

PD ARH-106

**Project Assistance
Completion Report**

**Population and Family
Planning Support Project
Phase III (608-0171)**

TABLE OF CONTENTS

I. <u>ACRONYMS AND ABBREVIATIONS</u>	4
II. <u>EXECUTIVE SUMMARY</u>	6
III. <u>INTRODUCTION</u>	17
A. Purpose of Project Activity Completion Report (PACR)	17
B. Methodology	18
IV. <u>PROJECT BACKGROUND</u>	19
A. Project History	21
B. Initial Conditions	25
C. List of Project Inputs	25
D. List of Project Outputs	26
E. Summary of Borrower/Grantee, Donor, Consultant Activities	28
V. <u>REVIEW OF PROJECT ELEMENTS</u>	32
Element N° 1: VDMS Expansion	32
Element N° 2: Establishment of FP/H Outreach Services in Major Urban Areas	34
Element N° 3: Improved Training and Services at the National Training Center for Reproductive Health	35
Element N° 4: Establishment of Voluntary Sterilization/ Reproductive Health Services in 30 Provincial Hospitals	38
Element N° 5: Improved Information, Education and Communication (IEC) Programs in the GOM and Private Sector.	39
Element N° 6: Improved Family Planning Services Availability Through all Clinics and Outreach Activities (Commodities)	41
Element N° 7: Establishment of a Contraceptive Sales Program in the Private Sector	42
Element N° 8: Establishment of a Natural Family Planning Component in the Program	44
Element N° 9: Establishment of Family Planning Information and Service Activities in Other GOM Ministries and Agencies	45
Element N° 10: Improved Operations Research, Data Collection and Analysis	46

Element N° 11: Improved Population Analysis and Planning in the Ministry of Plan	48
Element N° 12: Improved Technical and Management Skills	49
Element N° 13: Child Survival Component	50
<u>VI. POST PROJECT USAID MONITORING RESPONSIBILITIES</u> . . .	53
<u>VII. CONCLUSIONS/LESSONS LEARNED</u>	53

APPENDICES:

I	Financial Summary
II	Summary of Contraceptive Purchases
III	Summary of Technical Assistance and Training Provided by RONCO Consulting Corporation
IV	Summary of Project-Financed Short- and Long-Term Training
V	Summary of Project-Financed Commodities
VI	VDMS Provinces (by Phase)
VII	List of Supporting Documents and Persons Interviewed
VIII	VDMS Case Study
IX	Relevant Data

I. ACRONYMS AND ABBREVIATIONS

A.I.D.	:	Agency for International Development
A.I.D./W	:	Agency for International Development/Washington
AIDS	:	Acquired Immune Deficiency Syndrome
AMPF	:	Association Marocaine de la Planification Familiare "Moroccan Association for Family Planning"
AVSC	:	Association for Voluntary Surgical Contraceptior
BUCEN	:	United States Bureau of the Census
CBR	:	Crude Birth Rate
CPS	:	Contraceptive Prevalence Survey
DHS	:	Demographic and Health Survey
DPT	:	Diphtheria, Pertussis, and Tetanus
FY	:	Fiscal Year
GOM	:	Government of Morocco
IEC	:	Information, Education and Communication
INTRAH	:	International Training in Health
IPPF	:	International Planned Parenthood Federation
IUD	:	Intra-Uterine Device
JHPIEGO	:	Johns Hopkins Program in International Education for Gynecology and Obstetrics
JHU/PCS	:	Johns Hopkins University/Population Communication Services
LOP	:	Life of Project
MCH	:	Maternal/Child Health
MIS	:	Management Information System
MOPH	:	Ministry of Public Health
MWRA	:	Married Women of Reproductive Age
NFP	:	Natural Family Planning

NTCRH : National Training Center for Reproductive Health

OR : Operations Research

ORS : Oral Rehydration Salts

ORT : Oral Rehydration Therapy

PACD : Project Assistance Completion Date

PACR : Project Assistance Completion Report

PSI : Population Services International

RAPID : Resources for the Awareness of Population Impacts on Development

TOT : Training of Trainers

VDMS : Visite à Domicile de Motivation Systématique
"Household Visits for Systematic Motivation"

UNFPA : United Nations Fund for Population Activities

UNICEF : United Nations Children Fund

USAID : United States Agency for International Development

WHO : World Health Organization

II. EXECUTIVE SUMMARY

The purpose of this report is to describe the activities undertaken and accomplishments of Project No. 608-171, Population and Family Planning Support III, USAID/Morocco (also called Phase III), and to outline recommendations for evaluation. The process of completing this report included the analysis and synthesis of available written materials concerning project activities and interviews with individuals who participated in the project (see Appendix VII). While the intended purpose of this report is to summarize the accomplishments of the Project, it also seeks to provide a basis for final evaluation by suggesting questions for post-project consideration.

Project Description

Population and Family Planning Support III (608-0171) was a seven-year project initiated in 1984 with an original Project Assistance Completion Date (PACD) of September 30, 1989, later extended to September 30, 1991, with a Project Paper (PP) supplement and two PP amendments. The goal of the project was 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. The project was designed to strengthen the Government of Morocco's (GOM) capacity to plan, implement and evaluate cost-effective family planning and child survival programs by providing technical assistance, training and commodities. Program components focused on extending the successful family planning/child survival outreach program, Visites à Domicile de Motivation Systématique (VDMS); increasing accessibility to fixed facilities; improving training and management capabilities of the Ministry of Public Health (MOPH); and promoting research for program planning and development. Often described as an "umbrella" project, its stated purpose included four major elements:

1. Establishment of availability of family planning (FP) information and services for 70% of the Moroccan population;
2. Attainment of contraceptive prevalence of 35% of married women of reproductive age (MWRA);
3. Introduction of population planning, analysis, modeling and forecasting methods into the GOM development process; and
4. Improvement of mother and child health (MCH) status.

While the project was primarily designed to strengthen MOPH programs, it also strengthened private sector involvement in FP service expansion. Private sector activities were conducted by the local IPPF-affiliate, Association Marocaine

de la Planification Familiale (AMPF), the Morocco social marketing program for condoms and Oral Rehydration Salts (ORS), and factory-based activities.

Four key activities were established as objectives for Phase III:

1. Increasing program coverage, adding and expanding GOM/FP service networks in additional areas of the country;
2. Establishing new service networks, particularly in the private sector;
3. Elevating population concerns in the GOM development planning process, particularly in association with the Ministry of Plan; and
4. Continuing/consolidating major elements of the program "base" to ensure effective institutionalization.

Initially, twelve Outputs, or elements were developed to address these objectives, with a thirteenth Output added in 1986 in conjunction with the Child Survival Program. At that time, a Project Paper supplement was developed describing the added activity and adding the fourth element of the Project Purpose: to improve mother and child health status. The project elements were:

- 1 • 1. Expansion of VDMS from 13 to 18 Moroccan provinces
2. Establishment of family planning/health outreach services in major urban areas;
- 3. Improved training and services at the National Training Center for Reproductive Health, an already existing training facility;
4. Establishment of voluntary sterilization/reproductive health services in 30 provincial hospitals;
- 5. Improved information, education and communication (IEC) programs in the GOM and private sector;

¹Activities marked with a (•) denote components begun under the predecessor project, Phase II - 608-0155, which were continued under this follow-on project. All other activities were initiated under this project. All activities are described in detail in the Sub-project Review section of this report.

- 6. Improved family planning services availability through all clinics and outreach programs;
- 7. Establishment of a contraceptive sales program in the private sector;
- 8. Establishment of a natural family planning program in the private sector;
- 9. Establishment of family planning information and service activities in other GOM ministries and agencies;
- 10. Improved operations research, data collection and analyses;
- 11. Improved population analysis and planning in the Ministry of Plan;
- 12. Improved technical and management skills; and
- 13. Provision of a program to support the MOPH's Expanded Program of Immunization (EPI) and other child survival activities.

Project Status as of Project Activity Completion Date (PACD)

Project 608-0171 met or surpassed all its stated objectives. With A.I.D. and other donor assistance, the GOM has been successful in lowering infant and child mortality, and fertility. Overall project accomplishments include:

- * The infant mortality rate (IMR) declined from an estimated 122 deaths per 1000 live births in the early 1970s to 57 in 1992.
- * Child mortality (based on children ages 1-4) fell from 77 deaths per 1000 in the early 1970's to 20 per 1000 in 1992.
- * Contraceptive prevalence increased from approximately 19% in 1978 to an estimated 41.5% in 1992.
- * The total fertility rate (TFR) declined from 5.8 in 1980 to 4.2 in 1992.
- * Vaccination coverage increased from 40-50% in 1985 to over 90% confirmed by interview, and 72% fully documented in 1991.

Much of this success can be attributed to the MOPH program, with its comprehensive national health infrastructure; a strong commitment to family planning and maternal and child health; and a pragmatic, innovative approach to service delivery. The Morocco family planning program uses multiple

approaches to outreach including household visits, mobile units and community service sites. The outreach program, developed originally as a pilot, has been expanded to household-based package of key services provided nationwide: family planning, immunization, diarrheal disease control and growth monitoring. A recent evaluation found consistently more favorable practices (i.e., immunization, attended births, use of ORS, etc.) and lower fertility among rural uneducated women in areas served by the VDMS outreach project.

Highlights of Project Accomplishments:

- The VDMS program was expanded from 13 to 40 provinces, and to 8 urban prefectures. As a result, more than 80% of the total population has access to an integrated health care package, either outreach or clinic-based. More than 7000 health care workers have received family planning training under this program.
- High quality voluntary surgical contraception (VSC) is now available in 34 provincial centers. During this project, over 32,000 procedures were performed, 4,500 in 1990 alone, increasing the percentage of contraceptive prevalence attributable to VSC from negligible to 7%. Materials have been purchased to expand services to 17 new sites.
- Intra-uterine devices are now available in over 600 provincial and district level facilities.
- The National Training Center for Reproductive Health (NCRH) carries out the quality training, supervision and management essential to implement the VSC and IUD clinical services programs mentioned above. The VDMS EXPERDATA evaluation indicated that from 1983-1991, in the NCRH family planning unit alone, 30,000 consultations had been made. The clinical training program has been so successful that the NCRH has become a regional training center for Francophone Africa.
- A contraceptive logistics management system effectively delivers contraceptive supplies to 40 provinces and 8 prefectures with over 2200 service delivery points.
- A new central contraceptive warehouse has been constructed and construction planning is underway for two family planning reference centers. Construction will continue under the

**Family Planning and Child Survival project
(608-0198), Phase IV.**

Vaccine and support was provided to the national vaccination campaigns. Childhood vaccination coverage rates have consequently increased from 50% to 90% (72% with complete documentation) for children under the age of five. Approximately 18,000 GOM employees received training in conjunction with the campaigns. Under the leadership of His Majesty King Hassan II, Morocco has led the way in the organization of the five-country Magrebian Vaccination Campaign held annually in October.

Educational materials, products and training support for the GOM's family planning, diarrheal disease, immunization and nutrition programs were developed and distributed.

Approximately 2,000 health workers and 450 physicians have received training in family planning communications for use in the clinic-based and outreach programs. The MOPH, AMPF and the social marketing program routinely air reinforcing family planning and health messages via both national and regional radio stations. The MOPH, in collaboration with Population Communication Services (PCS), has developed Information, Education and Communications (IEC) materials. A curriculum for training of trainers in communication skills has been developed and will be employed in the nine regional training centers under Phase VI. As a result of intensive IEC efforts, 98 percent of the population is aware of family planning methods. The social marketing program advertised BIOSEL, the private sector marketed oral rehydration salt, on television -- a first attempt to provide health messages to television audiences, and one that breaks new ground for future IEC efforts.

The Institut National de l'Administration Sanitaire (INAS) received assistance to develop a two-year, Masters in Public Health (MPH) -equivalent training program. The first class of 29 physician administrators graduated from this program in July 1991.

Major research was undertaken to provide baseline data critical to program planning, including the 1987 Demographic and Health Survey (DHS), the 1988 National Survey on

Causes and Circumstances of Infant and Child Death, and Causes and Prevalence of Maternity-Related Interventions. The project also financed design of the 1992 DHS.

The Protex condom social marketing campaign was successfully launched and plans made for expansion to other MCH/FP products such as oral contraceptives and weaning foods. Protex condoms are now available in over 1500 pharmacies throughout the country. CY 1991 sales were 1.8 million units, well above projected sales of 1.2 million. The condom program should be completely self-sufficient by 1993, one year ahead of schedule. A strategy for social marketing of pills has been developed. Oral contraceptives and condoms are currently sold in 12 provinces under the AMPF "agent communautaire" program, which also includes a fee-for-service IUD insertion program. AMPF also provided technical training in family planning to private sector physicians, nurses and pharmacists, (approximately 25% of all family planning services are currently provided by the private sector).

An interactive, multi-sectoral, microcomputer-based population projection model, along with sector-specific sub-models in health, education and employment were developed to assist development planning in Morocco. The initial data generated by these models were used in 1985 to organize a National Population Seminar, in preparation for development of the GOM 1988-1992 Development Plan. The MOPH has since developed a computer simulation which demonstrates the impact of the MOPH family planning and child survival program. This presentation has been used in many policy-level forums. Data from the 1987 Demographic and Health Survey are employed by the GOM as the official service statistics for family planning and child survival programs.

In support of child survival, national oral rehydration therapy promotion campaign was held during July and August, 1988. Social marketing of oral rehydration salts (BIOSEL) was launched in the summer of 1990 and continues with a strong media campaign and successful sales. A nutrition monitoring reference guide has been prepared, and training conducted to increase knowledge of MOPH workers and improve care. The 1989-90 MOPH Infant Mortality and Morbidity Survey was

completed, providing valuable information for program strategic planning. This survey identified large numbers of children with neonatal tetanus, resulting in the decision to focus on maternal tetanus immunization during the 1991 vaccination campaign.

A management information system (MIS) was designed by the MOPH, and provincial-level staff were trained in its use in June-September 1991. The MIS is specifically designed to collect family planning, pregnancy and birth monitoring, nutritional status, diarrheal control, and immunization data for local-level program planning and management.

Project Strengths

The strongest elements of Phase III include the expansion of the VDMS outreach program and integration of child survival activities into this program; the increased awareness of population at the national planning level, and the national data collection underlying program planning; the management and technical training programs developed and conducted under project auspices; expansion of clinical services programs for long-term contraceptive methods; and commercial-sector activities.

The VDMS outreach program in particular is a model component. While it can be replicated elsewhere, it should not be considered apart from the Moroccan context. The integration of mother and child health activities into a "package" of outreach services has been an effective approach to improving health, especially in rural areas.

The project has successfully increased awareness of population concerns among Moroccan officials and policy-makers. The use of data collected through the Demographic and Health Survey combined with computer simulation of the effects of population growth have contributed to this success and are considered one of the project's biggest assets.

Phase III has successfully supported a broad range of essential management and technical training programs for local staff. Approximately 42,000 person-days of Morocco-based training in critical subject areas for project-related staff was carried out under a direct contract with the RONCO Consulting Cooperation (see appendix III). The project financed long-term MPH training for five Moroccan program staff, as well as development of an in-country MPH training program at INAS. The National Training Center for Reproductive Health is also an asset to the program, especially in its supervisory/instructional role to surgical contraceptive centers nationwide. Not only does it contribute significantly to the sustainability of family planning and the

institutionalization of training within Morocco, but it also services sub-Saharan Africa and the Middle-East as an international training center.

The project has successfully promoted the expansion of more permanent family planning methods (VSC and IUDs) as alternatives to temporary methods (e.g. oral contraceptives). Project-financed technical assistance and equipment established a voluntary surgical contraception (VSC) program operating from 34 fixed centers nationwide. As a result, an estimated 7% of contraceptive users currently employ VSC as a contraceptive method. Project financing also supported the development of a training program in IUD insertion. IUD training for service providers will continue under Phase IV, based on the groundwork laid during Phase III.

Finally, the Moroccan Social Marketing Program has had tremendous impact on commercial contraceptive sales. Though this component got off to a late start, it took hold quickly, illustrating the success of a well-researched, pre-tested approach. This activity elicited and consolidated the private sector involvement necessary for overall family planning program sustainability. Studies predict that the social marketing component will be fully sustainable, including contraceptive supply, by 1993.

Project Weaknesses

The primary weaknesses of Phase III include the effective application of recommendations derived from operations research and special studies; focus within the program's IEC component; and the availability of complete information required for efficient contraceptive commodity logistics management. The National MIS was implemented during the final months of Phase III, and effective use of MIS data for program planning and management purposes will be a challenge during Phase IV.

Operations research played a very important part in the initial success of the family planning program. As a result of Phase II operations research, the initial VDMS pilot was established in Marrakech. VDMS has since been expanded to serve 80% of the population. Based on additional research findings, VDMS was subsequently modified: door-to-door services in urban areas were eliminated, and point-of-contact services were established in rural areas. The social marketing program has also effectively employed research findings to modify and improve its activities.

Many other studies have been conducted, but findings have not been consistently applied to program implementation. Topics studied have included the VSC referral system; IEC myths and rumors; maternal mortality; and, causes of child death. The effective application of the findings from these and future studies presents a challenge to be addressed during Phase IV.

A number of IEC activities and campaigns were implemented during Phase III. The MOPH successfully developed a national family planning logo, developed a brochure on contraceptive use for illiterate women, and developed effective IEC materials for use in support of the 1987 Magrebian diarrheal disease campaign and the 1991 Magrebian immunization campaign. The project also supported development of a training of trainers (TOT) curriculum focusing on effective counseling techniques, technical reference materials for VSC, and an AIDS brochure.

Owing to the vertical nature of service delivery programs; the expansion of project assistance to include child survival interventions; and turnover within the MOPH division responsible for IEC, project assistance directed to IEC has been coordinated with individual, vertical MOPH programs, rather than with one MOPH program unit. Although this pragmatic approach has resulted in materials development that might not have taken place otherwise, it has also resulted in a re-active, rather than pro-active, approach to IEC programming. A Phase IV challenge, therefore, will be development of a sector-wide IEC strategy, and a programming approach that complements this strategy, i.e., coordination of IEC activities through one, rather than several, MOPH units.

Contraceptive commodity logistics and programming presents a challenge as Phase III draws to a close. Although the MOPH effectively manages a nation-wide distribution program, there have been occasional stock-outs and overstocks resulting in forced destruction of "past-date" commodities (in one instance AID/W shipped the same order twice, resulting in overstocks; in another, IUDs were shipped to provinces for lack of central warehouse space, resulting in short stocks during an IUD insertion training program). The problem is three-fold: MOPH distribution and usage data must be reviewed and updated; USAID procurement data must be verified and projected requirements defined; and central financial and procurement accounting must be initiated at the AID/Washington level and this information transmitted to USAID/Morocco. Technical assistance is planned during Phase IV to facilitate accurate and timely commodity forecasting and procurement, thus addressing this problem area.

Finally, the recently implemented MIS could provide a wealth of program data. Phase IV efforts will determine whether these data are effectively employed for program management and planning purposes.

Despite these identified problems, each of the project's four purposes have been realized beyond expectations:

Family planning information and services are now available to close to 80% of the Moroccan population.

- ◆ Contraceptive prevalence has reached an estimated 40%.
- ◆ The MOPH now benefits from strong leadership in family planning and child survival policy planning.
- ◆ There was outstanding improvement in the status of maternal/child health nationwide as evidenced by the decreased incidence of vaccination target diseases and reduced TFR.

A 1988 midterm evaluation made five major recommendations:

- ◆ Broaden contraceptive method mix beyond the pill by strengthening other methods of contraception;
- ◆ Revise and target the IEC strategy at all levels;
- ◆ Redesign the family planning information system;
- ◆ Assure that the MOPH can assume recurrent costs of the VDMS program; and
- ◆ Expand Mission resources for project management and consolidate future project activities.

The project grappled with all of these recommendations and measurable steps were taken to address them, as described in subsequent sections of this report.

