning of Phase III, the Ministry had been reluctant to promote any pharmacy-based contraceptive sales effort, especially of subsidized contraceptives. It feared opposition of the pharmacies to the potential downward pressure on commercial prices for these products, as well as the possibility of a cultural backlash to the advertising that would accompany a commercial effort. The Ministry also anticipated confusion among users of oral contraceptives about numerous brands and an increase in side effects among those who switched brands. Finally, the Ministry was concerned about a possible decline in the perceived worth of "free" MOPH products. The Ministry's reluctance has eased in recent years, however, and the Mission has taken advantage of the opportunity to move forward with plans for consumer and market research and development of specific private sector subprojects.

6.1.1 AMPF Activities

The major private sector activity under the original plan for Phase III was to demonstrate the feasibility of contraceptive sales by non-pharmacy sources through support to the AMPF. Planned AMPF activities included selling contraceptive

products in rural towns and villages through resident, local community agents; selling contraceptive and health products in kiosks in urban and semi-urban areas; and holding family planning "expositions" and sales at fairs, markets ("souks") and public events. Original plans also called for support for the natural family planning training and service activities of a Moroccan private voluntary organization (PVO), L'Heure Joyeuse.

Implementation of the community-based contraceptive sales Project is well under way, having expanded beyond the original four provinces to include over 100 community agents in 12 provinces of AMPF's Rabat and Casablanca regions. Under this Project, AMPF mobile teams provide contraceptive supplies every three months to resident community agents, who charge a small fee (2 DH, about \$.25) for one-month's pill supply and .5 DH for each condom. The agents keep 25 percent of the proceeds and return 75 percent to the AMPF. AMPF markets three brands of oral contraceptives through this system, none of which is identical to the brand used in the MOPH.

The AMPF contraceptive sales Project is backed up by its ongoing mobile team effort and fixed clinic sites. Small fees are also charged for IUD insertions and family planning consultations provided through these services. Prior to the community-based sales Project, the AMPF had charged fees only in urban areas.

Overall, the AMPF has 12 clinics, 5 rural service delivery centers, and 5 mobile teams in 20 provinces and urban prefectures, with another rural center and mobile team scheduled to start operations in AMPF's Agadir region. According to the ENPS 1987 survey, about 1 percent of Moroccan married women who use contraception receive their services and supplies from AMPF. The AMPF data collection system for contraceptive use suffers from the same ambiguities of definition and misleading information as does the MOPH family planning information system. Further, the AMPF information system is not compatible with the MOPH system, a problem identified in the 1983 Evaluation. Available AMPF data suggests, however, that it provides a more balanced mix of IUD and oral contraceptive services than does the MOPH program.

Other than a small study of the AMPF fee system conducted by EXFERDATA, no in-depth Evaluation of AMPF's community-based sales program took place before it began to expand beyond the original four provinces. It was clear, however, that controversy had existed over the possibility of duplication and overlap with VDMS outreach efforts in the same provinces. This possibility may not be serious since the AMPF mobile and fixed service delivery capacity represents a much smaller effort than VDMS. It is, however, the only experiment in community-based pill resupply and should be carefully monitored and evaluated before the end of Phase III (see Section 7).

6.1.2 Natural Family Planning

With the termination of the grant to L'Heure Joyeuse, the natural family planning research and development activity has moved to AMPF, where it utilizes the services of the L'Heure Joyeuse-trained Project staff. This is currently a relatively limited activity, involving promotion of periodic abstinence and the sympto-thermal method. The VDMS guide includes description of this method, but it is not a significant part of the training. It would be useful to assess the results of this activity after a year's operation to see if it merits further expansion.

6.1.3 Expanded Commercial Contraceptive Sales and Company-Based Family Planning Services

The Mission has substantially expanded original private sector activities over the past three years. It has completed the first phase of a major social marketing research effort on attitudes and practices of consumers, providers, and distributors, as well as legal studies, employer-employee studies, and policy awareness workshops for the business and manufacturing community. Contracts now under negotiation or recently signed include support for additional commercial promotion and sales of contraceptives, as well as provision of family planning services and information through company-based health services for employees of three Moroccan companies.

The contraceptive social marketing contract provides for promotion and commercial retail sales of oral contraceptives and condoms through the largest Moroccan pharmaceutical supplier, SOPHA, a conglomerate that is responsible for 100 percent of rural pharmacy sales and 70 percent of all pharmacy sales nationwide. Distribution outlets will include Morocco's 450 licensed pharmacies and perhaps the 5,000 tobacco shop outlets of Regie Tabac. In addition to importation and distribution of the products, the Project will include training for pharmacists, market research on consumer attitudes and access to distribution points, and product advertising and promotion. SOMARC is providing the primary technical assistance for development of the commercial retail sales Project.

The three subprojects with Moroccan private sector firms also include a major pilot effort that involves over 35,000 employees. The Groupe Office Cherifien des Phosphates, a parastatal phosphate mining, processing and shipping conglomerate, is the largest employer in Morocco and expects to serve approximately 13,000 family planning acceptors. Regie des Tabacs is a parastatal tobacco organization with 3,000 employees in five provinces. A potential exists to expand family planning service delivery to Regie's extensive network of growers and distributors. The Societe Industrielle Chella Confection

(CHELCO) is a small Rabat-based garment manufacturer, with 800 female employees. CHELCO is to be used as a one-year pilot demonstration Project for the Moroccan garment industry, which employs about 130,000 people. The Enterprise program is the primary source of technical assistance for the company-based Projects.

6.2 Use of Other Ministry Resources

The Mission has continued efforts begun under Phase II of the Project to encourage the involvement of ministries in addition to the MOPH in promoting the availability and use of family planning services and supplies. The 1983 Evaluation of Phase II noted that field level linkages between health personnel and those of other ministries (e.g., Social Affairs, Agriculture) had not been fully exploited (see Section 4). That such collaboration could produce sterling results was demonstrated in the 1987 immunization campaign. This level of collaboration is not yet institutionalized, but now a strong and positive base has been laid to keep these linkages open and possibly to use them to further the goals of the family planning program.

One of the major efforts under Phase III of the Project to expand the family planning activities of other ministries has included training for Ministry of Social Affairs fieldworkers in family planning motivation and referral. By the end of 1987, 650 Social Affairs fieldworkers ("monitrices") had received this training. The Ministries of Public Health and of Social Affairs have also issued formal directives encouraging field level collaboration between employees of the two ministries.

The Mission stimulated the interest of the Ministry of Interior in family planning by providing, through the Ambassador, some well-done materials on childspacing. On receipt of the materials, the Ministry requested copies of brochures for distribution to all its local field offices. Further discussion between USAID staff and Interior officials suggests the possibility of collaboration in several important areas through Interior field offices responsible for local finance and tax revenue (Division de Finance Locale) and for local communities (Direction de Collectivites Locales).

6.3 Local Government and Communities

Current budget constraints and an active decentralization policy have led the MOPH to speak increasingly of using local level resources to supplement its activities. Community contributions are identified as one way to cover the costs of transportation vouchers and of health worker allowances for outreach services. The MOPH has also made extensive use of local level mobilization committees to help implement the recent immunization campaign.

Some efforts have been undertaken or are planned to study the feasibility of participation by local governments and communities in health activities. One component of the major health sector financing study the Ministry plans to begin in April 1988 will examine the potential availability and feasibility of financing for health service delivery from local communities ("collectivites locales"). Another, smaller scale study already under way by Ministry personnel is reviewing current activities of a sample of provinces and communes in relation to health, as well as relevant laws and regulations. Findings from this study, including recommendations for activities that can be carried out under current law, are expected in June 1988.

RECOMMENDATIONS FOR MOBILIZATION OF NON-MOPH RESOURCES

1. The Ministry and USAID should continue their support for activities already begun in the private sector, but no new activities or extensions should be initiated until the impact and results of current activities are fully evaluated. A separate, in-depth evaluation of private sector activities should be scheduled for the final evaluation of Phase III. It should include impact of private sector activities on use of MOPH family planning services, their effect in increasing availability of services and supplies for people not now served by the public sector, their effect on issues previously of concern to the Ministry (see Section 6.1), and their impact on the contraceptive method mix (especially use of commercially marketed oral contraceptives and condoms).

2. Monitoring should take place of the promotion activities for pills and condoms to be conducted under the contract with SOPHA. Systematic pre- and post-testing of messages is planned, including the use of focus groups, to see if these strategies prove useful for adoption in the MOPH IEC strategy. Consideration should be given to including in SOPHA's market research activities a study of user-effectiveness for oral contraceptives. This information does not now exist for Morocco specifically and could prove useful as a measure of the extent to which the current, dominant reliance on oral contraceptives in Morocco reflects effective use of this method.

3. The MOPH and USAID should continue their efforts to collaborate with other government ministries, especially Social Affairs and Interior, to extend information and referral services for family planning and other preventive MCH services. Collaborative efforts should assure that informational activities are consistent with the Ministry's overall IEC strategy.

4. The Ministry should consider institutionalizing the concept of provincial and local level mobilization committees

used for the immunization campaign. This might involve establishing the committees on a permanent basis for purposes of promoting use and availability of preventive health services, including family planning.

5. USAID should consider, for design of subsequent phases of the Project, alternatives to implementing the entire private sector strategy through an OPG with the AMPF, as well as using this organization for pilot projects and the national communications strategy. Although the current arrangement provides considerable flexibility, it does not allow for diversification and competition, which is one of the purposes of promoting increased private sector participation.

7. FINANCING AND COST ISSUES

7.1 MOPH Budget Constraints

Financing and cost issues have become increasingly important in the course of Phase III of the Project. Of immediate concern is the problem the Ministry faces in taking over operating (recurrent) costs for fieldworker allowances and gasoline in VDMS provinces, as USAID begins to withdraw funding (see Section 3).

At the heart of the situation is that the MOPH's recent budget allocations have not kept pace with either inflation or population growth. For example, the Ministry's total investment and operating budget in 1985 in real terms was only 75 percent of the level of the 1980 budget. Real per capita spending in 1985, 51 DH (\$6 at the 1988 exchange rate), was equal to the Ministry's budget per capita in 1965 (see Appendix G).

Although the average annual increase in the MOPH operating budget (salaries and support costs) has been 10.5 percent in nominal terms from 1980-1986, the operating budget has been declining by an annual average of 4 percent in real terms over this period. Most of that decline has been in funding for medicines, vehicle maintenance and gasoline, and other support costs (-7 percent real decrease vs. -3 percent decrease in salaries). Support costs for health workers now represent only 27 percent of the total operating budget, compared with 45 percent in 1970. Very limited hiring is now permitted, and personnel levels barely stay even with turnover and retirement.

The share of the total government operating budget allocated to MOPH operations had been cut in half, from 8 percent to 4.6 percent, from 1970 to 1985. In the past three budget years, the MOPH share has increased slightly to 5 percent for 1988. The operating budget authorized for the current year, 1988, 1.3 billion DH (\$165 million), however, is virtually the same as for 1987, 1.29 billion DH. This 1988 funding level represents less than a 1 percent increase over the prior year, lower than either the rate of population growth or inflation. Further, the Ministry of Finance had not yet released actual allocations for these authorized amounts as of the end of the first quarter of this fiscal year.

The implications for the VDMS Project are apparent. Estimated annual costs for gasoline ("vignettes") for 28 VDMS provinces are 2 million DH (\$250,000) (USAID estimates). This is not a substantial share of the total MOPH operating budget but would still represent a 20 percent increase in the relevant MOPH budget line item ("rubrique") for vehicle maintenance and gasoline (10 million DH authorized for 1988). A funding source

for field-worker allowances is even harder to identify. The only apparent budget line item, other than salaries, that might fund these payments is authorized at 3 million DH for 1988. Estimated average annual allowance costs of 7.3 million DH (\$912,000) are more than double that amount.

7.2 MOPH Financing Policy

The Ministry's 1988-92 Plan reflects recognition of increasingly limited resources. The planning process recently undertaken by central and provincial Ministry personnel has led them to speak often of the need to reduce costs of current activities; to increase their ability to use and manage existing resources more effectively; and to mobilize non-Ministry resources in the private sector and in local communities.

The Ministry's current policy with respect to charging fees is open but cautious. There is debate and skepticism regarding whether the population is either willing or able to pay fees for most health services, and particularly for family planning services. The VDMS Field Effectiveness Survey provides some evidence that people are willing to pay for family planning services. Findings from this survey suggest that willingness to pay depends on whether the question is put to men or women and asked in relation to oral contraceptives or family planning services in general. In 1984, the Ministry proposed a 5 DH charge (\$.60) for an outpatient consultation visit at MOPH facilities, but the Parliament rejected the proposal.

In April 1988, the Ministry will begin a two-year study and experiment to improve the effectiveness and efficiency of hospital operations, including charging selected fees to test cost recovery. This study will be conducted in five hospitals and is one of the components in the Ministry's World Bank-assisted SSB Project. The MOPH will also conduct, beginning in April 1988, a second major long-term (15-18 months) study in the context of the SSB Project. This study will review all sources and methods of financing in the public and private health sectors in Morocco, assess the overall efficiency and effectiveness of national health expenditures, and identify other potential sources of financing, as well as willingness and ability of the population to pay fees for health services and medicines.

7.3 Project Financing Activities

The 1983 Evaluation of Phase II recommended that the next phase provide assistance to efforts to develop self-financing capabilities for family planning. Phase III includes one such activity, carried out as part of the overall

private sector strategy: the initiation of charging small fees for oral contraceptives and condoms in AMPF's community-based contraceptive supply Project (see Section 6).

This experiment is of considerable moment: It is the first attempt, after many years of consideration under the Project, to conduct a pilot experiment with community-based supply. Given evidence presented in this report of the likelihood that the main family planning activity carried out by VDMS outreach workers is pill supply and re-supply, the feasibility of alternative supply mechanisms is a major program issue. It is not clear that the current VDMS practice is the most cost-effective use of health personnel time or that it is the most cost-effective way to assure availability of contraceptive re-supply.

Evaluation of the AMPF community-based Project could help provide some answers to these questions. This activity presents an opportunity to test both 1) the financing implications (for cost recovery, for administration of a fee system, and for consumer willingness and ability to pay) of charging fees for contraceptives, and 2) the cost-effectiveness of local, non-pharmacy sources of contraceptive supply.

It is doubtful, however, that the AMPF community-based supply Project as it is currently designed will answer these questions. It is important that the Mission review the design of the Project from this point of view to see if it will in fact help provide some answers to key program cost and effectiveness issues.

The Mission has also conducted a range of health sector financing activities outside the direct auspices of the Project. These have included financing conferences, seminars, observational travel, provision of documents and materials, and support for a comprehensive analysis, conducted by PRITECH, of the organization and financing of the public and private health sector in Morocco. All have been instrumental in encouraging the Ministry and private health care providers to consider alternative means of financing and organizing service delivery.

RECOMMENDATIONS FOR FINANCING AND COST ISSUES

1. The Ministry and USAID should continue their efforts to address financing issues related to hospital costs, alternative funding and organizational arrangements in the private sector, and local level sources of funding for public sector health services. Progress in these efforts may enable the MOPH to allocate more resources to basic health service delivery, including family planning services. Although these efforts will take time to translate into budget savings, the studies and

experiments being undertaken warrant monitoring to identify immediate actions that the Ministry could take to improve efficiency and to mobilize other resources to achieve its program objectives.

2. The Ministry and USAID should place a high priority over the next several years on 1) identifying the most efficient and effective ways to extend family planning and related preventive maternal and child health services and 2) developing viable cost recovery mechanisms for primary health care services, including family planning.

Within the remaining life of Phase III, special studies should be conducted on

Cost saving strategies for VDMS outreach services;

Effectiveness of VDMS outreach services, using the VDMS Field Effectiveness Survey, supplemented by a targeted follow-up study in areas where its methodology or findings are unreliable or inconclusive. The Mission should conduct an independent, technical review of principal survey findings before basing program decisions on the survey. Particular attention should be directed to the sample design and phrasing of questions; and

Cost-effectiveness of community-based vs. outreach worker supply methods for oral contraceptives, using the AMPF project if appropriate.

3. For the final Evaluation of Phase III, a serious, in-depth analysis should be conducted of the costs and effectiveness of the VDMS program, compared with other health outreach programs in Morocco, and with facility-based services.

For recommendations on funding of allowances and transportation for VDMS fieldworkers, see Recommendation 1 in Section 3.2.

8. TRAINING ACTIVITIES AND STRATEGY

Training activities under the Project have been extensive in technical aspects of family planning, MCH and child survival service delivery; related IEC; and selected aspects of program administration. Training has been a major component of subprojects related to VDMS, AMPF, other ministries (Social Affairs), reproductive health and voluntary sterilization, and population policy development (see Appendix H).

The principal training strategy of the Project is to concentrate on periodic in-service, in-country training and short-term overseas training, with an action and task orientation. The Mission's long-term training strategy is currently to emphasize strengthening of planning and management skills for family planning and primary health care services.

This strategy is appropriate and no major problems were identified in implementation of this component.

RECOMMENDATIONS FOR TRAINING

For recommendations on training for service delivery, see Section 3.1, Recommendations 4-7 and 9 and Section 3.2, Recommendations 2-6.

For recommendations on training for IEC, see Section 4, Recommendation 7.

For recommendations on management training, see Section 5.1, Recommendation 2.

9. RESEARCH ACTIVITIES AND STRATEGY

The Mission has concentrated its research activities under Phase III on several important data collection activities related to knowledge, attitudes, and practice in family planning and MCH (e.g., ORT, immunization); consumer, health service provider, employer, and employee attitudes toward family planning; and a major field survey of the VDMS program. At least two new service delivery approaches have been initiated that could be used for operations research analysis: VDMS services in urban areas and the AMPF community-based contraceptive supply project. Several of these data collection and research activities were planned in the original design for Phase III; others have gone substantially beyond the original plans.

In three areas research and special studies under Phase III have not fulfilled their promise: 1) pre-testing and systematic impact studies for family planning IEC activities; 2) relative effectiveness and relative costs of VDMS outreach services; and 3) impact of the VDMS outreach services on contraceptive prevalence and on coverage (see Sections 4, 5, and 7).

RECOMMENDATIONS FOR RESEARCH PRIORITIES

1. USAID and the MOPH should jointly develop a targeted research and special study agenda for short-term analyses to be carried out in the remaining life of Phase III. The research agenda should make use of the extensive data and service delivery experiments that already exist, before attempting to generate new data or new operations research experiments.

2. The focus of the special studies should be on 4-5 priority questions with major policy and program implications for family planning and preventive health service delivery in Morocco. The studies should be designed so that results help provide a sound, objective base for future program design. Suggested areas for investigation include IEC; cost-savings for preventive health outreach; and effectiveness and impact of the VDMS program, compared with other outreach approaches in Morocco.

10. PROJECT MANAGEMENT BY USAID

USAID management of the Project is in many respects exceptionally good. The Project is one of the most important in the Mission's program in Morocco and receives considerable attention from the Mission director and his senior staff. That most Project sub-activities are on track or have exceeded original plans is a testament to the competence and hard work of the Division Director, Population Officer and Health Officer. The staff has done particularly well in developing new openings and taking advantage of unanticipated opportunities to promote the availability of family planning services in Morocco. Relations between USAID staff and the MOPH are outstanding.

The Project demands significant management effort and a wide range of skills and competencies. The Project now has 13 subprojects, includes the Mission's entire \$22 million population and health program, and touches nearly every aspect of the public, private, and PVO health system in Morocco. The subprojects include a major regional outreach family planning and preventive health service program; clinically based family planning and child survival services nationwide; and health communication and education efforts nationwide. Phase III activities also include work with numerous ministries in addition to Public Health, private sector organizations and commercial firms. All these activities require training, logistics management, purchasing, contracting and managing technical assistance, special studies and research, and specific kinds of data analysis and program monitoring.

The Mission has chosen to manage all Project activities with its own staff resources, rather than to contract out all or a portion of the Project management. Certain activities are conducted under ongoing contracts with consulting firms and organizations to help provide continuity in particular types of training and technical assistance, a process that has produced 12 subcontractors whose work must be managed and guided.

Current Mission staff resources to manage the Project includes a Division Director, with all the management responsibilities of the Population and Human Resources Office, a Health Officer and a Population Officer. The Health Officer is assigned to health, training, and Title II activities. He is due to leave Morocco in the fall 1988 and current plans do not provide for a Health Officer position after his departure.

The Population Officer is currently the only professional assigned to work full-time on the Project. He is now assisted by one full-time administrative assistant and a secretary just assigned in March 1988. The personal services contract professional hired locally in 1987 to assist the

Population Officer particularly on the VDMS Field Study is not scheduled to be replaced or continued after April 1988. The Mission has planned for some months to hire one more full-time professional to work on the Project in a PIT position, but is having difficulties in filling the position.

Although the Mission has managed the Project relatively successfully to date with a limited number of personnel, these personnel are currently overextended, all regularly working 10 hours/day and part-time Saturdays and Sundays. It is unrealistic to expect continued adequate planning, management, and monitoring with the current number of staff assigned full-time to the Project. Several areas were noted in which more people with a wider range of skills might have addressed weaknesses. In addition, considering the scope of the health system involved in the Project and the specific child survival activities, against the limitation in the amount of time that the Health Officer can devote to these responsibilities, it is clear that the health components do not get the attention they deserve.

RECOMMENDATIONS FOR USAID PROJECT MANAGEMENT

1. Recruitment efforts should be continued to fill a full-time PIT position assigned to the Project.

2. A full-time Health Officer position should continue to exist, unless all health components other than family planning are dropped from the Mission's follow-on activities to Phase III of the Project.

3. A review should be undertaken of allocation of staff time, priorities, and objectives to see if some reorganization and consolidation of work might improve productivity of current staff.

4. Consideration should be given to consolidating Project activities in the follow-on to Phase III. A few manageable priorities should be developed for the balance of this phase of the Project. For example, the Mission might concentrate in the remaining life of Phase III on

Helping to assure that means are in place to sustain progress achieved in the VDMS provinces;

Providing assistance to the Ministry to resolve key service delivery issues such as how to broaden the mix of contraceptive methods and to assess the costs and effectiveness of 1) alternative mobile strategies to extend coverage for preventive vs. curative services, and 2) alternative ways to assure resupply of oral contraceptives; and

Developing a plan for consolidated and targeted assistance for the next phase of the Project.

APPENDIX A.

Evaluation Scope of Work

Appendix A
Evaluation Scope of Work

Attachment No. 1: STATEMENT OF WORK

I. PROGRAM TO BE EVALUATED

The evaluation is a midterm review of the Population and Family Planning support Project, Phase III (608-0171), of support provided under related centrally funded activities, and of expanded immunization activities supported with Child Survival funds. The project was authorized in July 1984 as a five year (1984-1989) activity. Life-of-project funding of \$5,280,000 approved at that time was increased in March 1985 to \$17,890,000. This funding was further increased on August 7, 1986 to \$19,890,000 and to \$22,890,000 on August 18, 1987 when additional Child Survival funds, in increments of \$2 and \$3 million, respectively, were obligated under the Project.

II. PURPOSE OF THE EVALUATION

The objective of this evaluation is twofold: to determine the extent to which the Project's goal and specific purpose are being or can be met within the life of project, and to provide the Mission and the GOM with guidelines as to changes in project design or implementation procedures required. The evaluation will also assess the continuing validity and appropriateness of the logical framework (Attachment No. 4).

The evaluation is scheduled for January 1988, a bit more than halfway through the currently anticipated length of project life. The evaluation addresses the overall effectiveness of the project in achieving the stated purposes. Thus although individual parts of the evaluation may focus on one or more of the 12 subcomponents, for the most part the questions to be addressed by the evaluation team are crosscutting in nature. As such they are designed to assess the extent

not only of the effectiveness of specific subcomponents, but also of the linkage and synergistic effect of those subcomponents.

Given the major importance of the VDMS program in USAID's population and child survival strategies, a special study of the field effectiveness of that component will be carried out as a preliminary part of the evaluation. That study will be contracted to a Moroccan firm which will collaborate with a GOM representative and a U.S. social scientist with experience in Morocco to carry out the study. This study will provide input to the evaluation and be included as an appendix to the final evaluation report (See Part V, Methods and Procedures).

III. BACKGROUND

This project is a sequel to two earlier projects, Family Planning Support I, 1971 to 1977 (608-0112), and Family Planning Support II, 1978-1984 (608-0155). The latter, which was similar in design to the current effort, received a favorable evaluation in December 1983. In addition to addressing weaknesses noted in that evaluation in the areas of data collection and analysis; information, education and communication (IEC); and collaboration with the private sector, the present project was designed to reinforce and expand effective interventions, i.e., the outreach contraceptive and MCH service delivery activity, "Visite à Domicile de Motivation Systématique" (VDMS), and clinical family planning services.

Under this third stage of assistance in population and family planning to the GOM, services both from fixed centers and through the outreach activity, VDMS, have been greatly expanded. The program now covers 28 provinces and prefectures which include nearly 70 percent of the population. According to the national contraceptive prevalence survey carried out in 1983, prevalence nationwide had reached 26 percent

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with a combination of modern and traditional methods. With the expansion of activities under this phase of the project, including an increase in the number of personnel trained in surgical contraception and IUD insertion, as well as the extension of VDMS to an additional 15 provinces and prefectures, it is anticipated that prevalence will have increased substantially, nearing the estimated targeted level of 35% by 1988 discussed in the Project Paper.

The project's 12 subcomponents are designed individually and collectively to support increased accessibility and acceptability of family planning services. In response to earlier evaluation findings a emphasis has been placed under the project on (1) broadening the capability of the private sector in family planning promotion and service delivery; (2) upgrading both private and public service capabilities in development, testing and dissemination of promotional materials in family planning and child survival technologies (particularly oral rehydration therapy and immunization), and (3) improving MOPH capabilities to collect, analyze, and use data gathered on family planning and child survival services to monitor and manage performance. Specific subcomponents address each of these thrusts. Most important of the subcomponents, however, is that of VDMS which receives more than 23 percent of project funding, with four of the other subcomponents relating largely to support of that activity. Improving the effectiveness of VDMS is USAID's and the Ministry's major focus under the project at present.

The emphasis on VDMS, with its combination of the key six MCH/child survival interventions reflects the fact that the GOM continues to support population and family planning activities within the framework of its maternal child health program, focusing almost entirely on child spacing. In its policy dialogue, USAID is simultaneously continuing to encourage greater GOM consciousness of the implications of the country's growth rate on development. Steps in that policy dialogue are designed

to increase GOM resolve to affect the growth rate as demonstrated by resource allocation, organizational and management improvement, and greater collaboration with the private sector. This dialogue and related activities broaden the focus of the project beyond the Ministry of Health, engaging especially the Ministry of Plan, and the private sector including the Moroccan Family Planning Association.

Project activities with both the Ministries of Health and Plan are carried out in collaboration with those of other donors in particular the UNFPA, UNICEF and the IPPF.

IV. SCOPE OF WORK

A. Overall Questions: The evaluation team will be asked to address a set of eleven major project-related questions. For each of these major questions, a series of subquestions has been posed to guide the team in specific areas of inquiry. The team will be expected to generate data, both qualitative and quantitative, based on interviews, field visits, and review of a wide range of documentation and materials.

1. Contraceptive Practice—To what extent has contraceptive prevalence increased among the target population?

2. Coverage -- To what extent are contraceptive information and services available to the Moroccan population (rural, urban, by region)? Are gaps a function of a lack of resources, infrastructure, management or what?

(Note: In responding to the above questions in particular the team will be expected to review preliminary results of the National Survey of Family Planning, Fertility, and Family Health 1987 (ENPFESF), as well as service statistics and results of any provincial or other studies.)

3. Population Awareness—To what extent are key GOM officials

- o Aware of rapid population growth as a development problem?
- o Aware of Government and private family planning activities and results?
- o Committed to resolving or addressing the problem of rapid population growth?

a) To what extent has an increased awareness been translated into effective support for population and family planning activities? Into increased public communication about such activities and about the program?

b) To what extent are population information and demographic variables integrated into development planning and resource allocation? What specific use of this information has been made in development planning? In resource allocation?

4. Demand—Is there any evidence from the ENPFSP and other sources of an increase in demand for family planning services? To what extent can changes be related to project activities?

a) What is the status of development of communications strategies and planning at national and provincial level? To what extent are messages adapted to the needs of the target audience?

b) Are audiovisual materials and equipment available at national and provincial level to promote and support service delivery?

c) What is the capacity of the MOPH and the AMPF to develop, test, produce and disseminate appropriate audiovisual materials?

d) To what extent have modern techniques for attitudinal and market research message testing and impact education been used in the development of promotional materials.

e) To what extent have project activities resulted in increased knowledge of confidence in and use of contraceptive services?

f) What project activities appear to be most effective in creating demand?

5. VDMS—To what extent is VDMS having an impact on contraceptive prevalence, and on knowledge, attitudes and practice of mothers regarding family planning, use of ORI, breast-feeding and correct weaning practices, and immunization? Input for much of this section will come from the assessment of VDMS field effectiveness to be carried out prior to the evaluation (see Section IV. B, Methods and Procedures).

a) What evidence exists of the effectiveness of VDMS workers in various kinds of environments, i.e., urban, rural; and periurban?

1) What are the strengths and weaknesses of VDMS workers by sex, in each environment?

2) What steps have been taken to increase effectiveness or resolve problems faced by VDMS workers by sex, in each?

