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Morocco Policy Agenda:

**Identification of Key Areas
of Concentration**

Technical Report

by

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BACKGROUND

The Moroccan family planning and maternal and child health (FP/MCH) program has made great progress in improving the health of the Moroccan population in the past two decades as a result of a broad public service delivery network and growing participation of the private sector. However, many challenges lie ahead. There remains a large unmet need for critical FP/MCH services and a significant gap between urban and rural use of these services. In the face of growing demand, national resources are scarce, and foreign assistance is very limited.

The King and the Minister of Health are committed to continued improvement of the program, and the Government of Morocco (GOM) and USAID/Rabat are meeting the challenge with a new five-year bilateral project, the Family Planning and Child Survival Project (Phase V). The project is designed to strengthen the quality and accessibility of services and to promote future sustainability by expanding the base of public and private sector resources.

A favorable policy environment is essential to achieving the goals of the bilateral project. Consequently, USAID/Rabat and the GOM have agreed to the development of an agenda that identifies priority areas for policy reform as a condition precedent to the implementation of activities under the bilateral. The agenda is intended by USAID/Rabat to provide a framework for policy dialogue and for specific interventions to bring about the needed changes. The condition precedent will be fulfilled by the development of the policy agenda; benchmarks of progress are not required for disbursement of project funds.

The OPTIONS II team worked with both the Ministry of Public Health (MOPH) and USAID/Rabat to identify the areas that should be included in this policy agenda. In addition, to determine the level of support needed to analyze, identify, and implement reforms, technical assistance from OPTIONS was also discussed during these deliberations. The MOPH and USAID/Rabat will finalize the selection of key policy areas and develop the content and wording of the policy agenda to complete the condition precedent for the bilateral Family Planning and Child Survival Phase V Project.

PROCESS EMPLOYED BY OPTIONS II STAFF

Extensive analysis and planning have been conducted over the past year and a half to identify specific program interventions required for a quality, sustainable FP/MCH program. However, the legal, regulatory, and policy implications of these interventions have not been fully explored and actions to address them have not been developed and agreed upon. The OPTIONS II Project staff worked to improve the understanding of how policies can support or constrain planned interventions and to build consensus for selection of priority areas for policy reform.

OPTIONS II reviewed numerous documents and interviewed staff at the MOPH, USAID/Rabat, and other key organizations that play a significant role in the delivery of FP/MCH services in Morocco. The team traveled to four provinces, visited health care facilities of all levels in both urban and rural settings, and met with MOPH staff and health care providers to develop a thorough understanding of the management and service delivery operations of the Moroccan program.

In collaboration with MOPH representatives, the OPTIONS II team examined current policies which determine how FP/MCH services are delivered and identified those which impede expansion, limit the efficiency of service delivery, and reduce access to services. The team also collected ideas for improving program efficiency and undertaking policy reform. The team used the information gathered from documents and the field visit to identify several areas in which policy reform should be pursued. Following discussions with staff at the Directorate of Prevention and Health Training (DPES) of the MOPH and USAID/Rabat, priority areas were selected. The MOPH and USAID/Rabat will finalize the selection of key policy areas, develop the content and wording of the policy agenda, and complete the condition precedent.

This paper presents the results of these discussions. It begins with an overview of the Moroccan context, identifies the priority policy areas, and concludes with an in-depth discussion of each of the potential areas for reform including justification for their consideration, policy implications, and potential policy interventions.

COUNTRY CONTEXT

The population of Morocco is approximately 26.2 million and is growing at a rate of 2.4 percent. While the rate of population growth has declined considerably, the population continues to grow and will double in only 29 years if the current rate continues. The number of women of reproductive age alone will increase from approximately 5.6 million in 1991 to 8.1 million in the year 2000. Consequently, the MOPH will need to provide services to an increasing number of women and children merely to maintain current levels of coverage for

preventive health services. In addition, the MOPH must target resources to currently underserved populations in order to increase their use of family planning, prenatal and maternity care, ORT for treatment of diarrhea, and other critical services.