Sustainability

When Phase IV was designed in 1988, it was envisioned as the final phase of USAID assistance in the sector. Accordingly, the project design called for a planned phase-out of all assistance, including contraceptive commodities, by 1996. Towards this objective, the MOPH is progressively assuming responsibility for sector-related costs previously financed by USAID/Morocco.

For instance, the MOPH is now financing most recurrent costs associated with service delivery programs. The bulk of USAID support has financed contraceptive commodities, other commodities and equipment, technical assistance, and training for service delivery and program management staff. Financing for contraceptive commodities beyond 1996 is a major issue to be addressed during Phase IV. In addition, increased GOM and private sector support for program operations will be required to sustain ongoing activities at current levels beyond 1996. Cost recovery, in both the public and private sectors, must

training and research capability must be a key focus during Phase IV if staff training and research are to continue at current levels.

The MOPH now pays VDMS fieldworker indemnities as well as all salary, facilities, utilities, and basic recurrent costs (except contraceptive commodities) to support the nationwide maternal and child health program. Expansion of this program to the remainder of the population, however, will be impossible short of increased budget allocations. In fact, a hiring freeze in effect for the past two years has serious implications for the current and planned VDMS program and must be addressed.

Some important steps have already been taken to promote sustainability. The MOPH has decentralized management and decision-making for resource allocation to the local level, and is in the process of providing decentralized training of health staff at the provincial and lower levels. Cost-benefit analyses that were prepared early in Phase IV revealed project-financed activities are extremely cost beneficial. These analyses provide valuable information for ongoing discussions with Moroccan policy-makers and planners. The Child Survival Impact Evaluation stated that "an investment in family planning would be paid back in reduced public spending in health and education within only 2 years" (pp. 14-15). Finally, the increased involvement of the private sector in family planning programs reduces the financial burden on the public sector.

It may, however, be unrealistic to require a total phase-out of assistance to the sector by 1996. This issue should be examined during the program management review.

Towards Evaluation

An impact evaluation for the family planning and child survival program, including project 608-0171 is planned for January 1993. The Family Planning and Child Survival, Phase IV, Project is underway, and is currently addressing many of the problems and issues described in this report. The chief observation to be recorded in PACR is that the project achieved and surpassed its objectives. Recommendations made by evaluators were taken seriously and acted upon quickly. Both USAID and the MOPH anticipate increased focus and continuing success during Phase IV.

The following documents provide additional information on key project elements:

MOPH Family Planning Logistics Management Assessment, John Snow Inc. (JSI), and Family Planning Logistic Management (FPLM) contract, January 1988.

Midterm Evaluation of the Population and Family Planning Support III Project 608-171, ISTI POPTECH contract, March 1988.

Preliminary Report of the 1987 MOPH Demographic and Health Survey, MOPH and Westinghouse contract, November 1987 and 1988.

Preliminary data from the 1992 Demographic and Health Survey, MOPH and Institute for Resource Development Contract, May 1992.

The MOPH 1988 VDMS Field Operational Study, EXPERDATA, May, 1988.

Preliminary Report of the GOM Voluntary Surgical Contraception Client Satisfaction Survey, NTCRH in collaboration with the Association of Voluntary Surgical Contraception, March 1988.

An additional evaluation of the Child Survival Strategy was completed in June of 1990 and approved for publication as an impact evaluation in 1991.

Child Survival in Morocco, A.I.D. Impact Evaluation Report No. 79, Center for Development Information and Evaluation (PPC/CDIE), July, 1991.

III. INTRODUCTION

A. Purpose of Project Activity Completion Report (PACR)

The purpose of this report is to describe the accomplishments of Project No. 608-0171, Population and Family Planning Support III, USAID/Morocco (also called Phase III), and to outline suggestions for evaluation. Therefore, in accordance with A.I.D. Handbook No. 3 the elements of this report include but are not limited to the following:

- ◆ Project status at the time of the Project Assistance Completion Date (PACD), including the status of completion of various project elements (e.g., procurement, construction, technical assistance, training);
- ◆ A summary of contributions made by the Borrowers/Grantees (B/G), donors and participants (i.e., planned versus actual inputs);
- ◆ A brief review of project accomplishments in light of: 1) Conditions at the outset (initially planned outputs); 2) Expectations of the project design; 3) Changes in the project environment and/or design during implementation (including a comparison of revised outputs and actual outputs);

- ♦ Recommendations for final adjustments in project design;
- ♦ Definition of continuing and/or post-project A.I.D. monitoring responsibilities, including the timing and resources involved;
- ♦ A summary of lessons learned from the project that might be relevant to programming, design and implementation of other activities; and
- ♦ A review of data collection results and evaluations.

B. Methodology

The process of completing this report included the analysis and synthesis of available written materials concerning project activities and interviews with individuals who participated in project implementation (see Appendix VII).

While the intended purpose of this report is to define the accomplishments of the Project, the report also seeks to set the stage for final evaluation by recommending topics for post-project consideration. The topics recommended will be based on the following:

- ♦ What did the project accomplish in terms of its implementation and operations targets?
- ♦ What impact has the project had or is expected to have? How does this compare with intended impact?
- ♦ Are the financed activities viable in light of ongoing development priorities? Should any activities be expanded, replicated or redirected? Should A.I.D., or perhaps another donor, be encouraged to participate in the expansion, replication or redirection of the activities identified?
- ♦ What new development opportunities did the project create and what might, if acted upon, accelerate the realization of benefits, or be the next step in the development sequence?

IV. PROJECT BACKGROUND

Population and Family Planning Support III (608-0171) was a seven-year project initiated in 1984 with a Project Assistance Completion Date (PACD) of September 30, 1989, and subsequently extended to September 30, 1991 with a PP supplement and two PP amendments. The goal of the project was 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. The project was designed to strengthen the Government of Morocco's (GOM) capacity to plan, implement and evaluate cost-effective population and child survival programs by providing technical assistance, training and commodities. Program components focused on the extension of the successful family planning/child survival outreach program, Visites a Domicile de Motivation Systématique (VDMS); increasing accessibility to fixed facilities; improving training and management capabilities of the Ministry of Public Health (MOPH); and utilizing research for program planning and development. Often described as an "umbrella" project, its purpose included four major components:

1. Establishment of availability of family planning (FP) information and services for 70% of the Moroccan population;
2. Attainment of contraceptive prevalence of 35% of married women of reproductive age (MWRA);
3. Introduction of population planning, analysis, modeling and forecasting methods into the GOM development process; and
4. Improvement of maternal/child health (MCH) status.

While Phase III primarily sought to strengthen MOPH programs, it also strengthened private sector involvement in FP service expansion. Private sector activities were conducted by the local IPPF-affiliate, Association Marocaine de la Planification Familiale (AMPF), the Morocco social marketing program for condoms and Oral Rehydration Salts (ORS), and factory-based activities.

The Project was initially authorized in FY 1984 at a level of \$5,260,000. The initial Project Agreement was signed in August, 1984 for \$3,555,000, and was amended nine times. The following table summarizes project obligations:

DOCUMENT	DATE	PROJECT FUNDING	COMMODITIES	TOTAL FUNDING
Grant Agreement	8/7/84	3,555,000	1,655,000	5,210,000
Amendment # 1	3/29/85	2,430,000	1,000,000	3,430,000
Amendment # 2	5/19/86	1,300,000	1,900,000	3,200,000
Amendment # 3	8/22/86	2,000,000	-	2,000,000
Amendment # 4	8/29/86	1,000,000	-	1,000,000
Amendment # 5	6/30/87	485,000	1,100,000	1,585,000
Amendment # 6	8/21/87	1,500,000	-	1,500,000
Amendment # 7	8/31/87	1,400,000	-	1,400,000
Amendment # 8	6/13/88	1,500,000	-	1,500,000
Amendment # 9	7/28/88	2,180,000	1,320,000	3,500,000
OPG with AMPF		1,885,000	-	1,885,000
GRAND TOTAL		19,235,000	6,975,000	26,210,000

In August, 1986, a Child Survival component was added to the Project as described in the Project Paper Supplement. An additional \$2 million dollars of earmarked funds was added to the project at that time to fund Expanded Program of Immunization (EPI) activities. This component specifically supported an activity that was begun by the MOPH in 1981 with assistance from the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), and included four basic vaccinations: DPT, BCG, polio and measles. The initial success of this project laid the foundation for the PP supplement to 608-0171, especially for procurement of necessary items for EPI in hard-to-reach rural areas. Procurement included: vaccine stocks, vehicles and "cold chain" equipment and supplies for facilities. The child survival component was added to the VDMS infrastructure because of the already successful activities in the VDMS areas, the assistance described in the PP supplement eventually developed into a comprehensive program of child survival interventions including vaccination, diarrhea control, nutrition, growth monitoring, and pregnancy and birth monitoring. Additional A.I.D. inputs financed sterilization materials, printing, training, mass media and motivation.

In August, 1987, the Project Paper was further amended, and an additional \$3 million added to continue child survival activities, increasing the LOP funding level to \$22,890,000. Analysis of the 1987 Demographic and Health Survey data revealed that high infant and child mortality could be addressed with increased focus on vaccination, diarrheal control and nutrition interventions, owing to the high incidence of death from diarrhea, tetanus, dysentery and infectious diseases. These funds were used to purchase vaccines, vehicles and to finance the promotional support associated with this campaign. The 1988 Midterm Evaluation remarked on the success and organization of this media

campaign, but what was perhaps most significant was the heavy support from the King of Morocco for the activity. A.I.D. also promoted the increased use of oral rehydration salts; financed improvements in the MOPH's growth monitoring and nutrition rehabilitation program; and supported improvements in fixed facilities for the MOPH's pregnancy and birth monitoring program. The VDMS component was servicing 28 provinces and urban prefectures representing 70% of the country's population at that time.

In July 1988, the PP was amended again, adding \$4,320,000, and bringing the LOP funding level to \$27,210,000. These funds were designated as follows: \$500,000 for Child Survival; \$500,000 for AIDS activities; \$2 million for Family Planning; and \$1.32 million for contraceptives. Support was provided for the following: a) fieldworker mobility; b) commodities logistics management and supply; and c) improved family planning and MCH services. This amendment also extended the PACD to September 30, 1991. This final amendment set the tone for the final two years of the project.

Summary of Project Funding Authorizations

Description	Amount	Date
Initial LOP Funds:	\$17,890,000	1985
Child Survival Earmark:	2,000,000	1986
PP Amendment #2	3,000,000	1987
PP Amendment #3	4,320,000	1988
<hr/>		
TOTAL:	\$27,210,000	1991

Since Phase III is the third installment of a two-decade effort to build a strong population program in Morocco, a brief review of phases I and II follows.

A. Project History

The Government of Morocco has maintained an official family planning program since 1966, although organizational problems and political sensitivity inhibited its implementation during its first 15 years. The 1968-1972 Development Plan set a target of 500,000 new contraceptive acceptors during the five-year period; less than 20% of this goal was achieved. The 1973-1977 plan revised the target downward to 391,400 acceptors, and about 75% of this goal was achieved. Following an interim plan (1978-80) without a specific FP objective, the

1981-1985 Plan called for the attainment of a contraceptive prevalence rate of 24% of married women of reproductive age (MWRA) by the end of the plan period. It was during this most recent planning period that the MOPH began to seriously pursue its own family planning (FP) objectives. The prevalence target for 1985 was achieved by 1983, and since that time, contraceptive prevalence rates have exceeded projected targets.

USAID/Morocco has supported family planning activities in Morocco since 1971 with the advent of its first sector project, or Phase I of the population program. There has been a substantial increase in FP activities around the country during the period of USAID involvement. Health and population indicators have shown improvements linked to project interventions. A brief outline of population activities supported by USAID follows:

Phase I: FY 1971-1977 Family Planning Support (608-0112) Project

(Project funding: approximately \$3 million dollars over a seven-year period).

Achievements:

- * 13 provincial family planning reference centers were constructed.
- * An MOPH family planning headquarters in Rabat was established.
- * USAID purchased contraceptives, supplies, and equipment for the national FP program.

Weaknesses:

- * Only physicians prescribed contraceptives, requiring full physical examinations in a hospital or clinic. Many women could not afford to either travel to hospitals or clinics or to purchase the services of a physician.

End of 1978 Status:

150,000 contraceptive users	= 5% of MWRA served by the public sector
200,000 contraceptive users	= 7% of MWRA served by the private sector

350,000 total users	= 12% of MWRA of population

Phase II: FY 1978-1983 Population/Family Planning Support II (608-0155)

(Project funding: approximately \$11 million including \$6 million in centrally-managed funds, over a five-year period.)

Phase II had three major objectives: increase contraceptive prevalence; increase the population awareness and commitment of key GOM officials and opinion leaders; and generate new demand for FP services.

To achieve these objectives the project supported eight activities:

1. Completion of the VDMS pilot program begun in the Marrakech region;
2. Expansion of household delivery (VDMS) services to ten provinces (later this increased to 13 when three of the original ten provinces split into two);
3. Construction and equipping of ten additional Family Planning Reference Centers;
4. Development of the professional skills of key GOM and private sector personnel (participant training);
5. Improvement of FP service availability in MOPH health facilities (provision of contraceptive supplies);
6. Establishment of a commercial distribution program;
7. Establishment of a national Information, Education, and Communication program rooted in the private sector; and
8. Realization of a national fertility and family planning survey.

Four additional project components were later added:

1. RAPID (Futures Group) computer simulations of the development impact of demographic trends;
2. Establishment of a National Training Center for Reproductive Health in Rabat (USAID, AVSC, JHPIEGO);
3. Completion of a Contraceptive Prevalence Survey (USAID, Westinghouse); and
4. Development of a communication/FP training module for Nursing and Midwifery Schools (USAID, INTRAH).

Among the most significant of these activities was the VDMS Marrakech Pilot project. Its success set the stage for the primary focus of Phase III, especially the GOM's role in service delivery. From 1978-1980, USAID assisted the Ministry of Public Health to test the feasibility of household-level delivery of contraceptive services. Trained health workers made two home visits to virtually all women aged 15-44 in Marrakech province at three or four-month intervals. The

health worker asked families about their contraceptive practices and fertility; explained various contraceptive methods, and provided a four to five month supply of oral contraceptives or condoms. If there were problems concerning contraception, the women were referred to the nearest MOPH facility. At a subsequent visit, health workers reviewed any problems previously identified.

The Marrakech pilot project proved so successful that it was expanded to additional provinces. It demonstrated that family planning training at the paramedical level, combined with increased availability of contraceptives, laid the groundwork for effective service delivery. Client acceptance rates approaching 60% revealed high rates of unmet need. With the expansion of the household visit program other basic health care services were added. USAID was in agreement with the political and practical basis for this decision, given that the health workers' household visits might represent the only likely contact between the MOPH health delivery system and much of Morocco's rural population. As a result, USAID and MOPH developed a "package" of integrated services in conjunction with the population and health outreach program. This "package" included:

- * Contraceptives (pills and condoms, referrals for IUDs and sterilizations);
- * Oral Rehydration Salts (ORS), health worker training and client counseling;
- * Diet supplements for pregnant and nursing women;
- * Promotion of breastfeeding and good weaning practices; and
- * Immunization verification and referrals.

These services laid the groundwork for the Child Survival component added to Phase III in 1986, and had a measurable impact on Morocco's health status indicators.

Also significant during this phase was the construction of the National Training Center for Reproductive Health (NTRH). The former Rabat Maternity Hospital was renovated and equipped to serve as a family planning reference center, offering services for maternity, obstetric-gynecologic and family planning clients, and to provide training for medical and paramedical personnel in surgical techniques for reproductive health. In 1983, the center was designated an international training center by JHPIEGO, and began to accept trainees from all over Africa and the Middle East.

Key Achievements of Phase II:

1. The contraceptive prevalence rate rose to approximately 27%, or more than double the 1978 level;
 2. Heightened awareness of family planning, especially in the public sector, occurred.
- The prime example of this increased awareness

was illustrated by the inclusion of FP targets in the 1981-1985 GOM Five Year Plan;

3. Increased availability and accessibility of FP services took place. As of 1984, 1200 MOPH facilities provided FP services, compared to 300 facilities in 1978. Moreover, these services were primarily provided by paramedical personnel, rather than physicians.

Weaknesses:

- * The MOPH carefully guarded control of pharmaceutical distribution, and continued to oppose the role of the commercial sector in contraceptive sales.
- * There were some delays in expansion of services, including construction of the ten reference centers and VDMS expansion.

B. Initial Conditions for Phase III

Though the family planning program was potentially very strong at the outset, with a contraceptive prevalence rate of 27% in 1983, and crude birth rate (CBR) and child mortality on the decline, the project faced several challenges:

Coverage: The Ministry of Public Health utilizes a system of hospitals, reference centers, health centers, and dispensaries with a vertical referral system as well as the VDMS outreach program. In 1984, existing MOPH fixed facilities and field workers serviced only 40% of the Moroccan population. The challenge was to increase coverage, especially in rural areas.

Exclusivity: There was little private sector involvement. The Moroccan Family Planning Association (AMPF) had been operating in-country two years before the GOM adopted a family planning program. In 1984, however, private sector potential had yet to be fully exploited.

Vision: The challenge remained to raise the awareness of the GOM concerning population growth and then adequately integrate population programs into GOM planning and policy-making.

Fragility: At the beginning of the project, family planning programs did not have a strong infrastructure. The project would seek to provide infrastructure and institutionalize FP facilities and programs.

C. List of Project Inputs

U.S. assistance included financing for long- and short-term participant training, technical assistance, contraceptive and other commodity purchases, and local cost support.

Training fell into two broad categories, training and invitational travel. Smaller categories consisted of U.S./third country and in-country training. Appendices III and IV provide detailed information regarding training activities financed.

Technical Assistance was financed via A.I.D. direct contract and buy-ins to centrally-managed projects.

Commodity Purchases included contraceptives, medical/surgical equipment, data processing equipment and software, fieldworker supplies, IEC supplies, weaning food, and miscellaneous materials. Appendices II and IV summarize project-financed commodities.

Local Cost Support financed the start-up and in-country operating costs of the various projects components. Activities that required significant local support included VDMS, Urban Services, and Private Sector activities.

Project Financing by Input (Source: Project Agreement, as amended)

Technical Assistance	:	\$2.135 million
Commodities (including contraceptives)	:	\$14.348 million
Training	:	\$ 2.05 million
Local Cost Support	:	\$ 1.885 million
Other Costs	:	\$ 5.172 million
Contingency	:	\$ 620 million
Total		<hr/> \$26.210 million

D. List of Project Outputs

Four key activities were established as objectives for Phase III:

1. Increasing program coverage, adding and expanding GOM/FP service modalities in additional areas of the country;
2. Establishing new service modalities, particularly in the private sector;
3. Elevating population concerns in the GOM development planning process, particularly in association with the Ministry of Plan; and
4. Continuing/consolidating major elements of the

program "base" to ensure effective institutionalization.

Initially, twelve Outputs, or elements were developed to address these objectives, with a thirteenth Output added in 1986 through the Child Survival Program. At that time, a Project Paper supplement was developed describing the added activity and adding the fourth component of the Project Purpose: to improve mother and child health status. Therefore, the project elements included:

- ² 1. Expansion of VDMS from 13 to 18 Moroccan provinces;
- 2. Establishment of family planning/health outreach services in major urban areas;
- 3. Improved training and services at the National Training Center for Reproductive Health, an already existing training facility;
- 4. Establishment of voluntary sterilization/reproductive health services in 30 provincial hospitals;
- 5. Improved information, education and communication (IEC) programs in the GOM and private sector;
- 6. Improved family planning services availability through all clinics and outreach programs;
- 7. Establishment of a contraceptive sales program in the private sector;
- 8. Establishment of a natural family planning program in the private sector;
- 9. Establishment of family planning information and service activities in other GOM ministries and agencies;
- 10. Improved operations research, data collection and analyses;
- 11. Improved population analysis and planning in the Ministry of Plan;
- 12. Improved technical and management skills; and

² Activities marked with (•) denote components begun under the predecessor project, phase II -- 608-0155, which are being continued under this follow-on project. All other activities were initiated under this project. All activities are described in detail in the Sub-project Review section of this report.