3) What factors seem to be most effective in influencing contraceptive rates in each environment?

4) What problems are faced by VDMS workers in promoting and providing family planning services? In other areas?

b) Has adequate logistic support, in the form of transport and supplies, been provided to VDMS agents?

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c) To what extent is supervision of VDMS workers systematic, with feedback provided to the worker and to the system?

d) What is the effect of VDMS on the use of health centers/dispensaries for each of the following: family planning services, diarrhea control, immunizations, other kinds of care?

e) To what extent has VDMS training been adequate in the following areas: technical skills, communications, data gathering and analysis?

f) To what extent has training in technical aspects of VDMS work, i.e., family planning promotion and service delivery, use of oral rehydration therapy, vaccination referrals and administration, and nutrition education been followed up and evaluated?

g) Is the packet of services provided by the VDMS workers appropriate in terms of target population's needs, demands, training of the VDMS worker, and his/her credibility?

h) To what extent is there an effective referral system between the VDMS worker and the health system, i.e., for immunizations? for cases of acute diarrhoea; for malnutrition; for family planning services or complications; for pre- and post-natal care? for other reasons?

i) What forms of formal or informal collaboration are prevalent between VDMS workers and other social agencies, including but not limited to the Ministry of Social Affairs and Artisanal Centres Socio-educatifs, the Ministry of Education, and the Ministry of Agriculture?

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j) Which of the 5 VDMS interventions is of greatest importance in terms of (a) time or effort expended, and (b) in the minds of:

- o VDMS workers
- o SIAAP medicine chef
- o Provincial medicine chef.
- o Population

From the above, to what extent can a correlation be drawn between effort expended, perceived significance of the intervention, and effectiveness?

k) What steps, at provincial and central levels should be taken to strengthen the effectiveness of the VDMS program?

6. Data Collection and Analysis—To what extent do the data collection and analysis systems of, and special studies carried out by, the GOM (MOPH and MOP) and private sector family planning organizations provide accurate, timely and useful information on service effectiveness and outputs needed to monitor performance and to manage effectively?

a) Assess the MOPH monitoring system as a means of providing a monthly or quarterly estimate of method and province specific family planning acceptor and prevalence rates? immunization rates? diarrheal illness and use of ORS? Are results fed back to officials responsible for program implementation; within what time period? Are necessary data available from the MOPH system to provide required periodic reporting on child survival activities?

b) What use is made of data collected at circumscription, provincial and central levels? What data have been particularly

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useful for monitoring performance and making decisions? For identifying problems and taking action? What efforts are being made to assure that data collected are (1) limited to what is useful and (2) provided in a form appropriate for effective management.

c) To what extent is information on costs available to permit studies of cost effectiveness of various sources of family planning services?

d) To what extent is there collaboration between the Ministries of Health and Plan in collection, analysis, and use of data?

e) To what extent has the project contributed to improving GOM capacity to collect, process, analyze and use demographic and FP statistics?

7. Training—To what extent is the project providing assistance in diagnosing training needs and organizing, implementing and evaluating training programs to meet those needs?

a) What changes have taken place in management practices or systems as a result of management training under the project? What further training is needed?

b) To what extent has training under the project in (a) IUD insertion and (b) surgical contraception been backed up with effective counseling and follow-up?

c) To what extent has communications training undertaken increased worker skills in promoting and explaining family planning and child survival skills?

8. Logistics Support--Is a full range of contraceptive supplies as well as other VDMS and MCH materials available on a continuing basis at central, provincial and circumscription level as required for effective service delivery?

Has a system been established that permits timely ordering and resupply of contraceptive materials and other VDMS and MCH commodities? Is provision made for adequate shelf life at all levels of the system? Are supply shortages identified quickly and remedied?

9. Private Sector—To what extent have activities supported under the project contributed to increasing the involvement of the private sector in the promotion and delivery of family planning services?

a) What gaps and weaknesses exist in the public sector family planning activities that could be filled by the private sector?

b) To what extent have these been adequately addressed in the Mission's private sector family planning strategy?

c) To what extent are current activities in the private sector effective in increasing family planning acceptance? In creating demand?

d) What progress has been made in establishing a natural family planning capacity in the private sector? (Number of persons trained; numbers practicing; results?)

e) What steps have been taken to eliminate administrative and legal barriers to the delivery of FP products and services by private sector providers?

10. Financing—To what extent are project activities fostering increased Moroccan (public and private) financing for family planning activities?

a) To what extent is adequate financing available for services at present? Is there any evidence that cost is an obstacle to greater prevalence?

b) To what extent have self financing experiments carried out by the AMPF been successful? Which ones. In what context?

c) What are the longer range cost implications of VDMS for the health system? Is information available that permits regular monitoring of relative cost effectiveness of this outreach effort in rural, urban, and periurban areas, as opposed to service from fixed centers and other alternatives?

11. Project Management and Design—What strengths and weaknesses characterize management of this project on both USAID's and the GOM's side? How can the management of the project on both sides be strengthened?

a) USAID

1) Has Mission staffing been adequate to meet project needs in terms of:

- (a) Management of technical assistance
- (b) Development and processing of documentation
- (c) Monitoring of performance
- (d) Identifying problems and possibilities for their resolution, and responding to identified GOM concerns about the project
- (e) Administrative and secretarial support

2) What steps, regarding project design or project implementation structure in the Mission need to be taken to increase project effectiveness?

b) GOM

1) Has GOM staffing and organization, particularly at the central level, been adequate to provide necessary leadership, support, supervision and monitoring to the project? To what extent is authority, responsibility and support effectively delegated or provided to the field (provinces) for implementation of the project?

2) Are there additional policy and organizational steps that the GOM could take to facilitate and promote child spacing and family planning?

c) Other Donors

What collaboration and/or coordination has taken place with each of the following organizations (UNFPA, UNICEF, IPPF, WHO)? What problems have been noted? In what areas, should coordination be strengthened?

APPENDIX B.

Scope of Work for VDMS Field Effectiveness Survey

Appendix B

Scope of Work for VDMS Field Effectiveness Survey

I. BACKGROUND

In Morocco the VDMS program was launched in 1977 in the Province of Marrakech as a pilot program. The purpose of the program was to study the acceptance of FP services by the population and to collect useful data in this area. The encouraging data which were obtained have led to an expansion of the VDMS program in additional provinces and prefectures, 28 at the moment, where basic health services are delivered including:

- Family planning services
- Oral rehydration therapy (ORT)
- Control of child protein caloric malnutrition
- Control of pregnant and feeding women anemia (iron deficiency)
- Reference of non-vaccinated or partially vaccinated children to insure completion of all required vaccinations.

The VDMS program is one of the 5 coverage strategies used by the Ministry of Public Health (MOPH) in attempts to assure the delivery of basic health services in Morocco. More than 70% of the population of Morocco is presently living in areas covered by the VDMS program. Since this program is now entering its fifth year of operation (a table listing provinces and prefectures concerned by each of the three phases of program implementation is presented under Attachment No. 1), the MOPH wants to evaluate the VDMS technical, operational and financial capacities to provide a package of family planning and basic MCH/child survival services.

II. PURPOSE

The purpose of this assessment is to collect information on the results obtained by the VDMS program in urban as well as rural areas, and to provide MOPH decision makers with the field level information required to consider the changes to be made in the comprehensive approach, as well as content, of the program in conformity with the MOPH basic health services strategy developed in the provinces of Seltat, Agadir and Taroudant.

This study will be used by an evaluation team charged with reviewing the current collaborative program between USAID and the MOPH in the area of population and family planning activities. The results and conclusions of this study must be available prior to the month of December 1987. This RFP concerns the implementation of a study for the

MOPH which will provide the Ministry with qualitative and quantitative information on the implementation of the VDMS program. This study will be funded by USAID.

III. OBJECTIVE OF THE PROJECT

The specific objectives of this study are to:

- A. Collect information on how the VDMS program is perceived by:
 1. Persons using the services (the population, community) and local officials (local authorities, elected officials and people from other sectors)
 2. MOPH staff (VDMS agents, supervisors, and personnel based in MOPH fixed facilities)
- B. Review the program's impact in changing the attitudes and practices of consumers toward the use of FP and maternal child health services
- C. Identify the program's positive and/or negative effect relative to other MOPH preventive health programs:
 1. Attitudes and work conditions
 2. Volume of services provided
 3. Monitoring and supervision of program activities
 4. Population coverage
 5. Program planning and management
- D. Collect information concerning attitudes relative to the following points:
 1. Possibilities for increased local participation in the financing of services
 2. Reorganizing aspects of the program to reduce costs without reduction in the quality of services offered (personnel, support materials, increased use of resources available in the community or through other ministry programs)
- E. Identify aspects of the VDMS program which support its adaptation in line with the MOPH basic health strategy and potential obstacles linked to modifying the program in this manner.

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IV. SCOPE OF WORK

A. Qualitative Research

1. Initial Research: a preliminary qualitative study conducted among VDMS clients, field agents and supervisors, focussing on the following points:

a. VDMS Clients (women)

- Differences in cultural attitudes toward male and female VDMS workers.
- The nature of services delivered by rank of importance. Assess to what extent FP/MCH service needs are satisfied and identify which other needed services should be provided.
- The level of motivation created by the VDMS workers (thru communication and demonstration activities).
- Changes in attitudes and practices noticed by VDMS agents and thru review of services statistics.
- Level of understanding of activities and services provided (FP, ORT, protein caloric malnutrition, vaccinations, anemia, etc.).

b. Local Authorities

- Opinions concerning the services provided by the VDMS program; how are these services perceived in terms of their usefulness or inadequacy and with respect to need for such services.
- Level of effectiveness of male VDMS workers relative to female workers.
- Identification of other groups (Women's associations, social affairs, etc) or/and other staff categories (traditional midwives, community agents etc) able to provide or to help to provide services offered under the VDMS program.
- Types of changes to be made in the organization of the program to render it more efficient. Indicate such changes.
- Level of potential community financial support available to the program.

c. VDMS Workers and Supervisors: the survey to be conducted among the VDMS workers and supervisors will focus on establish the following points:

- Worker opinions concerning the VDMS program and their role in the program.

- Types of groups (women's associations, social affairs or other) and other staff categories (traditional midwives, community agents, or other) able to deliver, or help to deliver, services offered under the VDMS.

- Type of information communicated to women about FP and MCH.

- Opinion of the staff on all the services and commodities being provided. Other services requested by rank of priority, including those which are not provided.

- Problems encountered and how they are being resolved.

- Collaboration of the VDMS workers with people from other organizations, agencies, institutions (local authorities, elected members, staff from other health programs).

- Views of workers concerning their working conditions and the logistic support they receive.

- Type of training received and appropriateness for assigned tasks.

- Changes in the attitudes and practices of the women recorded by the workers while delivering VDMS services.

- Means used by VDMS staff to monitor and evaluate their activities.

- Nature of relations between VDMS agents and their supervisors.

2. Observations and Interviews: the second component of the qualitative study will consist in observing the VDMS workers on the field and in interviewing the VDMS workers, their supervisors and the staff working in dispensaries, clinics and health and reference centers. The following issues will be addressed:

a. Attitudes and reactions of VDMS clients relative to the sex (male, female) of the VDMS worker.

b. Type of information actually provided by VDMS workers to their clients (for each activity).

c. To what extent is the VDMS worker convinced regarding the efficiency of the door-to-door method of providing health services in general. Is the worker well qualified.

d. Procedures used by VDMS workers to introduce their visit and offer their services. Identification of most appropriate procedures and of the blunders to be avoided.

e. Appropriateness of the utilization by the VDMS worker of demonstrations as a motivational and informational tool. Describe process and accuracy of execution.

f. Type of documentation being maintained and in what condition. Describe general status of forms, notes, tables and reports maintained by the workers.

g. Type of feedback provided by supervisors to VDMS workers about their work (skills, maintenance of files, etc).

h. Average number of clients visited each day relative to the number expected and perceptions concerning the adequacy of coverage.

i. Type of services delivered to households by geographic areas. Changes recorded in services provided. Indicate the quantity for each service.

j. Availability in a timely manner of needed commodities. Types of problems encountered regarding transportation. Usefulness of carrying items in the VDMS bag.

k. Type of information available on costs and budget. How is it collected and used.

l. How are cost data taken into consideration. Are activities projected according to available budget and required expenses. Type of activities being undertaken based on fund availability.

m. Changes in the attitude of the VDMS worker vis-à-vis services to be delivered as a result of the allowance received, in the VDMS program, in a clinic or in an other situations.

n. Problems related to the fact that the agent is a man or a woman. Changes which could be made to address these problems.

o. Changes recorded in the behavior of the population covered under the VDMS program and which can be attributed to services delivered under VDMS.

p. Perceived value of the VDMS worker position. Turnover rate of VDMS workers. Why do they leave.

q. Job opportunities due to VDMS experience (within MOPH or somewhere else). Other jobs preferred by VDMS workers in the health system; why?

r. Acceptance of clients towards 1) the VDMS agents; 2) services provided; and 3) the way services are delivered (to their home, or in a center). (List any missing services; services to be delivered at home preferably; and services to be provided outside the VDMS program).

s. Level of efficiency of the agent in terms of communication of information and organizing demonstrations.

t. Knowledge acquired by VDMS beneficiaries (FP, ORT, protein caloric malnutrition, vaccination, anemia, etc) in relation with the above.

u. Behavior expected from beneficiaries to obtain health services in case the VDMS program was cancelled. Listing of alternatives.

v. Opinion of various officials regarding the impact of the VDMS on remaining MOPH activities.

w. Frequency of VDMS visits. Time devoted by the worker (enough or not) during visit. Number of visits desired per year.

x. Changes in the profile of MOPH clients following the introduction of VDMS. Reasons for these changes.

y. List of interventions viewed as inappropriate or less important for the area or region in question.

B. Quantitative Research

The collection of quantitative data on progress recorded in the implementation of the VDMS project and the Ministry's child survival programs will be conducted on the basis on the indicators/measures of program efficiency listed below. In order to analyze such data it is necessary to know which data are available, at what level and to be able to follow their circulation.

1. Basic Project Activities/Service Information

During the study, information on the following subjects will be identified and collected:

a. Number and percentage of VDMS workers having received appropriate training in PF, ORT, vaccination, anemia, breastfeeding, nutrition, etc.

b. ~~Num~~ of references being done. Their nature, direction, level of coordination within the MOPH system or with others.

c. Process being followed to establish a schedule of visits. Number of visits per year, and frequency. Length of the shortest one, and of the longest one.

d. Quantity of ORT packages being distributed (in the field and by each agent).

e. Number and type of vaccination completed.

f. Percentage of vaccinated children per type of vaccination.

g. Available products: Quantity of ORS distributed number of doses provided for each type of vaccination

Other products available: type and amount

h. How many health centers are equipped with a cold chain.

i. How product needs are determined, requested and programmed.

j. Access to available information on coverage, programming. Objective of information and how they are recorded.

k. How the information on costs, coverage and impact is used.

2. Indicators of System Efficiency and Quality Control

The evaluation will determine which indicators among those listed below are available and will describe the methods being used for collecting the information, commenting of the. Reliability of this information (a more comprehensive evaluation of information reliability will be conducted later).

a. Number and percentage of health workers able to demonstrate their knowledge and ability in ORT/FP/vaccination/breastfeeding/nutrition/anemia, etc.

b. Number and percentage of persons aware of ORT/FP/vaccination/breastfeeding/nutrition/anemia, etc

c. Number and percentage of children who have received all vaccinations.

d. Number and percentage of children breastfed and receiving additional food at 6 months.

e. Number and percentage of children who have been weighed during 3 previous months. Number and percentage of high risk children who have been followed.

f. Available information on costs for each type of activity.

Also, the availability of following constants should be reviewed:

a. Mortality rate/age (0-12; 13-60).

b. Mortality as related to diarrhoeas (0-60)/10.000.
Was the child suffering from diarrhoea during the period preceding his death?

c. Severe rate of dehydration associated with diarrhea.

d. Mortality rate associated with measles.

e. Mortality rate associated with neonatal tetanus.

APPENDIX C.

Log Frame for Phase III of the Project

Log Frame for Phase III of the Project*

Revised
PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK
(Including new sub-project No. 11)

Life of Project:
From FY 84 to FY 88
Total U.S. Funding: \$1,000,000
Date prepared: August 1987

Project Title & Number: Population and Family Planning Support, Phase III (608-0171)

RELATIVE PRIORITY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS										
<p><u>Program Sector goal: The broader objective to which this project contributes:</u></p> <p>Reduce Morocco's rapid rate of population growth and thereby diminish a key constraint to achievement of the country's economic and social development objectives.</p>	<p><u>Measure of goal achievement:</u></p> <ol style="list-style-type: none"> 1) Population growth rate reduced. 2) Reductions in age-specific fertility rates. 3) Reduction in infant, child and maternal mortality. 	<p>Demographic survey to be conducted by GDM Ministry of Plan in 1985 (part of MOPH's inter-census survey survey).</p>	<p><u>Assumptions for achieving goal targets:</u></p> <p>Continuing high rates of population growth significantly increase the cost and difficulty of achieving basic development objectives by imposing burdens on economic processes presently unable to provide sufficient goods and services for the growing population.</p>										
<p><u>Project Purpose:</u></p> <ol style="list-style-type: none"> 1) Establish regular availability of a full range of family planning (FP) information and services for at least 70% of eligible couples in Morocco. 2) Attain contraceptive prevalence of 35% of married women of reproductive age (MWR). 3) Develop a broader "population" awareness as part of GDM development planning. 4) Improve the health status of Moroccan mothers and children. 	<p><u>Conditions that will indicate purpose has been achieved:</u></p> <ol style="list-style-type: none"> 1) FP services available at 1,200 MOPH health facilities; through 2,000 VPMs outreach personnel; at rural markets (souks) in 15 provinces; and thru ANPF sales agents in towns, villages and thru urban areas. 2) Number of couples practicing family planning to increase from 1983 total of 920,000 to 1988 total of 1,345,000. 3) GDM Five-Year Plan includes population growth and impact analyses across various development sectors. 	<ol style="list-style-type: none"> 1) MOPH, USAID records and reports 2) FP program service statistical analysis of contraceptive stock flow. 3) ANPF sales statistics. 4) Contraceptive prevalence surveys. 5) On-site verification. 6) Examination of GDM Five-Year Plan. 7) 1987 National Family Health and Demographic Survey. 	<p><u>Assumptions for achieving purpose:</u></p> <ol style="list-style-type: none"> 1) The GDM will continue to invest substantial resources in health and FP programs. 2) High fertility norms and societal pro-natalist attitudes, a sizable unmet need exist for FP services (the unmet need). 3) A properly designed and managed FP program will satisfy much of this unmet need and lead to higher contraceptive prevalence. 										
<p><u>Outputs:</u></p> <ol style="list-style-type: none"> 1) Household Service Delivery Program operational; 2) Reproductive Health/Voluntary Surgical Contraceptive Services installed; 3) Improved Private Sector Contraceptive and Health Products marketing initiated; 4) FP, Oral Rehydration, and vaccination education materials produced; 5) Population analyses in GDM planning process introduced; 6) Improved vaccination coverage for DPT-polio, measles, BCG; 7) Improved coverage for OMT, nutrition, and pregnancy and birth monitoring programs. 	<p><u>Magnitude of Outputs:</u></p> <ol style="list-style-type: none"> 1) 70% national coverage, i.e. 70 provinces and 8 urban prefectures; 2) Available in 30 provincial hospitals; 3) 15 provinces and 3 major cities; 4) Radio/TV spots; household distribution of materials; national public health education campaign; 5) Population projections included in 1986-92 five year plan; 6) 90% of children (0-5 years) vaccinated; 7) 35% children with diarrhea treated with OMT; 30% urban and 25% rural at risk groups screened for malnutrition; equip 200 new MCH centers and 60 maternities. 	<ol style="list-style-type: none"> 1) On-site verification of project activity. 2) Examination of household visitation records of VPM fieldworkers. 3) Monitoring of radio, T.V., movie presentations. 4) Examination of planning documents for the 1986-92 Five Year Plan. 5) MCHP vaccination coverage surveys. 	<p><u>Assumptions for Achieving Outputs:</u></p> <ol style="list-style-type: none"> 1) The GDM will pursue its stated plan to expand the VPM project into 3 additional provinces and into major urban areas. 2) The GDM will assume the costs of the VPM project in the 15 "original" VPM provinces. 3) The GDM will implement VS services in provincial hospitals without being deterred by considerations of political/religious considerations to GDM involvement in VS. 4) GDM will authorize "air-time" for broadcast FP messages. 5) GDM will cover planning/monitoring/evaluation methodologies introduced under the project into the Five-Year Plan development process. 										
<p><u>Inputs:</u></p> <p>FY 84-88:</p> <table border="0"> <tr> <td>Technical assistance</td> <td>2,360</td> </tr> <tr> <td>Commodities</td> <td>17,494</td> </tr> <tr> <td>Training</td> <td>3,770</td> </tr> <tr> <td>Other</td> <td>3,843</td> </tr> <tr> <td>Total</td> <td>27,467</td> </tr> </table>	Technical assistance	2,360	Commodities	17,494	Training	3,770	Other	3,843	Total	27,467	<p><u>Implementation Target (Type and Quantity):</u></p> <ol style="list-style-type: none"> 1) 116 P/M Ts (project evaluation special studies/surveys, local training/outreaches, resident LV contractor, AVS project support). 2) 100 P/M short-term training in U.S. and 3rd countries. 3) 30,000,000 monthly cycles of oral contraceptives at \$1,850,000, 1,600,000 condoms at \$350,000, Other: \$800,000. 4) Local Costs: VPM - Urban Outreach program: \$1,300,000; program: 400, \$1-C: 400, ANPF sales: 1000, non-MOPH \$1 institutional 300, Miscellaneous: 130. 	<ol style="list-style-type: none"> 1) USAID and AID grants/contractor reports 2) Shipping documents & reports on contraceptive and commodity deliveries. 3) Consultant reports. 4) PIU/Co, P10/Co, P10/Pe. 5) USAID financial records. 6) P10-Ms submitted by recipient agencies. 	<p><u>Assumptions for providing inputs:</u></p> <ol style="list-style-type: none"> 1) GDM can effectively absorb and utilize AID-provided resources. 2) The GDM processes the political will to undertake an expanded FP/health program, but lacks sufficient technical, training and physical resources needed to do so. 3) Other donors are not able to provide the assistance described herein.
Technical assistance	2,360												
Commodities	17,494												
Training	3,770												
Other	3,843												
Total	27,467												

* Output number 7 has been added to initial additional accomplishments under the new sub-project No. 11
 **Inputs have been increased as follows for sub-project No 11 (\$1000): Technical assistance- 233; Commodities- 1,334; Training- 200; Other- 207; Total- 3000.

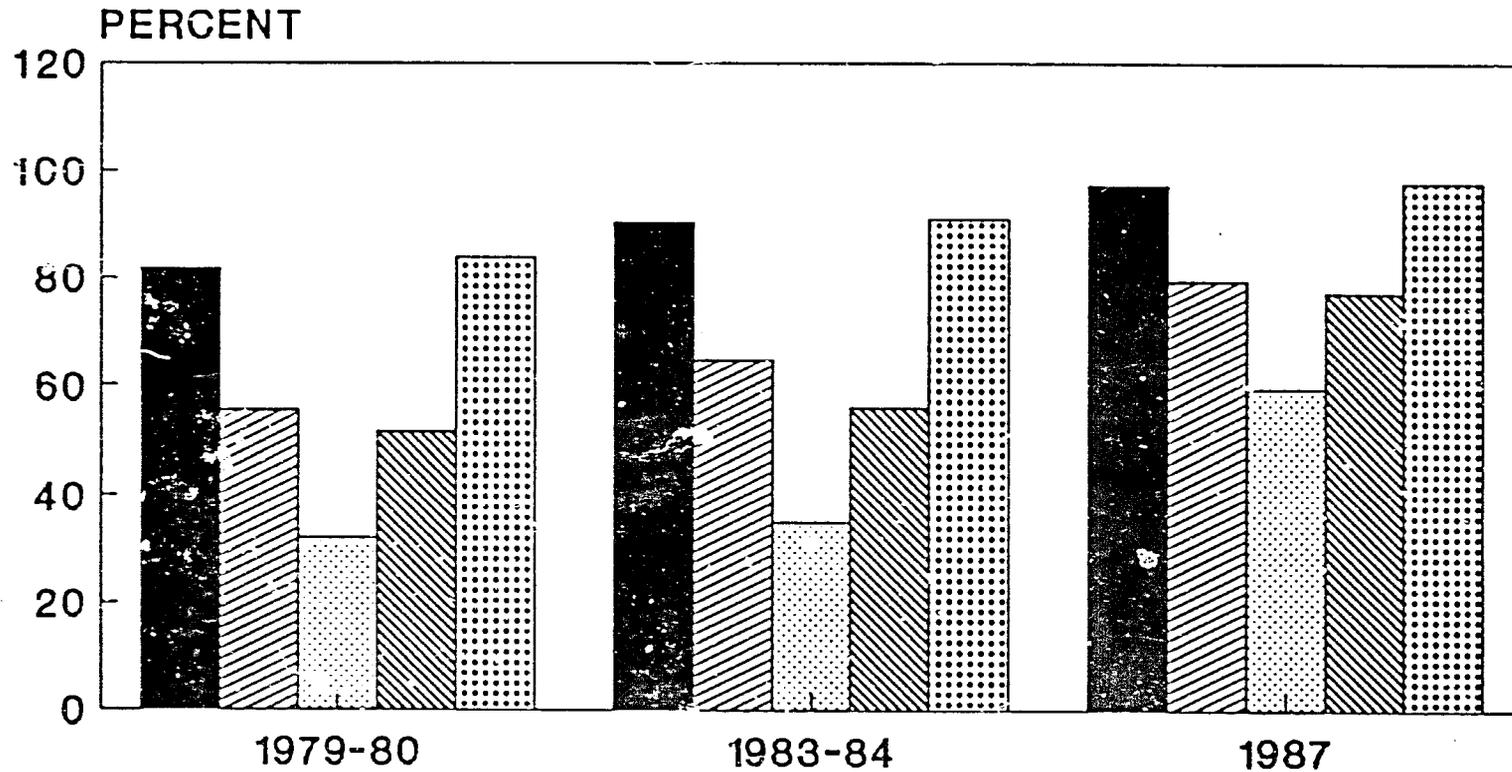
*Original of this sheet unavailable

APPENDIX D.

Special Data Analysis of Contraceptive Prevalence and VDMS Impact

Excerpt from report of evaluation team member
William Trayfors, AID/W representative
submitted to USAID/Rabat March 1988.

MOROCCO-CONTRACEPTIVE KNOWLEDGE 1979- NON-SINGLE FEMALES AGED 15-49



SOURCE: ENFPF, ENPC, ENPS SURVEYS

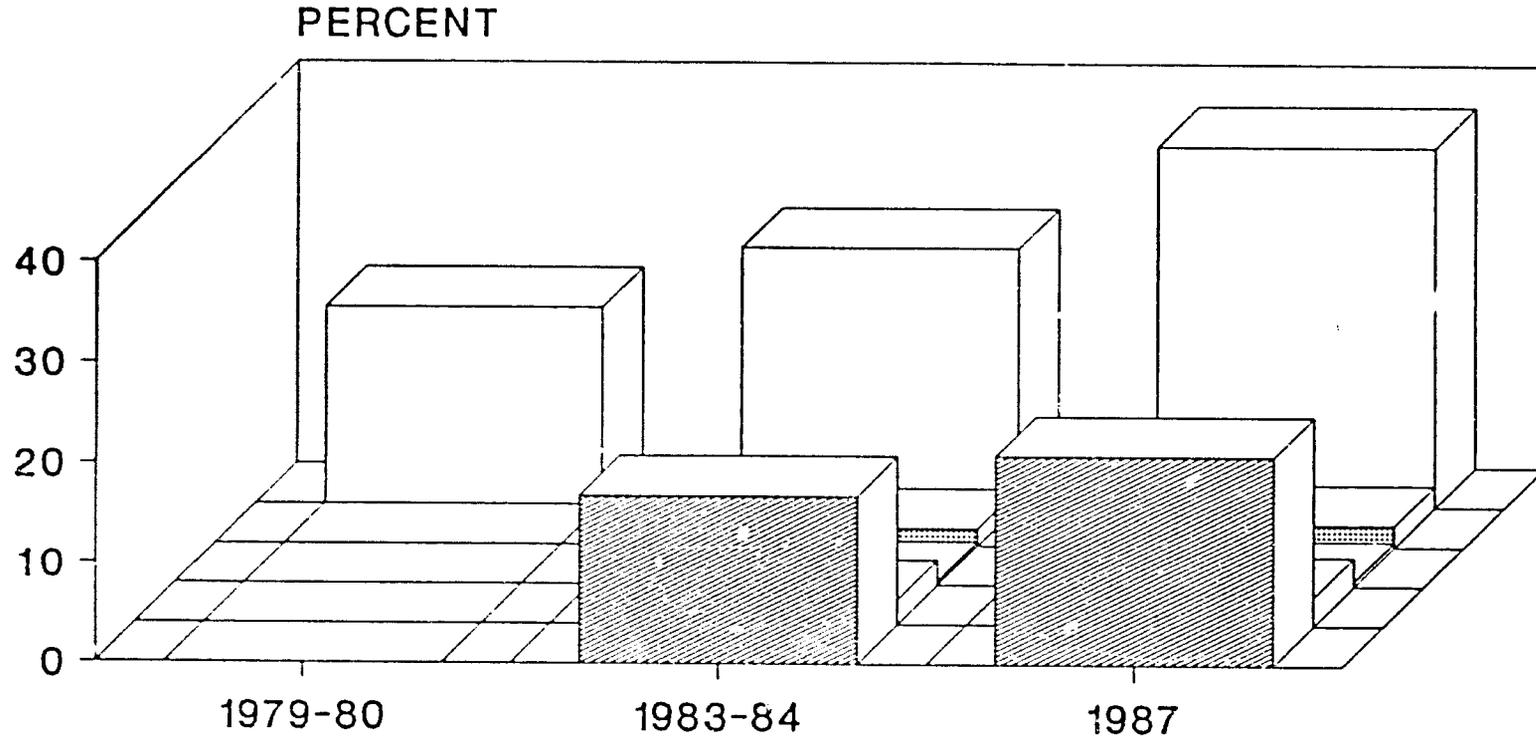
ORALS
 IUD
 CONDOM
 VSC
 ANY METHOD

Findings from the three cited surveys show high levels of contraceptive knowledge. By 1987, almost 100 percent of married females 15-49 knew at least one contraceptive method.