Progress in Improving Health Status

The results of the 1992 Demographic Health Survey (DHS) indicate progress in improving the health status of the Moroccan population:

- **Infant mortality has declined from 122/1000 live births in the early 1970s to 57.4/1000 live births in 1992.**
- **Child mortality has declined from 77/1000 children aged 1-4 in the early 1970s to 20/1000 in 1992.**
- **Contraceptive prevalence has increased from 19 percent of married women of reproductive age in 1978 to 41.5 percent (35.5 percent modern) in 1992.**
- **The total fertility rate has declined from an average of 5.9 children born during a woman's reproductive years in 1979 to 4.2 in 1992.**

A strong FP/MCH service delivery system has contributed to these achievements. The MOPH utilizes an extensive network of fixed facilities that provides health care coverage to over 80 percent of the population. The MOPH also uses outreach workers through its successful *Visites a Domicile de Motivation Sytematique* (VDMS) program, *points de contact*, and other channels to provide services to hard-to-reach populations. In addition, Morocco's private sector plays an important role in service provision.

Problems in Service Delivery

While the program has achieved significant success, considerable challenges remain. The 1992 DHS revealed the following:

- **There is a significant gap between the levels of knowledge and use of family planning methods.** While 73 percent of married women of reproductive age want no more children or want to space their births, only 35.5 percent are using a modern method of contraception. Of these women over 80 percent are using the pill.
- **Less than a third of pregnant women are receiving maternal and prenatal care.** Maternal mortality continues to be high in certain areas of the country. Only 31 percent of deliveries in 1992 were attended by medical practitioners. Only 32 percent of pregnant women received prenatal care.

- **There is a significant gap between the use of preventive health care and family planning services in urban and rural areas.** The contraceptive prevalence rate (CPR) in urban areas is 54.5 percent. This is almost twice that of the CPR in rural areas (31.6 percent). The number of women receiving prenatal care and maternity care is also dramatically higher in urban areas than in rural areas.

- **The private sector is not fulfilling its potential in the provision of FP/MCH services.** Currently the private sector provides 36 percent of family planning users with their methods. The bulk of private sector provision of family planning consists of pharmacy distribution of oral contraceptives. While private physicians provide a significant proportion of curative care services, their role in the provision of preventive health care and family planning is not as great as it could be.

Bilateral Project Goals

These problems will be addressed by the MOPH with the support of the Family Planning and Child Survival Phase V Project. Two major project goals are to increase use of services through improved quality, greater efficiency, increased channels of service distribution, expanded range of long term contraceptives, and IEC services; and to build future sustainability by developing a broader resource base in the public and private sectors, decentralizing authority and responsibility for services, and assuming greater responsibility for areas historically subsidized by donors.

Key Program Issues

Interventions are planned around program issues that must be addressed in order to achieve the project goals of increased utilization and future sustainability:

- The GOM can only mobilize adequate resources for meeting unmet demand for FP/MCH services by expanding and diversifying public support and by eliciting a vast increase in participation of the private and commercial sectors.
- USAID/Rabat will gradually phase down its procurement function and the GOM and MOPH must therefore assume both financial and functional responsibility for ensuring a stable flow of contraceptives for a growing national program.
- A centralized MOPH management structure cannot sustain the expanded effort required to reach underserved populations, and must therefore increase program responsibility and authority at regional and local levels.
- A significant investment of resources is anticipated for the public sector under the bilateral, but to maximize its impact on health status, the inefficiencies identified in the existing delivery system must first be corrected to improve deployment of personnel, use of facilities, and integration and referral among services.

- To successfully expand FP/MCH services, support must be secured from opinion leaders and policy makers for an increase in resources, and their assistance must be enlisted to allay concerns of potential opponents as services become increasingly visible through vigorous IEC.

It is essential that laws, regulations, ministry policies and professional practices be supportive of the interventions that are designed to resolve these critical issues: policy areas need to be analyzed; reforms and modifications identified that can facilitate the success of interventions; and strategies must be developed and implemented to bring about the desired change.

SELECTION OF AREAS FOR POLICY REFORM

Several areas were identified for policy analysis and reform, and objectives were established which would be most likely to contribute to the success of the Moroccan FP/MCH program and achievement of the goals of the forthcoming project. Priority areas were selected from the initial list of identified areas for reform.