13. Provision of a program to support the MOPH's Expanded Program of Immunization (EPI) and other child survival activities.

E. Summary of Borrower/Grantees, Donor, Consultant Activities

Moroccan Cooperating Institutions:

Ministry of Public Health (MOPH)

USAID's GOM counterpart agency for phase III was the MOPH. The majority of MOPH activities have been and still are focused on outreach activities and institutionalizing of training in family planning/reproductive health services. The Project Paper describes the MOPH's planned contributions as "paramedicalization" of FP services (including insertion of IUD's by nurses); the initiation of sterilization training and services; delivery of FP services to individual households; and promotion of print and broadcast media in support of family planning. With the addition of the Child Survival component, the MOPH became actively involved in the design and implementation of EPI and other child survival activities.

Association Marocaine de Planification Familiale (AMPF)

AMPF, the local International Planned Parenthood Federation (IPPF) affiliate, is the most active private voluntary organization involved in Morocco's family planning sector. USAID assisted AMPF to implement its family planning strategy. Even though AMPF existed before the GOM implemented a formal FP component, FP representation in the private sector was negligible. The major private sector activity planned under Phase III was to be a contraceptive sales program. The AMPF provided the program infrastructure for sales of contraceptives and health products in villages, urban areas, and rural souks or markets. AMPF was also responsible for the development of IEC messages and activities to promote family planning.

L'Heure Joyeuse

This Moroccan PVO managed the natural family planning program in the private sector.

Moussahama

Moussahama is a local marketing company and actively associated with the social marketing campaigns financed by the project.

Major Contractors/Cooperation Agencies:Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO)

JHPIEGO was contracted to complete the training for family planning (GYN/Obstetrics), tubal ligation and laparoscopy for doctors, nurses, and anesthesiologists in collaboration with the National Training Center for Reproductive Health. Moroccan trainees were also sponsored to JHPIEGO's training facility in Baltimore. JHPIEGO also designed a training course instructing the MOPH on how to decentralize training capacity to nine regional centers. Decentralization is intended to promote institutionalization of training capacity and development of a cadre of skilled trainers nationwide.

RONCO Consulting Corporation

USAID contracted directly with the RONCO Consulting Corporation in 1985 to provide in-country training support and related short-term technical assistance to strengthen various aspects of the MOPH's family planning services program. RONCO provided the following: a) fieldworker training programs for the expansion of VDMS; b) provincial-level physician communications training; c) in-service training for VDMS workers from existing provinces; d) communications training for paramedical staff from the Ecole des Cadres; e) and management information systems training for staff in the Ministry's Family Planning Service.

Westinghouse Applied Health Systems

Westinghouse assisted the MOPH to design, carry out, analyze and report its most recent Demographic and Health Survey, completed in 1987.

John Snow, Inc. (JSI)

JSI was contracted through a buy-in to the centrally-managed Family Planning Logistics Management contract to provide technical assistance in the management and maintenance of contraceptive stocks. Commodities logistics became a very important component of Phase III. In 1988, JSI, in collaboration with the MOPH, completed an in-depth assessment of the MOPH family planning and logistics management system. The findings of the assessment correctly predicted a sustained increase in demand for all contraceptives during the 1988-1992 GOM Plan period. JSI recommended increased storage space and provided logistical training to MOPH staff.

The Futures Group

The Futures Group was responsible for three key activities during Phase III: the OPTIONS package of indicators and information; RAPID, a population growth computer simulation; and SOMARC, a contraceptive social marketing program. Through OPTIONS, the Futures Group assisted the MOPH to analyze available demographic and related FP/MCH program cost data, equipped the Ministry with microcomputers and software, and assisted the MOPH to effectively incorporate these data in its program planning, budgeting, project monitoring and technical/financial presentation activities. Futures also developed a desk top publishing training program that enabled the MOPH to prepare more and higher-quality presentational materials, as well as IEC and training materials. In conjunction with the GOM, the Futures Group created a computer simulation of projected population growth for policy-level discussions. Through a subcontract with RAPID, Futures staff assisted the USAID/Morocco to present a financial sustainability strategy to GOM policy-makers. Futures also developed tools used to explore the implications of alternative strategies which were employed in conjunction with policy dialogue.

The Futures Group is also the umbrella contracting organization for SOMARC, the centrally-managed Contraceptive Social Marketing Project. SOMARC provided technical assistance, commodities, and local cost support for the development of private sector family planning product sales activities. SOMARC launched the very successful PROTEX condom sales program during Phase III.

U.S. Bureau of the Census (BUCEN)

USAID contracted with BUCEN for technical assistance designed to enhance the utility and timeliness of statistical analysis at the Department of Plan, Office of Statistics through the effective use of microcomputers for data entry, program development, data editing and tabulation, statistical analysis, graphics, word processing, and spreadsheet applications.

Columbia University

Columbia University was initially contacted to design and develop operations research activities. A needs assessment was completed but a comprehensive operations research program was not established.

Association for Voluntary Surgical Contraception (AVSC)

AVSC signed a subagreement with the NTCRH to promote the availability and accessibility of surgical reproductive health services. Through this agreement, AVSC managed the voluntary sterilization component of NTCRH as well as sterilization

programs at fixed centers nationwide. AVSC also supplied institutional reimbursement, and promoted high quality services by providing on-going supervision for trainees in surgical contraceptive programs.

John Hopkins University/Population Communication Services (JHU/PCS)

JHU/PCS was contracted to advise regarding various IEC activities directed to improving the quality and impact of MOPH family planning education and promotional activities. JHU/PCS employed its expertise to develop a national IEC strategy, a module for training of trainers in interpersonal communication, and a FP logo. PCS also financed a study on myths and rumors associated with FP practices and contraceptive use; assisted in the design of brochures and materials on contraception for women; and aided in the design of FP educational messages for radio and television broadcast.

Population Services International (PSI)

PSI was contracted to assist in the social marketing of an oral rehydration salt, BIOSEL.

Hahnemann University

Through an IPA agreement with A.I.D., Hahnemann University provided a Technical Advisor for AIDS and Child Survival (TAACS) to assist USAID/Morocco in the design and management of its technical assistance activities.

Contributions of Other USAID Programs:

The Title II Food for Peace Program funded the preparation and transportation of a weaning food to the MOPH distribution points. The Program also donated funds for a nutrition education campaign. Monetization funds were also used to finance the repair, disinfection and equipping of fourteen provincial warehouses used to store weaning food; training of central office and field personnel; and supervision and evaluation of the Ministry's program for the prevention of nutritional deficiency diseases.

Contributions of other donors:

Major donors: UNFPA, UNICEF, WHO, Rotary International. Other donors active in Morocco during Phase III include UNICEF, UNFPA and WHO. UNICEF actively supported development and implementation of a broad range of child survival activities including immunization, nutrition and diarrheal disease programs. UNFPA support included assistance to the MOPH for service delivery, data collection and management training programs. UNFPA also took the lead in assisting the MOPH to revise and implement a nationwide management

information system, and has provided technical assistance and training in support of the two-year masters -equivalent training program at Morocco's National Institute of Health Administration, INAS. WHO has provided financing for seminars and short-term training supporting sector objectives. Rotary International provided financing for vaccines used in Morocco's immunization campaigns. USAID has worked closely with each of these donors to assure complementarity of programs and to minimize duplication of efforts.

V. REVIEW OF PROJECT ELEMENTS

The Project Paper described an ambitious schedule to meet stated objectives, and project implementors achieved, if not surpassed, expectations by PACD. The project was not without problems, however. Owing to the broad scope of this project, this report will detail findings by project element. These findings include a description of each activity, projected impact, actual accomplishments, and final recommendations for each of the 13 project elements.

Element N° 1: VDMS Expansion.

Description: The "Visite à Domicile de Motivation Systématique" is one of the principle service delivery modalities employed by the Family Planning Program. It provides integrated family planning and MCH preventive services. Under this program, MOPH nurses provide family planning counseling and supplies and MCH services including (1) promotion and supply of oral rehydration salts; 2) nutrition surveillance; 3) breastfeeding promotion; 4) immunization referral; 5) and weaning food and iron supplements on a house-to-house basis in communities surrounding rural dispensaries and urban areas. At the beginning of Phase III, VDMS was operational in 13 provinces.

Projected Impact: Under Phase III the VDMS component was to be expanded to 18 of 49 Moroccan provinces, based on the premise that VDMS had special potential to decrease fertility and to improve health. The 13 provinces in which VDMS operated in 1984 contained 40% of the country's population; the planned expansion would serve 70% of the population.

Actual Accomplishments: By 1988, VDMS was operational in 31 provinces. The 1987 Demographic and Health Survey indicated that contraceptive prevalence was higher in areas served by VDMS, with a prevalence rate of 27% in VDMS rural areas as opposed to 17% in non-VDMS provinces. The outreach program also had an impact on child health status by increasing the numbers of children immunized and having access to other integrated health services. Studies indicated that infant mortality began to decline faster in VDMS provinces than elsewhere. The program appeared to increase contraceptive prevalence nationwide by extending services to underserved populations. The integration of health services

into VDMS also increased the program's impact on Morocco's primary health care system. By 1991, the outreach program was effective and operating in 40 provinces and 8 urban prefectures, serving more than 80 percent of the population.

Problems: Two valuable evaluations, the 1988 project midterm evaluation and the EXPERDATA VDMS evaluation revealed constraints to effective VDMS program implementation. One of the most significant was that some VDMS outreach workers had incomplete or inaccurate knowledge about family planning. Another constraint to VDMS effectiveness was fieldworker mobility. In 1988, Phase III was amended to increase fieldworker mobility through provision of motorbikes and other equipment. Another problem was the rugged terrain the outreach workers travel through, making accessibility to some populations difficult. The project financed the purchase of 44 all terrain vehicles in response to this identified problem. The 1988 midterm evaluation also cited the lack of day-to-day trouble-shooting techniques among outreach workers, and also recommended a redesign of the kit a VDMS worker carries.

Recommendations: Though this program element is strong, efforts should focus on strengthening the referral, supervisory, and management systems of the primary health care system if family planning and preventive health service delivery is to remain effective. Based on recommendations from the EXPERDATA evaluation, the following program modifications took place:

- * Activities were managed so that populations were better targeted, i.e., urban middle class populations and populations near fixed facilities were eliminated as priority targets for services.
- * The Family Planning Logistics Management contract enabled the program to receive technical assistance and training in stock management, thus assuring improved contraceptive logistics management. Activities are continuing under Phase IV to ensure that efficient management systems are in place.
- * In a mobile strategy designed to increase coverage, meeting centers in inaccessible areas or "contact points" were established. This service strategy is continuing under phase IV.
- * The Ministry of Public Health organized in-service training for personnel, especially in ambulatory care and health education.
- * The materials and supplies carried by the VDMS

workers were improved and expanded. The VDMS bag was redesigned, and more supplies like ORS and contraceptives were added.

- * More studies were completed, and a management information system designed. The VDMS questionnaire for clients was redesigned, especially with regard to use rates of all contraceptive methods. A database of statistics was developed and a CYP study was completed.

Further Recommendations: Continue assistance to the VDMS outreach program under phase IV, with ongoing attention to supervision, referral and management.

Element N° 2: Establishment of FP/H Outreach Services in Major Urban Areas.

Description: This activity is a variation of the VDMS program, employed in urban areas. At the time of project implementation, the urban population represented 43% of the Moroccan population. In 1984, the urban population was growing at a faster rate than the rural population (4.4% and 1.4%, respectively). There was and still is a high rate of rural to urban migration, and continuing high birth rates in urban areas. Much of this urban growth is taking place in Morocco's major metropolitan areas of Casablanca, Mohammedia, Tangier, Méknés, Fez, Marrakech, and Rabat-Sale, and in particular, among populations that live in shanty towns within urban borders (or bidonvilles) in and around these urban centers. This activity illustrates the MOPH's intent to address the family planning and health problems of these populations. A VDMS-type (door-to-door) program was developed to serve the needs of urban communities.

Projected Impact: Initial activities included a pre-project planning session among MOPH staff and MOPH personnel at the prefecture level in consultation with municipal officials. Activities were tentatively scheduled to begin in the summer of 1985. The program was specifically designed to meet the needs of urban "slum-dwellers" and residents of the temporary housing in and around the country's three largest cities. Design of this project was very much like the design of the VDMS program, with a "package" of integrated FP/health services. AMPF was to provide a back-up referral system.

Actual Accomplishments: Family planning outreach services were established in eight urban prefectures. Door-to-door servicing was subsequently eliminated in urban areas because studies showed that urban residents already knew about family planning and mother and child health, and that the population lived near fixed facilities serving its needs.

Problems: The urban VDMS outreach program worked as well

as the rural program, but was found not necessary. The service was discontinued.

Element N° 3: Improved Training and Services at the National Training Center for Reproductive Health (NCRH).

Description: The NCRH provides comprehensive services for maternity, obstetric-gynecologic and family planning clients, and provides training for medical and paramedical personnel in surgical techniques. In 1983, the NCRH was designated by the Johns Hopkins University Program for International Education In Gynecology (JHPIEGO) as an institutional training facility. The joint JHPIEGO-NCRH program then trained candidates from other Francophone and Arabic countries in Africa and the Middle East. The NCRH also conducts operations research on new techniques of fertility management; provides continuing technical supervision and oversight of provincial health personnel trained at the Center; and operates a repair and maintenance unit for the surgical and diagnostic equipment (laparoscopes and laparocators) in use throughout Morocco. The NCRH receives financial and commodity assistance through JHPIEGO and AVSC.

Projected Impact: The NCRH was expected to train more than 150 Moroccans and international physicians in techniques of reproductive health and surgical contraception, perform approximately 5,000 surgical procedures, and was to have established itself as a national center of excellence in training, services and research in family planning/reproductive health. The NCRH was also expected to play a major role in the initiation and continued technical oversight of the sterilization activities described under Element number 4, below. The Center was expected to train hospital personnel responsible for sterilization program activities, provide refresher training, monitor the performance of hospital staff, and repair/maintain laparoscopic equipment distributed to participating hospitals.

Actual Accomplishments: During the 1983-1991 period, the NCRH completed a broad range of training programs and reproductive health procedures. A recent evaluation reveals the following information: the 30-bed obstetric unit completed 4,000 deliveries and 2,000 prenatal consultations; in the 30-bed gynecological unit, 3,000 interventions were performed with 4,000 outpatient consultations; the family planning unit performed 30,000 consultations, completing 1,000 tubal ligations and 20,000 IUD insertions and oral contraceptive prescriptions combined. In the emergencies unit, 6,000 consultations with 1,000 actual interventions were performed. Over the total seven-year period, 433 nurses and 295 doctors were trained. Of these, 159 doctors and 226 nurses were Moroccan, with the remaining 136 and 207 from other African

countries.³ The training sessions covered IUD insertion, laparoscopy, and anesthesiology for both physicians and nurses. The NTCRH developed a university model training facility which will provide technical assistance and back-up for a more decentralized program during phase IV. Until recently, the NTCRH was the sole provider of training for family planning, IUD insertion, and sterilization, limiting its capacity to provide technical assistance to the MOPH in supervision or management.

Problems: Though the NTCRH has increased the availability of clinical family planning services in Morocco, especially tubal ligation and IUD insertion, the 1988 evaluation pointed out that at least one of the goals stated by the PP, a decline in the proportion of oral contraceptive users, was not reached. Indeed, pill usage increased from 75% of contraceptive users in 1984 to 80% of users in 1987 and 1992. This extensive reliance on the pill was one of the major criticisms of the 1988 evaluation team: "Although 43 percent of Moroccan married women want no more children at all, only 3 percent of married women use IUDs and only 2 percent have had tubal ligations". The evaluation called for a broader contraceptive mix, with emphasis on the use of long-term and permanent contraception, bringing the responsibility for addressing this recommendation into NTCRH's realm.

Recommendations: As a result, the mid-term evaluation made several recommendations concerning clinical family planning services:

- * A revised protocol for IUD insertion that would accommodate minimal amounts of equipment and space and address issues pertaining to vaginal infections, quality of resources and physical infrastructure.
- * An assessment of in-service training needs for nurses and other paramedicals in IUD and sterilization techniques. IUD training should be carried out on a regional basis with second level training conducted by midwives, nurses or physicians during a one-week session.
- * Postpartum IUD insertion should be considered.
- * The necessary equipment for IUD insertion should be purchased for maternities.
- * The NTCRH should continue training in quality female sterilization procedures, including mini-laparotomy.
- * Consideration should be given to opening

³REDSO funded the training of African doctors.

additional training centers specializing in mini-lap, with laparoscopy as a secondary method.

- * The referral and follow-up system for IUDs and sterilization should be strengthened. A small scale operations research effort could identify efficient and effective methods to manage referral and follow-up procedures.
- * The MOPH should play a stronger role in coordinating IUD and sterilization training and service delivery provided by the University Ob-Gyn department, the NTCRH, and the reference centers and maternities.
- * The IEC strategy should be revised and targeted to promote a broader range of contraceptive mix.

Many of these recommendations were acted upon. The following actions were undertaken after the 1988 evaluation:

- * USAID and the MOPH are currently training 359 doctors and nurses in IUD insertion. Curriculum and protocols were developed for IUD and sterilization procedures using JHPIEGO guidelines. Training is also being conducted at a new regional training center established in response to the criticisms that training should be institutionalized.
- * Training will be decentralized to eight proposed regional training centers.
- * An assessment of in-service training of nurses and doctors in IUD insertion and sterilization procedures was completed.
- * Maternity equipment has been purchased from UNICEF.
- * Under Phase IV, physicians will be sponsored to go on mini-lap and Norplant study tours, as part of an effort to make mini-lap and Norplant available.
- * A research study on referral was conducted in 3 provinces from October 1990 to March 1991. Based on this study, a model referral system will be implemented and evaluated during phase IV.

- * The MOPH is considering decentralizing training for tubal ligation procedures in collaboration with JHPIEGO during phase IV.

Element No 4: Establishment of Voluntary Sterilization/ Reproductive Health Services in 30 Provincial Hospitals.

Description: A major responsibility of the NTCRH is to train physicians and surgical nurse assistants from throughout Morocco in surgical family planning techniques. The purpose of this training is to increase the availability and accessibility of surgical reproductive health services, including sterilization, diagnosis and treatment of disorders of the reproductive system, and treatment for infertility. The NTCRH training program itself represents the initial phase of this service-extension effort; this project element provided the financial, technical and material resources required to install and consolidate these services in provincial hospitals. Specifically, this project component provided medical equipment and supplies, funding for renovation of operating theaters and reimbursement for surgical procedures in 30 provincial hospitals. Support for this project component was provided by AVSC.

Projected Impact: This component was designed to increase the availability of reproductive health services, especially surgical procedures in the chosen provinces. The personnel who managed and this activity were primarily graduates of the NTCRH training program.

Actual Accomplishments: High quality VSC services were established in 34 provincial hospitals. At each site, services are provided on a routine basis. In 1990, over 4,500 VSC procedures were performed. Although presently at a plateau, VSC rates are expected to increase owing to increased training of physicians, and increased numbers of service delivery sites. In fact, training is underway and materials have been purchased to expand services to 17 new service sites. Based on operations research, a new referral system is being designed to promote access to VSC services.

Problems: An Operations Research study on the referral system indicated that the referral system itself was a barrier to the dissemination of FP information and the provision of FP services because of the many stops the client had to make (see problem discussion for Element 3). In some provinces, it is estimated that 50% of women who request services don't get them owing to the referral system, or lack of personnel.

Recommendations: Under Phase IV, a new referral system is planned in three provinces based on the OR study cited above. Training in tubal ligations and mini-lap is also planned for 60 teams of doctors, nurses and anesthetists. See Element No. 3.

Element N° 5: Improved Information, Education and Communication (IEC) Programs in the GOM and Private Sector.