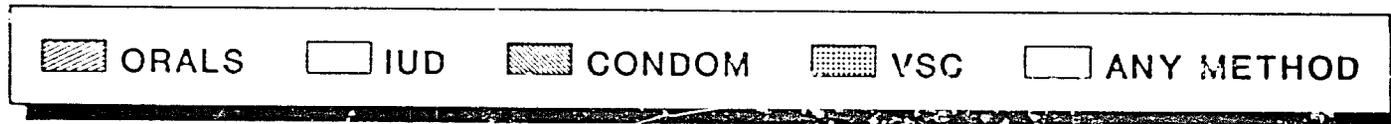
11

CHART T2

MOROCCO: USE OF CONTRACEPTIVE METHODS MARRIED WOMEN AGED 15-49



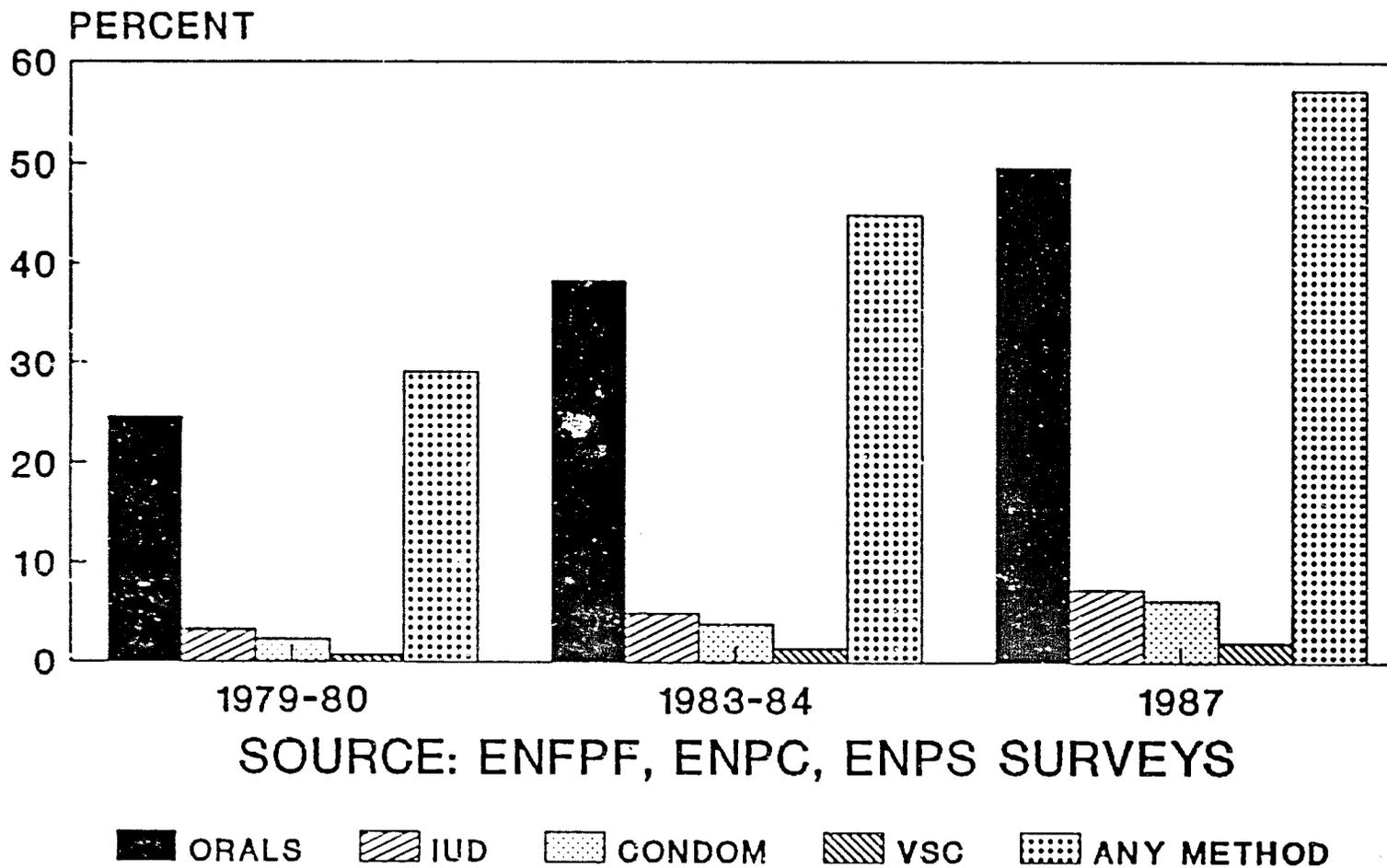
SOURCES: ENFPF, ENPC, ENPS SURVEYS



Three successive surveys have shown increasing prevalence of contraceptive use. Due to definitional problems, only the "any method" index is available for 1979-80.

28

MOROCCO: EVER USE OF CONTRACEPTION NON-SINGLE FEMALES AGED 15-49

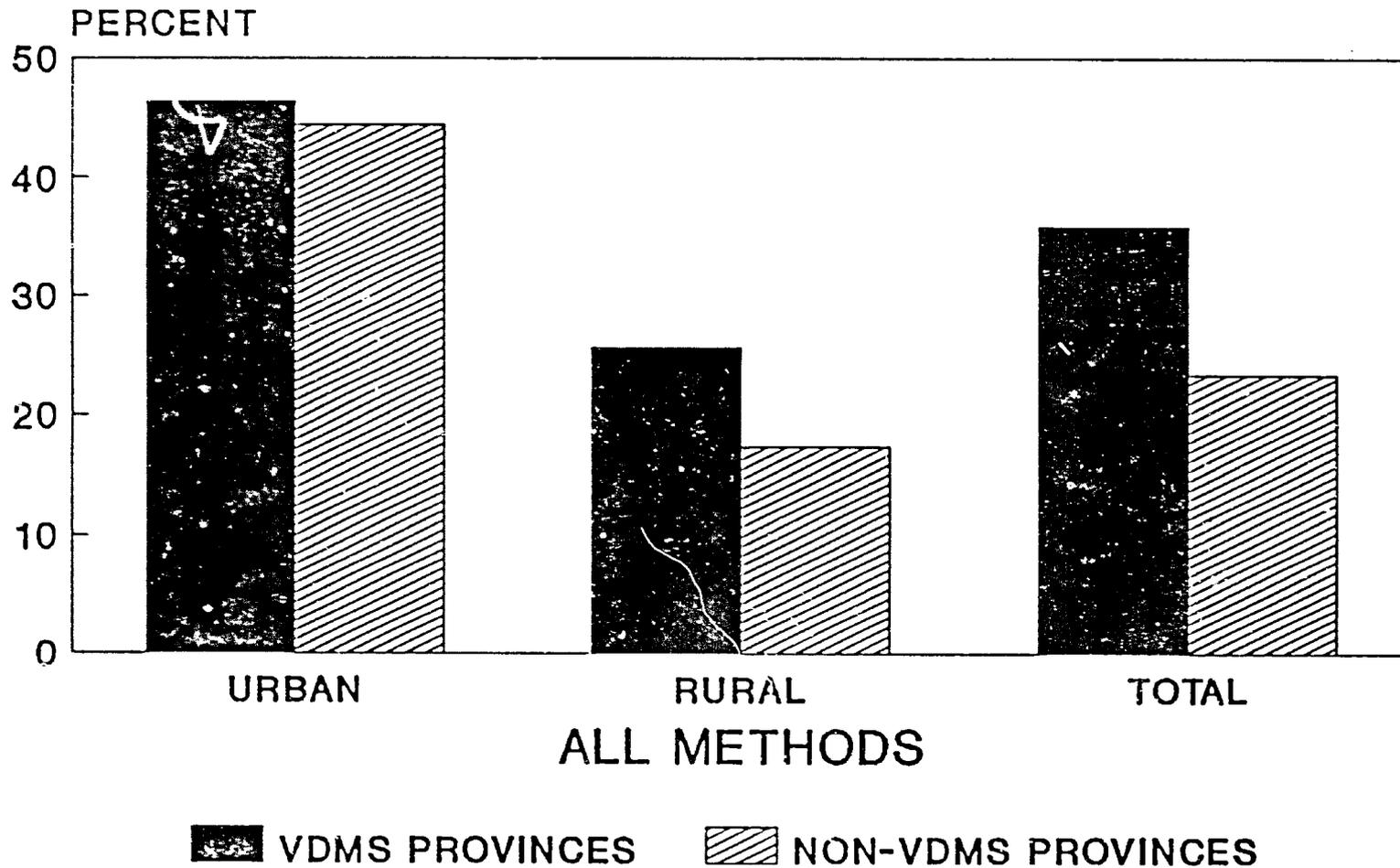


D-3

As these surveys show, Moroccan women are gaining experience in the use of contraceptives, with ever use approaching 60 percent.

10

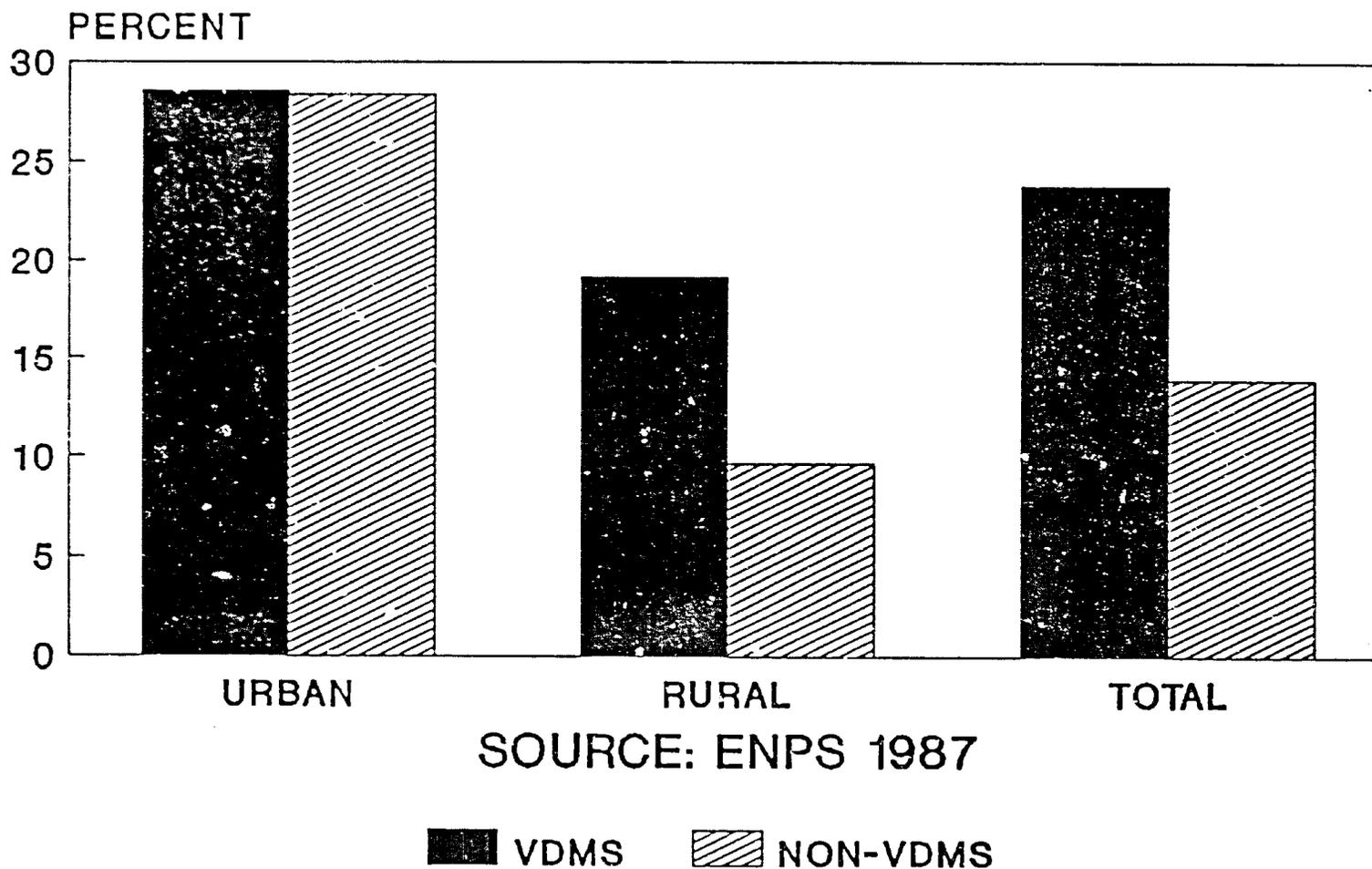
MOROCCO: CONTRACEPTIVE PREVALENCE NON-SINGLE FEMALES 15-49 (1987 ENPS)



D-4

Urban contraceptive prevalence is considerably higher than rural prevalence. VDMS Provinces have a higher prevalence rate than do non-VDMS provinces, especially in rural areas.

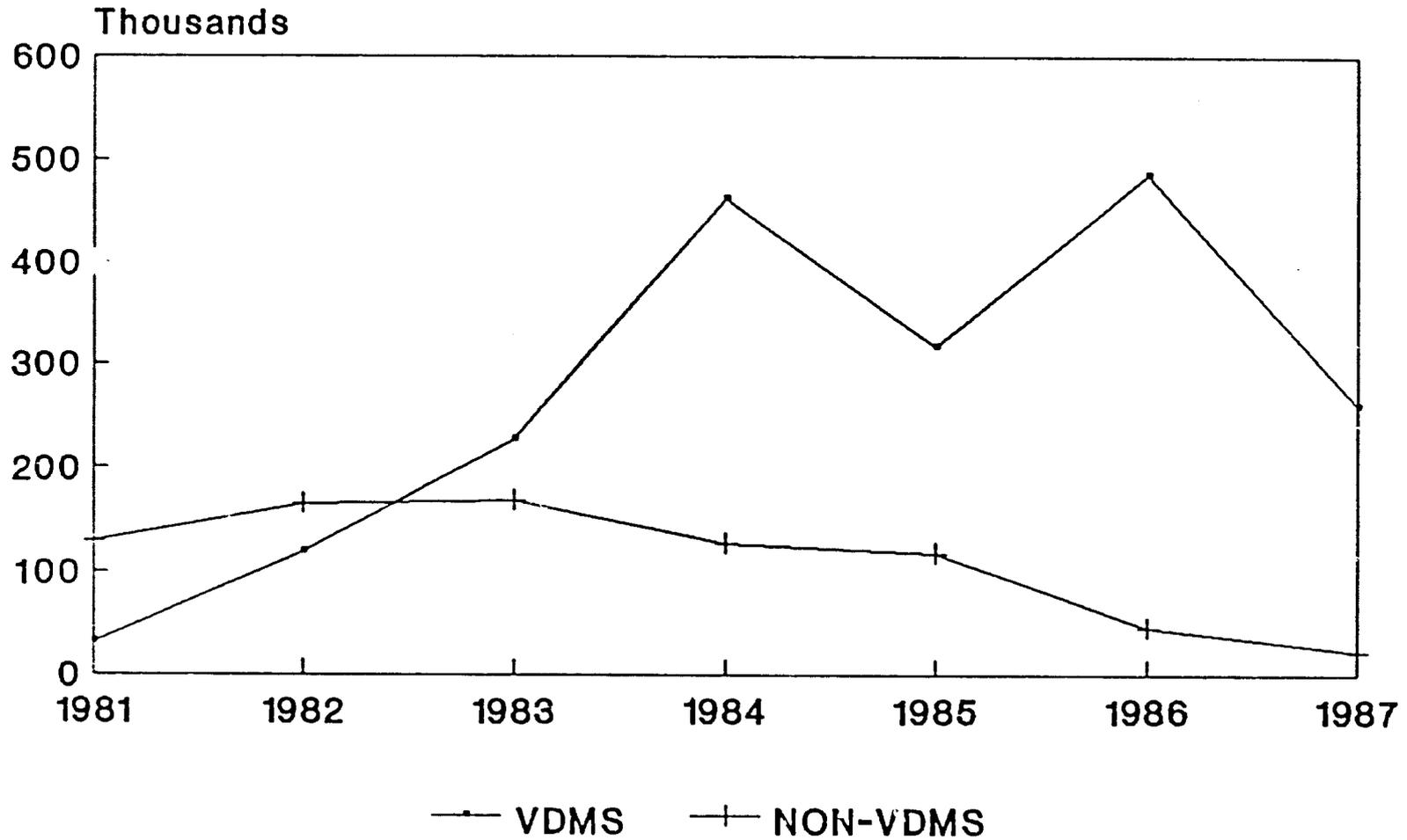
MOROCCO: PREVALENCE ORALS & CONDOMS RURAL/URBAN AND VDMS VS. NON-VDMS



The prevalence rate for use of orals and condoms is much higher in VDMS provinces than in others, especially in rural areas.

10

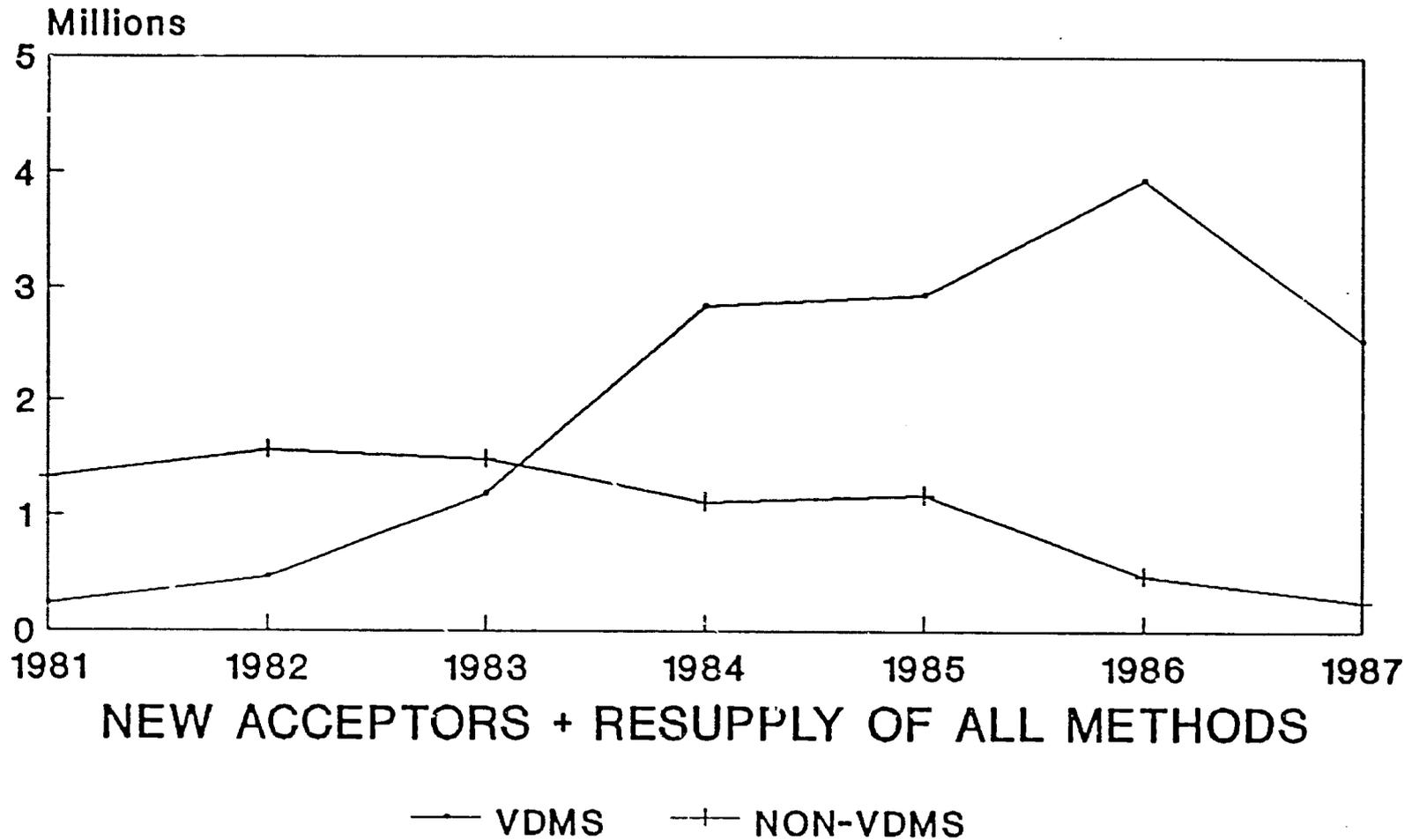
MOROCCO: NEW PILL ACCEPTORS 1981-87 VDMS VS. NON-VDMS PROVINCES



This chart demonstrates the important impact of VDMS on new acceptors of orals during the 1981-87 period.

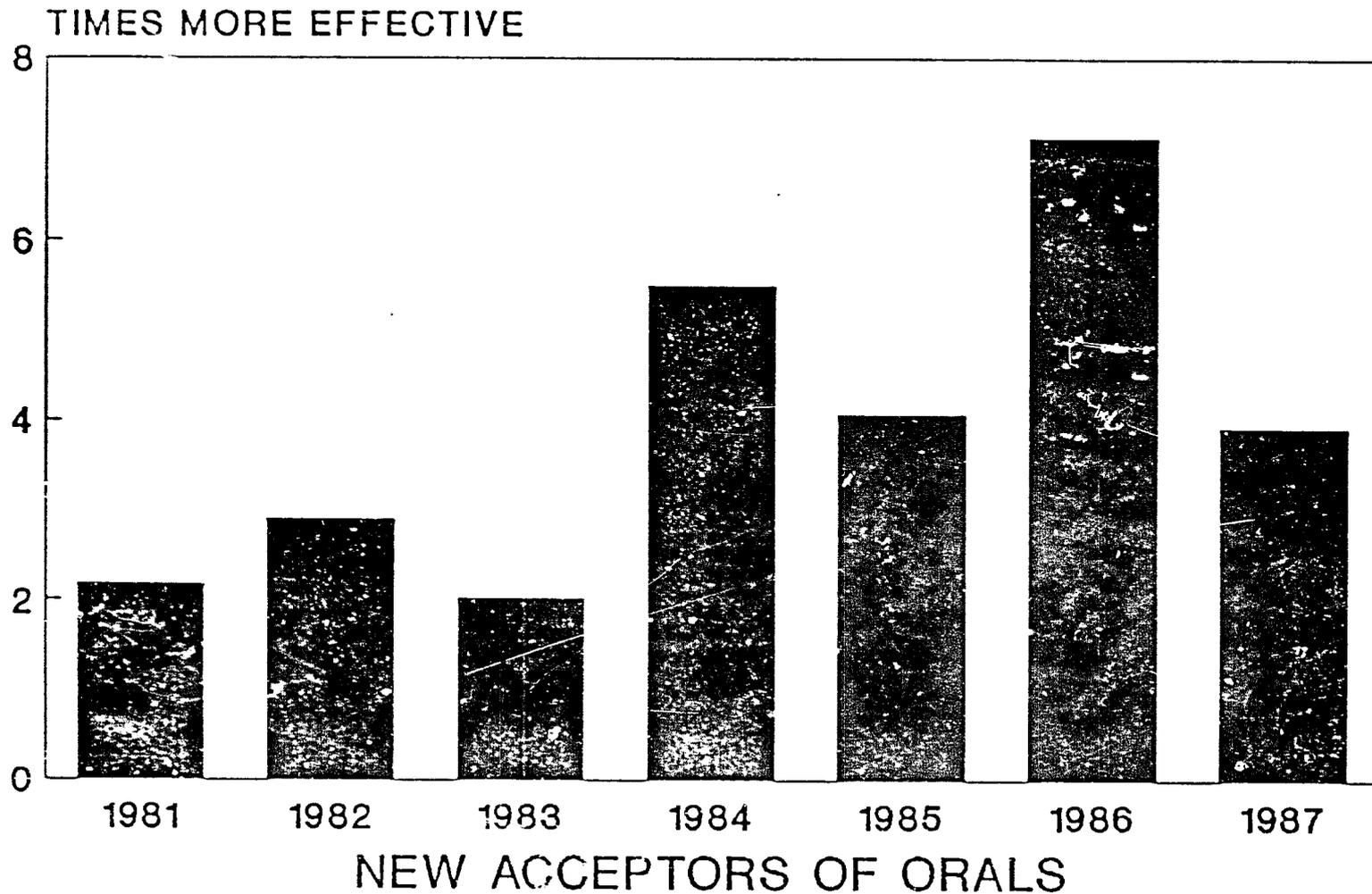
182

MOROCCO: MOPH FP ACTIVITY 1981-1987 IN VDMS VS. NON-VDMS PROVINCES



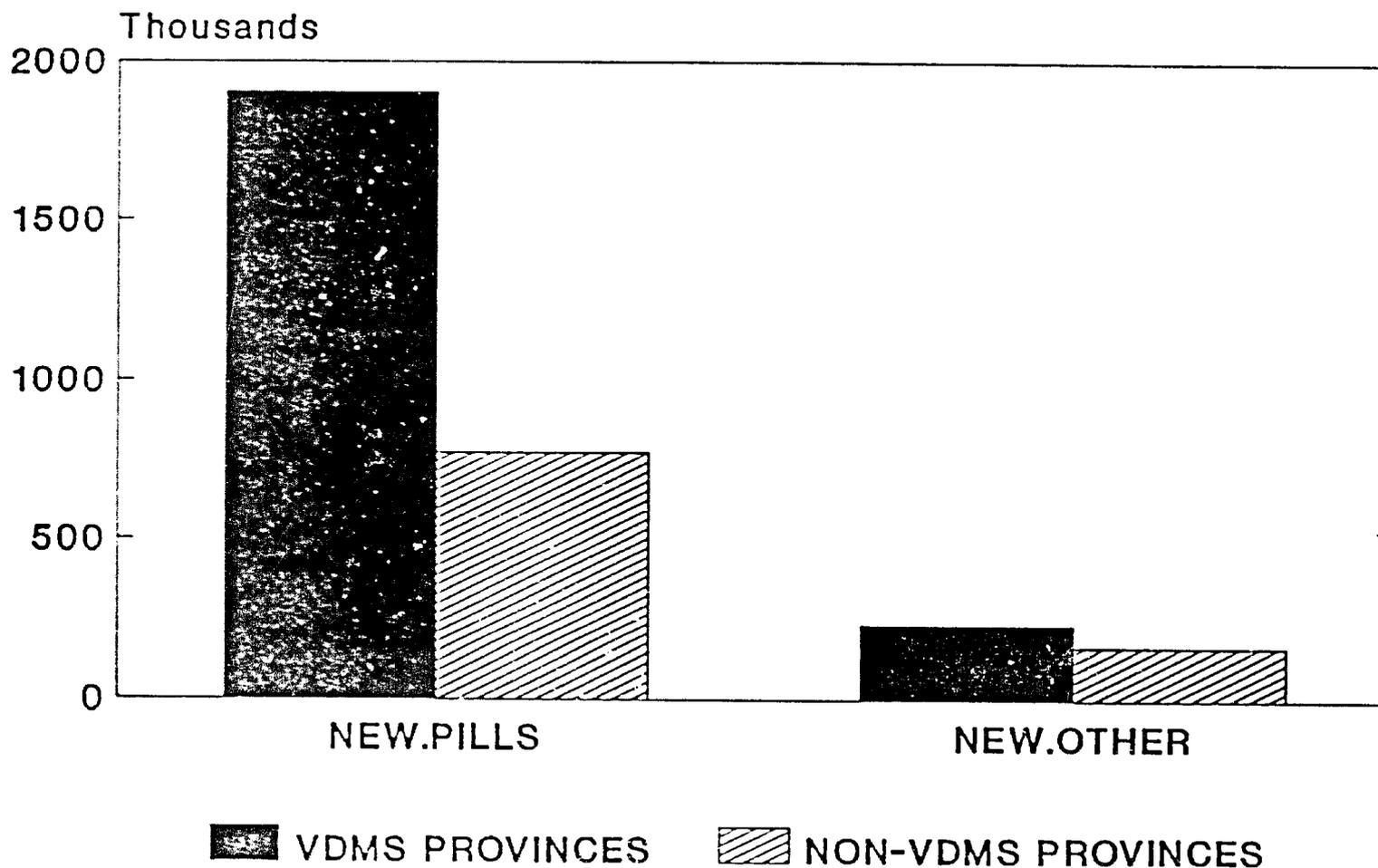
VDMS accounted for the lion's share of family planning activities during the period following 1983.