Description: This project element involved both the public and private sector. In the public sector, USAID originally planned to assist the MOPH with three activities: 1) the development, pretesting and production of IEC materials; 2) equipping MOPH health facilities with basic audio-visual supplies and equipment; and 3) communications/motivation training for MOPH health personnel, particularly at the provincial level. Assistance was provided to the MOPH for print materials (poster, brochures, VDMS-related hand-outs), and to both AMPF and the MOPH for broadcast materials (radio, T.V. spots). A video studio was purchased and installed at the AMPF for its media activities. Similarly, USAID assisted the AMPF with development, pretesting, and production of IEC materials, with emphasis on broadcast and film materials, and also assisted with conferences, and the development of training programs in population and family planning. One component of the private sector IEC effort included the use of traditional media such as storytellers and folk troupes.

Projected Impact: This project component sought to raise national level awareness population, family planning and mother and child health, as well as increase the effectiveness of already established programs through training in communication.

Actual Accomplishments: Approximately 2,000 health workers and 450 physicians employed in clinic-based and outreach programs were trained in family planning communications techniques. The MOPH, AMPF and the social marketing program routinely aired family planning and health messages on both national and regional radio stations. AMPF negotiated an agreement with Morocco's communication agency (RTM) and has produced and aired several televised family planning educational messages. Finally, the MOPH, in conjunction with JHU/PCS, has developed an action plan for family planning program-related IEC training, materials development, and communication activities. A curriculum for training of trainers in communication skills has been developed and will be employed in the eight regional training centers during Phase IV. As a result of intensive IEC efforts, 98 percent of the population is aware of family planning methods. In the child survival arena, IEC activities played a successful role in motivating the nation's population to participate in immunization and ORS campaigns and on-going programs. Virtually all children under five were vaccinated at 11,000 sites throughout the country. The 1988 evaluation praised the efforts of campaign organizers, especially the MOPH, for using "a well-managed, targeted and systematic communications and mobilization strategy" (1988 Midterm Evaluation, p. 27).

Problems: While it is obvious that IEC efforts have attained a high level of success in terms of reaching projected goals, the program was not without problems. The 1988 mid-term evaluation identified several problems which have been addressed to some extent in the last three years. VDMS outreach workers were reluctant to communicate about the many different kinds of contraceptives available, saying that it was easiest to talk about oral contraceptives. It was observed that information provided regarding IUDs was not always correct. VDMS workers also spent too little time in the households they visited (15 minutes) for substantive communication to occur. In the private sector, AMPF activities often lacked clarity and focus. The 1988 evaluation describes AMPF activities, especially pretesting, as inadequate, with little attention of message impact or target audience. The television spots the AMPF produced did not impart a clear message. According to VDMS surveys, the mass media appears to have a significant impact on its audience; thus, systematic pretesting and reliable messages are essential. The MOPH Health Education Office also lacked clarity and focus in its IEC efforts. On the other hand, the social mobilization campaign for immunization had tremendous success, focus and clarity which suggests that organizations such as the Ministry of the Interior, Ministry of Education, Ministry of Health, RTM, UNICEF and USAID are capable of working together towards a common goal. Key factors that made a difference include the support of the King and strong leadership within the organizations developing the campaign.

Recommendations: The 1988 mid-term evaluation made the following recommendations regarding IEC:

- * The MOPH should analyze the effectiveness of the Health Education Division and its organizational ability to develop and carry out effective IEC activities. The MOPH's lack of clarity and focus on IEC related to family planning and contraception is part of the reason there is so much reliance on the pill as a contraceptive method.
- * An in-depth, systematic evaluation should be conducted on the impact of mass media and print materials that have been used to date in family planning. This should be completed prior to phase IV.
- * A fact-finding study about rumors and myths should be conducted.
- * AMPF should develop a clear strategy based on a systematic approach that complements MOPH activities. No equipment should be purchased for the organization until this occurs.

- * Consideration should be given to including a component in a new media strategy promoting the role of health personnel as providers of family planning.
- * IEC messages employed by health personnel should be modified to reduce over-reliance on the pill as a contraceptive method and to promote a diversified contraceptive mix.
- * A counseling module for training outreach workers should be considered under phase IV to increase this group's ability to mobilize communities.

To address these recommendations, USAID provided technical assistance to both the public and private sector, in collaboration with the Johns Hopkins University/Population Communication Services. PCS activities included the following:

- * Organization of a national IEC conference in 1989 entitled: Seminar National de Reflexion sur la Strategie d'IEC en Matière de P.F. au Maroc.
- * Development of a counseling module for training of trainers in interpersonal communication.
- * Development of a national family planning logo.
- * Organization of a qualitative study on myths and rumors in family planning and contraception.
- * Design of an oral contraceptive brochure targeted to illiterate women.
- * Assistance in the design of other broadcasting spots on radio and television.

Further recommendations: IEC is one of the weakest program components and should be a primary focus during Phase IV.

Element N° 6: Improved Family Planning Services Availability Through all Clinics and Outreach Activities (Commodities).

Description: The objective of this component was to maintain adequate, available contraceptive supplies for the MOPH family planning program. In 1986, the A.I.D./W Office of Population signed the Family Planning Logistics Management contract with John Snow, Inc. JSI provides technical assistance in the management of contraceptives and supplies,

including logistics and forecasting needs. Record-keeping is key to effective contraceptive stock management. Consultants from John Snow, Inc. assisted both the private and public sector to develop stock information systems. This logistics support brought the public and private sectors together concerning commodity availability and distribution.

Projected Impact: A.I.D. finances almost all commodities for the country. Estimates of contraceptive use over the LOP were based on projected increases in contraceptive use. Contraceptive use was expected to increase from 600,000 users in 1984 to approximately 900,000 users in 1988. Private sector use was expected to climb proportionately from 330,000 users in 1984 to 450,000 in 1988. The contraceptive mix was expected to change due to other activities in the program. For planning purposes, A.I.D. and the MOPH estimated a five-year contraceptive requirement as follows: 30 million monthly cycles of oral contraceptives, 8 million condoms, 300,000 IUDs and 3 million foaming tablets. With the addition of the child survival component, logistics support for commodities was expanded to include weaning foods, vaccines, packets of ORS, and scales for growth monitoring.

Actual Accomplishments: A central warehouse was constructed. Construction activities are underway for two family planning reference centers and garages. Construction will continue under the Phase IV.

Problems: Although consultants continue to aid USAID and the MOPH in the organization of a contraceptive tracking system, determining contraceptive needs and stocks is key to effective management. Stockouts, though infrequent, did occur during Phase III. USAID and MOPH must fine-tune contraceptive tracking management and needs forecasting as soon as possible.

Recommendations: The two most important recommendations are the construction of additional storage space and refinement of the contraceptive tracking system. Both of these activities are planned early in Phase IV. The 1988 midterm evaluation also recommended that the A.I.D. logo be placed on all family planning and health program commodities financed to reflect the breadth of A.I.D. support for primary health care in Morocco.

Element No 7: Establishment of a Contraceptive Sales Program in the Private Sector.

Description: The activities of this component are considered one of the major successes of the Project. The Project Paper gives a lengthy discussion of the conditions at the outset of the project. In 1984, the MOPH still kept a strong hold on contraceptive sales. By working with the MOPH, AMPF, the Futures Group, and several local contraceptive manufacturers and pharmaceutical companies, this project component has become large and effective. The AMPF portion of

the project was a non-pharmacy selling strategy which included the sale of contraceptives in rural areas through local agents who are residents, at kiosks in urban and semi-urban areas, and at exhibitions and booths at markets or souks.

A major component of the private sector effort is the Morocco Contraceptive Social Marketing Project (MCSMP) which began in 1988 at the request of the MOPH and USAID/Morocco. The primary objective of this activity is to strengthen the role of the private sector in family planning service delivery efforts targeted to low-income consumers. PROTEX condom social marketing activities were implemented under Phase III and are expected to continue during Phase IV. The social marketing program was developed by Moussahama, a local marketing firm. During 1988 and 1989, Moussahama, the Futures Group (SOMARC) and USAID devised a promotion and distribution plan for condoms. With the launch of the program in 1989, sales were phenomenal. By 1990, over 90% of Moroccan pharmacies and medical depots sold PROTEX. The program is expected to be totally self-sustaining (including condoms) by 1994.

A strategy for the social marketing of pills has been developed and will be launched by September, 1992. Discussions regarding social marketing of weaning food were initiated under Phase III and continue under Phase IV.

Projected Impact: Contraceptives were to be marketed in four provinces. It was hoped that contraceptive use would increase a considerable amount due to the increased availability of the product. Sales of the PROTEX condom alone were projected at 150,000 units during 1989, 1.1 million in 1991, 1.8 million in 1992, and 2.6 million in 1993. With the addition of oral contraceptives, the public/private contraceptive use ratio could shift from 70/30 to 50/50 in less than three years.

Actual Accomplishments: Implementation of the community-based contraceptive sales project was well underway in 1988, having been expanded beyond the original four provinces to include over 100 community agents in 12 provinces. The AMPF contraceptive sales project is backed up by mobile teams and fixed clinic sites and delivers at least 25% of all family planning services originating in the private sector. Sales of PROTEX exceeded all expectations. PROTEX condoms are now available in over 1500 pharmacies throughout the country and FY 1991 sales were approximately 1.8 million units, more than likely approaching 2 million.

Problems: Initial problems with the private sector sales program involved the reluctance of the Ministry to promote pharmacy-based contraceptive sales, especially of subsidized contraceptives. The MOPH feared opposition of pharmacies to the potential downward pressure on commercial prices for contraceptives, as well as the possibility of a cultural backlash to advertising accompanying the marketing effort.

The Ministry also stated that offering the public so many contraceptive choices would be confusing. The MOPH was also concerned about its own position as a contraceptive provider. MOPH reluctance has since eased.

Recommendations: The 1988 Midterm Evaluation recommended the following:

- * Private sector activities previously initiated should continue, but an in-depth evaluation of the impact of these activities should be completed prior to the final evaluation of the project. This evaluation should measure the impact of the private sector activities on use of MOPH family planning services, their effect in increasing availability of services and supplies not provided by the public sector, and their impact on contraceptive method mix, especially commercially-marketed oral contraceptives and condoms.
- * Additional monitoring and evaluation should be conducted on SOPHA's activities. Support to SOPHA need not continue, as the program is becoming sustainable at a local level.
- * Dialogue between the Ministry, USAID/Morocco and other government tranches should continue.

Further Recommendations: These activities should continue under the new phase.

Element N° 8: Establishment of a Natural Family Planning Component in the Program.

Description: This project component resulted from a population program assistance mandate supporting natural family planning (NFP) activities. In Morocco, USAID worked with L'Heure Joyeuse, a local PVO affiliated with the International Federation for Family Life Promotion and financed three main activities: 1) the training of lay-educators in the delivery of NFP services; 2) the diffusion of information and education in the use of the NFP self-observation method of regulating fertility; and 3) the training of trainers who will be capable of training other PVO personnel in NFP.

Projected Impact: To raise awareness of family planning nationwide and to provide a natural contraceptive method. Eight educators were to be trained during the course of this activity. Of these eight, four would be chosen as trainers of trainers, who would train personnel of other organizations interested in NFP. Information diffusion would be institutionalized within the organization.

Actual Accomplishments: The grant to L'Heure Joyeuse was

terminated and the NFP activity was transferred to AMPF which continues to utilize L'Heure Joyeuse staff. This activity is limited, mainly promoting periodic abstinence and the symptothermal method.

Problems: L'Heure Joyeuse ceased to exist as an organization.

Recommendations: Natural Family Planning should be continued as part of the AMPF program.

Element N° 9: Establishment of Family Planning Information and Service Activities in Other GOM Ministries and Agencies.

Description: Under this component, USAID was to support the development of family planning activities in ministries/agencies other than the MOPH. USAID funds were used for training and invitational travel grants for key personnel from various ministries/agencies; medical supplies and equipment to support the clinical FP activities of non-MOPH organizations such as the Caisse Nationale, the Office Cherifien des Phosphates, and the Office Nationale des Chemin de Fer; and seed money for various non-MOPH agencies to launch FP service activities. This component was designed to be closely linked to AMPF IEC activities to consolidate AMPF's continuing program for FP training for personnel of non-MOPH agencies.

Projected Impact: This project component sought to strengthen the linkages between MOPH personnel and other ministries such as Social Affairs and Agriculture, especially at the field level. It was also intended to provide training for personnel important to the project and the family planning program in general.

Actual Accomplishments: An example of the kind of cooperation and collaboration supported by this project component is the 1987 vaccination campaign. Several ministries and agencies worked together to produce a sterling effort and achieved the vaccination of almost all children under five. By the end of 1987, 650 Sociale Affairs fieldworkers ("monitrices") had received training in family planning motivation and referral. The MOPH and the Ministry of Social Affairs also issued formal directives encouraging field level cooperation between the employees of these two ministries. The Ministry of the Interior was also stimulated when USAID/Morocco provided its staff some well-done materials on childspacing through the American Ambassador. After the receipt of these materials, the Ministry requested that additional copies be distributed to all local offices.

Problems: No problems were found.

Recommendations: Collaboration should continue under phase IV.

Element N° 10: Improved Operations Research, Data Collection and Analysis.

Description: Operations research (OR) is an activity highly valued by the MOPH (based on original VDMS research), and a necessary activity for the program. Both the Project Paper and the original Project Agreement outline plans for OR and data collection activities. A list of studies were planned to inform project implementation. In addition, the development of a management information system, which included purchase of data processing equipment and software and provision of training was planned in support of OR.

The data collection and analysis component of this project element was designed to support OR activities as well. This included efforts to improve the scope, quality and utilization of population and health data.

Projected Impact: A vigorous OR program was envisioned to provide management feedback on selected aspects of the FP program, and to test modifications/additions to the project. Proposed research topics included: an examination of the potential role of traditional birth attendants (TBAs) as village-level FP agents; investigation of FP/MCH service delivery mechanisms in urban and squatter settlements; client understanding of user instructions for contraceptives, oral rehydration salts, and weaning food; tests of client charges and fees for services at MOPH health facilities; and assessments of the acceptability and feasibility of new contraceptive techniques and methods. A continuing series of mini-impact assessments of the differential effects of various program elements was also planned.

The data collection component was designed to produce effective reports. Two contraceptive prevalence surveys were planned during the IOP (one in 1986 and one in 1988) as well as analysis of data collected during the Morocco National Fertility Survey. A management information system was included in the project design to aid in the collection and analysis of FP/MCH data. An MOPH infant mortality and nutritional status baseline survey was planned for 1988. Additional research planned included: assessment of the quality and impact of the program's MCH interventions; collection of information on the prevalence of AIDS and other sexually-transmitted diseases; development of a clearer understanding of Moroccan sexual practices; and identification of key factors affecting IUD service program performance.

Actual Accomplishments: This project component was one of the weakest links in the project as a whole. Of the many OR studies proposed, only one--the study of delivery, acceptance and continuation of new contraceptives--is being considered, but under phase IV. A new MIS was designed and will be implemented under phase IV as well. This system is designed to collect data along the lines of VDMS component

programs. One contraceptive survey was completed, the A.I.D./Westinghouse Demographic and Health Surveys Project (ENPS 1987). It provided a wealth of information on contraceptive prevalence, practice, demand, and availability and coverage of family planning services and supplies. This study provided the basis for OPTIONS reports and RAPID presentations. The infant mortality study planned for 1988 was completed and analyzed in a final report, National Survey on Causes and Circumstances of Infant and Child Death, in August, 1989. This report is highly prized by Mission staff which gives some indication of the importance of data analysis to the project.

Problems: The collection, processing, analysis and presentation of family planning and preventive health data has encountered numerous problems during the course of project implementation. USAID assistance in the design and implementation of an automation system at the central level began in 1985, and experienced numerous problems related to computer hardware, software, and data quality control. A consultant review in 1987 stated that the computer in the family planning central office was overloaded with information, and that data produced were largely unusable for program management purposes. Though the VDMS program diligently collected data, there were major constraints to its actual analysis such as 1) lack of skills in family planning program analysis and monitoring, and 2) lack of microcomputer capacity to facilitate the task. Ongoing debate regarding appropriate indicators for accurate program analysis and measurement also stalemated work in data collection. The ENPS survey provided excellent data, but did not address data management problems. Findings from research studies conducted have not been consistently applied to program management and implementation.

Recommendations: The midterm evaluation suggested that "[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" (p. 36). New definitions need to be established regarding appropriate indicators of program performance and impact. Information needs to be tailored to meet the needs of Ministry officials in particular. Specific recommendations included:

- * A modified information system should be pretested in a pilot program in eight provinces.
- * Microcomputers, related software, and on-site training should be provided to the central family planning office and the pilot provinces. The midterm evaluation listed specific suggestions for hardware and software purchases.
- * A technical assistance team should be selected

that includes family planning specialists and information systems specialists with a strong practical orientation to field program management.

The first two of these recommendations were addressed during phase III, and the third is planned during phase IV.

Further Recommendations: OR should be consistently employed to diagnose problems and implement program modifications. OR activities should also be decentralized.

Element N° 11: Improved Population Analysis and Planning in the Ministry of Plan.

Description: Under the predecessor project (608-0155), the GOM conducted some preliminary examinations of population growth and its consequences across other sectors including education, health and agriculture. Activities financed included a RAPID project component, AMPF's series of conferences on population issues, and dissemination of Morocco's contraceptive prevalence survey results. A.I.D. also provided assistance via another project (Statistical Services--608-0162) with the Ministry of Plan to enhance the Ministry's capacity in population modeling, forecasting, and analysis. This project component supported GOM initiatives in the development of methodological and analytical foundations for an integrated approach to population as a development issue. Specific activities included the synthesis and analysis of census and survey data; development of computer simulations of population growth and impact; preparation of appropriate software applications; training in planning methodologies; and support for Moroccan participation in international conferences on population and development.

Projected Impact: This project component was developed to address project purpose number three, the introduction of population planning, analysis, modeling and forecasting methods into the GOM development process. The computer simulations developed in conjunction with the RAPID buy-in were especially intended to rally support for family planning programs among key government officials.

Actual Accomplishments: An interactive, multi-sectoral, microcomputer-based population projection model, along with sector-specific sub-models in health, education and employment, were developed to inform development planners in Morocco. The initial data generated by these models were used in 1985 to organize a National Population Seminar, and as inputs for preparation of the GOM 1988-1992 Development Plan. The MOPH has since developed a computer simulation which demonstrates the impact of the MOPH family planning and child survival program. This presentation has been used in many policy-level forums. The Demographic and Health Survey, conducted in 1987, continues to provide a wealth of information to decision-makers and program managers.

Problems: RAPID activities have had a very positive effect on the GOM, and are considered among the strongest elements of A.I.D.-funded technical assistance under 608-0171. There appeared to be one weakness: convincing the Ministry of Finance of the importance of population programs.

Recommendations: The 1988 Midterm Evaluation made the following specific recommendations:

- * Further USAID assistance in RAPID-type policy development and awareness modeling need not be continued under the new phase.
- * Future efforts, if continued, should be concentrated on policy implementation at the central level of government, especially on practical budgetary issues with the Ministry of Finance.
- * The MOPH should now be able to complete awareness-raising activities at the provincial and local level on its own, however USAID should continue to provide assistance as necessary.
- * The MOPH should canvass the Ministry of Finance on its own to place a high budgetary priority on population and family-planning related programs.

Element N° 12: Improved Technical and Management Skills.

Description: A.I.D. financed the development of various types of trained cadre needed to plan and implement an effective family planning program. Training was conducted in the U.S. and third countries as well as in-country. In-country training supported the development of population, family planning and health skills among several categories of personnel including nurses, administrators, physicians, statisticians, health educators, and non-governmental personnel including private physicians, pharmacists and social workers. Much of the U.S. and third country based-training was short-term.