VDMS PERFORMANCE VS. NON-VDMS 1981-87 WEIGHTED ON POPULATION COVERAGE BASIS



This chart illustrates the exceptionally strong impact of VDMS on recruiting new acceptors for oral contraceptives during the period 1981-87. Compared to non-VDMS provinces, the performance varied between 2.0 and 7.1 times as effective.

MOROCCO: CUMULATIVE NEW FP ACCEPTORS MOPH SERVICES 1981-1987 (ALL METHODS)



Over the period 1981-87, VDMS accounted for more than twice as many new acceptors of orals as did non-VDMS provinces, and slightly more new acceptors of other methods. NOTE: IUD acceptors and VSC acceptors recruited and referred by the VDMS program are NOT counted as VDMS activity.

CONTRACEPTIVE PREVALENCE (ALL METHODS)

VDMS VS. NON-VDMS PROVINCES

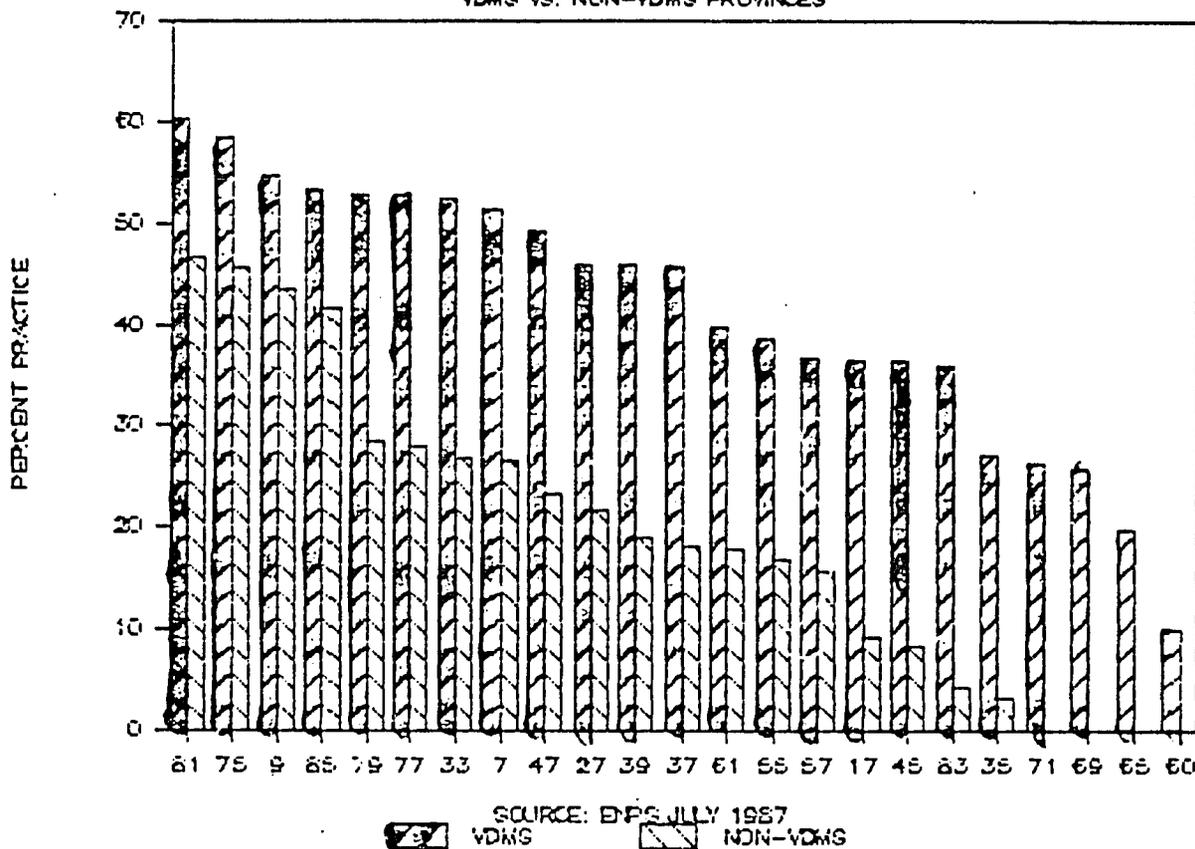
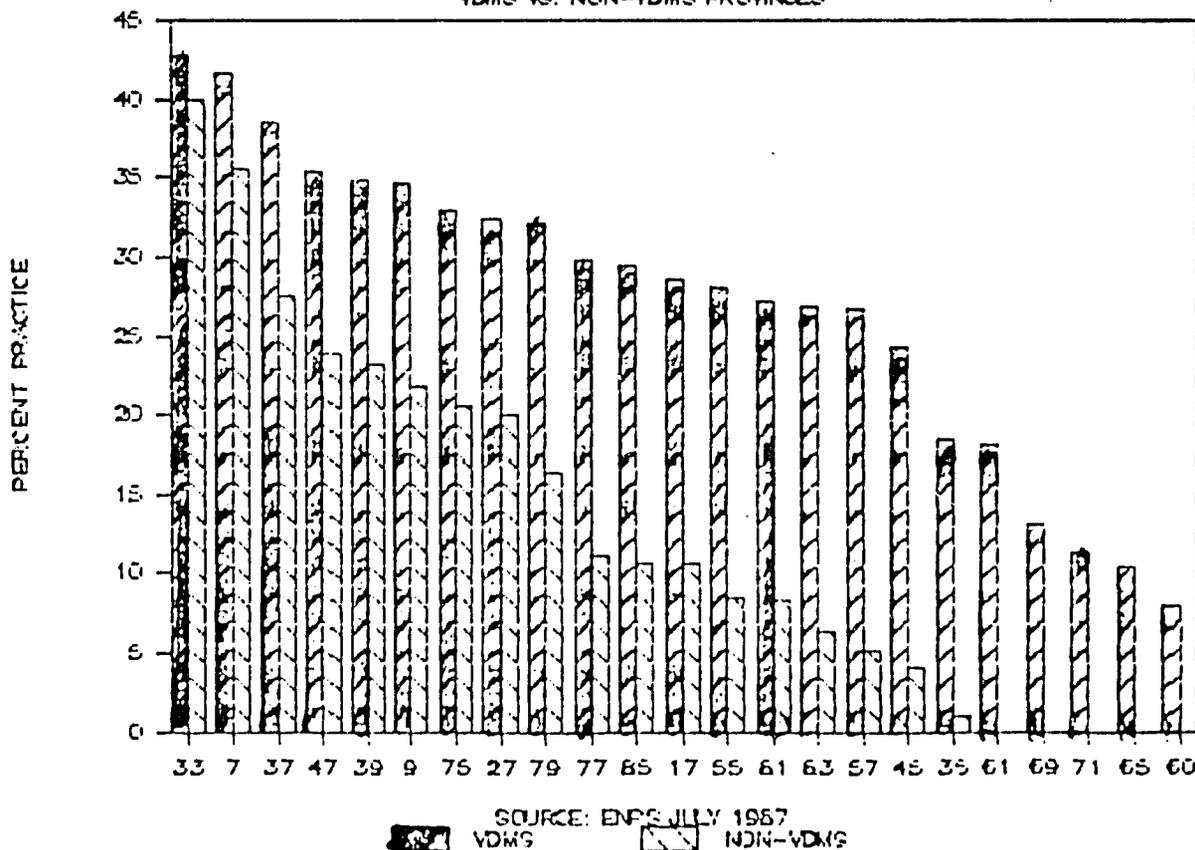


CHART T11

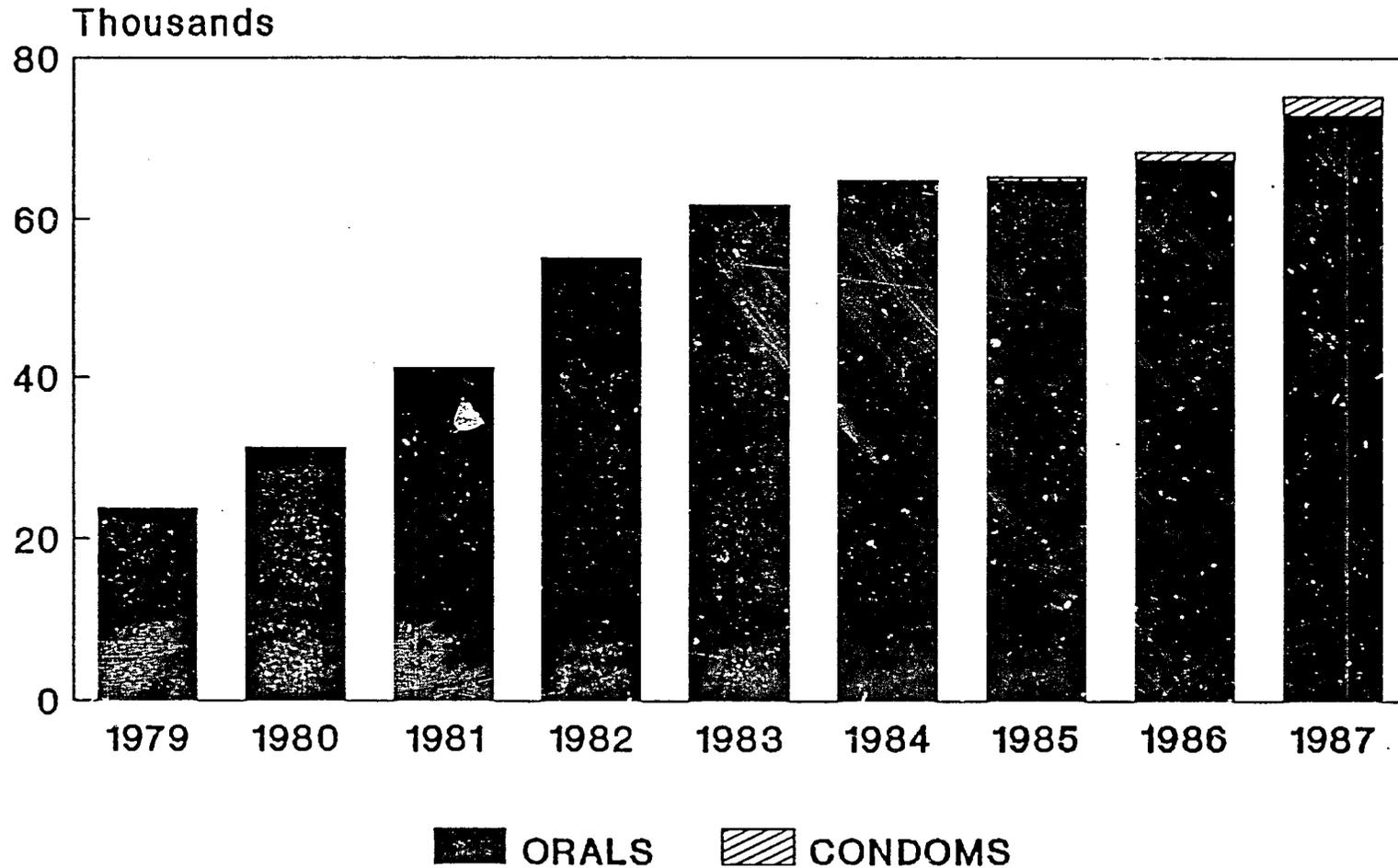
CONTRACEPTIVE PREVALENCE (ORALS)

VDMS VS. NON-VDMS PROVINCES



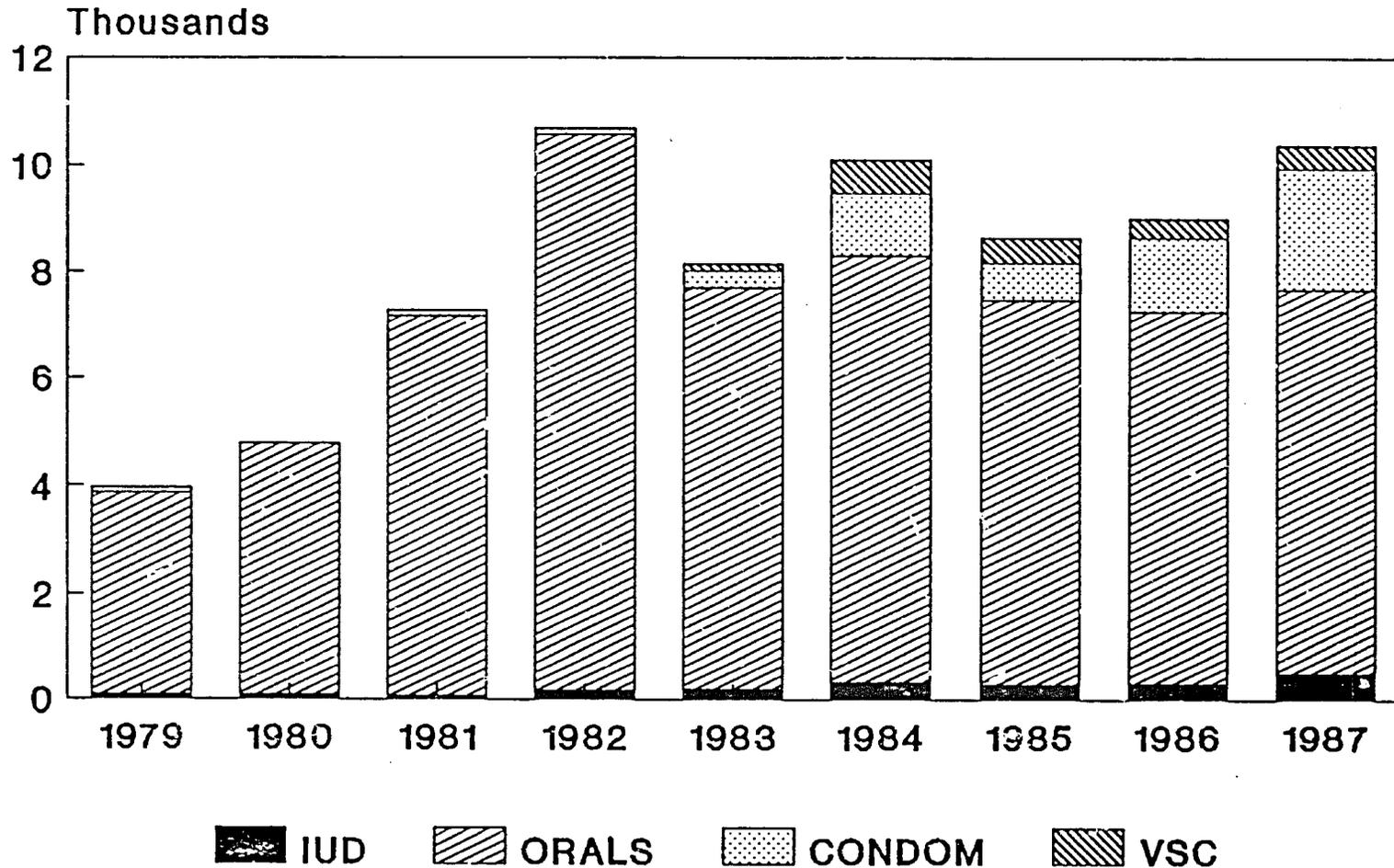
48

AGADIR: RESUPPLY FOR ORALS AND CONDOMS FIXED AND AMBULATORY SERVICES



Family planning activity in Agadir has been steadily growing since 1979.

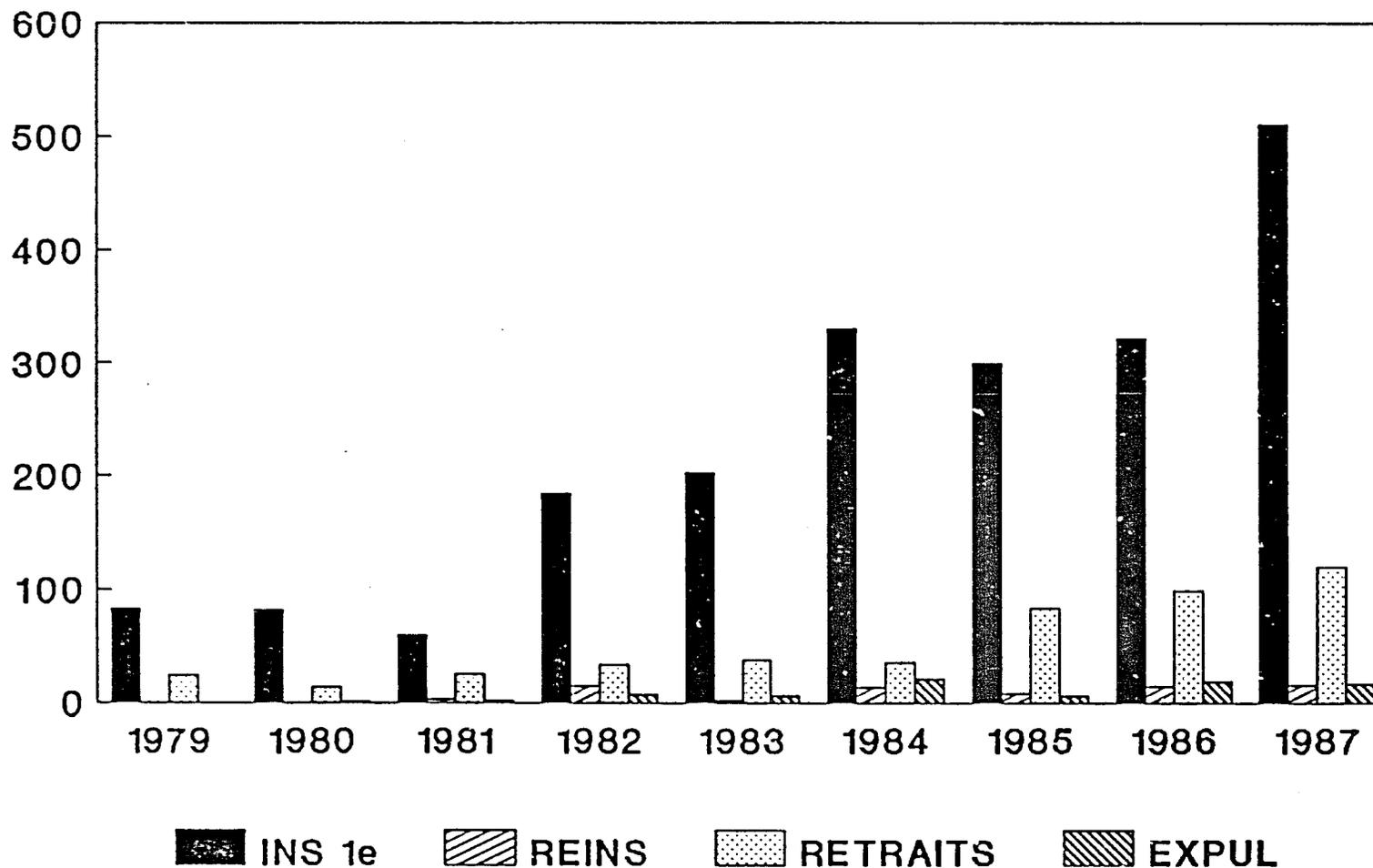
AGADIR: NEW ACCEPTORS BY METHOD FIXED AND AMBULATORY SERVICES 1979-87



Note the generally increasing level of new acceptors for the past decade, especially of condoms since 1983.

70

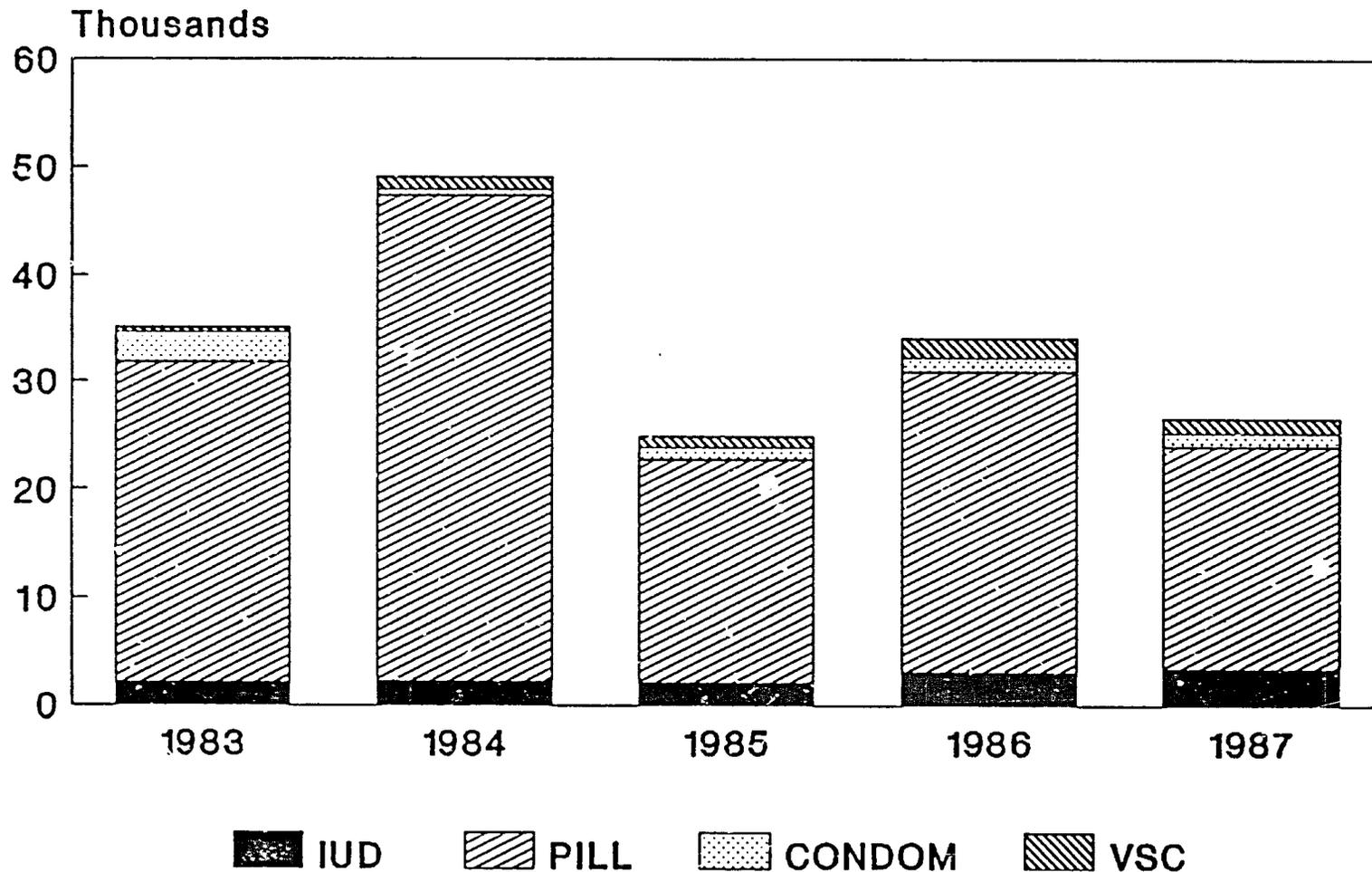
AGADIR: RECAPITULATIF ANNUEL DES ACTIVITIES DE P.F.



Unlike much of the rest of the country, IUD use has been increasing in Agadir.

2

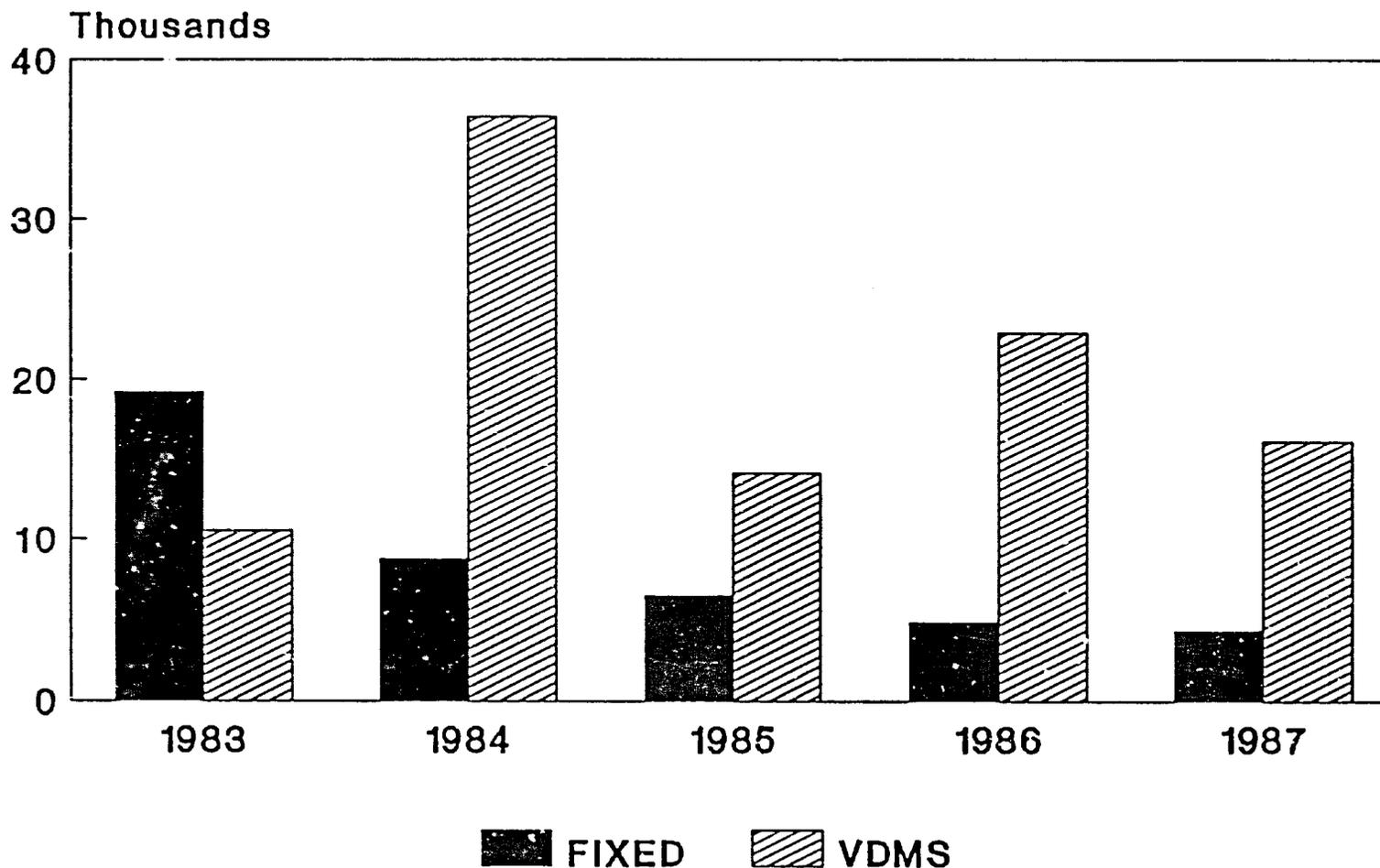
MARRAKECH: NEW ACCEPTORS BY METHOD VDMS + FIXED CENTERS 1983-1987



In Marrakech, there has been a decline of new acceptors of orals since 1984, and a slight increase in IUD use.

an

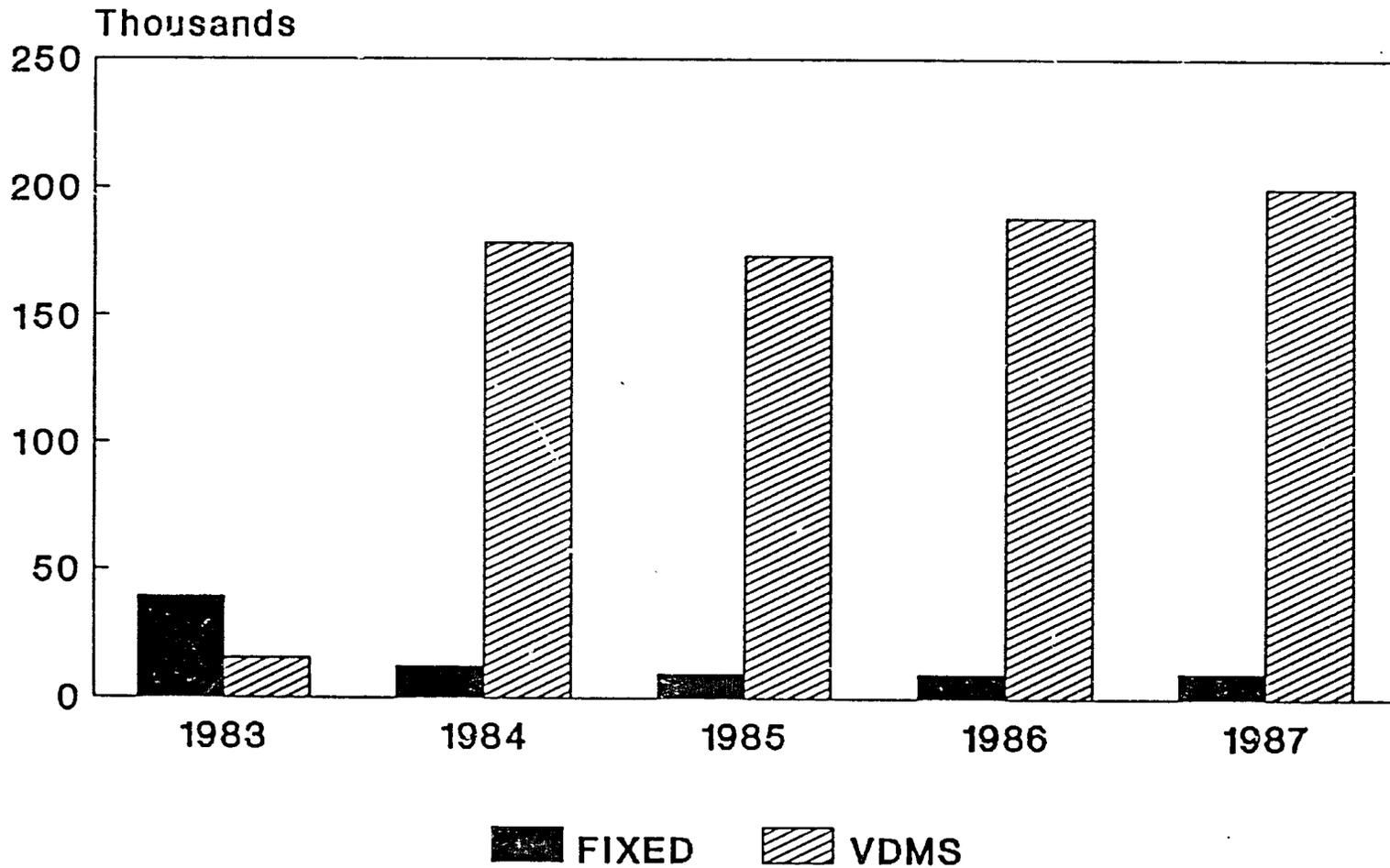
MARRAKECH: NEW ACCEPTORS FOR ORALS FIXED CENTERS VS. VDMS 1983-1987



There has been a substantial decline in new acceptors of orals in Marrakech since 1984, both in the fixed facilities and in VDMS outreach.

CPB

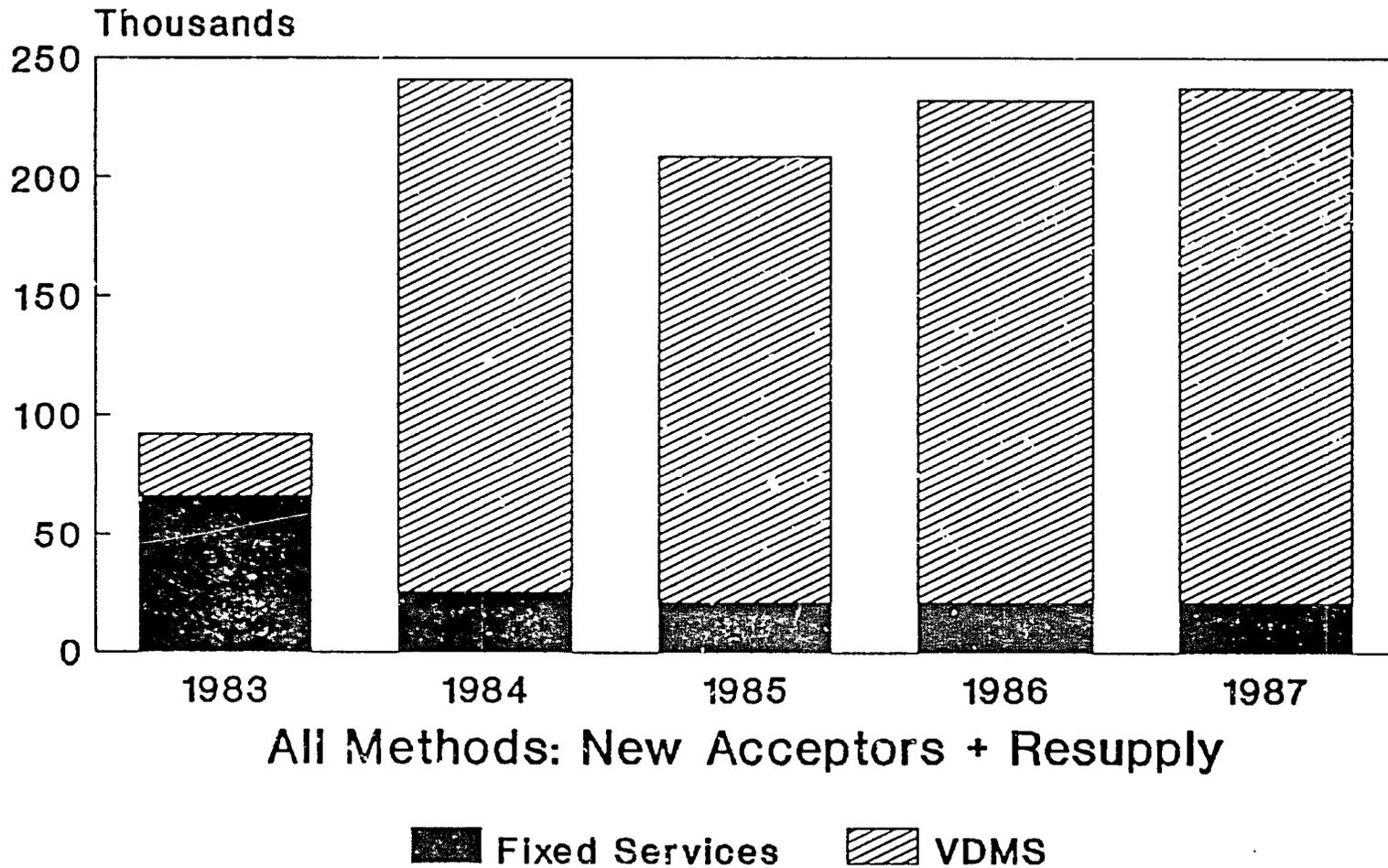
MARRAKECH: REVISITS FOR PILL RESUPPLY FIXED CENTERS VS. VDMS 1983-1987



Overall, there appears to have been a pretty steady trend in revisits for orals in the outreach program.

59

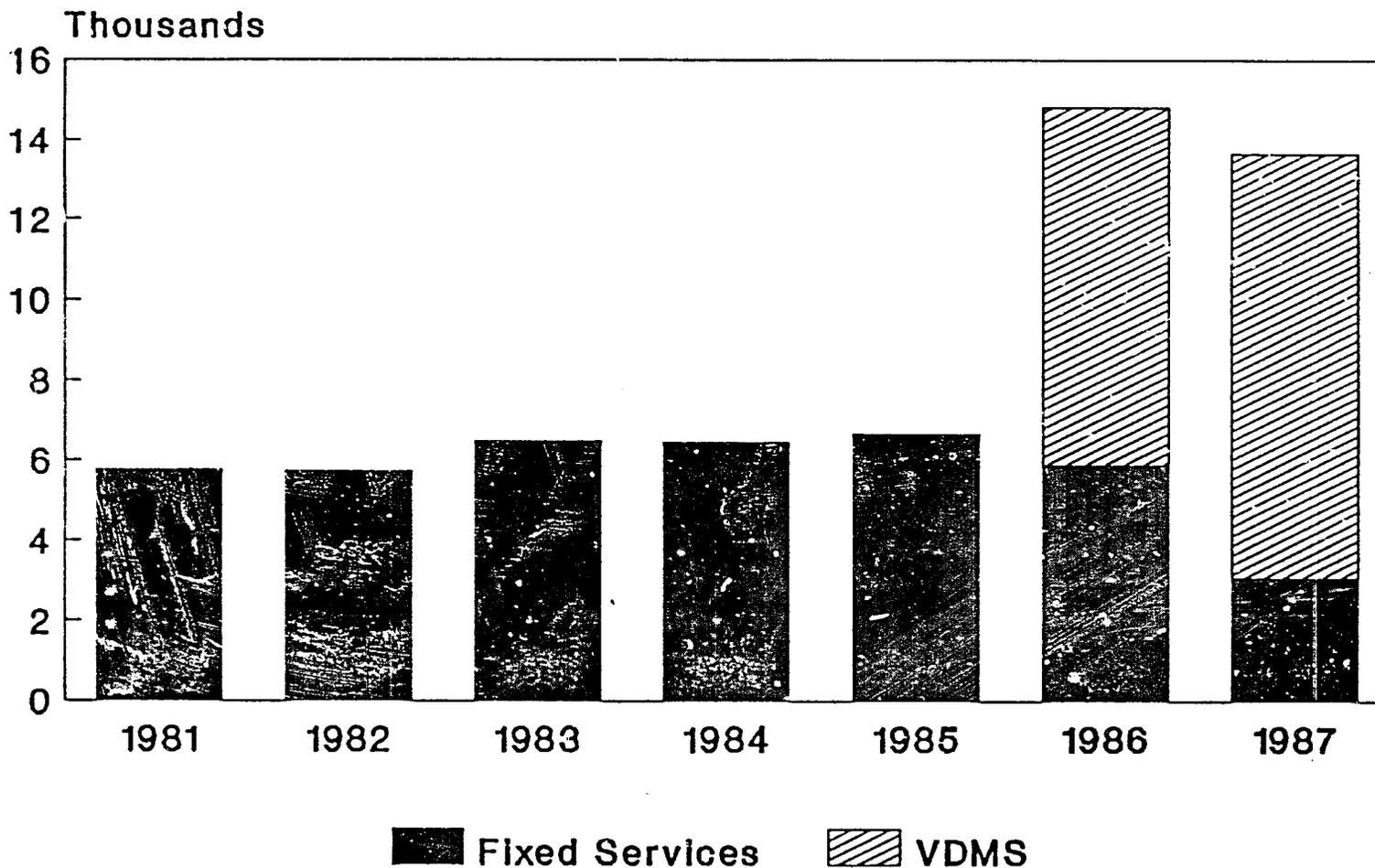
MARRAKECH: FAMILY PLANNING ACTIVITY VDMS vs. FIXED SERVICES 1983-1987



In Marrakech, the overwhelming percentage of all family planning activity is carried out by the outreach program, a steady trend since 1984.

51

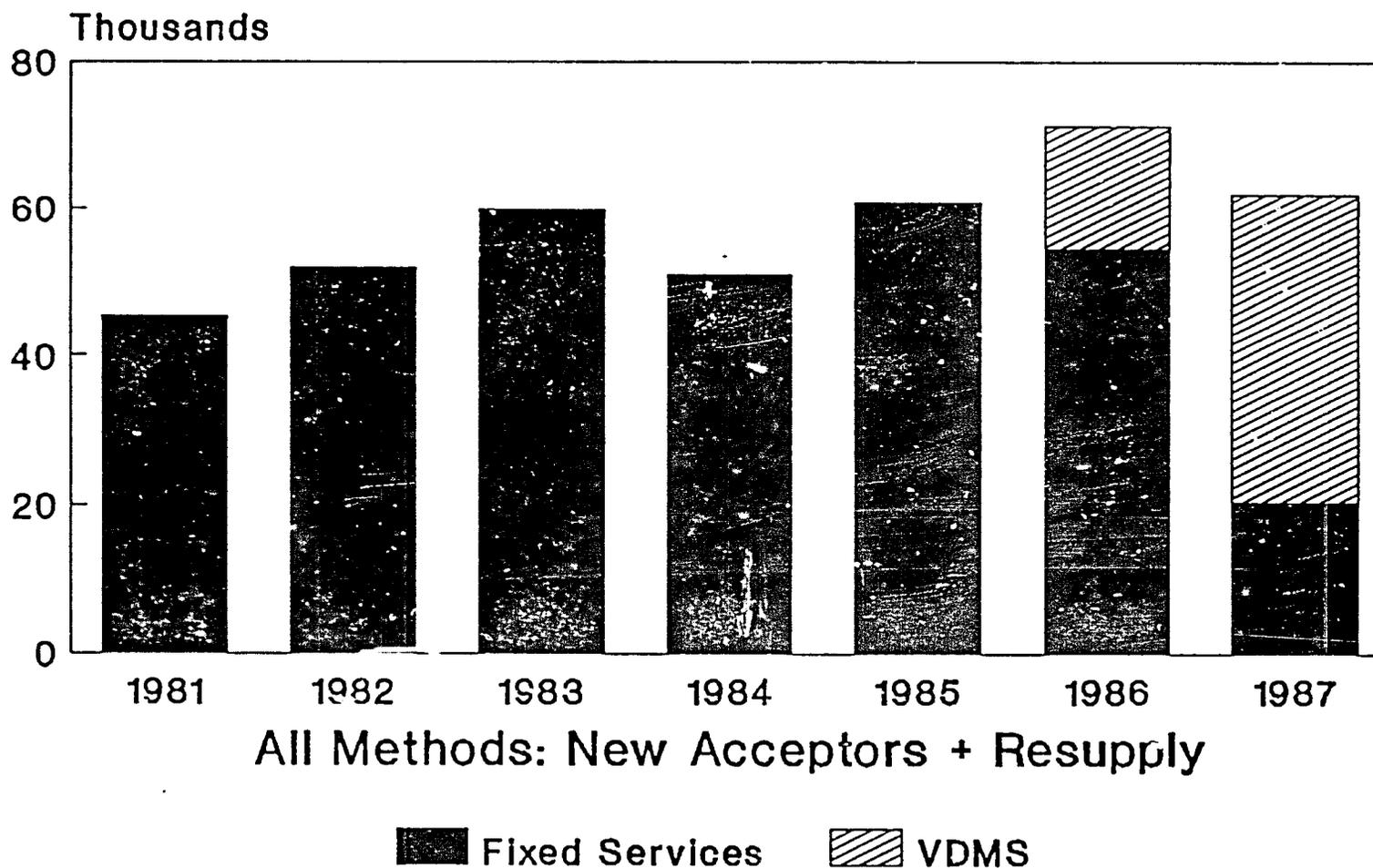
SAFI: NEW ACCEPTORS ORALS VDMS vs. FIXED SERVICES 1981-1987



Note the tremendous increase in new acceptors of orals with the introduction of VDMS in Safi Province in 1986.

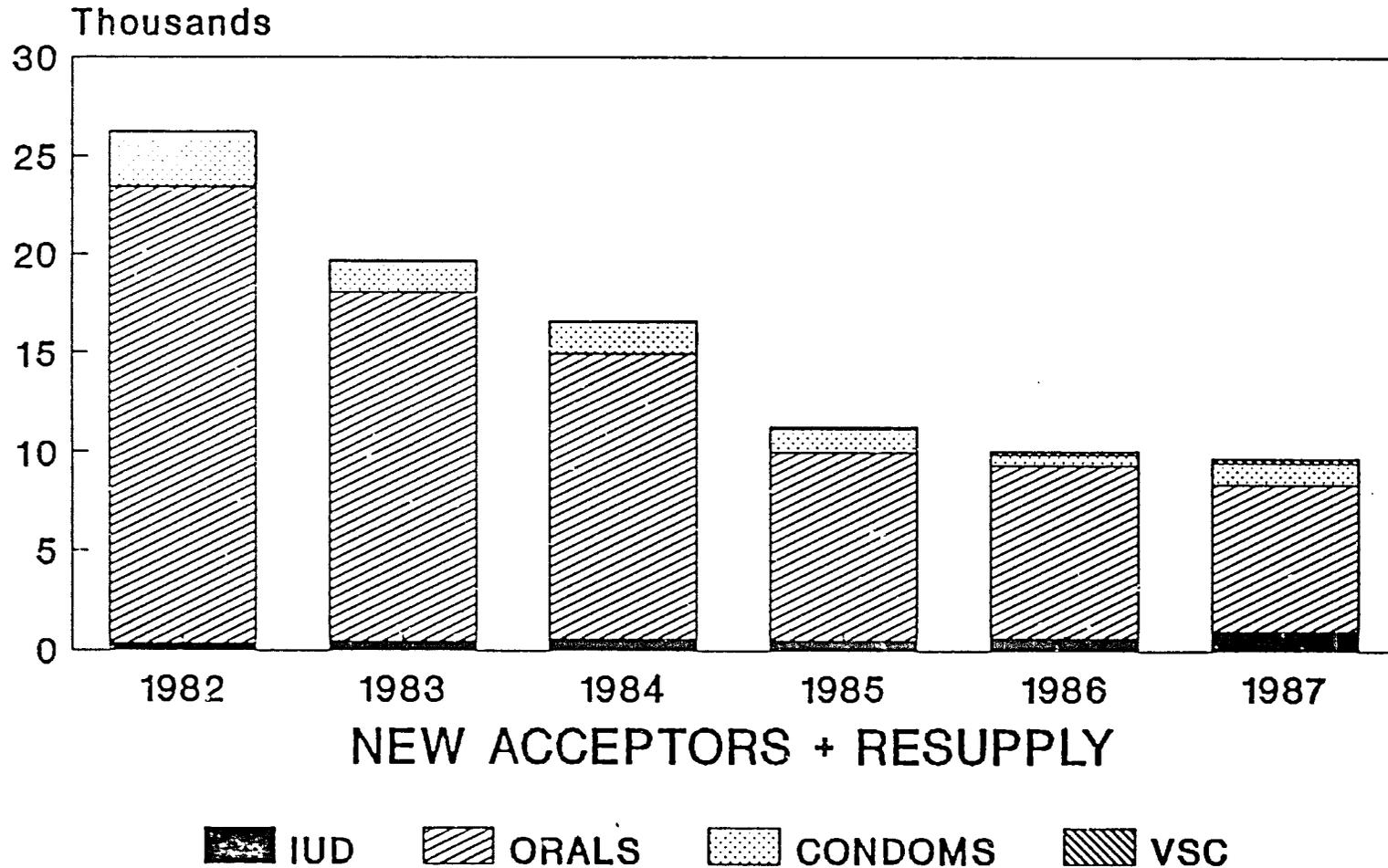
4/10

SAFI: FAMILY PLANNING ACTIVITY VDMS vs. FIXED SERVICES 1983-1987



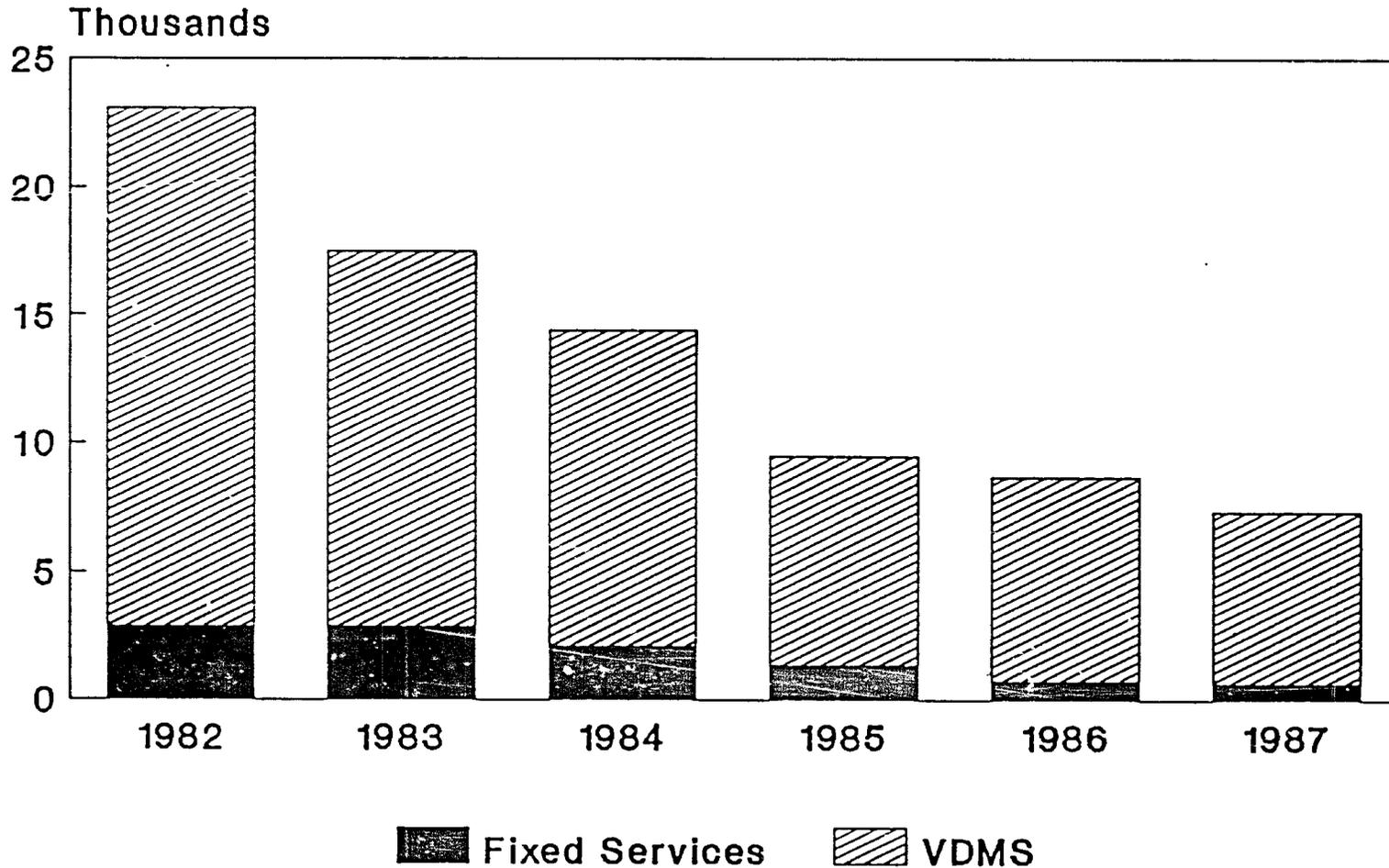
Overall, it would appear that there has been a slight increase in family planning activity since 1981.

EL JADIDA: NEW ACCEPTORS 1982-1987 FIXED + VDMS -- ALL METHODS



El Jadida appears to be having a continuing problem in recruiting new acceptors for family planning.

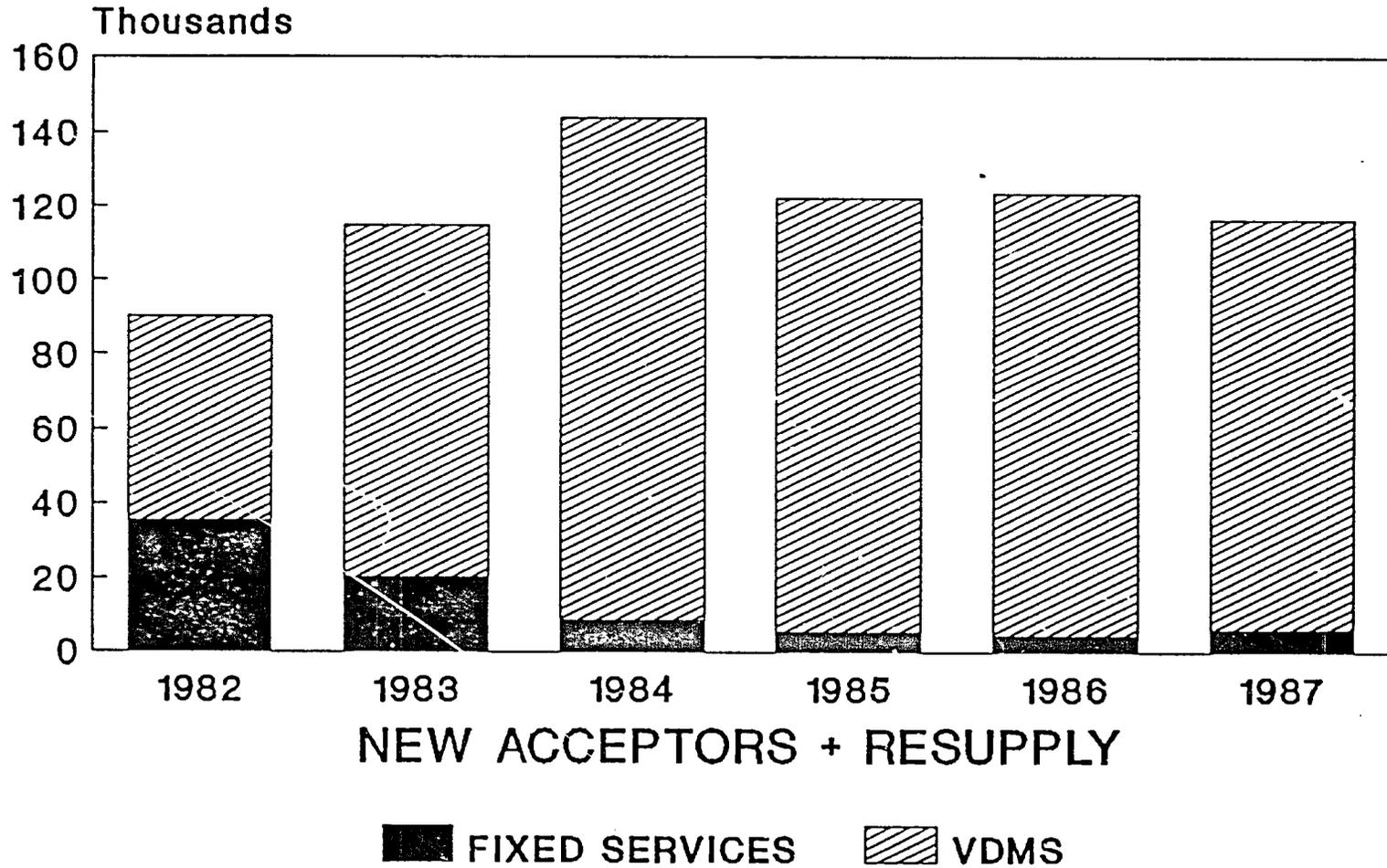
EL JADIDA: NEW ACCEPTORS ORALS VDMS vs. FIXED SERVICES 1982-1987



Since 1982 there has been a big decline in new orals acceptors, both in VDMS and in the fixed centers.

59

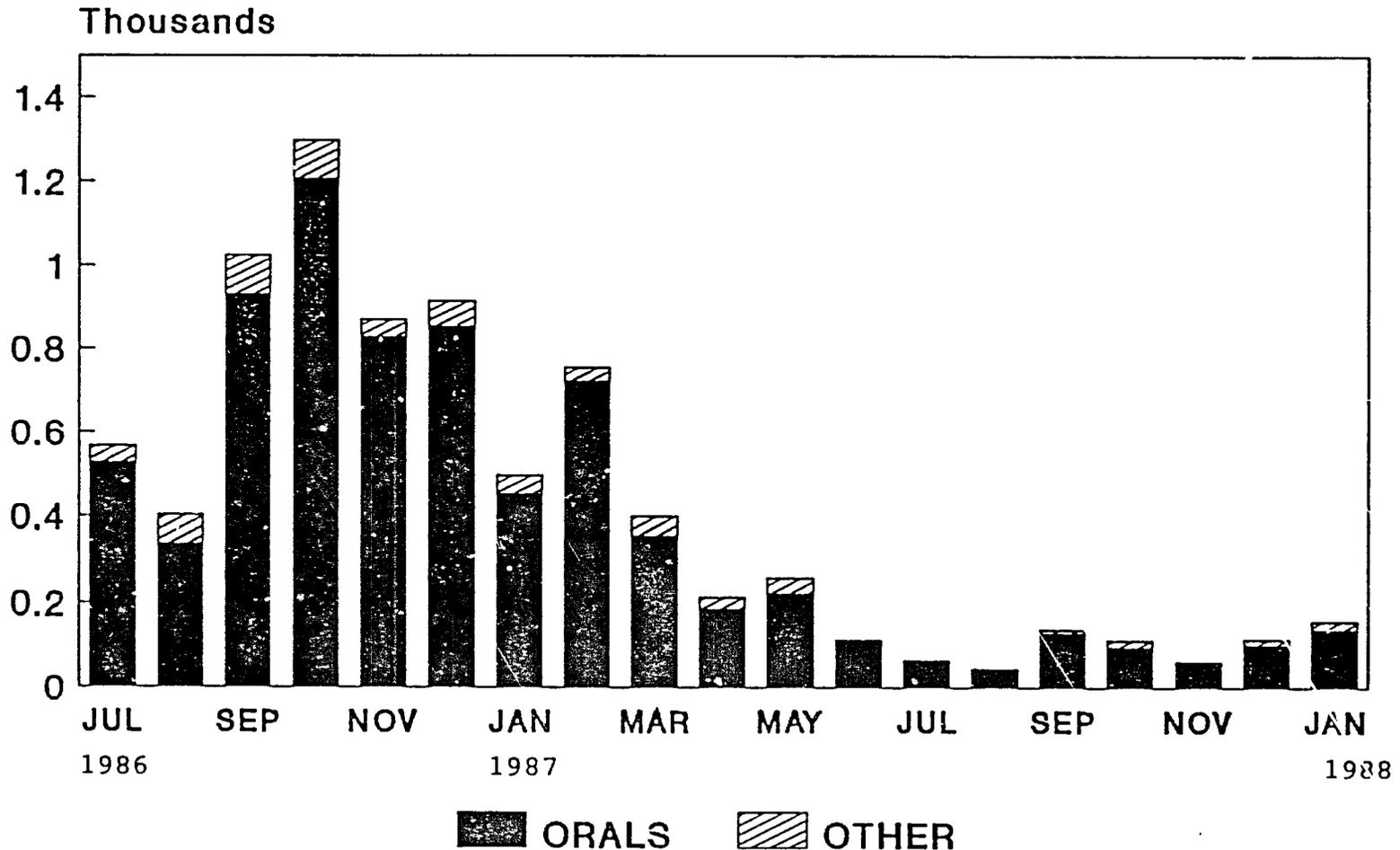
EL JADIDA: FAMILY PLANNING ACTIVITIES ALL METHODS 1982-1987



Overall family planning activity in the province seems not to be impressive.