Projected Impact: This project element was designed to support the broader objectives of the overall program and to ensure institutionalization and sustainability of family planning programs. Some examples of training included: in-service training for 1200-1800 physician-graduates serving their "obligatory service" (two years) to various GOM ministries and agencies; the development and installation (in collaboration with WHO/European Region) of a FP module in the Moroccan medical school curriculum; support for a MOPH-sponsored FP training program for private pharmacists; and provision of refresher training in FP and related activities for MOPH clinical and field personnel.

Actual Accomplishments: Training has been a major component of project components related to VDMS, AMPF, other Ministries, reproductive health and voluntary sterilization, and population policy. A summary of project-financed training is included in Appendices III and IV to this report.

Problems: No major problems identified.

Recommendations: See recommendations under Element number 1,2,3,4,5,6,8,10, and 13.

Element N° 13: Child Survival Component

Description: The Child Survival component of Phase III was added with the advent of the child survival earmark of \$2 million in 1986 for immunizations, and \$3 million in 1987 for diarrhea control and nutrition surveillance (including promotion of breastfeeding and good weaning practices). This project element cut across several other project components, and thus became an integral part of the project. The VDMS program provided the foundation for child survival and a package of child survival activities were added to its outreach services. These included: immunization, diarrhea control, nutrition, and pregnancy and birth monitoring. A new list of USAID inputs was formulated for this activity: vaccine, cold chain, sterilization material and vehicle procurement; printing; training, mass media; and motivation. The integration of child survival activities with family planning activities resulted in the program's capacity to offer services to women and children simultaneously. With one visit, a mother could now receive family planning advice and vaccinations for her children, treatment for diarrhea or other childhood diseases, and get nutritional information for herself and her family. In addition, the social marketing program feature a commercial sector effort in the marketing of weaning food and oral rehydration salts. This child survival component is being featured in Phase IV.

Projected Impact: This project component was designed to decrease infant and child mortality in Morocco as well as to affect the overall health of the population.

Actual Accomplishments: In January, 1991, a technical advisor for AIDS and Child Survival (TAACS) was placed on USAID/Morocco staff.

Immunization: A 1987 vaccination campaign launched in collaboration with the MOPH, WHO, UNICEF, Rotary International, and other Moroccan government and nongovernmental organizations was extremely successful. In three stages over three months, the campaign succeeded in providing the complete course of vaccinations to more than 1.2 million children and two tetanus toxoid doses to 1.6 million women of childbearing age. In addition, there was marked improvement in the health infrastructure: the number of fixed vaccination centers increased from 800 in 1987 to 1,800 thus

ensuring that ongoing immunization activities reach the vast majority of Moroccan children. In April, 1988, a nationwide survey of vaccination coverage indicated that 84% of children aged 12-17 were fully immunized. The 1989-90 MOPH Infant Mortality and Morbidity Survey was completed, providing valuable information concerning program strategy. This survey identified large numbers of children with neonatal tetanus, resulting in the decision to focus on tetanus during the 1992 vaccination campaign. Vaccine campaigns have been held annually since 1987. Documented vaccination coverage of children under five has risen from approximately 50% in early 1987 to over 90% in 1991. Incidence in childhood diseases has been markedly reduced and infant mortality has significantly decreased.

Diarrheal Disease: The National Oral Rehydration Therapy Promotion Campaign was held during July and August, 1988. Social marketing of oral rehydration salts--BIOSEL--was launched in the summer of 1990 and continues with a strong media campaign and successful sales.

Nutrition: A nutrition monitoring reference guide has been prepared, and training conducted to increase knowledge of MOPH workers and improve care. The Title II Food for Peace Program funded for the raw materials and transport of Actamine 5, a weaning food, and training. USAID/Morocco financed a conference that provided valuable information for planning activities. The VDMS outreach program carried out growth monitoring activities.

Pregnancy and Birth Monitoring: Many rural maternities were provided with commodities and equipment.

Problems: The A.I.D. Impact Evaluation Report on Child Survival in Morocco stated that the MOPH became more dependent on donor financing for critical and promotional activities. Mission staff have echoed this sentiment, stating that donor activities under the family planning program have included the purchase of materials with little control over the way they are used. This may raise issues in sustainability for future MOPH activities.

Immunization: There is a serious question about whether the program is sustainable without donor support.

Diarrheal Disease: New MOPH data from 1992 indicate that only 16% of the population use ORS. Problems in diarrheal disease control programs include infrequent and unavailable stocks of ORS in health centers.

Nutrition: There are concerns about reduced duration of breastfeeding by large numbers of women. Weaning foods will no longer be available under Title II.

Pregnancy and Birth Monitoring: Less than 25% of women

receive prenatal care or supervised deliveries.

Recommendations: The Impact Evaluation suggested several future directions for USAID/Morocco and its Child Survival program. They are as follows:

- * Privatization and decentralization in the family planning and health sector needs to be monitored. The GOM is exploring several ways to meet the demand for preventive health measures. Privatization and decentralization are becoming mainstays. While private sector activities are becoming more important, the public sector provision of health services, especially for poorer populations cannot be forgotten. The tendency of the GOM has been to decentralize public activities, transferring the financial burden for providing health care to local governments. This may not always be the best strategy.
- * Longer-lasting contraceptive methods must be emphasized. There is still an overdependence on oral contraceptives in Morocco. Contraceptives such as IUDs and implants need to be emphasized.
- * More diligence is needed in disease surveillance, particularly for neonatal tetanus. Despite the vaccination of some women of reproductive age, the effort needs more focus.
- * Priority needs to be given to pregnancy monitoring and prenatal care. Infant and child mortality surveys have revealed that many infant deaths are in fact neonatal deaths. An increased focus on pregnancy monitoring and prenatal care is recommended to try and decrease these incidents.
- * The IEC activities for all aspects of USAID/Morocco's Child Survival Program need to be strengthened.
- * More attention must be given to mobilizing additional public sector resources and to using existing resources more efficiently.

AIDS Activities

Planning activities were undertaken in IEC and epidemiologic follow-up will be implemented under phase IV. Health care workers were trained in AIDS-related symptoms and illnesses. USAID/Morocco financed participant training of MOPH and PVO personnel by sending them to international AIDS conferences.

Condoms for family planning have been readily available for AIDS and STD prevention. AIDS interventions are in keeping with family planning, especially interventions associated with sexually transmitted diseases (STDs). It is expected that AIDS-related activities will aid in the surveillance, monitoring, and treatment of STDs.

VI. POST PROJECT USAID MONITORING RESPONSIBILITIES

Project 608-0171 was one phase of an ongoing, long-term family planning and child survival program and, as such, the major recommendations outlined in this report will be addressed in the course of continuing project implementation.

In addition, the following actions have been or will be taken:

1. All questions regarding project financing will be resolved, and project-financed accounts will be "zeroed-out" by June 30, 1992.
2. End use accounting for all major commodities financed will be requested from the MOPH. This information will be distributed to USAID staff for spot checks during monitoring visits.
3. USAID will formally request that all project-finance long-term trainees be quickly and appropriately assigned positions by the MOPH.

VII. CONCLUSIONS/LESSONS LEARNED

At the time of the PACR, the project has achieved its goals and strengthened the weaknesses described at the time the project was initiated. Program coverage was greatly increased by the expansion of the VDMS program, and the establishment of voluntary surgical/reproductive health centers in 34 provinces. The Family Planning and Mother and Child Health program no longer suffers overall systematic weaknesses in either the public or private sector. Owing to the presentation of RAPID to government officials, the program has experienced expansion of vision and understanding about the effects of population growth. Finally, the program has a much stronger physical infrastructure, but still suffers from logistical and managerial problems. These problems are being addressed by construction and renovation of warehouses and Mother facilities as well as the establishment of nine regional training centers that aid in the institutionalization of family planning knowledge and training.

Each of the project's four purposes have been realized beyond expectation:

Family planning information and services are now available to over 80% of the Moroccan population.

- ♦ Contraceptive prevalence has reached 41.5%.
- ♦ The Ministry now benefits from strong leadership in family planning and child survival policy planning.
- ♦ There was outstanding improvement in mother and child health status nationwide as reflected by the 1987 immunization campaign, the 1987 and 1992 DHS reports and the Infant and Child Health Survey of 1988.

The 1988 Midterm Evaluation made five major recommendations:

- ♦ Broaden contraceptive method mix beyond the pill by strengthening clinical methods of contraception;
- ♦ Revise and target the IEC strategy at all levels;
- ♦ Redesign the family planning information system;
- ♦ Assure that the MOPH can assume recurrent costs of the VDMS program; and
- ♦ Expand Mission resources for project management, and consolidate future project activities.

The project grappled with most of these recommendations and measurable steps were taken to address them. The exception is the sustainability of the VDMS program by the MOPH. Although the Ministry now pays VDMS fieldworker indemnities as well as all salary, facilities, utilities, and basic recurrent costs to support the nationwide maternal and child health program, program funding has not kept pace with VDMS expansion.

Each component of the project is interactive with others; no one activity stands alone. In addition, there are key factors that have influenced the performance of all components, namely stalled economic growth, cultural and geographic barriers, leadership, the project's pragmatic approach to timing program interventions, donor coordination, and the condition of the private sector.

Sustainability

When Phase IV was designed in 1988, it was envisioned as the final phase of USAID assistance in the sector. Accordingly, the project design called for a planned phase-out of all assistance, including contraceptive commodities, by 1996. Towards this objective, the MOPH is progressively assuming responsibility for sector-related costs previously financed by

USAID/Morocco.

For instance, the MOPH is now financing most recurrent costs associated with service delivery programs. The bulk of USAID support has financed contraceptive commodities, other commodities and equipment, technical assistance, and training for service delivery and program management staff. Financing for contraceptive commodities beyond 1996 is a major issue to be addressed during Phase IV. In addition, increased GOM and private sector support for program operations will be required to sustain ongoing activities at current levels beyond 1996. Cost recovery, in both the public and private sectors, must therefore be addressed during Phase IV. Institutionalizing training and research capability must be a key focus during Phase IV if staff training and research are to continue at current levels.

Some important steps have already been taken to promote sustainability. The MOPH has decentralized management and decision-making for resource allocation to the local level, and is in the process of providing decentralized training of health staff at the provincial and lower levels. Cost-benefit analyses that were prepared early in Phase IV revealed project-financed activities are extremely cost beneficial. These analyses provide valuable information for ongoing discussions with Moroccan policy-makers and planners. The Child Survival Impact Evaluation stated that "an investment in family planning would be paid back in reduced public spending in health and education within only 2 years" (pp. 14-15). Finally, the increased involvement of the private sector in family planning programs reduces the financial burden on the public sector.

To further increase the efficiency of the population program, the Child Survival Impact Evaluation suggests that the use of fixed facilities and use of personnel be examined. The report's authors observed that many facilities were underutilized and were more expensive to operate than the VDMS program. The staffing system of these facilities is of concern. Recent hiring practices reveal a decrease in nurses while doctors continue to be hired for activities that can be completed by nurses. Finally, operations research should be taken more seriously, particularly at the local level. Testing of alternative ideas should be encouraged. Operations research might also examine the impact of cultural and geographical barriers on program interventions.

The Child Survival Impact Evaluation listed Lessons Learned from the Moroccan experience. They include:

- Providing a number of child survival interventions as a package is more effective than offering each separately. The integrated VDMS outreach program proved highly effective.

- Giving priority to family planning and immunization is a valid strategy for a Child Survival Program. Both interventions are effective strategies in dealing with child mortality and morbidity. The Moroccan program combined the two in several project elements.
- Careful phasing-in of activities can lead to a more successful program. The Morocco program has been a series of phases, each with its own characteristics. The success of the family planning and child support program has happened over time.
- The Morocco model is replicable--but its success cannot be divorced from the context in which it functions. Morocco represents its own mix of social, economic, and religious characteristics to which these particular program approaches seem particularly well suited.
- A family planning program can be successfully initiated even in the absence of a stated public policy, however it is strongly suggested that the public sector approve of and be involved in program initiation and maintenance.⁴ Had the Morocco program waited for legislative and other public policy pronouncements, it might never have reached its present stage of acceptance. The program achievements along the way helped convince policy-makers.
- Good quality data can make an effective contribution to program planning and evaluation. The DHS reports and other survey results contributed to persuasive presentations and eventual program decisions.
- The private sector needs to be involved as early as possible. The overwhelming success of the social marketing program, and the support of private sector organizations not only increases FP/MCH information and services, but leads to greater sustainability.

Towards Evaluation

The final evaluation for 608-0171 is planned for January,

⁴This emphasis added by PACR author, not in Child Survival Evaluation.

1993. Its successor, the Family Planning and Child Survival IV Project is ongoing, and will address problems and issues outlined by this report. The overall finding of the PACR is that the project achieved and surpassed its objectives. Recommendations made by evaluators were taken seriously and acted upon quickly. USAID/Morocco's management has been commendable, and anticipates more activity and success with phase IV.

The following documents represent the assessment of several components of the first five years of the project:

MOPH Family Planning Logistics Management Assessment, John Snow Inc. (JSI), and Family Planning Logistic Management (FPLM) contract, January 1988.

Midterm Evaluation of the Population and Family Planning Support III Project 607-171, ISTI POPTECH contract, March 1988.

Preliminary Report of the 1987 MOPH Demographic and Health Survey, MOPH and Westinghouse contract, November 1987; and 1988.

The MOPH 1988 VDMS Field Operational Study, EXPERDATA, May, 1988.

Preliminary Report of the GOM Voluntary Surgical Contraception Client Satisfaction Survey, NTCRH in collaboration with the Association of Voluntary Surgical Contraception, March 1988.

Preliminary Data from the 1992 Demographic and Health Survey, MOPH and Institute for Resource Development Contract, May 1992.

An additional evaluation of the Child Survival Strategy was completed in June of 1990 and approved for publication as an impact evaluation in 1991.

Child Survival in Morocco, A.I.D. Impact Evaluation Report No. 79, Center for Development Information and Evaluation (PPC/CDIE), July, 1991.

FINANCIAL SUMMARY BY ELEMENT AS OF May 14, 1992 (\$)

Element No (not output)	Amount Obligated/ Earmarked	Amount Committed	Amount Disbursed	Unliquid Oblig/Ear	Unexpended Oblig/Ear
1. VDMS	4,900,000	5,238,912	5,235,086	- 335,086	-335,086
2. Urban Services	650,000	649,458	648,492	1,508	1,508
3. MTCRH	600,000	538,440	253,440	346,560	346,560
4. Reproductive Health Services	1,405,000	1,747,096	1,735,333	- 330,333	-330,333
5. IEC	700,000	515,017	500,522	199,478	199,478
6. FP Services*	2,715,000	2,092,896	2,005,821	709,179	709,179
7. Operations Research	440,000	534,000	444,503	- 4,503	- 4,503
8. Population Policy Dev.	192,000	193,965	193,965	- 1,965	- 1,965
9. Training	930,000	843,759	843,759	86,281	86,241
10. Evaluation	518,000	485,061	481,430	36,520	36,520
11. Operating Program Grants	1,885,000	1,885,071	1,627,056	257,944	257,944
12. Support for FP Activities	250,000	282,029	282,029	-32,029	-32,029
13. Child Survival	4,050,000	4,110,795	3,928,772	121,228	121,228
PROJECT TOTALS	19,235,000	19,116,508	18,180,258	1,054,742	1,054,742**

* Does not include contraceptives

** Advice of charge for nine buy-ins and purchases totalling approximately \$640,000 remain outstanding as of 4/20/92. Actual unexpended total is, therefore, estimated to be approximately \$414,742 MOPH.

APPENDIX II:
SUMMARY OF CONTRACEPTIVE PURCHASES

Statement of Contraceptive Account
For the period 10/01/86 to 06/30/91

Run Time: 16:26:08

Page: 2

Customer: USAID/Rabat

Trx Date	Description	Details of Financial Activity	Ordering Document	Funds Added To Account	Charges To Account
08/30/87	Ocean charges for 52CS shipment to Ministère de la Santé Publique		608-0171-5-60031		\$2,574.88
09/30/87	Allotment Transfer Received		BAT 100129	\$1,100,000.00	
10/31/87	Shipment of 2,210,400 Lo-Femoral, Blue Lady to Ministère de la Santé Publique		608-0171-5-60030		\$287,352.00
10/31/87	Ocean charges for LFMP shipment to Ministère de la Santé Publique		608-0171-5-60030		\$12,233.00
11/30/87	Shipment of 2,210,400 Lo-Femoral, Blue Lady to Ministère de la Santé Publique		608-0171-5-60030		\$287,352.00
11/30/87	Ocean charges for LFMP shipment to Ministère de la Santé Publique		608-0171-5-60030		\$9,821.50
12/30/87	Shipment of 672,000 52mm Colored Sultan to Ministère de la Santé Publique		608-0171-5-60031		\$28,694.40
11/30/87	Ocean charges for 52CS shipment to Ministère de la Santé Publique		608-0171-5-60031		\$2,840.38
01/31/88	Shipment of 2,210,400 Lo-Femoral, Blue Lady to Ministère de la Santé Publique		608-0171-5-60030		\$287,352.00
01/31/88	Ocean charges for LFMP shipment to Ministère de la Santé Publique		608-0171-5-60030		\$12,468.25
03/31/88	Shipment of 2,210,400 Lo-Femoral, Blue Lady to Ministère de la Santé Publique		608-0171-5-60030		\$287,352.00
03/31/88	Ocean charges for LFMP shipment to Ministère de la Santé Publique		608-0171-5-60030		\$11,621.50
07/31/88	Shipment of 2,917,200 Lo-Femoral, Blue Lady to Ministère de la Santé Publique		608-0171-5-70048		\$350,064.00
07/31/88	Ocean charges for LFMP shipment to Ministère de la Santé Publique		608-0171-5-70048		\$10,971.50
08/09/88	Shipment of 120,000 Ovrette to Ministère de la Santé Publique		Cable: 04533		\$19,600.00
08/09/88	Ocean charges for OVRP shipment to Ministère de la Santé Publique		Cable: 04533		\$2,365.00
08/09/88	Shipment of 760,000 52mm Colored Sultan to Ministère de la Santé Publique		Cable: 04533		\$41,240.20
08/09/88	Ocean charges for 52CS shipment to Ministère de la Santé Publique		Cable: 04533		\$3,000.00
09/19/88	Allotment Transfer Received		BAT 100223	\$1,320,000.00	
09/30/88	Funds from related time ACC R.P. POP/CPSD		BAT 100486	\$62,213.20	
12/31/88	Shipment of 2,327,400 Lo-Femoral, Blue Lady to Ministère de la Santé Publique		608-0171-5-70048		\$291,312.00
12/31/88	Ocean charges for LFMP shipment to Ministère de la Santé Publique		608-0171-5-70048		\$11,529.00
02/26/89	Shipment of 1,702,000 Lo-Femoral, Blue Lady to Ministère de la Santé Publique		608-0171-5-70048		\$228,240.00
02/26/89	Ocean charges for LFMP shipment to Ministère de la Santé Publique		608-0171-5-70048		\$11,140.00
05/15/89	Shipment of 1,242,000 52mm Colored Sultan to Ministère de la Santé Publique		608-0171-5-80000		\$92,909.20

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Summary of Financial Activity

Description	Funds Added To Account	Charges To Account
Beginning Balance (as of 10/01/86)	\$2,150,000.11	
Net Change for Statement Period	\$1,892,430.27	
Ending Balance (as of 06/30/91)	\$4,042,430.38	
Current Value of Transactions Occurring (or scheduled to occur) after 06/30/91	\$2,600,000.00	\$1,606,948.69
Current Status of Account (as of 08/23/91)	\$6,642,430.38	\$1,606,948.69
Value of Product Owed to Field	\$5,035,481.69	

Trx Date	Description	Details of Financial Activity	Ordering Document	Funds Added To Account	Charges To Account
10/11/86	Shipment of 100,000 Copper T. 380 to Ministere de la Sante Publique		608-0171-5-60091		\$92,500.00
10/11/86	Ocean charges for CT38 shipment to Ministere de la Sante Publique		608-0171-5-60091		\$3,332.50
11/30/86	Shipment of 1,268,400 Lo-Femoral, Blue Lady to Ministere de la Sante Publique		608-0171-5-60090		\$152,200.00
11/30/86	Ocean charges for LFMP shipment to Ministere de la Sante Publique		608-0171-5-60090		\$4,954.50
01/31/87	Shipment of 478,400 Size Colored Sultan to Ministere de la Sante Publique		608-0171-5-60031		\$28,747.20
01/31/87	Ocean charges for S202 shipment to Ministere de la Sante Publique		608-0171-5-60031		\$3,422.50
05/31/87	Shipment of 478,400 Size Colored Sultan to Ministere de la Sante Publique		608-0171-5-60031		\$28,747.20
05/31/87	Ocean charges for S202 shipment to Ministere de la Sante Publique		608-0171-5-60031		\$2,492.95
06/30/87	Shipment of 1,280,000 Lo-Femoral, Blue Lady to Ministere de la Sante Publique		608-0171-5-60030		\$273,600.00
06/30/87	Ocean charges for LFMP shipment to Ministere de la Sante Publique		608-0171-5-60030		\$17,010.00
07/31/87	Shipment of 1,142,000 Lo-Femoral, Blue Lady to Ministere de la Sante Publique		608-0171-5-60030		\$257,040.00
07/31/87	Air charges for LFMP shipment to Ministere de la Sante Publique		608-0171-5-60030		\$26,508.95
08/30/87	Shipment of 672,000 Size Colored Sultan to Ministere de la Sante Publique		608-0171-5-60031		\$28,694.40

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Trx Date	Description	Details of Financial Activity	Ordering Document	Funds Added To Account	Charges To Account
05/15/89	Ocean charges for 52CS shipment to Ministère de la Santé Publique		608-0171-5-00000		\$3,728.75
07/03/89	Shipment of 672,000 52mm Colored Sultan to Ministère de la Santé Publique		Cable: 03050		\$28,627.20
07/03/89	Ocean charges for 52CS shipment to Ministère de la Santé Publique		Cable: 03050		\$3,161.07
08/14/89	Shipment of 40,000 Copper T. 380 to Ministère de la Santé Publique		Cable: 03050		\$40,640.00
08/14/89	Ocean charges for CT30 shipment to Ministère de la Santé Publique		Cable: 03050		\$2,244.94
08/25/89	Shipment of 672,000 52mm Colored Sultan to Ministère de la Santé Publique		Cable: 03050		\$28,627.20
08/25/89	Ocean charges for 52CS shipment to Ministère de la Santé Publique		Cable: 03050		\$3,172.31
09/12/89	Fund received		BAT 100283	\$2,000,000.00	
09/14/89	Shipment of 2,004,000 La-Pomonal, Blue Lady to Ministère de la Santé Publique		Cable: 02521		\$260,520.00
09/14/89	Ocean charges for LFMP shipment to Ministère de la Santé Publique		Cable: 02521		\$17,131.90
11/30/89	Shipment of 2,004,000 La-Pomonal, Blue Lady to Ministère de la Santé Publique		Cable: 02521		\$260,520.00
11/30/89	Ocean charges for LFMP shipment to Ministère de la Santé Publique		Cable: 02521		\$15,075.00
01/17/90	Shipment of 672,000 52mm Colored Sultan to Ministère de la Santé Publique		Cable: 03050		\$29,534.40
01/17/90	Ocean charges for 52CS shipment to Ministère de la Santé Publique		Cable: 03050		\$3,177.07
02/28/90	Shipment of 660,000 52mm Colored Sultan to Ministère de la Santé Publique		Cable: 03050		\$21,871.70
02/28/90	Ocean charges for 52CS shipment to Ministère de la Santé Publique		Cable: 03050		\$2,900.00
02/28/90	Shipment of 12,600 Copper T. 380 to Ministère de la Santé Publique		Cable: 03050		\$12,149.55
02/28/90	Ocean charges for CT32 shipment to Ministère de la Santé Publique		Cable: 03050		\$4,706.74
02/28/90	Shipment of 27,400 Copper T. 380 to Ministère de la Santé Publique		Cable: 03050		\$26,420.45
02/28/90	Ocean charges for CT32 shipment to Ministère de la Santé Publique		Cable: 03050		\$450.00
03/19/90	Shipment of 2,004,000 La-Pomonal, Blue Lady to Ministère de la Santé Publique		Cable: 02521		\$260,520.00
03/19/90	Ocean charges for LFMP shipment to Ministère de la Santé Publique		Cable: 02521		\$29,600.00
05/03/90	Fund received		BAT 100317	\$2,200,000.00	
05/29/90	Shipment of 150,000 Copper T. 380 to Ministère de la Santé Publique		Cable: 02232		\$24,360.00
05/29/90	Ocean charges for OVRP shipment to Ministère de la Santé Publique		Cable: 02232		\$1,757.34
08/22/90	Shipment of 12,600 Copper T. 380 to Ministère de la Santé Publique		Cable: 06307		\$12,149.55

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Trx Date	Description	Details of Financial Activity	Ordering Document	Funds Added To Act: --	Charges To Account
08/22/90	Ocean charges for CT38 shipment to Ministère de la Santé Publique		Cable: 06307		\$1,170.00
10/31/90	Shipment of 270,000 Ovette to Ministère de la Santé Publique		Cable: 06307		\$50,699.25
10/31/90	Ocean charges for CVRP shipment to Ministère de la Santé Publique		Cable: 06307		\$2,000.00
11/02/90	Shipment of 2,040,000 52mm Colored Sultan to Ministère de la Santé Publique		Cable: 06307		\$89,739.80
11/02/90	Ocean charges for 52CS shipment to Ministère de la Santé Publique		Cable: 06307		\$7,190.00
11/30/90	Shipment of 120,000 Ovette to Ministère de la Santé Publique		Cable: 06307		\$22,533.00
11/30/90	Ocean charges for OVRP shipment to Ministère de la Santé Publique		Cable: 06307		\$1,287.00
12/12/90	Shipment of 204,000 52mm Non Colored, No Logo to Societe de Promotion Pharmaceut. Maghreb		Cable: 06307		\$9,338.10
12/12/90	Air charges for 52MX shipment to Societe de Promotion Pharmaceut. Maghreb		Cable: 06307		\$2,848.00
12/12/90	Shipment of 396,000 52mm Non Colored, No Logo to Societe de Promotion Pharmaceut. Maghreb		Cable: 06307		\$10,126.90
12/12/90	Ocean charges for 52MX shipment to Societe de Promotion Pharmaceut. Maghreb		Cable: 06307		\$3,474.90
12/31/90	Shipment of 10,000 Copper T, 300 to Ministère de la Santé Publique		Cable: 06307		\$10,413.90
12/31/90	Ocean charges for CT38 shipment to Ministère de la Santé Publique		Cable: 06307		\$0,090.00
01/31/91	Shipment of 800,000 52mm Non Colored, No Logo to Societe de Promotion Pharmaceut. Maghreb		Cable: 06307		\$27,469.00
01/31/91	Ocean charges for 52MX shipment to Societe de Promotion Pharmaceut. Maghreb		Cable: 06307		\$4,690.00
01/31/91	Shipment of 1,308,000 52mm Non Colored Blue/Gold to Ministère de la Santé Publique		Cable: 06307		\$59,873.70
01/31/91	Ocean charges for 52MX shipment to Ministère de la Santé Publique		Cable: 06307		\$5,700.00
02/28/91	Shipment of 120,000 Ovette to Ministère de la Santé Publique		Cable: 06307		\$22,533.00
02/28/91	Ocean charges for OVRP shipment to Ministère de la Santé Publique		Cable: 06307		\$1,287.00
04/05/91	Shipment of 1,446,000 52mm Non Colored Blue/Gold to Ministère de la Santé Publique		Cable: 06307		\$66,190.65
04/05/91	Ocean charges for 52MX shipment to Ministère de la Santé Publique		Cable: 06307		\$4,690.00
05/23/91	Shipment of 498,040 52mm Non Colored, No Logo to Societe de Promotion Pharmaceut. Maghreb		Cable: 01414		\$22,795.95
05/23/91	Ocean charges for 52MX shipment to Societe de Promotion Pharmaceut. Maghreb		Cable: 01414		\$4,369.95
06/30/91	Shipment of 1,446,000 52mm Non Colored Blue/Gold to Ministère de la Santé Publique		Cable: 06307		\$66,190.65
06/30/91	Ocean charges for 52MX shipment to Ministère de la Santé Publique		Cable: 06307		\$5,082.00
Total Activity for Staccato Period				\$6,682,213.20	\$4,789,782.93
Net Change				\$1,892,430.27	

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APPENDIX III:
**SUMMARY OF TECHNICAL ASSISTANCE AND IN-COUNTRY
TRAINING PROVIDED BY
RONCO CONSULTING CORPORATION**

APPENDIX B

TRAINING DAYS

PROJECT/ DIVISION	ACTIVITY	MTH/YR	DAYS
VDMS	TOT-New VDMS Modules	Nov.1985	944
VDMS	Provincial VDMS Training	Dec.1985 Feb.1986	12, 250
Health Ed. Service	Journee De Reflection	Sept.1985	120
Health Ed. Service	A/V Production	Oct.Dec.	290
Health Ed. Service	Info Day : Children's Drawings	Nov.1985	122
Health Ed. Service	Physician Training Communication Skills	Mar, Apr Jul., Oct. 1986	2,448
VDMS	Refresher Training	June-July 1986	2,786
Health Ed. Service	Training for Students at Ecole des Cadres	Sept -Nov.1986	594
In-Service Training VDMS	Training of Trainers Provincial Training	Dec. 1986 Jan. 1987	162 2,690
VDMS/Computer Training		Jan.-Feb.1987	60
Stats Service		Jan. 1987	200
MSA/MOPH	TOT for Directrices of Centres Socio-Educatifs	April 1987	432
Stats Service	Training for Superv. + Interviewers DHS	April 1987	1,020
VDMS	Admin. Training	April 1987	200
VDMS	Preparation for Training	June 1987	36

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MAAS/MOPH	Training Preparation Workshops for MAAS Directrices and MOPH Consumers	June 1987	387
HES/Diarrhea	Central Level Training Provincial Training	June 1988 June 1988	245 1,920
MAAS/MOPH	Provincial training for monitrices in Socio-Educ. Centers	July 1988	4,360
INAS	Health Planning Course	July 1988	300
FP Service	Micro Computer Training	Nov. 1988	154
INAS	Intro to Mgmt Course Intro to Mgmt Course	May 1989 Dec.-Jan.1989	280 280
FP Service	Time Mgmt./Providing Care	Feb. Mar.1990	45
VDMS	Training of Moto Mechanics	June, July 1990	280
VDMS	Seminar : Intro of VDMS to Phys. & Other FP Pros.	June 1990	60
INAS	TOT : Intro to Health Management	June 1990	270
VDMS	TOT : Expansion Provincial Training	Sept. 1990	240
VDMS	Provincial Level Trg.	Oct. 1990	3,372
INAS	Financial and Budgetary Management Course	Oct. 1990	280
INAS	Human Resources Mgmt. Course	Oct./Nov. 1990	280
VDMS	Mechanics Training for Motorcycles	Sept. 1991	27

VDMS	Training in new VDMS Info System -- TOT Central Level Provincial Level	Jul.-Oct.1991	33 675
INAS	Operations Research Trg.	Sept. 1991	209
MOPH/Div.of Pop	IUD Trg.-- TOT Central Provincial Regisseurs	Sept. 1991 Oct. 1991 Oct. 1991	175 3,570 9
MOPH/Div. of Pop	Jeep Trg.	Oct. 1991 Dec. 1991	126

BREAKDOWN OF TRAINING DAYS

1985 - 1991

MOPH :

Division of Population		
- VDMS	23,815	57.0%
- Other	4,079	10.0%
Division of Health Educ.	5,739	13.5%
INAS	1,899	4.5%
Division of Statistics	1,220	3.0%
MAAS :	5,179	12.0%
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TOTAL	41,931	100%

APPENDIX IV:
**SUMMARY OF PROJECT FINANCED SHORT- AND
LONG-TERM TRAINING**

POPULATION AND FAMILY SUPPORT III (608-0171)
INVITATIONAL TRAVEL

Title of Course/Conference	Dates	Place	Participants
USSUP General Conference	06/05-12/85	Florence	M'hamed Oualdim, MOPH
JHU/PCS Communication Workshop	07/29-08/85	Baltimore	Hamid El Achhab, MOPH (Settat)
ANE Evaluation Conference	09/29-10/85	Tunis	Zhor Laaziri, MOPH
Health Financing Mobile Seminar	11/16-26/85	U.S.	Prof. Abderrahmane Alaoui M'hamed, C.H.U., Rabat Dr. Nouredine Benomar Alami, C.H.U., Rabat Dr. Chakib Bourquia, C.H.U. Casablanca Col. Major M. Driss Archane Hôpital Militaire, MOPH M. Ahmed El Hariti, MOPH Dr. Azzedine El Mansouri, MOI (Marrakech)
Int. Conf. on Rehydration	12/10-13/85	Washington	Dr. Omar Rachid Tahiri
(JHPIEGO) Infertility Course -STD	06/17-23/85	Baltimore	Dr. Ali Salamiou, MOPH, Nado
(JHPIEGO) Infertility Course -STD	11/11-22/85	Baltimore	Dr. Farid Jouahri, NTCRH
Oral Rehydration	04/02-04/86	Egypt	Dr. Mohamed Zarouf, MOPH Dr. Abderrahim Barodi, Hôpital d'Enfants

Health Concentration	12/16-08/86	Univ.Miami	M. Brahim Ouchrif, MOPH
(JHPIEGO) Microsurgery for Tubal Reanastomosis	03/22-04/86	Baltimore	Dr. Khalil Sebti, NTCRH
(JHPIEGO) Administrator's Course	06/01-21/86	Baltimore	Dr. Mokhtar Belghiti, MOPH
(JHPIEGO) Infertility Course	03/30-04/87	Baltimore	Dr. Abdelwahab Bachouchi, NTCRH
(JHPIEGO) Academic Skills Course	06/01-16/87	Baltimore	Dr. Karim Mentak, NTCRH
(MSH) Formation en Gestion (Première Réunion du Comité Consultatif Régional Francophone)	04/06-10/87	Boston	Dr. Mohamed Zarouf, MOPH
(RONCO/PAC II) Curriculum Development in FP skills for paramedical workers	06/16-7/4/87	Istambul	Kharkhach Fatiha, CR, Oujda Friz Fatima, Conseillère sur la PF Lasel Hassania, RC, Rabat El Haddadi Khadija, CNFRH Hafs Khadija, Cons. sur la PF, Casa - Anfa Hamdane Mahjouba, CR, Marrakech Mehamdi Mohamed, Cons. sur la
Meknes			Benamar Moumna, sage femme Sabir Tahra, sage femme
Int. Conf. on Oral Rehydration Therapy (ICORT III)	12/14-16/88	Washington	Dr. Abdelouhab Zerrari, MOPH Dr. Abdelmajid Tibouti, MOPH
Drug Supply	02/08-26/88	U.S.	M. Hmidani Filali, MOPH
(JHPIEGO) Academic Skills Course	06/6-7/01/88	Baltimore	Dr. Rachid Bezad, NTCRH
(RONCO/PACII) Regional FP Workshop	02/26-3/02/88	Tunis	Dr. Abderrahmane Zahi, MOPH Dr. Mustapha Tyane, MOPH M. Mohamed Boulgana, MOPH

INTRAH 3rd TAC Francophone Mtg for FP DIR	07/10-15/89	Lome	Dr. Mohamed Zarouf (MOPH)
Int'l Conf. for Emergency Health Care Dev.	08/15-18/89	Washington	Dr. Najib Zerouali Hopital Averoes, Casa
XIII World Congress on Fertility & Sterility	10/01-06/89	Marrakech	Dr. Ahmed Izddine (MOPH) Dr. Mohamed Zarouf (MOPH)
Fertility Data Conference (ISI)	10/03-26/89	Yaounde	Mahfoui Archach (MOPH) Abdelylah Lakssir (MOPH)
Congress on Islam & Population Policy	02/18-24/90	Jakarta	Rachida Tazi Laraki, Casa (MOPH) Radouane Benchekroun (Min/Habbou
Colloquium on Hormonal Contraception & Laboratory Testing	02/21-22/90	Dakar	Pr. Abdelouahab Bachouchi (NTCHR)
BKKBN Family Planning Program Management	05/07-14/90	Jakarta	Brahim Oucherif (MOPH)
BKKBN Planning & Managing Pop. Communications	08/08-28/90	Jakarta	Dr. Mohamed Zarouf (MOPH)
Microcomputer Processing	10/15-19/90	Singapore	Abderrahin Sarti (MOP) Sabah Mrini (MOP)
JHPIEGO Teaching Skills for Moroccan Physicians Educators	6/12-07/07/91	Baltimore	Khallaf Oucherif, Agadir (MOPH) Fatiha Guezzar, Agadir (MOPH) Nadifi Halima, Casa-Anfa (MOPH) M'Barki Abdeloihid, Casa Ben M'Si Ahuary Hassan, Fes (MOPH) Abdelkader Baston, Marrakech (MOPH) Abdellatif Fassi-Fihri, Oujda (MOPH)

AV

			Amina Chahtane, Maternite Ibn Si Bensaid (NTPRH) Wafia Lantry (MOPH) Larbi Guessous, Tanger (MOPH) Hmidou El Hasnaoui, Tetouan (MOPH)
Options Desktop Publishing	08/03-24/91	Washinton	Abdelmajid Bouazza (MOPH) Ahmad Lazrak (MOPH) Hassan Hasbi (MOPH) Mohamed Fathelkheir (MCPH) Brahim Hasmi (MOPH)
DHS Conference	08/05-07/91	Washington	El Arbi Housni (MOPH) Mustapha Azelmat (MOPH) Mohamed Zarouf (MOPH)
MSH/FPMD/Frac Meeting	08/12-22/91	Paris	Mohamed Abouakil (MOPH) Ahmed Laabid (MOPH)
International Nutrition Planners Forum			Dr. Najia Hajji (MOPH) Dr. Mustapha Essolbi M. Ahmed Akhchichine

**OBSERVATIONAL STUDY TOUR
(3rd Country)**

PROGRAM	DATES	PLACE	PARTICIPANTS
Contraceptive Social Marketing	11/03-14/86	Thailand & Indonesia	Prof. M. Tahar Alaoui, NTCRH
ANE Regional Contraceptive Social Marketing Conference	02/14-18/88 02/21-25/88	Thailand & Egypt	Dr. Mohamed Zarouf, MOPH M. Ahmed Kchichen, MOPH Dr. Mustapha Denial, MOPH

111

POPULATION & CHILD SURVIVAL PHASE IV (608-0198)
INVITATIONAL TRAVEL

CONFERENCE TITLE	DATE	LOCATION	PARTICIPANTS/ORGANIZATION
JHPIEGO Administrative Course	02/05-23/90	Baltimore	Dr. Mohamed Abouakil
Teaching Skills of Moroccan Physicians & Nurse Midwife Educators	6/09-08/03/90	Baltimore	Abdellah El Omari, Kenitra (MOPH) Naima Bouhaik, Kenitra (MOPH) Mohamed Benchaou, Marrakech (MOPH) Saadia El Ouardi, Marrakech (MOPH) Taibi Ouazzani, C.H.U. Rabat Brahim Rhrab, C.H.U. Rabat Ahmed Moussayir, Agadir (MOPH) Khaddouj El Faqir, Agadir (MOPH) Abderrahim Sefiani, Meknes (MOPH) Zohra Abouadellah, Meknes (MOPH) Chakib Bousoubaa, Fez (MOPH) Aicha Machtaqi, Fez (MOPH)
6th Int. Conference on AIDS	06/20-24/90	San Francisco	Latifa Imane, Casa (ALCS) Othman Akalay (MOPH)
HCF & Role of Health Insurance	12/10-15/90	Bali, I.	Abdelmajid Tibouti (MOPH)
Development of Computer Presentation Materials	2/11-03/01/91	Washington	Mohamed Fathelkheir (MOPH)
ICCARA Conference	12/11-13/91	Washington	Dr. Safia Bouaddi (MOPH)
VI Int. Conf. on AIDS in Africa	12/16-19/91	Dakar	Nadia Bezad (MOPH) Leyla D'khissy, Agadir (MOPH) Ali Bendihaj, Fez (MOPH) Souad Sekkat, Casa (I.P.) Majida Zahraoui, Casa (ALCS)