1990

CASABLANCA-ANFA: VDMS NEW ACCEPTORS JULY 1986 THROUGH JANUARY 1988

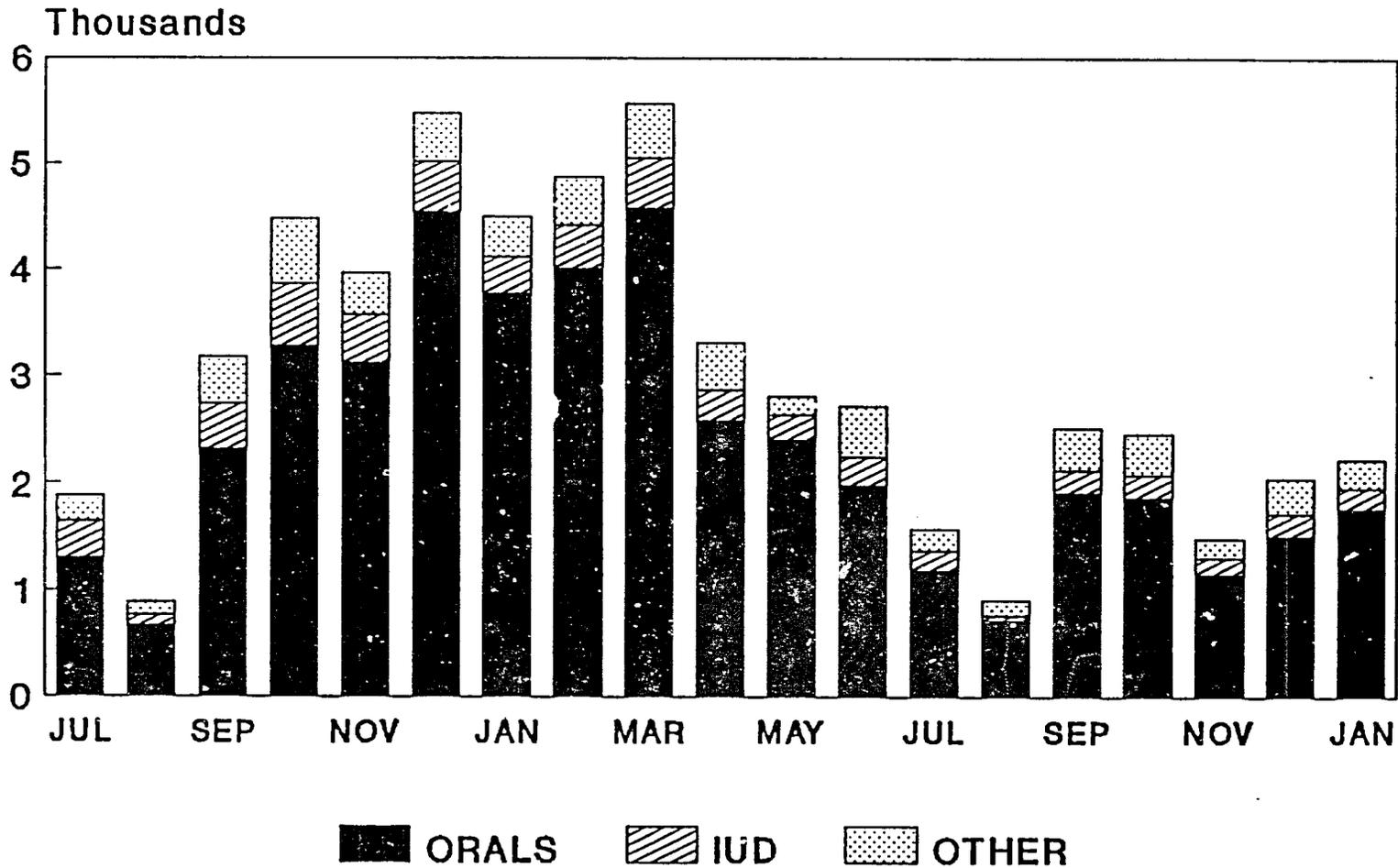


D-23

Note the big jump in new acceptors with the introduction of VDMS in late 1986. Then, the huge impact of the vaccination campaign beginning in March-April 1987 and continuing to the end of the year. Outlook for 1988???

10

CASABLANCA-ANFA: VDMS FP "USERS" JULY 1986 THROUGH JANUARY 1988

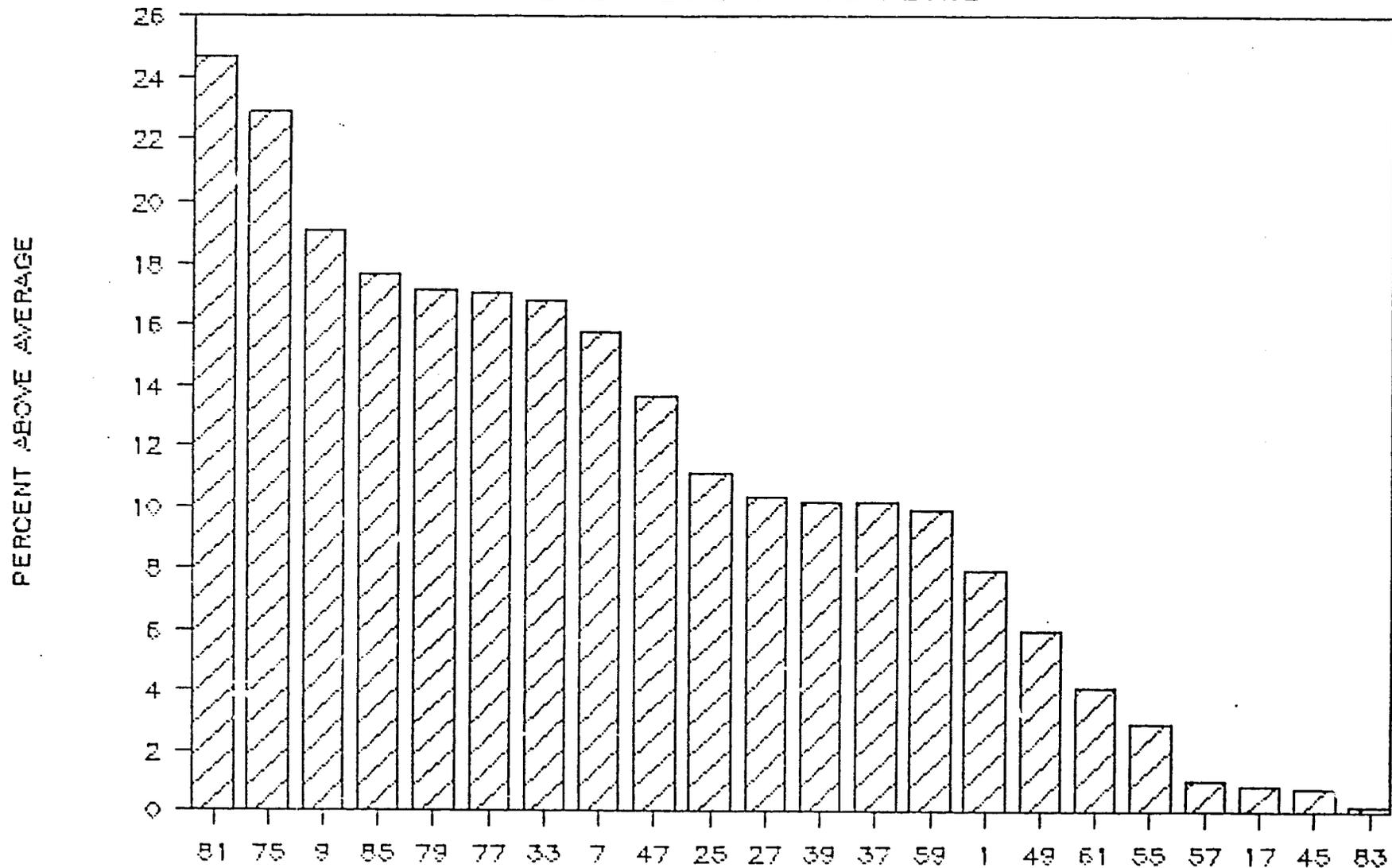


Similar trend for "users" as for new acceptors shown in Chart T24.

1007

CONTRACEPTIVE PREVALENCE BY PROVINCE

PERCENT ABOVE NATIONAL AVERAGE



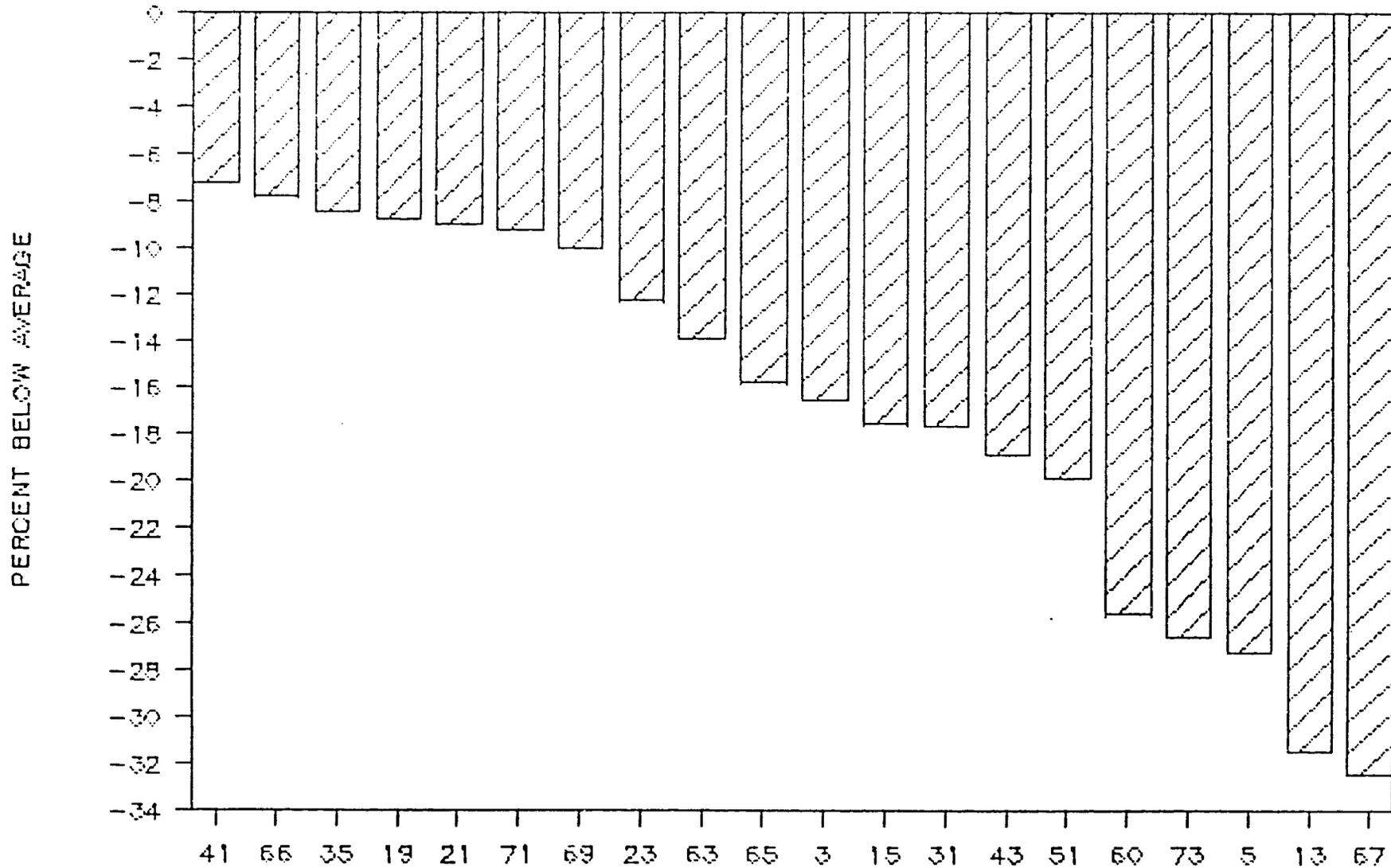
SOURCE: ENFS JULY 1987

This chart ranks provinces (using ENPS province numbers) according to their prevalence as compared to the national average, showing those provinces which are above average.

CHART T27

CONTRACEPTIVE PREVALENCE BY PROVINCE

PERCENT BELOW NATIONAL AVERAGE

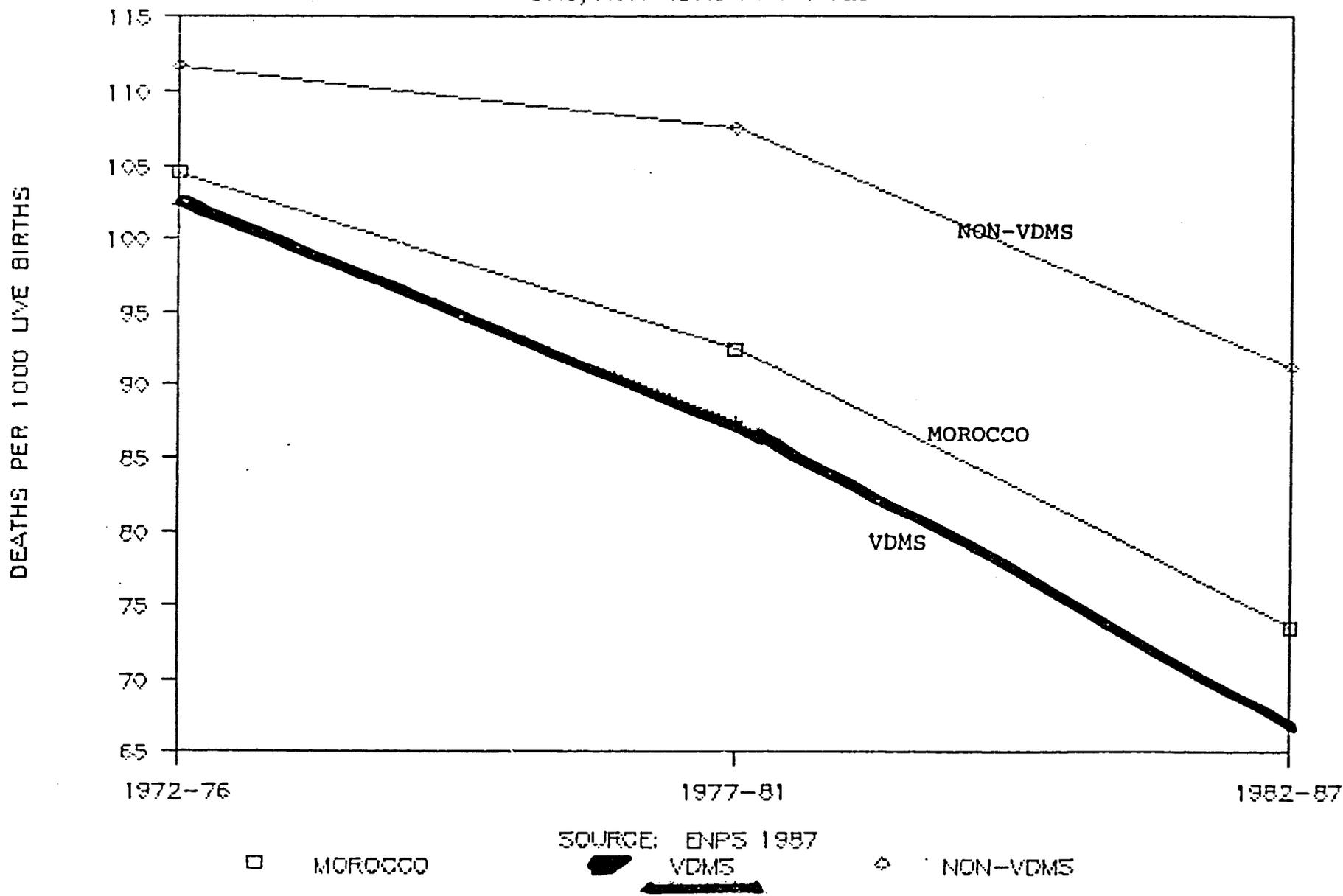


SOURCE: ENPS JULY 1987

This chart shows those provinces which are below the national average, according to the ENPS findings. CAUTION: the numbers for charts T27 and T26 are small.

INFANT MORTALITY TRENDS — MOROCCO

VDMS/NON-VDMS PROVINCES



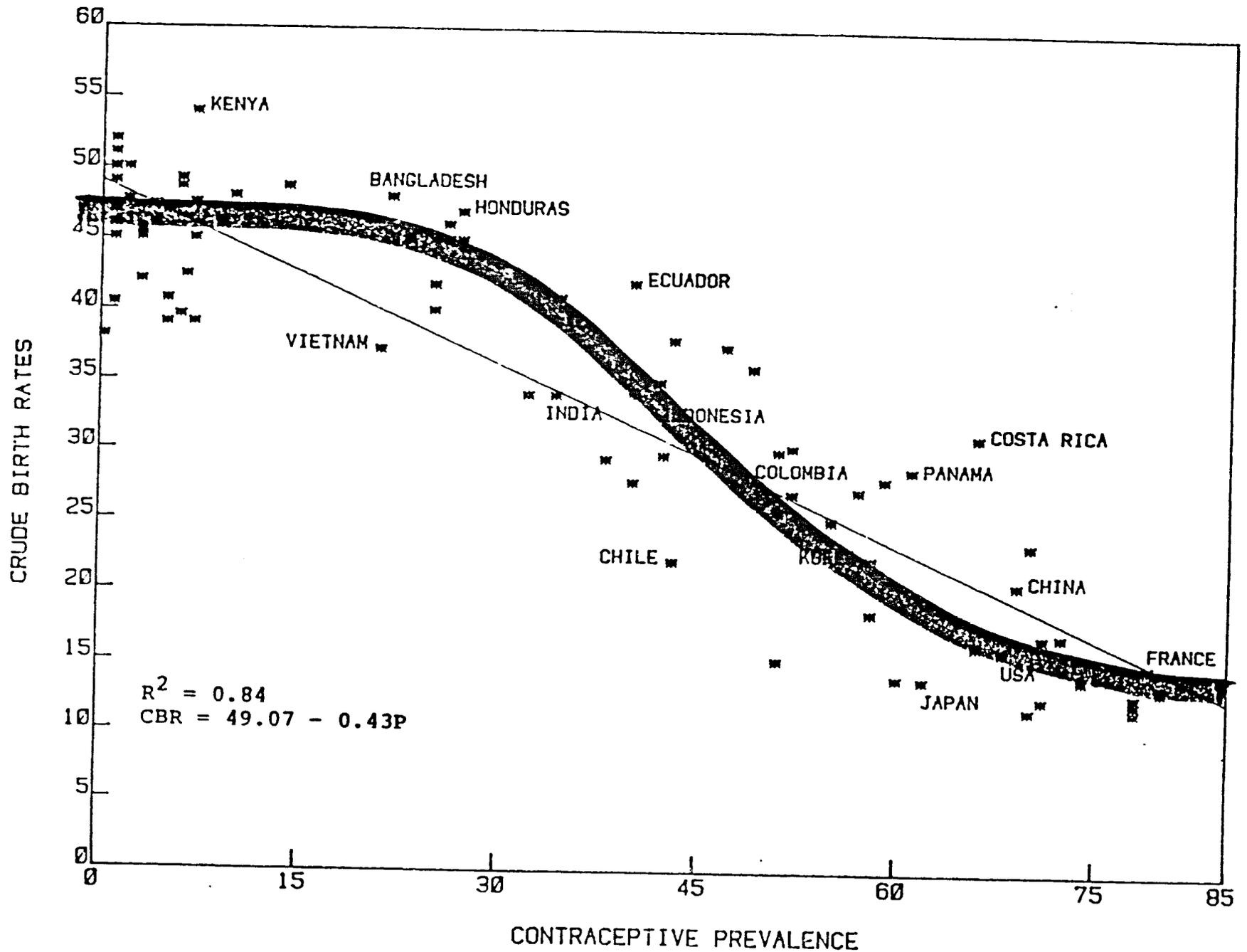
D-27

It would appear that infant mortality is significantly lower in VDMS provinces.

105

CHART T29

CRUDE BIRTH RATES, 1980, AND PREVALENCE OF CONTRACEPTIVE USE, 1977-1983



1000

APPENDIX E.

MOH Management Training Structures and Personnel Needing Training

Excerpt from report of evaluation team member
Charles Tilquin, Ph.D.
submitted to USAID/Rabat March 1988.

11. Project Managementb) Ministère de la Santé

En injectant de nouveaux moyens et renouvelant les façons de penser et de travailler, le projet VDMS a contribué à revigorer le management à tous les niveaux du système de santé. Le VDMS a remis au premier plan une notion fondamentale en santé qui est celle de couverture*; il a

confronté les administrateurs avec la nécessité de la planification, la programmation, l'évaluation, le monitoring dans un système qui s'était assoupi. Le VDMS a aussi contribué à faire comprendre l'importance de la communication aussi bien avec les clients qu'entre agents du système de santé. En bref, le VDMS a favorisé la redynamisation non seulement de la planification familiale mais aussi de l'ensemble des soins de santé de base. Il a été un des facteurs qui ont amené le Ministère à tous les niveaux à s'engager sur la voie du "management moderne" dans le secteur sanitaire. C'est ce qui a permis au Ministère non seulement d'introduire avec succès le programme dans trente Provinces, mais aussi d'étendre rapidement à toutes les provinces certains éléments essentiels de son projet de soins de santé de base; i.e.: d'amener les provinces à faire le bilan de leur infrastructure, à confectionner un nouveau plan de couverture, à redéployer leurs ressources, à participer activement à la préparation du PLAN 1988-1992 en réalisant un PLAN PROVINCIAL, toutes ces opérations culminant dans les Journées Nationales de Vaccination dont le succès a démontré l'incontestable maîtrise du Ministère au niveau de la planification, de la programmation, de la communication et de l'exécution.

Ces réalisations n'ont cependant été possibles que grâce à l'engagement et à l'implication de tous les instants d'un petit nombre d'individus très bien formés et expérimentés qui oeuvrent au niveau central**. Le fait que le système de santé dépende de ces quelques personnes pour se dynamiser, innover, se développer, atteste de la fragilité des changements en cours. Il est donc important de donner rapidement à un plus grand nombre d'individus, aussi bien au niveau central que périphérique, les connaissances, habiletés et attitudes qui leur permettront d'être à leur tour des agents plutôt que des exécutants du changement.

Assez paradoxalement, le Ministère a peu investi en moyens humains au niveau de la gestion centrale du programme de PF et de ce fait, c'est à peu près le même nombre de personnel que celui qui a piloté l'implantation du programme dans trois provinces en 1982, qui gère maintenant celui-ci dans plus de trente provinces. Ceci témoigne incontestablement d'une croissance phénoménale de la productivité de ce même personnel mais en même temps a constitué sinon un frein, du moins une contrainte au plein épanouissement du programme national de

* Certes, la façon de concevoir la couverture dans VDMS est simpliste et sa stratégie n'est qu'un "remake" de l'itinérance traditionnelle. Il fallait cependant passer par là pour arriver aux stratégies plus sophistiquées du projet SSB.

** La même chose a été observée au niveau des Provinces où les "performances" du système dépendent largement de la personnalité et des compétences du médecin-chef.

planification familiale. Le SCPF a du en effet et malheureusement consacrer l'essentiel de ses efforts à "administrer" vignettes, indemnités, stocks, etc., plutôt qu'à "gérer" le programme, c'est-à-dire 1) à rechercher tous les moyens pour le faire tendre le plus vite et le mieux possible vers ses objectifs fondamentaux de diminution de la mortalité et de la morbidité maternelle et infanto-juvénile et d'augmentation de l'intervalle intergénéral, et 2) à préparer l'avenir en élaborant des scénari originaux pour faire suite à la stratégie VDMS. La lenteur du développement et de la mise en opération d'un véritable système d'information de gestion par objectif, de même qu'un certain déséquilibre actuellement observé dans le mix de méthodes contraceptives, témoignent à leur façon de la contrainte précitée.

En bref, donc, si le programme de PF est "administré" de façon très satisfaisante, il lui reste encore à améliorer sa capacité de gérer à tous les niveaux en fonction de ses objectifs fondamentaux et de produire les idées et d'être à l'origine des initiatives qui assureront non seulement sa survie mais aussi son plein épanouissement.

Management training

Depuis quelques années la façon de "gérer" les services de santé a beaucoup évolué au Maroc. D'un style de management paternaliste, hiérarchique, statique et bureaucratique, non responsabilisant et peu motivant pour les agents, on est passé à une gestion plus active et créative, plus stimulante redonnant leur vraie place aux objectifs fondamentaux du système de santé: fournir des soins et services préventifs et curatifs de qualité et accessibles. L'image de la santé publique auprès de la population s'est améliorée. Des besoins et des attentes ont été créés. En même temps, on a réalisé que les ressources dont dispose et dont disposera le système sont et resteront très limitées. Le Ministère et ses agents n'ont donc pas d'autre choix que de tirer le maximum de profit de ces "maigres" ressources (ce qui pourrait peut-être convaincre le gouvernement de lui en accorder plus - boucle de feedback négative). Tirer le maximum de profit, cela signifie qu'il faut et faudra être hautement productif aussi bien en dispensant des services de qualité que dans les efforts consacrés à obtenir le support et l'aide des autres ministères, des collectivités locales et des clients eux-mêmes. C'est tout un déficit et les agents du Ministère sont les premiers à admettre qu'ils sont mal préparés à le relever. Un plan global de formation en management à tous les niveaux est ainsi esquissé dans le PLAN 1988-1992.

L'importance fondamentale et la nécessité de la formation en management est donc reconnue par le Ministère de la Santé. Il convient cependant d'insister sur le fait que les actions de formation sont d'autant plus indispensables dans le contexte marocain de dispensation des services de santé que celui-ci se caractérise par:

- 1) un développement important des programmes dans les dernières années: extension du VDMS, programme de vaccination, projet de développement des soins de santé de base, etc.
- 2) une stagnation des ressources humaines, médicales et surtout paramédicales, disponibles pour gérer et exécuter les actions sanitaires.

La coexistence de ces deux phénomènes appelle donc une plus grande rationalité dans l'utilisation du personnel, sinon la pression tôt ou tard fera "sauter le couvercle de la marmite". Elle implique aussi que les agents sanitaires soient capables de mobiliser les ressources locales pour combler, au moins en partie, le déficit en ressources humaines auquel le système de santé doit faire face. Or, cette capacité de mobiliser dépend essentiellement de la crédibilité de ces mêmes agents, crédibilité qui est elle-même fonction de la pertinence et de l'efficacité de leurs actions, donc de leur capacité d'utiliser leur temps de la façon la plus rationnelle possible. On en revient ainsi à la question de la rationalité de l'utilisation des ressources déjà invoquée.

Or, il existe au moins deux conditions nécessaires à une utilisation rationnelle des ressources: c'est que les agents soient bien formés techniquement, mais aussi et peut-être surtout qu'ils soient capables de bien diagnostiquer les problèmes, déterminer et prioriser les besoins, identifier et comparer les différentes options disponibles pour y répondre, programmer leurs actions, évaluer enfin les résultats de celles-ci.

Si l'on accepte le postulat que la formation technique des personnels est assez bonne, et si l'on considère par ailleurs que, dans le cadre de cette formation technique, les agents sanitaires sont peu exposés aux théories/concepts/outils etc. de la planification, de la programmation et de la gestion, il apparaît assez évident qu'un effort tout particulier de formation doit être consenti rapidement dans ce secteur. Ceci n'exclut évidemment pas la nécessité de certaines actions spécifiques de formation continue à caractère technique. On devrait cependant s'attendre à ce que dans le futur, les proportions respectives de la formation technique et de la formation en "gestion" dans l'effort global de formation soient inversées, à savoir 75% pour la gestion et 25% pour le technique.

Dans le présent projet AID, on a fait beaucoup de formation continue mais essentiellement de la formation technique. La formation en communication donnée à plus de 5000 agents n'est cependant pas sans rapport avec les habiletés que doit posséder tout gestionnaire. Une centaine de gestionnaires provinciaux ont aussi reçu une formation en gestion du VDMS: sa portée était cependant très limitée puisqu'il s'agissait essentiellement de gestion des indemnités, des vignettes, des stocks, etc. du programme. Dans ce type de formation, on apprend en général plus des recettes ad hoc qu'on acquiert des connaissances de base (ce qui ne veut pas dire que ce n'était pas nécessaire pour le bon fonctionnement du programme).

Diverses sessions de formation de courte durée en planification, programmation et évaluation ont aussi été organisées au Maroc par divers donateurs. Malheureusement sans grande coordination et elles n'ont touché qu'un nombre restreint d'individus. Un certain nombre de cadres du Ministère ont aussi bénéficié de stages/études de courte ou moyenne durée à l'extérieur. Il est impossible de recenser toutes ces actions de formation mais il est certain qu'elles ont eu des impacts. Ce sont elles qui avec l'avènement de programmes comme VDMS, SSB et le PNI ont conduit les cadres du système de santé à une conception résolument moderne de la gestion.

Le Ministère compte à l'avenir essentiellement sur trois structures pour supporter son effort de formation en management.

L'Ecole des Cadres du Collège de Santé Publique qui existe depuis
.... ans

Le Service de formation continue créé au début 1988

L'Institut de Recherche et Formation en Santé Publique dont la
création devrait avoir lieu prochainement.

1) L'Ecole des Cadres

L'Ecole des Cadres produit les ASDES (Agent de Santé Diplômés d'Etat Spécialisés) qui sont des paramédicaux appelés à exercer des fonctions d'enseignement ou d'encadrement. La formation des ASDES reste essentiellement technique. Le curriculum de l'Ecole des Cadres est cependant en évolution et pourrait à l'avenir être davantage axé sur l'acquisition de connaissances, attitudes et habiletés de gestion. Actuellement, ce curriculum est encore faible dans le secteur de l'art et de la science de la gestion. (Il reste que malgré cette relative pauvreté, les paramédicaux ont quand même ainsi la chance d'être exposés à quelques principes et outils de gestion, chance que les médecins n'ont pas, la gestion étant totalement absente de leur formation. C'est un problème grave puisque ce sont ceux qui occupent les fonctions (de gestion) clés dans le secteur de la santé publique).

2) Le service de formation continue

Depuis 1981, un grand nombre d'actions de formation continue ont été conduites mais sans grande planification, ni coordination, ni évaluation. Aucune structure n'était en effet responsable de la formation continue au niveau du Ministère et les donateurs ne se préoccupent guère de coordonner leurs actions. Dès lors, chacun des services ou divisions réalisait indépendamment ses propres actions de formation avec l'aide des différents donateurs. Cette façon de procéder était par certains côtés peu productive; exemples: redondances dans le contenu de certaines actions de formation, éclatement dans le temps et dans l'espace d'actions qui auraient pu fort bien être réalisées consécutivement dans un même lieu, etc.

De plus, les actions de formation étaient commandées du niveau central et ne répondaient pas toujours, au moins en terme de priorités, aux besoins des différentes provinces/préfectures.

Par ailleurs, les actions de formation technique ont été beaucoup plus nombreuses que les actions de formation en organisation/gestion: + 75% pour les premières versus 25% pour les secondes.

Le Ministère a récemment décidé de créer une structure responsable de la formation continue. Son directeur a été nommé le 22 janvier 1988. Il est assisté d'une équipe de quatre personnes, toutes ayant une formation paramédicale. Cette structure doit maintenant "faire sa place", se faire reconnaître par les autres services pour sa compétence et l'excellence des services qu'elle leur rend. Il est à noter que le directeur de la formation continue n'a pas d'autorité hiérarchique sur les autres divisions et services. Son autorité ne peut être que fonctionnelle et ne lui sera donc reconnue que dans la mesure où les actions qu'elle prendra dans les prochains mois correspondront aux attentes et aux besoins aussi bien du niveau central que de la périphérie. Il est certain que la perception des besoins peut grandement varier d'un niveau à l'autre, d'un programme ou d'un service à un autre. Dans cette perspective, la

direction de la formation continue doit donc se doter rapidement de mécanismes lui permettant, de concert avec toutes les instances concernées, d'identifier les besoins de la façon la plus objective possible.

La direction de la formation continue conduit actuellement une première action décisive en ce sens. Il s'agit d'établir le bilan de toutes les actions de formation continue conduite au Maroc dans le secteur de la santé depuis 1981. L'enquête, dont le terrain est maintenant terminé, comporte trois parties:

- partie I: chaque province/préfecture fait le bilan de toutes les actions de formation dont a bénéficié son personnel
- partie II: chaque action de formation est décrite
- partie III: le portrait de chaque formateur actuel et potentiel est établi (on a ainsi recensé \pm 500 formateurs à travers le système de santé).

Les données de l'enquête sont en cours d'exploitation par le SIES. De plus, la base de données qui vient d'être constituée à travers l'enquête devrait à partir de maintenant être mise à jour au fur et à mesure de la réalisation de nouvelles actions de formation.

On peut donc dire qu'à l'heure actuelle, la relative confusion qui a prévalu dans le passé au niveau de la formation continue a cédé la place à la coordination et à la concertation. Cependant, l'édifice qui vient d'être bâti est encore fragile; ses ressources humaines sont peu nombreuses et manquent elles-mêmes de formation, ses moyens sont eux aussi très limités. Soutien et renforcement sont donc de mise.

3) L'Institut de recherche et formation en santé publique

Enfin, troisième structure, le Ministère projette de créer un Institut de Recherche et Formation en Santé Publique (IRFSP) qui, selon le Plan, serait "spécialisé dans la formation des cadres supérieurs (médicaux, paramédicaux et administratifs) dans le domaine de l'administration sanitaire, de l'épidémiologie et la médecine sociale. Cette institution se chargerait de l'organisation du recyclage et de la formation (courte, moyenne, longue durée) pour répondre aux besoins du Ministère de la Santé Publique et ceux d'autres organismes. Cette institution devra être un important outil de développement de la recherche opérationnelle sur le système sanitaire, être ouverte sur les diverses institutions de formation et de recherche universitaire et être capable de développer des liens avec les divers secteurs de l'administration... Cette institution devrait être suffisamment souple pour échapper aux contraintes structurelles imposées par le fonctionnement du Ministère, sans toutefois avoir l'indépendance qu'ont les Universités par rapport aux priorités et aux nécessités du plan de la santé et des différents projets gérés par le Ministère".

Cette volonté s'est concrétisée par la mise sur pied d'un comité technique et scientifique de 15 membres. Au moins trois missions d'assistance technique de courte durée, (deux supportées par l'ACDI et l'une supportée par l'AID en février 1988), ont été consacrées au projet de l'IRFSP. A l'heure actuelle, il est prévu, avant même la constitution formelle de l'IRFSP, qu'un embryon de programme (5 à 6 cours de 3 crédits = 45 heures) soit lancé par le biais de sessions intensives associant des personnes ressources marocaines et étrangères.

Nous venons de voir que le Ministère disposait ou allait disposer de trois structures pour assurer la formation en gestion*. On peut maintenant essayer d'estimer quelles sont les clientèles potentielles de ces structures pour juger de l'importance de l'effort à fournir (on se préoccupera seulement ici de la clientèle des agents oeuvrant pour et dans les soins de santé de base aussi bien au niveau des administrations centrales et provinciales que du terrain).

Cette clientèle peut grossièrement être décrite comme suit (on notera que notre seul propos ici est de donner des ordres de grandeur):

<u>Administration centrale</u>	
Médecins hors cadres**	50
Autres hors cadres	25
Cadres médecins, paramédicaux, administrateurs	<u>100</u>
<u>Sous total</u>	175
<u>Administrations provinciales</u>	
Médecins chefs de provinces (= hors cadres)	50
Médecins chefs du SIAAP	50
Administrateurs-économistes de provinces	50
Administrateurs-économistes du SIAAP	50
Majors du SIAAP	50
Autres administrateurs	250
Animateurs de la province médicale et du SIAAP	<u>500</u>
<u>Sous total</u>	1000
<u>Terrain</u>	
Médecins chefs de circonscription	500
Majors de circonscription	500
Chefs de secteur	<u>1500</u>
<u>Sous total</u>	<u>2500</u>
<u>Grand total</u>	3675

Cette clientèle par profession se distribue donc à peu près de la façon suivante:

Médecins	675
Paramédicaux (ASDES et ASDE)	2610
Administrateurs-économistes	390

* Ces structures sont aussi responsables de la formation technique à divers degrés et à différents niveaux.

** Par "hors cadre" on entend ici les plus hauts responsables.

En ce qui concerne les paramédicaux, la majorité de ceux-ci sont des ASDE. En effet, en 1987, selon les données du PLAN, les paramédicaux se répartissaient comme suit:

	ASDES	ASDE	ASB	Total
SSB	113	1789	7039	8941
Hopitaux	256	3533	6242	10031
Admin. provinciale)				1200
(411	1151	1108		
Admin. centrale + en)				
formation + en affectation (1469
Total	780	6473	14389	21641

Ces données indiquent que, sur les quelques 2600 paramédicaux à former en management, au moins 2000 sont des ASDE qui donc n'ont aucune formation en management. C'est aussi le cas des médecins.

Les nombres présentés ci-dessus montrent que la tâche est surmontable et cela dans une période relativement restreinte (\pm 5 ans) si on procède de façon diligente. Les tâches qui apparaissent les plus pressantes à l'heure actuelle sont les suivantes:

- renforcement du curriculum de l'Ecole des Cadres dans le secteur de la gestion; ceci implique en particulier le renforcement d'un certain nombre d'enseignants dans ce secteur et l'engagement de quelques enseignants spécialisés en gestion des services de santé;
- renforcement du service de l'Education continue (moyens humains et techniques) au niveau central et provincial (i.e.: responsables provinciaux de la formation continue);
- création de l'équipe de l'Institut de recherche et formation en santé publique;
- évaluation des besoins de formation à tous les niveaux;
- établissement d'un plan global de formation pour les cinq prochaines années et programmation des activités de formation.

Recommandations

Il est certain que la formation en gestion dépasse la problématique de la planification familiale*. Il reste cependant que le succès de ce programme continuera de dépendre de façon critique des capacités de management des agents du Ministère, en particulier au niveau du terrain.

* La mission AID et le Ministère étudient actuellement la possibilité de la création d'un centre régional de formation en logistique PF. Ce type d'action est évidemment très important pour améliorer le management de la PF mais il a des limites évidentes.

Dans cette perspective, nous recommandons à l'AID de supporter substantiellement les entreprises de formation en management du Ministère au niveau de la formation continue, de l'Ecole des cadres et de l'Institut de formation et recherche en santé publique.

Un premier support pourrait être offert au niveau de l'identification des clientèles et de la détermination des besoins de formation de chacun des groupes cibles. Une étude devrait aussi être entreprise sur les modalités d'opérationnalisation de la formation, tant en ce qui concerne les caractéristiques des clients potentiels (plan de carrière, disponibilité, intérêt, etc.) qu'en ce qui concerne le partage des responsabilités entre les différentes structures de formation. Cette étude devrait déboucher sur une planification-programmation globale du recyclage et de la formation en management. Par ailleurs, certaines actions spécifiques peuvent ainsi être faites par chacune des structures.

1) Formation continue

La nouvelle direction de la formation continue a besoin d'être renforcée et aidée. Ceci pourra prendre différentes formes:

a) L'équipe elle-même de cinq personnes doit avoir la possibilité de se ressourcer et de compléter sa formation en terme de:

- leadership, habiletés de direction;
- planification;
- gestion de programmes, en particulier: analyse coût-efficacité des différentes stratégies;
- développement de matériel didactique;
- analyse qualitative: entrevues semi-structurées, etc.
- recherche opérationnelle.

Les besoins en formation de chaque membre de l'équipe devraient être évalués et un plan de formation établi qui ne mette pas en péril le bon fonctionnement du nouveau service.

b) La direction de la formation continue devrait disposer d'un micro-ordinateur pour gérer elle-même et exploiter sa banque de données sur les formateurs et les actions de formation. Un technicien en informatique devrait être mis à sa disposition ou bien quelques membres de l'équipe devraient être formés à l'utilisation de logiciels comme LOTUS 1-2-3 et DBASE III.

c) Pour en finir avec les goulots d'étranglement au niveau central, le Ministère veut autonomiser la périphérie*. Ceci est particulièrement vrai en éducation continue. Une fois l'opération "bilan" actuellement en cours terminée, on pourra mieux cerner les besoins de formation des formateurs, en particulier dans cette perspective d'autonomisation. Il faudra renforcer la formation des formateurs en conséquence. On devra aussi prêter un oeil attentif aux besoins de formation du responsable provincial de la formation continue qui, à priori, devrait bénéficier de formation dans les domaines déjà identifiés ci-dessus pour les membres de l'équipe de direction de la formation continue.

* Ceci doit être fait avec beaucoup de prudence et seulement dans certaines limites. Le central doit garder la haute main sur le curriculum, le contenu de chacun des cours/modules. Il devra aussi procéder à une évaluation systématique des enseignements.

d) La province pour être autonome devra aussi disposer de support didactique et bibliographique, d'outils pédagogiques. Elle devra être dotée de rétroprojecteurs, de machines de tirage, éventuellement d'équipement vidéo.

e) Il serait par ailleurs très avantageux que chaque province ou service/organisation puisse faire profiter les autres de ses expériences. Ainsi un journal ou une "Newsletter" devrait être créé pour servir de véhicule à ces échanges. L'organisation de séances de formation sur la façon de préparer un texte apporterait de meilleures garanties de succès à une telle entreprise.

2) Ecole des cadres

L'Ecole des cadres aura certainement besoin d'aide dans les mêmes domaines que ceux évoqués ci-dessus pour le service de l'Education continue:

- recyclage de certains de ses enseignants en gestion;
- assistance technique à court terme pour le développement du curriculum;
- enrichissement de la bibliothèque;
- matériel pédagogique.

3) Institut de recherche et formation en santé publique

L'AID a fourni une assistance technique à court terme pour d'une part analyser le contexte (physique, politique, légal, etc.) dans lequel la création de l'Institut s'inscrit et en identifier les forces et les contraintes, et d'autre part pour cerner les clients potentiels, déterminer leurs besoins et commencer à bâtir un curriculum et à l'implanter. Il est souhaitable que l'AID continue à supporter cet effort de conception et d'opérationnalisation. L'AID pourrait aussi fournir une certaine aide au niveau des moyens matériels (livres, matériel de bureau, etc.). Il paraît cependant plus prioritaire et essentiel que l'AID aide à la formation (MSc, PhD) du futur staff de l'Institut et qu'elle contribue au démarrage aussi rapide que possible des programmes de l'Institut en aidant à amener ici des enseignants étrangers qui pourront être pairés à des enseignants marocains.

On notera aussi que l'Institut est appelé à faire de la recherche Opérationnelle dans le secteur de la Santé. Dans la mesure où certaines études de recherche opérationnelle seraient prochainement entreprises en relation avec la planification familiale, il serait opportun d'étudier la possibilité d'y associer d'une manière ou l'autre l'Institut.

APPENDIX F.

History of Family Planning Information System Problems

Excerpt from report of evaluation team member
Charles Tilquin, Ph.D.
submitted to USAID/Rabat March 1988.

History of Family Planning Information System Problem

Data collection and analysis

L'implantation du système VDMS s'est accompagnée de l'implantation d'un certain nombre de formulaires permettant de suivre les activités du programme sur le terrain (fiches VDMS 1/1 et VDMS 1/2) à partir desquelles on peut remplir d'autres fiches rendant compte mensuellement (et par passage) des activités au niveau du sous-secteur (VDMS 2/1), du secteur (VDMS 2/2), de la circonscription (VDMS 2/3) et de la Province (VDMS 2/4). D'autres formulaires, au niveau des formations fixes, permettent de rendre compte des activités de PF prenant place dans ces formations. En combinant aux différents niveaux, les données issues du VDMS avec celles issues des formations fixes, on peut en principe établir un bilan complet des activités de PF et mesurer un certain nombre d'indicateurs de performance (couverture, prévalence...). Il existe aussi dans le VDMS d'autres formulaires destinés à la gestion des indemnités, des vignettes et des stocks.

Même dans sa dernière version (guide VDMS -2ème édition- juin 1987), le système de fiches VDMS apparaît lourd (redondant, répétitif) à manipuler. Nous avons cependant pu constater que partout les fiches VDMS 1/1 et 1/2 sont remplies par les itinérants et qu'ils ne font pas beaucoup d'erreurs*. Selon les endroits, les fiches VDMS 2/1 et 2/2 sont plus ou moins bien remplies, ce qui doit affecter dans une certaine mesure la qualité des données des cumulatifs 2/3 et 2/4. Si beaucoup de temps est consacré à remplir ces fiches, et au niveau de la circonscription et de la Province à produire des grands tableaux et diagrammes**, on utilise par ailleurs très peu ces données pour gérer le programme VDMS en fonction d'objectifs de productivité, couverture, prévalence, etc.

A compter de 1985, on a voulu informatiser au niveau du Ministère le système manuel des formulaires VDMS***. L'historique de cette informatisation est fait plus en détail en annexe No. .. Ici nous nous contenterons d'en établir le bilan. On a d'abord tenté d'informatiser les rapports d'activités provinciaux VDMS 2/4 (un tel rapport est produit par Province chaque mois, ce qui donne un total de plus ou moins 30 x 12 fiches = 360 fiches/an). Les multiples problèmes rencontrés dans cette

* Compte tenu des problèmes de définition des concepts de nouvelle acceptante et d'abandon. Ces concepts sont à notre avis difficiles à manipuler, ce qui résulte dans la production des données peu fiables. Ils devraient à notre avis être abandonnés. Le seul concept vraiment utile est selon nous celui d'utilisatrice .. acceptante (ancienne ou nouvelle, sans distinction).

** Cette production bouffe un temps considérable pour une fonction essentiellement décorative, les données n'étant pas utilisées pour gérer. Il serait plus rentable d'exiger plutôt du personnel concerné qu'il consacre le temps ainsi gagné à réfléchir sur les données et à essayer de gérer en fonction de ce qu'elles disent sur l'atteinte des objectifs.

*** Ce n'est jamais très efficace que de vouloir informatiser tel quel, sans le remettre en question un système conçu initialement pour être utilisé manuellement. On aboutit toujours à une solution sous-optimale, parfois même à quelque chose de peu fonctionnel !

entreprise résultent d'une part de la mauvaise conception de la fiche VDMS 2/4 elle-même et des insuffisances du SETI (Service d'exploitation et traitement de l'information) du Ministère et d'autre part du fait que le consultant fourni par l'AID a collaboré à cette démarche plutôt que d'essayer de proposer une approche plus raisonnée de l'informatisation.

A compter de mai 1987, un ordinateur IBM PC-AT est mis à la disposition du SCPF puisque l'autonomisation des utilisateurs finaux semble être la seule voie permettant de pallier aux carences du SETI. Un système centralisé de gestion des indemnités VDMS est d'abord développé et mis en opération avec de nombreux problèmes (dus en particulier au "bugs" dans le logiciel INFORMIX et au manque de formation du personnel du SCPF). Ce système fonctionne cependant tant bien que mal. A l'heure actuelle, la gestion des vignettes est elle aussi partiellement informatisée avec LOTUS et la gestion des stocks est en développement. L'ordinateur IBM PC-AT utilisé aussi pour le traitement de texte et pour la saisie des données est complètement saturé.

En mai 1987, le système d'information de la Planification familiale est évalué par les consultants à long terme du projet FPLM (Family Planning Logistics Management). Ils concluent que le système collecte trop d'informations dont une grande partie est inexploitable ou inexploitée, qu'il ne correspond pas aux besoins réels des opérations de gestion de la PF, qu'il est surtout un moyen de contrôle des activités et d'archivage des données. Suite à cette évaluation, le projet FPLM fournit un consultant à court terme qui prépare une proposition préliminaire de la conception administrative du système d'information de la PF intégrant la gestion des informations de référence, la gestion des activités, des indemnités, des vignettes, des stocks, la production d'indicateurs et la gestion du plan d'action. Cet effort de réflexion était vraiment nécessaire pour apporter davantage d'analyse dans une démarche où jusqu'ici on lui a préféré l'action.

A peu près simultanément, la Division de la Population produit un "Guide d'utilisation du système d'information du Programme National de Planification Familiale". Le système proposé dans ce guide correspond grosso-modo à celui dont une proposition préliminaire de conception a été faite par le consultant FPLM.

Globalement, les orientations prises sont excellentes: on structure, on simplifie, on évite les redondances et les répétitions, et surtout on s'inscrit franchement dans une perspective de management par objectifs. Au niveau opérationnel, le caractère approximatif du guide laisse malheureusement planer des doutes sur la qualité des informations qui seront produites par ce nouveau système. Certes, on procède actuellement à un essai pilote du système dans 2 Provinces. Mais c'est peu productif de procéder de la sorte (c'est comme bâtir un pont à partir d'une maquette et de plans "provisoires" en procédant à des ajustements au fur et à mesure de sa construction sur le terrain. Ce sont ces ponts-là qui croulent ! Avant d'aller sur le terrain, même de façon pilote, on devrait avoir un produit final, c'est-à-dire des formulaires en principe définitifs, un guide détaillé qui donne une définition précise de tous les termes, indicateurs, catégories utilisés. Ce n'est pas le cas du guide actuel. Le processus de mise au point du nouveau système, tel qu'engagé, pourrait durer longtemps parce qu'on privilégie à tort la conception par essai et erreur à la conception logique et structurée. Pourtant les leçons du passé indiquent qu'en matière d'informatisation un trop grand empressement ne donne guère de résultats.

En résumé donc, on a progressé considérablement depuis 1985 en ce qui concerne les systèmes d'information manuel et informatisé. Fondamentalement, les orientations sont correctes: volonté de simplification et d'intégration, finalités adéquates; certaines contraintes demeurent qui gênent encore la réalisation d'un système d'information tout à fait opérationnel, à savoir:

- une certaine confusion entre compétence et expérience en PF et compétence et expérience en systèmes d'information;
- une trop grande propension à passer rapidement à l'action sans prendre le temps de bien analyser les problèmes;
- secondairement, l'insuffisance de l'équipement informatique et des ressources humaines du SCPF en particulier en informatique et systèmes d'information (compte tenu des carences du SETI);

Recommandation

L'essai pilote manuel du nouveau système d'information de la PF n'était pas indispensable. On aurait pu directement préparer le support informatique du système. Pour que cette informatisation soit couronnée de succès, il faudrait reprendre minutieusement l'analyse des indicateurs de performance dont la nomenclature et les définitions sont encore trop approximatives. Il faudrait définir sans ambiguïté les différentes catégories de chacun des phénomènes sur lesquels il est nécessaire de collecter des données pour mesurer les indicateurs. Il faudrait effectuer l'analyse fonctionnelle du système en partant du principe qu'il sera informatisé au niveau central et au niveau des Provinces; en particulier préciser le contenu des extrants, spécifier le contenu des intrants, les modalités d'acquisition des données en particulier revoir les formulaires de recueil des données au niveau de la circonscription, du secteur et de la prestation des services. Ensuite, il faudrait faire le découpage du système pour la programmation, effectuer celle-ci, tester les programmes, rédiger un guide d'utilisation du système pour les agents qui recueillent les données, un guide d'utilisation pour les agents appelés à utiliser les données pour la gestion et un guide d'utilisation des programmes informatiques supportant le système. On pourrait alors faire un essai pilote du nouveau système informatisé aux niveaux Provincial et central.

Cette démarche, si elle est couronnée de succès, pourra alors servir de modèle au développement d'un système national d'information sanitaire intégrant les autres activités sanitaires. Il nous apparaît cependant prématuré d'attaquer directement la réalisation du système complet ou même de n'importe quelle autre de ses futures composantes avant de s'être fait la main sur celle qui à l'heure actuelle est la plus avancée, le sous-système de PF.

Nous recommandons donc à la mission de l'AID d'aider le Ministère de la Santé dans la démarche précitée de la façon suivante:

<u>Actions dans l'ordre chronologique</u>	<u>Support AID</u>
1. Finalisation du contenu PF du système: indicateurs et dictionnaire de données	Expert en PF (deux à trois semaines)
2. Renforcer capacités physiques informatiques du SCPF	Fournir micros et périphériques et logiciels au SCPF
3. Renforcer capacités humaines du SCPF. Au moins un analyste-programmeur et un opérateur/ préposé à la saisie	(MOH)
4. Analyse fonctionnelle du système informatique central-provincial	Deux analystes-programmeurs dont un chef de projet (trois mois pour le chef et deux mois pour l'analyste)
5. Programmation et tests	(Aide d'un analyste et d'un programmeur du SETI et de l'analyste-programmeur du SCPF pendant la même période)
6. Documentation des programmes et guide de l'utilisateur du système informatique	
7. Guide de l'utilisateur des formulaires de cueillette des données	(SEIS - SCPF)
8. Guide de l'utilisateur du système pour la gestion	(Service conseil DAT - SCPF)
9. Implantation pilote	Fournir micro périphériques et logiciels aux Provinces pilotes. Fournir formation en informatique*.

* Si le système est bien conçu, cette formation pourra être très légère (une demi journée). Cependant si on veut que les personnes formées puissent aller plus loin que ne le permet la version de base du système (c'est-à-dire faire plus que rentrer les données et sortir les extrants statutaires), il faudra leur donner une formation complémentaire en DBASE III, LOTUS 1, 2, 3, SPSS/PC, etc.

ANNEXE

Historique de l'informatisation du système d'information
du programme national de Planification Familiale

- Système expérimental pour traitement de la fiche VDMS 2-4 sur le mini-ordinateur HP3000 de la SETI avec le logiciel V-3000. Fonction principale: contrôler et corriger les formulaires VDMS 2-4 fournis par les provinces. octobre 1985
- Saisie d'une centaine de fiches VDMS 2-4. Les fiches saisies semblent ne pas avoir été traitées. La raison est qu'il n'existe pas d'outil complémentaire à V-3000 (REPORT/3000, RAPID/3000) qui permettent de produire des états à partir des données saisies. novembre-
décembre 1985
- Test d'une deuxième approche utilisant V-3000 mais remplaçant le programme de saisie standard, ENTRY, par un programme "sur mesure" permettant un accès plus rapide aux enregistrements lors des mises à jour. Cette version a été écrite par le consultant AID. (On notera cependant que les logiciels permettant de produire des états à partir des données saisies n'existent toujours pas). Une tentative d'exploitation des fiches déjà saisies (voir ci-dessus) montre que celles-ci sont en fait en grande partie inexploitable du fait de problèmes survenus lors de la saisie. juillet 1986
- Test d'une troisième approche sur HP 3000 utilisant le logiciel GENASYS pour créer une base de données et les écrans de saisie correspondant. Cette approche permet de produire des états et de satisfaire des interrogations simples. Le système a été développé par le SETI. Moyennant certaines conditions, un transfert des données est possible sur le PC-AT (qui est installé au même moment à la Division de la Population) pour effectuer des analyses statistiques. août 1986
- Installation d'un IBM PC-AT à la Division de la Population (Service central de la Planification Familiale) avec un ensemble complet de logiciels incluant LOTUS 1 2 3 et SPSS/PC. Des cours sont donnés à 3 personnes du SCPF, 1 personnes du SEIS et 2 personnes du SETI. juillet
août 1986
- Selon le rapport du consultant AID, la saisie des VDMS 2/4 de l'année 1986 est complète. Cependant aucun état n'a été produit, aucun contrôle des données n'a été mis en oeuvre, aucun dossier d'analyse ni aucune documentation n'existe. De nombreux problèmes semblent subsister en raison des contraintes dues à GENASYS/IMAGE et contrarient la mise en oeuvre du système. mars 1987

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- La saisie des fiches VDMS 1/1 est recommandée pour valider les taux de prévalence issus du traitement des fiches 2/4. A titre d'essai, un échantillon de 0.5% des fiches des provinces de Meknès, El Jadida et Béni-Mellal seront saisies. L'ensemble de la fiche sera saisi et non seulement les informations sur la dernière visite.

mars 1987
- Installation du logiciel de base de données INFORMIX sur le PC-AT du SCPF. Formation de neuf personnes. La version INFORMIX implantée est la dernière et de nombreux problèmes de jeunesse sont apparents.

mars 1987
- Développement et mise en opération d'un système de gestion des indemnités VDMS. Le système qui concerne 3500 agents fonctionne sur le PC-AT avec INFORMIX. Le consultant note que le IBM PC-AT est insuffisant: difficulté de concilier les activités de programmation avec celles de saisies, traitement, gestion ou formation.

mars 1987
- Développement d'un système permettant de traiter la fiche 2/4 sur le PC-AT. Reste à le tester. La saisie devrait continuer à se faire sur le mini-ordinateur HP 3000 et les données seraient ensuite transférées sur le PC-AT.

mars 1987
- Un programme de saisie de la fiche VDMS 1/1 est préparé sur le PC-AT au cas où la saisie ne pourrait se faire sur le HP 3000.

mars 1987
- Une base de données pour la gestion des inventaires est préparée. Le système devrait permettre le suivi des produits consommables distribués dans le cadre du VDMS. Seuls les tables et écrans de saisie ont été préparés. Les rapports et états restent à faire. Le travail reste aussi à faire en ce qui concerne la gestion des vignettes.

mars 1987
- Les consultants à long terme du projet FPLM évaluent le système d'information. Ils concluent que le système collecte trop d'informations dont une grande partie sont inexploitable ou inexploitées. Le système ne correspond pas aux besoins réels des opérations de gestion de la PF; il correspond plus à un moyen de contrôle des activités et à l'archivage des données collectées qu'à un outil de gestion. Le micro-ordinateur est par ailleurs saturé.

mai 1987
- Proposition d'une version préliminaire de la conception administrative du système d'information pour la PF par un consultant à court terme du projet FPLM. Le système devrait intégrer:

 - la gestion des information de référence;
 - la gestion des indemnités (déjà informatisées);

septembre 1987

- la gestion des stocks (en développement par le personnel du SCPF);
 - la gestion des activités (informatisation partielle/ fiches VDMS 2/4);
 - la gestion des transports (partiellement informatisée sur LOTUS);
 - la production d'indicateurs;
 - la gestion du plan d'action.
-
- Production d'un guide d'utilisation du système d'information du PNPf par la DAT (Division de la Population) avec la collaboration du SEIS. octobre 1987

 - Essai pilote du système précité dans les provinces de Meknès et Khémisset. février 1988

APPENDIX G.