TFG Contraceptive Technology & Safety Regional Workshop	04/08-14/92	Tunis	Abdelouahab Piro, Pharmacien Jamal Eddine Benazzou Pharmacien Khalid Boudali, Pharmacien Omar Mernissi, Pharmacien Najia Rguibi, Pharmacien d'O1
FPCS program Computer Graphics Presentation	5/25-6/3/92	Washington	FathElkheir, DPES (MOPH)
VIII Int. Conf. on AIDS/III STD World	07/19-24/92	Amsterdam	Amina

APPENDIX V:
SUMMARY OF PROJECT-FINANCED COMMODITIES

APPENDIX V: SUMMARY OF PROJECT-FINANCED COMMODITIES

PIECE JOINTE No. 1

LISTE RECAPULATIVE-DES ACHATS DE BIENS
EFFECTUES DANS LE CADRE DU
PROJET 608-0171

A) Achats par le pays hôte ou direct par l'AID:

ANNEE	DESCRIPTION	QUANTITE	COUT (\$)	SERVICE
1985	Micro-ordinateur IBM-PC	1	14.149	PF
1986/1988	Sacchoche	2550	64.748	PF
	Pèse-bébé	558	22.469	PF
1987	Armoire frigorifique (1200 litres)	16	21.924	PNI
	Réfrigérateur (140 litres)	150	45.458	PNI
	Land Rover	24	286.160	PNI
	Land Rover	11	153.379	PNI
	Land Rover	20	278.878	PNI
	Renault-4	12	82.684	PNI
	Renault-4	18	108.401	PNI
	Pièces détachées LR & R4		58.782	PNI
	Photocopieur U-BIX 178Z	1	6.876	PNI
	Fourniture de bureau		9.256	PF
	Matériel/Mobilier de bureau	*	52.676	PF
1988	Matériel de bureau	*	89.339	
	Pièces détachées LR & R4		84.703	PNI
1989	Photocomposeuse	1	58.300	ES
	Camion	2	58.800	PF
	Camion	1	28.313	SMI
1990	Matériel de bureau	*	10.991	PF/SMI
	Cyclomoteurs	375	349.606	PF
1991	Accessoires pour cyclomoteurs		110.000	PF
	Chariot élévateur et transpalettes	1 2		PF PF
	Jeep Cherokees & pièces détachées **	44	1.138.837	PF
	Table à dessin,	1	1.440	DEM
	Appareil photographique	1	1.272	DEM
	Casques**	775	40.243	PF

Equipement médical	*	1.053.000	PF/SMI
Photocopieur Xerox 1040(2)			
1025(1)	3	29.119	PF
Matériel clinique/de bureau	*	190.655	PF
Matériel informatique	*	82.427	PF
Moquette JUT beige	236m	6.160	PF
Matériel/mobilier de bureau	*	53.131	PF

B) Achat par les contractants:

1985	AVSC (equip. pour 15 centres)	412,500	CNFRH
1986	AVSC (18 ensembles d'equi. A&B)	216,000	CNFRH
1987	RTI/INPLAN (materiel informatique)	20,100	MP
1989	AVSC (2 ensembles d'equip. A&B)	20,125	CNFRH
1989	JHPIEGO (equip. medical/Chirurgical)*	105,185	CNFRH
1990/91	AVSC (Equip. ob/gyn)	307.134	CNFRH
1990/91	JHPIEGO (Equip. med/Chir.)	233.836	CNFRH/PF
1991	JHPIEGO (materiel medical/formation*	120,688	CNFRH
1991	TFG (Materiel informatique)	55.000	PF
1990/91	PCS (Tel., fax., phot. etc)	5.000	PF
1989	TFG (systemes informatiques) 10*	80.000	PF
		<hr/>	
		\$6.191.160	
		=====	

Note: * voir les listes ci-jointes
 ** avons déjà la répartition

APPENDIX VI:
VDMS PROVINCES (BY PHASE)

HOUSEHOLD DELIVERY PROGRAM
VDMS*

Pilot Project: 1979 - 1981

Marrakech

Phase I: 1982 - 1987

Beni Mellal
El Jadida
Meknes

Phase II: 1983 - 1988

Ifrane
Tetouan
Nador
Oujda
Kenitra
Fez
Khenifra
El Kelaa des Srarhna
Sidi Kacem
Marrakech

Phase III: 1986 - 1989

A. 7 Provinces

Essaouira
Khemisset
Khouribga
Safi
Taounate
Taza
Tanger

B. 8 Prefectures

Rabat
Sale
Temara-Skirat
Hay Hassani Ain Chock
Casa Anfa
Hay Mohammadi Ain Sbaa
Mehammedia-Zenata
Ben M'Sick Sidi Othmane

Phase IV: 1989 - 1996

Al Hoceima
Azilal
Ben Slimane
Boulmane
Chaouen
Errachidia
Figuig
Guelmim
Ouarzazate
Tantan
Tata
Tiznit

*VDMS: Visite a Domicile pour Motivation Systematique

APPENDIX VII:
LIST OF SUPPORTING DOCUMENTS AND
PERSONS INTERVIEWED

APPENDIX VII: LIST OF SUPPORTING DOCUMENTS AND PERSONS INTERVIEWED

List of Supporting Documents and Persons Interviewed

Population and Family Planning Support III (608-0171) Project Paper, 1984.

Project Paper Supplement, 1986.

Project Paper Amendment #2, 1987.

Project Paper Amendment #3, 1988.

Project Agreement, 1985, and subsequent Amendments:

- Amendment #1.....March 19, 1986.
- Amendment #2.....May 19, 1986.
- Amendment #3.....August 22, 1986.
- Amendment #4.....August 29, 1986.
- Amendment #5.....June 30, 1987.
- Amendment #6.....August 21, 1987.
- Amendment #7.....August 31, 1987.
- Amendment #8.....June 13, 1988.
- Amendment #9.....July 28, 1988.

Kingdom of Morocco Demographic, Health and Educational Facts on Morocco.

Moroccan Social Marketing Program Update -- Protex Condom Sales Program.

Project Implementation Report, 1991.

A.I.D. Handbook #3.

Midterm Evaluation of the Population and Family Planning Support Project Phase III, 608-0171, 1988.

Child Survival in Morocco, A.I.D. Impact Evaluation Report No. 79, 1991.

Le Programme de Visites a Domicile de Motivation Systematique (VDMS)--Rapport de Synthese d'Etude Operationelle Realisee par EXPERDATA, 1988.

Enquete National sur la Planification Familiale, la Fecondite et la Sante de la Population au Maroc, 1987--Demographic and Health Survey.

National Survey on Causes and Circumstances of Infant and Child Death--An Infant Mortality Study in Morocco, 1989 by Michele Garenne.

Morocco Child Survival and Population Program, USAID Morocco and

OPTIONS II, The Futures Group, 1991.

Maroc: Relations Entre les Facteurs Demographiques et le Developpement, RAPID, the Futures Group.

OPTIONS Project Briefing Packet -- Morocco, Population Reference Bureau, Inc.

Data Show: Selected Demographic Data and Indicators, the Futures Group, 1990.

NTCRH/JHPEIGO Evaluation, 1991.

Seminar sur le System National d'Information Sanitaire SMI/PF, 1991.

Seminaire National de Reflexion sur la Strategie d'IEC en Matiere de P.F. au Maroc, 1989.

Trip Reports

John Snow, Inc: October, 1987 by Margaret Morrow
July, 1988 by Edward Wilson
July - August, 1990, The Private Enterprise Program

Population Communication Services: July, 1991 by Gilberte A. Vansintejan

PIO/Ts Reviewed

608-0171-

3-70014	3-40192	3-70263	3-70039	3-60054	3-40230
3-40014	3-30192	3-40038	3-70032	3-70053	
3-50035	3-60142	3-40230	3-70264	3-50202	
3-70166	3-70272	3-70136	3-40028	3-50203	
3-40229	3-88080	3-70234	3-50177	3-80195	
3-50053	3-60161	3-70273	3-40048	3-50205	

Persons Interviewed:

Carol Payne, Population Officer
Michelle Moloney, Project Officer Technical Advisor, AIDS Unit
Annie Ringuede, Project Officer
Zohra Lhaloui, Project Officer

Sumud

APPENDIX VIII:
VDMS CASE STUDY

Morocco

VISITES A DOMICILE DE MOTIVATION SYSTEMATIQUE



Fifteen years after its introduction as an innovative pilot activity, Morocco's community-based distribution program, *Visites a Domiciles de Motivation Systematique* (VDMS), is widely regarded as a model for household service delivery. The program was initiated in Marrakech province to test the acceptance and effectiveness of house-to-house family planning services. Today, VDMS includes an integrated package of preventive health care interventions and operates in 51 of Morocco's 60 provinces and prefectures. Reaching an estimated 75 percent of the rural population, the program has significantly contributed to the country's increasing contraceptive prevalence rate (currently 41.5 percent) and has helped energize the entire primary health care system.

THE NATIONAL CONTEXT

From a demographic perspective, Morocco faces severe challenges. If its population growth rate of 2.4 percent persists, the population will double from 26 million to 52 million people in only 29 years. Yet, the population growth rate would be even higher if the government had not made remarkable strides toward reducing the fertility rate. In 1966, a Royal Decree created the framework for family planning action in Morocco, and one year later, another law decreed the removal of all criminal sanctions against contraceptive use. However, it took another decade — and the inception of the VDMS program — for contraceptives to become easily accessible. Since the late 1970s, Morocco's total fertility rate has decreased from 5.9 to 4.2 births per woman.

Although there is no formal public policy, family planning is broadly supported by government officials at all levels and by the general population. The King and members of the Cabinet publicly express concern about Morocco's demographic situation, and recently, increasing attention has been given to the interaction between population growth and socioeconomic development.

THE VDMS PROGRAM

Established in 1977, the first phase of VDMS was a USAID-funded pilot effort to test the acceptability and effectiveness of household distribution of family planning services and commodities. The initial program was carried out using existing Ministry of Public Health nurses in urban and rural areas of Marrakech, Morocco's second largest province.

Highlights of the Pilot Effort

Both female and male nurses were selected and trained as VDMS family planning providers. In general, nurses welcomed the opportunity to gain new skills and responsibilities through participation in the program. Selection as a VDMS worker conveyed prestige, and access to program transportation (motorcycles) enabled the nurses to better conduct the other outreach activities that were already part of their duties.

DEMOGRAPHIC INDICATORS, 1992

Population	26.2 million
Birth Rate	31.4 per 1,000
Death Rate	8 per 1,000
Growth Rate	2.4 percent
Population Doubling Time	29 years
Infant Mortality Rate	57 per 1,000 live births
Total Fertility Rate	4.2 births per woman
Contraceptive Prevalence	41.5 percent

After the training, the health workers made the first of two scheduled visits to each of the households in their areas. During the first visit, the health workers met with all women of reproductive age, regardless of marital status. The objectives of the visit included collecting fertility histories; identifying women eligible for services and screening them for

Household motivational visits program

This leaflet is one of a series on successful family planning programs being prepared by the International Programs of the Population Reference Bureau for global distribution. The series is part of a larger USAID-funded information dissemination project.

1992

contraindications to pill use; and offering counseling and/or family planning supplies to all women who were not currently pregnant or using contraceptives. The nurses distributed pills and condoms to those who requested them, and gave coupons for IUD insertions at village clinics to those who preferred this method.

During the second round of visits approximately three months later, workers completed follow-up questionnaires, resupplied initial acceptors with three to six cycles of pills, and motivated non-acceptors. A quarter of the women who had refused pills on the first visit accepted them during the second visit. Women were also informed about locations where they could obtain future supplies of contraceptives.

Combining service and research objectives, VDMS carried out the first family planning operations research project in Morocco. With observations made from the two household visits, program staff tested a number of hypotheses such as the ability of nurses to safely dispense and resupply oral contraceptives and whether orals could be supplied in lots of three to six cycles without significant wastage.

Careful data collection also helped to demonstrate the acceptability of family planning services which, in turn, was used to justify expansion into other provinces and prefectures. Data were derived from supervisors' and health workers' reports and from the interview schedules completed for all the women visited.

By the end of the pilot effort, contraceptive use among women who were visited twice increased dramatically, rising from 25 to 52 percent. Pill acceptance in the urban areas rose from 36 to 54 percent, and in the rural areas from 8 to 37 percent. Among the sample of urban acceptors surveyed two years after initial contact, 71 percent were still using contraceptives; of those using, 7 in 10 were still using the pill.

Why the Pilot Program Worked

The VDMS pilot program succeeded for two principal reasons:

- The program had political support from the highest levels.

From the very beginning, staff sought to build political support for the VDMS approach. The program coordinator involved the provincial Governor and key administrators early on, keeping them informed as program activities progressed. To help

ensure institutionalization of the VDMS approach within the Ministry of Public Health, staff met regularly with the Marrakech *médecin-chef* (chief physician) to discuss training techniques and the value of using itinerant nurses as family planning providers.

- Non-physicians were trained to counsel and distribute oral contraceptives.

Prior to the pilot effort, the prevailing thought among medical officials had been that only doctors were capable of dispensing the pill. This program demonstrated that with proper training in family planning counseling and how to identify contraindications for pill use, government nurses could safely distribute the pill. Research findings indicated a low incidence of reported side effects and low client discontinuation rates. Researchers also found minimal wastage, although over the course of the program the number of pill cycles supplied at each visit has varied among provinces.

VDMS Today

As VDMS expanded to 51 of Morocco's 60 provinces and prefectures, the program was modified in a number of ways. Owing to the availability of fixed-facility services and private pharmacies in urban areas, the government decided to phase out urban and peri-urban household service delivery except in areas not serviced by health centers. VDMS currently works almost exclusively with the underserved population of rural women who live more than three kilometers from fixed health facilities. Itinerant nurses are scheduled to make five visits per year to each household in their assigned areas.

The Ministry of Public Health also recognized VDMS as a potential vehicle for providing other maternal and child health services. Despite fears among health professionals that the addition of health interventions would weaken family planning efforts, the government insisted on expanding the role of VDMS workers. Today, in addition to family planning services, outreach workers monitor pregnant and lactating women, distribute iron supplements, refer unvaccinated children to dispensaries or provide vaccines directly, distribute oral rehydration salt (ORS) packets and instruct women in their use; and conduct nutrition surveillance of malnourished mothers and children.

In 1986 (the most recent data available), 2,137 VDMS nurses distributed 6.2 million pill cycles, 3.5 million condoms, 27.5 million IUDs, 2.1 million ORS

packets, 236 thousand packets of nutritional supplements and 1.8 million iron pills.

PROGRAM ASSESSMENT

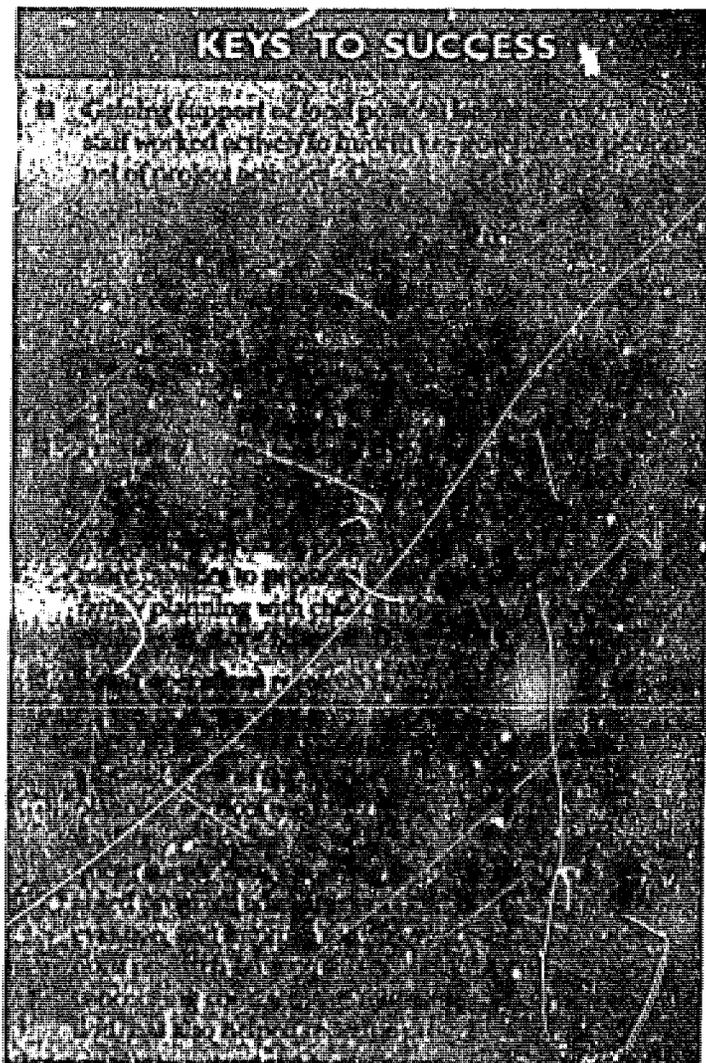
According to the 1992 Demographic and Health Survey (DHS), Morocco's contraceptive prevalence increased dramatically from 19 percent in the late 1970s to 41.5 percent in 1992. Reflecting this rise in prevalence, the total fertility rate decreased from 5.9 to 4.2 births per woman. Though many factors were at work, the VDMS program contributed significantly to fertility decline in Morocco, especially in rural areas. The 1987 DHS also showed that 28 percent of married women of reproductive age in rural areas served by the VDMS Program were using family planning, versus only 19 percent in non-VDMS provinces. In addition, of those women practicing family planning, a higher percentage were using modern methods in VDMS provinces (83 percent) as compared to non-VDMS areas (70 percent).

Recent reports have concluded that VDMS's integrated approach is a crucial element of the overall program effectiveness. Many local observers strongly believe that combining family planning with child survival interventions has made each more effective. VDMS brings valued health services to rural women and children who would otherwise have to travel to a distant clinic. Health workers develop rapport with these women and can encourage them to practice family planning.

VDMS is financed by funds from the Government of Morocco and USAID. A recent financial analysis found that the government's family planning program, including VDMS, has an extremely favorable cost benefit ratio: investments in family planning are paid back in reduced public spending on health and education within only two years. A separate analysis determined that urban-based services were essentially substituting a public source of contraceptive supply for private pharmacy supply, and hence were not cost-effective. Partly as a result of these findings, household based VDMS services were phased out in urban areas served by health facilities.

For rural services, a 1990 study found that the cost per couple year of protection (CYP) was US \$5.00 for users of VDMS services, versus approximately US \$13.00 for users of rural health centers. Considering that over twice as many rural women are served by the VDMS than fixed facilities, and factoring in the costs to clients such as travel and waiting time, VDMS compares even more favorably with clinic-based services.

One of the most significant contributions of the VDMS program has been to demonstrate the cultural acceptability of providing family planning services in people's homes. A 1988 survey found that nearly 75 percent of wives and 68 percent of husbands felt that services were satisfactory and should be continued. In addition, the Marrakech pilot effort demonstrated that male and female service providers were able to generate approximately equal contraceptive acceptance rates.



FUTURE CHALLENGES

Despite impressive gains in contraceptive prevalence and fertility reduction, further progress will require increased financial sustainability, and a continuing effort to convince all women who would like to space or limit their births to use family planning services. Currently program staff are focusing on the following key elements:

ERRATA

By 1986, 2,137 nurses distributed
27.5 thousand IUDs NOT 27.5 million.