Ministry of Health Budget History

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Appendix G

TABLE I

MOPH OPERATIONAL AND INVESTMENT BUDGET (IN 1000 DH 1965-1985)

	MOPH BUDGET							TOTAL MOROCCAN BUDGET							HEALTH IN '970 CONSTANT DIRHAM	
	OPERATING BUDGET					(2) Investment Budget	(3) Total	(4) Operating Budget	(5) Investment Budget	(6) Total	(1)	(1)	(2)	(2)		(3)
	Personnel	Percent	Supplies	Percent	Total						(3)	(3)	(4)	(3)		(5)
1965	103,812	56.35	80,399	43.65	184,211	25,045	209,250	1,755,558	774,757	2,670,815	6.07	9.72	11.97	3.23	7.89	188,350
1970	119,326	55.23	96,752	44.77	216,088	21,317	237,405	2,718,679	1,132,861	3,851,540	91.02	7.55	8.98	1.89	6.14	237,405
1975	228,775	63.09	122,150	36.91	330,925	105,483	436,408	8,848,511	6,200,015	15,136,526	75.85	7.74	26.17	1.69	2.08	283,507
1980	424,350	67.29	201,101	32.71	630,101	129,304	759,405	12,634,510	8,427,960	21,062,470	82.97	4.99	17.03	1.53	3.61	526,143
1985	712,127	72.80	267,905	27.20	985,098	185,000	1,171,098	21,223,626	12,281,750	33,565,376	84.12	4.63	15.88	1.51	3.49	390,366

Source: PRITECH, Norris et.al. (1986)

TABLE 2

ACTUAL MOPH BUDGET LEVELS COMPARED TO THOSE LEVELS NEEDED
TO MAINTAIN CONSTANT PER CAPITA PURCHASING POWER, 1970-1975

YEAR	Total Population (millions)	Actual MOPH Budget (DH Millions)	Actual MOPH Budget Per Capita (DH)	1970 MOPH Budget in Current Values (DH Millions)	1970 MOPH Budget Per Capita in Current Values (DH)	Actual MOPH Budget Per Capita as % of 1970 MOPH Budget Per Capita in Current Values Col.3+Col.5
1970	16.0	237.4	14.84	237.4	14.84	—
1975	17.7	436.4	24.66	403.7	22.81	108%
1980	20.2	759.5	37.60	686.3	33.98	111%
1985	23.0	1,171.1	50.92	1,167.0	50.74	100%

NOTE: During the past five years, the relative decline in the level of resources committed to the MOPH budget has erased all of the gains that had been achieved during the previous 15 years. This is suggested in the final column of Table 1 (p. 7), which shows that the MOPH budget, in constant dirham, rose from DH188.3 million in 1965 to DH526.1 in 1980—before dropping back to DH309.4 in 1985. Given the 70 percent increase in population during the same period, the 1985 figure is—when averaged over the larger population—little different than the 1965 figure.

Table 2 above illustrates this point from a different perspective by adjusting the MOPH budget allocation of 1970 for subsequent price inflation (8.6 percent yearly) and population growth (2.6 percent yearly). The actual 1975 MOPH budget per capita was about 108 percent of the 1970 per capita budget (in 1975 currency values), and the 1980 per capita budget was higher still at 111 percent of the 1970 per capita budget (in 1980 currency values). However, by 1985 the MOPH budget per capita had dropped back to exactly the same level of resource commitment as was made 15 years earlier.

Given the level of investment in buildings and equipment which is implicit in previously increasing resource commitments to the sector, government's cutbacks in the budget must imply some significant losses in the productivity of those investments.

Source: PRITECH, Norris et.al. (1986)

TABLEAU NO 7:

EVOLUTION COMPARATIVE DU BUDGET DU MINISTERE DE LA SANTE
PAR RAPPORT AU BUDGET DE L'ETAT POUR LA PERIODE (1968-1988)
(EN 1000 DH)

NATURE DE BUDGET	BUDGET DE FONCTIONNEMENT			BUDGET D'INVESTISSEMENT			BUDGET GLOBAL		
	SANTE PUBLIQUE	ETAT	% E.F.S/ B.E.	SANTE PUBLIQUE	ETAT	% E.I.S/ I.E.	SANTE PUBLIQUE	ETAT	% B.G.S/ G.E.
1968	205196	2421053	8.39	13156	1155985	1.14	216352	3577038	6.05
1969	210934	2546184	8.28	14035	1198984	1.17	224969	3743158	6.01
1970	216080	2718675	7.95	21317	1125086	1.89	237405	3943761	6.18
1971	216965	2946801	7.36	14313	1307661	1.09	231298	4254442	5.44
1972	222907	3145533	7.09	29996	1608756	1.86	252903	4754336	5.32
1973	236666	3513179	6.74	23658	1195932	1.98	260324	4799111	5.55
1974	287201	6122745	4.69	41053	3336592	1.23	328254	9459942	3.47
1975	330924	8368511	3.74	105483	6288013	1.68	436407	15136324	2.89
1976	362539	8213430	4.41	206677	9873961	2.10	569216	18077459	3.15
1977	406869	6885519	4.58	195460	11741393	1.66	602329	120629912	2.92
1978	497815	9468729	5.26	146500	8127251	1.80	644315	17596550	3.66
1979	539994	10622120	5.08	119196	6727814	1.36	659190	19358061	3.41
1980	630181	12734510	4.99	129304	8421500	1.53	759485	21062470	3.61
1981	701182	15356649	4.57	237710	998723	2.38	938892	25353282	3.70
1982	803108	18104559	4.44	300000	1780000	1.70	1103108	34911198	3.16
1983	925255	20139609	4.59	260905	1821896	1.39	1186160	38853505	3.05
1984	933432	18964002	4.92	156737	10144287	1.54	1090169	29118759	3.74
1985	985098	21283626	4.63	186000	12281759	1.51	1171098	33565376	3.49
1986	1132040	21793526	5.22	500000	13213584	3.78	1637800	35022080	4.68
1987	1293403	23676924	5.46	400000	19894239	2.01	1693403	43601163	3.88
1988	1391145	25114371	5.26	400000	16059912	2.49	1721145	41185283	4.18

Source: Ministry of Public Health, GOM

TABLEAU NO 9 :

EVOLUTION EN POURCENTAGE DES DEFENSES COMMUNES A TOUT LES SERVICES
DU MINISTERE POUR LA PERIODE (1960, 1965, 1970, 1975-1987)

AN	meubles		meublier & frais de fonctionnement		fonction des vehicules auto		transports & remboursement des frais		fournitures pharmaceutiques & reparatiin de materiels		frais d'expertise medicales		remboursement des frais medicaux , chirurgicaux & pharmaceutiques		assurances du personnel contre les risques professionnelles		TOTAL	
	MONTANT	%	MONTANT	%	MONTANT	%	MONTANT	%	MONTANT	%	MONTANT	%	MONTANT	%	MONTANT	%	MONTANT	%
1960	1710000	5.29	5794500	17.91	1500000	4.64	755000	2.33	22500000	69.56	7500	0.02	30000	0.09	50000	0.15	32347000	100
1965	1120000	2.90	7450500	18.33	2550000	6.27	1000000	2.46	28357000	69.76	1000	.00	23240	0.06	90000	0.22	40651740	100
1970	2515000	4.88	9591186	18.60	3300000	6.40	920000	1.78	35074200	68.02	500	.00	60000	0.12	100000	0.19	51560836	100
1975	4245478	6.25	8199220	12.08	4250000	6.26	1010000	1.49	50000000	73.65	P.M	0.00	20000	0.03	165000	0.24	67889698	100
1976	4560000	5.53	11059000	13.41	5500000	6.67	1150000	1.39	60000000	72.75	P.M	0.00	25000	0.03	175000	0.21	82469000	100
1977	4740000	5.18	14064000	15.38	4500000	4.92	1140000	1.25	66800000	73.05	P.M	0.00	25000	0.03	175000	0.19	91444000	100
1978	5030000	5.04	15374000	15.41	5000000	5.01	1140000	1.14	73000000	73.19	P.M	0.00	25000	0.03	175000	0.18	99744000	100
1979	5030000	4.58	15374000	14.01	5000000	4.56	1140000	1.04	83000000	75.63	P.M	0.00	25000	0.02	175000	0.16	109744000	100
1980	5030000	4.19	15693000	13.07	5000000	4.16	1140000	0.95	93000000	77.46	P.M	0.00	25000	0.02	175000	0.15	120068000	100
1981	5185440	4.05	17953000	14.02	8500000	6.64	3129560	2.45	93000000	72.69	P.M	0.00	25000	0.02	175000	0.14	122948000	100
1982	5185440	3.78	18433000	13.44	10200000	7.44	3129560	2.28	100000000	72.91	P.M	0.00	25000	0.02	175000	0.13	137148000	100
1983	5185440	3.79	19583000	14.32	10700000	7.82	3129560	2.29	98000000	71.64	P.M	0.00	25000	0.02	175000	0.15	136798000	100
1984	4730000	3.78	19246900	15.40	7930000	6.39	2838350	2.27	90000000	72.01	P.M	0.00	22500	0.02	157500	0.13	124975250	100
1985	4730000	3.61	24776000	18.93	8100000	6.19	2920000	2.23	90000000	68.76	P.M	0.00	200000	0.15	160000	0.12	130886000	100
1986	4943610	3.33	31002000	20.86	10200000	6.86	3107890	2.09	99000000	66.62	P.M	0.00	200000	0.13	160000	0.11	148613500	100
1987	5258610	3.06	47271416	27.47	10200000	5.93	3049500	1.77	105950046	61.57	P.M	0.00	200000	0.12	160000	0.09	17280572	100

Source: Ministry of Public Health, GOM

Tableau no 22:

 BUDGET DU MINISTRE DE LA SANTE PUBLIQUE (1980-86)
 - VALEURS REELLES ET NOMINALES EN 1000 DH-

ANNEE	CATEGORIE	BUDGET DE FONCTIONNEMENT (B.F)				BUDGET D'INVESTISSEMENT (B.I)		TOTAL (BF+B.I)			
		PERSONNEL	VARIATION	MATERIEL	VARIATION	TOTAL	VARIATION	VALEUR	VARIATION	VALEUR	VARIATION
1980	-	424080	-	206101	-	630181	-	129304	-	759485	-
	!DH COURANT!	475021	+12%	226161	+10%	701182	+11%	237710	+84%	538892	+24%
1981	!DH CONSTANT!	415645	-2%	177891	-04%	613543	-03%	207996	+61%	621530	+8%
	!DH COURANT!	560907	+18%	242201	+07%	803108	+15%	300000	+26%	1103108	+17%
1982	!DH CONSTANT!	431898	+04%	186495	-06%	618393	+01%	231000	+11%	849393	+03%
	!DH COURANT!	633922	+13%	270833	+12%	904755	+13%	244405	-1%	1149160	+04%
1983	!DH CONSTANT!	448817	+04%	191750	+03%	640567	+04%	173039	-25%	813605	-04%
	!DH COURANT!	669564	+06%	244589	-10%	914153	+01%	139302	-43%	1053455	-08%
	!DH CONSTANT!	390356	-13%	142595	-17%	532951	-17%	81213	-53%	614164	-25%
1984	!DH COURANT!	717193	+07%	267905	+08%	985098	+08%	186000	+34%	1171098	+11%
	!DH CONSTANT!	362900	-07%	135560	-06%	498460	-06%	54116	+16%	592576	-04%
1985	!DH COURANT!	826696	+15%	311183	+16%	1137880	+16%	500000	+169%	1637880	+40%
	!DH CONSTANT!	354559	-02%	130074	-05%	475634	-05%	209000	+122%	684434	+16%
	VARIATION MOYENNE NOMINALE	+12%	-	+7,5%	-	+10,5%	-	+16%	-	+9,5%	-
	ANNUELLE REELLE	-3%	-	-7%	-	-4%	-	+2%	-	+4,5%	-

* CE MONTANT DE 500 MILLIONS DE DH INSCRIT AU B.I (ANNEE 1986) REPRESENTE EN FAIT LE REPORT DES ANNEES ANTERIEURES.

Source: Ministry of Public Health, GOM

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APPENDIX H.

Detailed Summary of USAID Training Activities under Phase III

Detailed Summary of USAID Training Activities under Phase III

POPULATION AND FAMILY PLANNING SUPPORT III (608-0171)

INVITATIONAL TRAVEL

<u>Title of Course/Conference</u>	<u>Dates</u>	<u>Place</u>	<u>Participants</u>	
U&TNA/JHU-PCS workshop	02/18-22/85	Dakar	Abdelhaq Jouahri, MOPH Noureddine Sail, RTM Mohamed Graigaa, AMPF	CANCELED
CEDPA workshop	03-18/4-19-85	Washington	Laila Soulami, MY&S	
Ivorian Parliamentarian's Conf.	03/21-23/85	Abidjan	Dr. Mohamed Rachidi (Khouribga)	CANCELED
IUSSP General Conference	06/05-12/85	Florence	Fouad Lahlou, MAAS Mohamed Abzad, MOP M'Hamed Ouakrim, MOPH Chaouki Benazzou, Dep of Prime Minister	
JHU/PCS Communication Workshop	07-29/08-16-85	Baltimore	Mohamed Graigaa, AMPF Amina Nain, AMPF Hamid El Achhab, MOPH (Settat) Malika Meliani, RTM	
3rd Annual Medical & Scientific Conference (SAC)	09/09-13/85	Bordeaux	Dr. Ahmed Moussaoui, NTCRH	CANCELED
Int. Conf. on Contraception (4th Annual Meeting)	09/23-26/85	Chicago	Dr. Ahmed Moussaoui, NTCRH	CANCELED
ANE Evaluation Conference	09/29-10/04/85	Tunis	Carl S. Abdou Rahmaan, USAID/PHR John Giusti, USAID/PROG Zhor Laaziri, MOPH Boudour El Aoufi, Prime Minister Office	

1985

Health Financing Mobile Seminar	11/16-26/85	United States	Prof. M. Abderrahmane Alaoui M'Hamdi, C.H.U. Rbt. Dr. Nouredine Benomar El Alami, C.H.U. Casablanca Dr. Chakib Bourquia, C.H.U. Casablanca Col. Major M. Idriss Archane, Hop. Militaire, Rbt Prof. Ahmed Alaoui Belghiti, Conseil Nat. de l'ordre des Medecins M. Mustapha Chafik, CNOPS M. Abdelmoughit Slimani, CNSS M. Abderrahmane Chaoui, MOF M. Ahmed El Hariti, MOPH Dr. Azzedine El Mansouri, MOPH (Marrakech)
Oral Rehydration Therapy	04/02-04/86	Cairo, Egypt	Dr. Mohamed Zarouf, MOPH Dr. Abderrahim Barodi, Hopital d'Enfants
Congrès International de la FIDAF	06/24-07/04/86	Ottawa	Hassan Alaoui, Heure Joyeuse
<u>AYSC</u> 2nd International Maternal and Child Health	11/23-25/84	Tunis	Dr. Abdellatif Chaoui, NTCRH
<u>JHPIEGO</u> Administrator's Course	June 1984	Baltimore	Dr. Ali Rachidi, MOPH Marrakech Dr. Mohamed Hassar, MOPH Beni Mellal
Infertility Course -STD	06/17-28/85	Baltimore	Dr. Ali Salamitou, MOPH Nador
Infertility Course -STD	11/11-22/85	Baltimore	Dr. Farid Jouahri, NTCRH
Microsurgery for Tubal Reanastomosis	03/22-04/04/86	Baltimore	Dr. Khalil Sebti, NTCRH
Administrator's Course	06/01-21/86	Baltimore	Dr. Mokhtar Belghiti
Infertility Course -STD	03/30-04/10/87	Baltimore	Dr. Abdelwahab Bachouchi, NTCRH
Nurse Family Planning trg Program	04/13-05/03/87	Dakar	Hassan Alaoui, Heure Joyeuse Zohra Loumatine, Heure Joyeuse
Academic Skills Course	06/1-16/87	Baltimore	Dr. Karim Mentak, NTCRH

<u>IFFLP (FIDAF)</u> Séminaire Inter-Africain sur les méthodes Naturelles de PF	01/21-25/85	Brazaville	Baptiste Cohen, Heure Joyeuse	
Séminaire Pan-Africain de la PFN	07/21-8/02/85	Ile Maurice	Baptiste Cohen, Heure Joyeuse	
Congrès International de la FIDAF	06/24-07/04/86	Ottawa, Canada	Baptiste Cohen, Heure Joyeuse	
<u>RONCO/Pop</u> Short-term trg	4/08-06/07/86	U.S	PIO/P Abdellah El Medhi, AMPF	CANCELED
FP Program Management	4/28-6/14/86	Santa Cruz	PIO/P Zineb Alaoui, MAAS	
IESC Workshop	11/17-12/13/86	Santa Cruz	PIO/P Abdellatif Ennajar, AMPF	
<u>INPLAN</u> Rapid II Workshop	05/12-16/86	Harare	M. Abdel Jabar Gandasi, MOPH Dr. Abdelhaq Jouahri, MOPH	CANCELED
<u>PATHFINDER/BOSTON</u> World Assembly of Youth's Workshop	06/10-16/86	Banjul (The Gambia)	Farouk Chahir, JOM Casablanca Mohamed Lechhab, JOB Tangiers	
<u>MSH/BOSTON</u> Formation en Gestion PF (1er Réunion du Comité Consultatif Régional Francophone	04/06-10/87	Boston	Dr. Mohamed Zarouf	
<u>RONCO/PAC II</u> Curriculum Development in clinical FP skills for paramedical workers	06/16-07/04/87	Istanbul	Karkhach Fatiha, Reference Center, Oujda Friz Fatima, FP counselor Lisel Hassania, RC, Rabat El Haddadi Khadija, NTCRH Hafs Khadija, FP Counselor, Casa-Anfa Hamdane Mahjouba, RC, Marrakech Mehamdi Mohamed, FP Counselor, Meknes Benamar Moumna, Midwife/staff trainer Sabir Tahra, Midwife/staff school certificate	
Regional FP workshop	02/26-03/02/88	Tunis	Dr. Abderrahmane Zahi, MOPH Dr. Mustapha Tyane, MOPH M. Mohamed Boulgana, MOPH	

IN-COUNTRY TRAINING AT NTCRH

World Federation Steering
Committee Meeting/Workshop

06/23-26/86

Rabat

Trg in fertility care services for
Physicians in the Arab World

1986

JHPIEGO EXPERTS MEETING

<u>MEETINGS</u>	<u>DATES</u>	<u>PLACE</u>	<u>EXPERTS</u>
Réunion du Conseil International	April 1984	Turquie	Prof. M. Tahar Alaoui
WF funded Experts Meeting	09/26-29/84	Rio de Janeiro	Prof. M. Tahar Alaoui
International Council Meeting	September 1985	Gannarth	Prof. M. Tahar Alaoui
International Advisory Committee Meeting	01/24-30/87	Lauzanne	Prof. M. Tahar Alaoui
Réunion d'experts en Services Professionnels d'espacement des Naissances	05/11-14/87	Abidjan	Prof. M. Tahar Alaoui

JHPIEGO CONSULTANCY VISITS

<u>SUBJECT</u>	<u>DATES</u>	<u>PLACES</u>	<u>CONSULTANTS</u>
Prévention et traitement de la stérilité	04/14-05/03/86	Dakar	Abdelwahab Bachouchi
Field consultant visit to install the laproscator in central hospital	08/29-09/05/87	Ndjamena	Dr. Ahmed Moussaoui
Field consultant visit to install 2 laproscators in C.H.U Zeraida & Kouba	03/10-19/88	Alger	Dr. Ahmed Moussaoui

OBSERVATIONAL STUDY TOURS
(In-Country)

<u>Visitors</u>	<u>Dates</u>	<u>Program</u>
Senegalse Religious Leaders	2/11-25/85	Moroccan Family Planning Program
Yemenese Health Workers	3.8-21/85	MOPH basoc health and FP service delivery
Yemenese Health Workers	12/16-20/85	MOPH nation wide fieldworkers trg activities
Senegalese FP Leaders	06/08-12/87	Evaluation of FP program in Morocco
Chadians	09/14-24/87	First-hand about the Moroccan FP program
Mauritanian MCH Representatives	10/18-25/87	Successfulness of Moroccan FP program
Ivorian MOSA Officials Pakistani parliamentarians Somalia religious & Political Leaders	Planned	

OBSERVATIONAL STUDY TOUR
(3rd Country)

<u>PROGRAM</u>	<u>DATES</u>	<u>PLACE</u>	<u>PARTICIPANTS</u>
Contraceptive Social Marketing	11/03-14/86	Thailand & Indonesia	Carl S. Abdou Kahmaan, USAID/PHR Prof. M. Tahar Alaoui, NTCRH M. Mohamed Graigaa, AMPF Dr. Najib Tazi, SOPHA-Rabat M. Salah Aachik, Régie des Tabacs
ANE Regional Contraceptive Social Marketing Conference	02/14-18/88 02/21-25/88	Pataya, Thailand Cairo, Egypte	Car. S. Abdou Rahmaan, USAID/PHR Dr. Mohamed Zarouf, MOPH Dr. Mustapha Denial, MOPH M. Ahmed Kchichen, MOPH M. Mohamed Graigaa, AMPF Dr. Najib Tazi, SOPHA-Rabat

OBSERVATIONAL STUDY TOUR
(3rd Country)

<u>PROGRAM</u>	<u>DATES</u>	<u>PLACE</u>	<u>PARTICIPANTS</u>
Contraceptive Social Marketing	11/03-14/86	Thailand & Indonesia	Carl S. Abdou Rahmaan, USAID/PHR Prof. M. Tahar Alaoui, NTCRH M. Mohamed Graigaa, AMPF Dr. Najib Tazi, SOPHA-Rabat M. Salah Aachik, Régie des Tabacs
ANE Regional Contraceptive Social Marketing Conference	02/14-18/88 02/21-25/88	Pataya, Thailand Cairo, Egypte	Car. S. Abdou Rahmaan, USAID/PHR Dr. Mohamed Zarouf, MOPH Dr. Mustapha Denial, MOPH M. Ahmed Kchichen, MOPH M. Mohamed Graigaa, AMPF Dr. Najib Tazi, SOPHA-Rabat

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RONCO IN COUNTRY TRAINING

Service Central de PF

Training of Trainers (VDMS launch)	11-28/12/06/85	Central level	120 trainers 1760 provincial VDMS trainees
Training and communications activities (VDMS launch)	June 1986	Provincial level	118 trainers 1565 provincial VDMS trainees
Training of trainers for Beni Mellal, El Jadida & Meknes	December 1986	Central level	18 trainers
Provincial training sessions	January 1987	Beni Mellal, El Jadida and Meknes	18 trainers 173 VDMS agents
Journée d'Information en Gestion	3-30/4-2-87	Central level	100 cadres des anciennes et nouvelles provinces
Etude et traitement des fiches VDMS 1/1	April 1987	Beni Mella, El Jadida & Meknes	15 trainees
Training in the use of microcomputer	March 1987	Central level	FP services personnel
Provincial TOT	7/6-11/87	Central level	33 provincial trainers
Preliminary provincial level study of the continuing Education structure	1/12-15/88	Rabat, Meknes Marrakech	45 paramedical MOPH personnel
TOT	Apr-Sep. 1988	11 provinces	44 provincial trainer 210 trainers of Circonscription Sanitaire 1450 Agents VDMS

Education Sanitaire:

<u>Training Program</u>	<u>Dates</u>	<u>Participants</u>
Evaluation de l'Impact de la formation en communication sur les programmes de Santé Familiale	January 1985	28 Agents, MOPH
Journée de reflexion sur les activités d'éducation pour la Santé	September 1985	40 animateurs provinciaux d'éducation
formation en communication audio-visuelle	October 1985	students of école des cadres
Séminaires provinciaux des médecins de circonscriptions Sanitaires sur la communication appliquées aux programmes de Santé Familiale	March 1986	197 physicians
Séminaires provinciaux de Communication appliquée au programme de Santé Familiale	June 1986	229 agents, MOPH

Minist[ere des Affaires Sociales (MAAS)

<u>Training Program</u>	<u>Dates</u>	<u>Participants</u>
Enquête sur l'évaluation des besoins en formation des Directrices et monitrices des Centres Socio-Educatifs	January 1987	4 enquêteurs
Dépouillement du questionnaires d'évaluation des besoins en formation	Feb. 2-12, 1987	3 MOPH/MAAS
Elaboration des messages de base, des plans des cours et des modules de formation	Feb. 13/March 1, 1987	7 MOPH/MAAS
Finition du module de formation	March 2-13, 1987	4 MOPH/MAAS
Journée de travail	April 2-4, 1987	9 MOPH/MAAS
Formation des Formateurs à l'école de Marrakech	April 5-18, 1987	37 trainers
Révision du programme de de formation	April 21-24, 1987	10 trainers
Révision et finition du module	April 30/March 15, 1987	6 MAAS/MOPH
Journée préparatoires régionales Rabat, Agadir et Tangerf	6/15 - 7/3/87	30 Dir. des CSE, 39 animateurs et 4 formateurs
Sessions de formation dansq	7/13 -8/1/87	600 monitrices

APPENDIX I.

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Appendix I
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April 1986
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- Analyses et tendances démographiques au maroc
Sept. 1986
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Trip reports:		
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-NMA 20 agreement review	Wallace	Feb. 1987

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11/87

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-Employer/employee study	LMS Conseil	July 1987

Trip reports:

-Laying of groundwork for the ENTERPRISE project in Morocco	Raleigh/Harris	May 1986
-Feasibility study of Family planning services in private firms and coordination of dinner/debate	Raleigh/O'Brien	Dec. 1986
-Development of sub-project proposals	Raleigh/Cantlay	April 1987
-Completion of development of sub-projects	Raleigh/LeComte/Hayek	Aug. 1987
-Finalization of agreements with MPF, OCP, CHELCO and Régie	Raleigh/Cantlay/Liberi	Nov. 1987

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Private sector, cont.FIACI

Trip reports:

-Survey of pharmaceutical distribution capabilities	Decouens/Halpert	
-Assessment of capacities for local production of OCPs	Morrow	Nov. 1987
L'HEURE JOYEUSE		
-Activity report for 2/84-3/85		March 1985
-Report on Pan-African seminar	Cohen	Sept. 1985
-Assorted trip reports	Inlaoui	Sept. 1984 Feb. 1985 Jan. 1986
-Various documents and IE&C materials		1985-1987

Child SurvivalVACCINATION PROGRAMS

-General file

-Proposition de programmation de l'aide américaine dans le cadre du "Child Survival"

-Focus group interviews regarding vaccination awareness MOPH July 1987

-Study of media impact of "Vaccination Days" programming LMS Conseil Nov. 1987

-"Vaccination Days" site visit Emer Dec. 1987

-Preliminary tables of results from the "Vaccination Days" MOPH Jan. 1988

PRITECH

-ORT/EPI Assessment and project proposal for Morocco Echols, et. al. May 1985

-An indicative survey of Health Services Delivery: Report and recommendations Norris, et. al. Jan. 1986

URC

-Assessment of the Health Management Improvement Project Dec. 1984

*Most of the Child Survival documents can be found in Paul Emer's office.

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APPENDIX J.

Persons Interviewed

Persons Interviewed

Ministere de la Sante Publique

S.E. Taieb Bencheikh	Ministre
Dr. Abdelhay Mechbal	Directeur des Affaires Techniques
Dr. Abdelhaq Jouahri	Directeur Adjoint, des Affaires Techniques
M. Ferkli	Directeur des Affaires Administratives
Dr. Mostafa Tyane	Chef du Service de Programmation Sanitaire
Dr. Abderkarin El Amri	Chef du Service Central d'Education Sanitaire
M. Mohamed Laaziri	Responsable du Division de l'Infrastructure
M. Ghiban	Responsable du Division du Budget

VDMS and Planification Familiale

Dr. Mohamed Zarouf	Chef du Service de la Planification Familiale
M. Brahim Oucherif	Administrateur Divisionnaire

PNI

Dr. Mohamed Denial	Responsable du Programme National d'Immunisation
M. Bimegdi	
Dr. Amina Saad	

PSMI

Dr. Alfreda Belhaj	Chef du Service
Dr. Zerrari Abdelouahab	
Mme. Moumena Benamar	
Dr. Najia Hajji	

Formation Continu

Dr. Mohamed El Omrani	Chef du Service
M. Mohamed El Ghazouani	
Mme. khadija Zouhar	
Mme. Fatima El Fatimi	

Cellule d'Economie

Bouchaib Wasfi	
Abdelkader Belkheidri	

National Training Center for Reproductive Health (CNFRH)

Dr. Mohamed Tahar Alaoui	Directeur
M. Haj Mimoun Boukhrissi	Administrateur
Mme. Fassi Fehri	Coordinatrice de Formation