■ **Maintaining staff motivation.**

Although VDMS workers enjoy certain benefits such as merit promotions, grade increases, in-service training, and personal use of VDMS motorcycles after working hours, workers find themselves increasingly burdened by heavy work loads. Budgetary constraints halted the recruitment of entry-level practical nurses in 1989, and many rural facilities are understaffed and unable to conduct outreach activities. A recent study suggests that given the preponderance of male VDMS workers, the program should seek a balance by hiring more female staff. Increasing the number of female VDMS workers could ease current staff shortages and workloads.

■ **Increasing client motivation and expanding available methods.**

Fertility among VDMS clients continues to be high because many clients have already had several children before they start practicing family planning. Heavy reliance on the pill, which is used by approximately 80 percent of VDMS's clients, may be one barrier to increasing contraceptive prevalence. Making a wider variety of methods available in rural areas, including longer lasting contraceptives such as IUDs, might be one way to serve more women. It has also been suggested that the program work more with husbands in order to increase male support for contraceptive use.

■ **Reducing program costs.**

Various options are being considered to help defray program costs. The government is actively supporting social marketing programs as a means to transfer some contraceptive costs to the private sector. In the public sector, the government is considering a plan to allow local governments more control over the services provided by facilities in their regions, including the right to charge fees for some services and to exercise control over the revenues. In theory, charging fees for curative services might make additional funds available for preventive health services.

Another option is the government's plan to make increasing use of mobile units. This option may prove to be a cost-effective way to continue serving the poor in areas where demand for family planning has already been established. Cost estimates based on the 1987 DHS suggested that in rural areas mobile, "point-of-contact" sources of supply would provide less costly CYPs than VDMS services. These mobile units (vehicles equipped as

mobile dispensaries) can provide services at an estimated cost of US \$1.74 per CYP.

■ **Reorienting information, education, and communication (IEC) programs.**

The program needs to expand its focus to include all modern contraceptive methods, particularly longer lasting methods such as the IUD, sterilization, and new technologies like implants (Norplant). While most Moroccan women recognize the pill as a contraceptive method, knowledge and acceptance of the IUD and sterilization are more limited. An IEC strategy that integrates both family planning and other health interventions is currently being conceptualized.

CONCLUSION

The VDMS program has had 16 years of experience with community-based services. Its success has hinged on its ability to evolve with changing circumstances, to maintain dynamism, and to respond to clients' perceived needs. With the ever-expanding number of women entering their reproductive years, VDMS will continue to play an important role in helping Morocco improve the health of its women and children as well as achieve population growth rates consistent with economic growth, employment opportunities, and natural resource availability.

**APPENDIX IX:
RELEVANT DATA**

KINGDOM OF MOROCCO
DEMOGRAPHIC, HEALTH, AND EDUCATIONAL STATISTICS

<u>General Population and Economic Data</u>		<u>Year</u>
Population (in Millions) ¹	25.1	1990
Population by age group (%) ²		
0-14 years	42	1990
15-64 years	54	
65+ years	4	
Dependency Ratio ¹	79	1990
Population Urban/Rural (%) ³	47/53	1989
GNP per capita (US\$) ¹	830	1980-88
Population below Poverty Level (Total %) ⁵	15.4	1990-91
Labor Force as % of Total Population ³	39	1990-91
Unemployment rate ³	12.1	1990-91
Urban/Rural	20.6/5.6	1990-91
 <u>Vital Indicators</u>		
Life Expectancy (in years) ¹	62.0	1990
Infant Mortality Rate		
per 1000 live births ⁴	57.4	1992
Crude Birth Rate per 1000 population ⁴	31.4	1992
Crude Death Rate per 1000 population ⁴	8	1992
Maternal Mortality Rate		
per 100,000 live births ³	300	1980-88
 <u>Population Growth and Projections</u>		
Annual Rate of Population Growth (%) ³	2.6	1989
Population Projections (millions) ³		
by the year 2000	31.4	1990
by the year 2020	43.3	1990
Total Fertility Rate ⁴	4.2	1992

¹United National Development Program, Human Development Report, New York: Oxford University Press, 1991.

²Population Reference Bureau, World Population Data Sheet. Washington, DC: PRB, 1990.

³UNICEF, The State of the World's Children. New York: Oxford University Press, 1991.

⁴Demographic Health Surveys, Enquete Nationale Sur La Population et La Sante Maroc 1992.

<u>Education/Literacy</u>		
Adult Literacy Rate Male/Female (%) ⁵	60.5/31.7	1990-91
Primary School Enrollment, Male/Female (%) ⁵	82.4/78.7	1990-91
Sec. School Enrollment, Male/Female (%) ⁵	43/40	1986-88
<u>General Health</u>		
Expenditures on Health as % of GNP ¹	0.9	1986
MOPH budget as % of total GOM budget ³	3.0	1985-88
Population per Doctor ¹	15,580	1984
Population per Nurse ¹	920	1984
Population with Access to Health Services Urban/Rural (%) ³	100/50	1985-88
Pop. with Access to Potable Water Network (%) ⁵	54.4	1990-91
Urban/Rural	93.8/12.9	1990-91
<u>Family Planning</u>		
Contraceptive Prevalence, all methods (%) ⁴	41.5	1992
Urban/Rural	54.4/31.5	1992
Source of FP Services, Modern Methods ⁴		
Public Sector (%)	63	1992
Private Sector	37	1992
Other Sources	1	1992
Mean age first marriage for women ⁶	22.3	1982
Estimated population of MWRA (millions) ⁶	3.650	1990
Estimated population of MWRA in 2010 (millions) ⁶	4.933	
<u>Maternal and Child Health</u>		
Low Birth Weight Infants (% under 2.5kg) ⁷	7	1982-87
Pregnant Women who have received at least one Tetanus immunization (%) ⁴	53.9	1992
Women who have medically supervised births (%) ⁴	31	1992
Women who have had prenatal visit (%) ⁴	32	1992
Children who have had diarrhea episode (%) ⁴		
in last 24 hours	6.0	1992
in last 2 weeks	12.6	1992
Children 12-23 months immunized for the six major diseases (%) ⁴		
Total	71.7	1992
Rural	63.4	1992
Urban	88.4	1992

⁵Ministry of Planning, Resultats Definitifs de l'Enquete Nationale sur les Niveaux de Vie 1990/91. Principaux Enseignements. March 1992.

⁶Options Project, Population Reference Bureau, Briefing Project, Morocco, June 1992.

⁷UNICEF, The State of the World's Children 1989. New York: Oxford University Press, 1989.

Nutrition		
Daily Calories Supply per Capita ¹	2920	1986
Daily per Capita Calories Supply as % of Requirement ¹	118	1984-86
Children 12-23 months under weight for age (Wasting) % ³	6	1980-89
Children 24-29 months under height for age (stunting) % ³	34	1980-89
Infants receiving breastmilk exclusively ⁴		
Infant 3 months of age (%)	61.5	1992
Infant 6 months of age (%)	19.1	1992
AIDS⁵		
Number of Cases since 1986-1992		1992
Asymptomatic HIV positive	102	
AIDS-related complex (ARC)	32	
AIDS	105	
Number of AIDS Cases by Sex		1992
Women	16	
Men	78	
Modes of Transmission		1992
Heterosexual	37%	
Homosexual	19%	
IV Drug Use	15%	
Multiple Factors	9%	
Blood Transfusion	9%	
Perinatal	5%	
Unknown	7%	

⁵All AIDS data comes from Moroccan Ministry of Public Health, Analytical Report on the Epidemiology of AIDS in Morocco, 31 March 1992.

**PROGRESS IN MCH/FP: THE 1992 DEMOGRAPHIC
AND HEALTH SURVEY**

Mortality Rates	1987	1992
Infant Mortality Rate:		
- Total:	73.3	57.4
- Rural:		64.8
- Urban:		43.5
Child Mortality Rate		20.0
Family Planning		
Total Fertility Rate:		
- Total:	4.8	4.2
- Rural:	6.2	5.7
- Urban:	3.4	2.8
Contraceptive Prevalence Rate, all methods:		
- Total:	35.9%	41.5%
- Rural:	24.6%	31.5%
- Urban:	51.9%	54.4%
Distribution of Modern Contraceptive Methods Used:		
- Oral Contraceptives:	64%	68%
- IUD:	8%	8%
- Condom:	1%	2%
- Tubal Ligation:	6%	7%
- Other Modern Methods:	1%	1%
- Traditional Methods:	15%	14%
Demand for Family Planning		
Women, By Age Group, Who Do Not Want More Children:		
- 15-19:	2.9%	3.1%
- 20-24:	16.6%	15.2%
- 25-29:	32.7%	35.5%
- 30-34:	49.5%	52.1%
- 35-39:	65.1%	63.6%
- 40-44:	75.6%	72.7%
- 45-49:	79.1%	73.2%
- Total:	47.8%	49.1%

Pregnant Women who have received at least one prenatal visit

- Total:	25%	32%
- From a Doctor:	15%	21%
- From a Nurse or Midwife:	10%	11%
- None	75%	68%

Births Attended by:

- a Doctor:	6%	6%
- a Nurse or Midwife:	20%	25%
- Other	74%	69%

Rate of Women Aged 15-44 who have received at least one vaccination for tetanus:

- Total:	53.9%
- Rural:	52.3%
- Urban:	56.9%

Child Health

Rate of Children 12-23 Months Fully Immunized:

- Total:	69.8%	71.7%
- Rural:	57.6%	63.4%
- Urban:	82.8%	88.4%

Children under 5 years having an episode of diarrhea in the last 24 hours

- Total:	17.6%	6.0%
- Rural:	18.6%	6.8%
- Urban:	15.7%	4.5%

in the last two weeks:

- Total:	28.9%	12.6%
- Rural:	28.8%	13.2%
- Urban:	29.0%	10.4%

Children with diarrhea

receiving ORS packets:	14.7%	13.9%
receiving home solution:	1.3%	2.5%

Children receiving breastmilk exclusively:

0-3 months	61.5%
4-6 months	19.1%

Sources:

1987 Data from National Survey of Family Planning, Fecundity, and Health in Morocco, 1987 (ENPS).

1992 Data from Demographic and Health Survey in Morocco, 1992 (ENPS).

1950-2000	
Year	Infant Mortality Rate
1950-1954	180
1955-1959	170
1960-1964	155
1965-1969	138
1970-1974	122
1975-1979	110
1980-1984	97
1985-1989	82
1990-1994	68
1995-2000	58

Source: World Population Prospects: 1988
United Nations Population Division

Table 2. Total Fertility Rate in Morocco, 1950-2000	
Year	Total fertility rate
1950-1954	7.2
1955-1959	7.2
1960-1964	7.2
1965-1969	7.1
1970-1974	6.9
1975-1979	5.9
1980-1984	5.4
1985-1989	4.8
1990-1994	4.2
1995-2000	3.6

Source: World Population Prospect: 1988

Table 3. Contraceptive Prevalence Rate in Morocco, 1970-1987	
Year	Prevalence rate (percent)
1970	1.0
1971	3.0
1972	4.0
1973	6.0
1974	7.0
1979	15.5
1979-1980	19.0
1983-1984	25.5
1987	36.9

Source: World Population Profile: 1989, U.S. Department of Commerce, Bureau of the Census, September 1989, WF-809.

Table 4. Share of Health/Population Activities in the USAID/Morocco Program (obligations in million dollars)			
Year	Total Assistance*	Health/Population	Percent of Total Assistance
1975	22.0	0.8	3.6
1976	43.3	1.3	3.0
1977	28.5	1.2	4.2
1978	34.5	0.5	1.4
1979	25.0	2.0	8.0
1980	24.8	3.0	12.0
1981	53.3	3.4	6.3
1982	60.1	2.2	3.6
1983	51.3	1.7	3.3
1984	31.0	5.2	16.8
1985	111.5	4.3	3.8
1986	64.3	6.2	9.6
1987	89.3	4.8	5.4
1988	91.4	5.0	5.5
1989	95.5	4.4	4.6
1990	102.9	5.2	5.0

*Total assistance includes Development Assistance, PL 480, Economic Support Fund, and so on.

Source: USAID/Morocco

Table 5. Differences in Health Practices Related to Child Survival, Selected Indicators for Project Assistance Areas, 1987 (percentage)		
	VDMS	Non-VDMS
Children with a Health Card	54	25
Women Who Did Not Receive Prenatal Care	85.6	90.3
Most Recent Birth:		
Assisted by doctor, nurse, or midwife	10.8	8.8
Assisted by birth attendant	73.5	62.5
Other	16.0	28.6
Children With Diarrhea	33.2	41.5
Use of ORS	14.0	6.0

Source: Futures Group: OPTIONS Project. Primary Analysis of Morocco, 1987 DHS data, (see Appendix, No. 11).

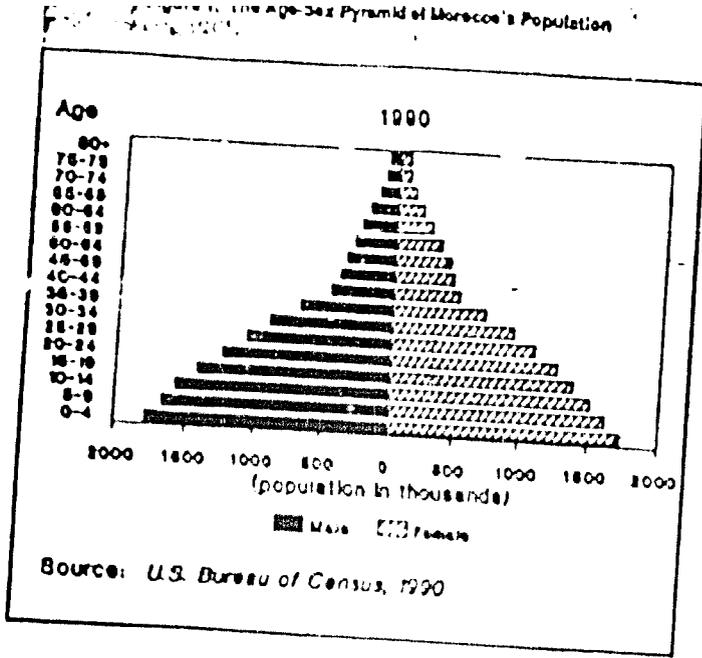


Figure 3. The Demographic Transition in Morocco, 1950-2000

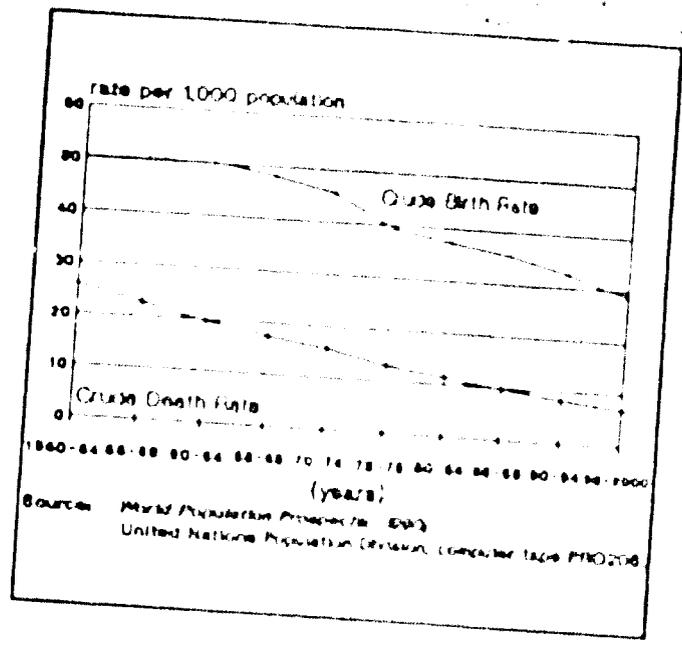


Figure 5. Birthspacing and Infant Mortality in Morocco

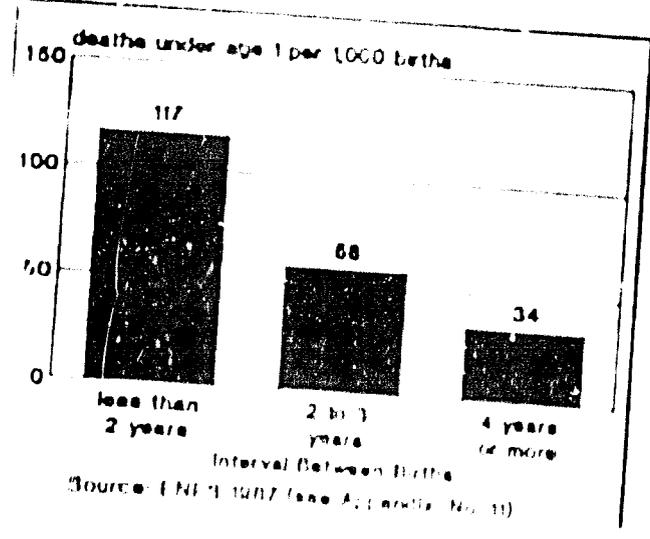


Figure 2. Infant Mortality Rate Versus GNP Per Capita In Six Near Eastern Countries

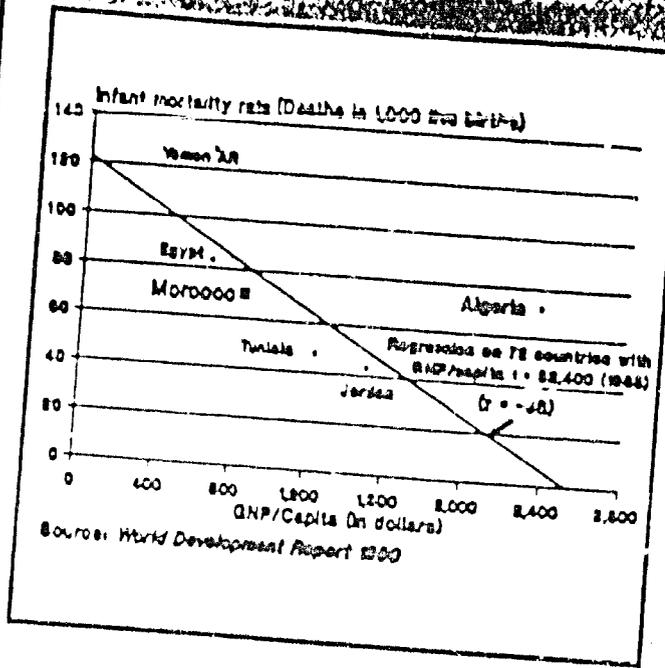
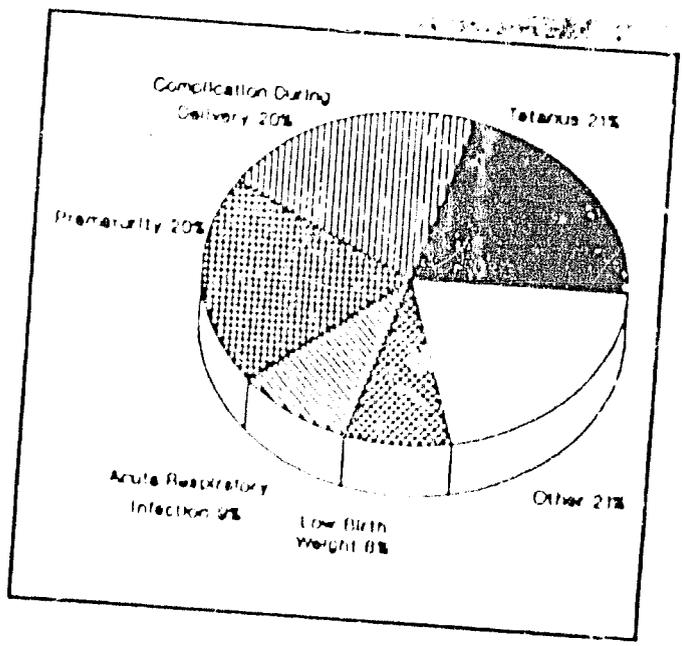


Figure 4. Principal Causes of Neonatal Death



FROM: Evaluation of AID Child Survival Programs - Morocco Case Study, 1991