Priorities for Inclusion in the Policy Agenda

Role of the Private Sector: Increase the role of the private sector in the provision of FP/MCH activities. The private sector provides services to over 40 percent of users of supply methods and 18 percent of users of clinical methods. The share of the market served by the private sector, as well as the range of methods and services it provides, should increase. If users shift from public sector services to the private sector, resources available to the program will increase and the public sector will be able to target its resources toward expanding prevalence by serving more costly and hard-to-reach populations as well as providing services to the indigent.

Procurement Responsibility: Implement a strategy for transferring the responsibility for procurement and purchase of contraceptives to the GOM. Currently, USAID/Rabat finances and procures contraceptives for the Moroccan program. USAID/Rabat and the GOM have agreed to transfer these skills and responsibilities from USAID/Rabat to the GOM. In order to ensure a steady supply of contraceptives to the program a strategy must be implemented and policies put in place to ensure that adequate funds are allocated for their purchase and to build the capability of the MOPH to project contraceptive needs, identify the most cost-effective sources for commodities, and effectively manage commodity procurement, logistics and distribution.

Decentralization: Support initiatives of the MOPH to decentralize its activities. The MOPH is moving to decentralize activities in conjunction with the GOM's overarching strategy to increase local participation and decentralize services. Improving planning capabilities at the regional and provincial levels will support these efforts. In order to increase efficiency and better respond to the needs of its clients, the MOPH must strengthen planning capabilities at the provincial level as well as implement policies to move authority for decision making, supervision, and planning closer to the client.

Service Delivery System: Improve the efficiency of service delivery by examining the roles of the different facilities and personnel in the delivery of services and streamlining service delivery. Currently, there is significant underutilization of FP/MCH services at all levels. At the same time there are cumbersome requirements and procedures for accessing clinical procedures, particularly sterilization. Owing to limited resources and trained staff, careful analysis of the staffing of each service delivery outlet and the policies determining which services they provide needs to be conducted in order to improve quality and expand access to FP/MCH services.

Support of Leaders: Develop an effective policy communication strategy to support progress in each of these policy reforms. Policy analysis and identification of needed reforms will result in change only if communication to build consensus for reform and inform people of the implications of new policies is undertaken in a systematic manner. Current reform initiatives will benefit from the development of a comprehensive, policy-level communication strategy whereby activities are clearly linked to specific reform issues.

Other Areas of Policy Reform

Service Delivery System: Integrate Family Planning into Primary Health Care Services.

Range of Contraceptive Methods: Expand the Method Mix and Appropriate Use of Contraceptives.

Decentralization: Establish Institutional Reforms for the Decentralization of MOPH Structures and Functions.

Diversify Resources: Introduce Cost Recovery Strategies.

The following section discusses these areas in-depth. It provides justification for pursuing policy reform in each of these areas, policy implications, potential interventions to promote reform and advantages and disadvantages of implementing each intervention.

AREAS FOR POLICY REFORM

ROLE OF THE PRIVATE SECTOR: INCREASE THE ROLE OF THE PRIVATE SECTOR IN THE PROVISION OF FP/MCH ACTIVITIES

Justification

The Moroccan program must meet the needs of more users with declining donor support. Transferring users from public sector services to the private sector will be critical to ensuring that the family planning needs of all Moroccans are met. This transfer will enable the public sector to expand prevalence by targeting its resources towards more costly and hard-to-reach populations and providing services to the indigent. Expanding the range of methods as well as the range of providers in the private sector will also increase prevalence by increasing access and providing a broader array of service delivery channels. Finally, expanding the role of the private sector will diversify the resource base of the program and can potentially shift the burden of commodity costs for methods such as the pill, which incur heavy recurrent costs, from the MOPH to the private sector.

The private sector currently plays an important role in the provision of family planning in Morocco. Through pharmacies, NGOs, and private physicians, the private sector provides 36 percent of family planning users with their methods. This role has increased dramatically in the past several years. Successful social marketing activities have expanded the provision of pills and condoms through pharmacies. Moreover, the MOPH has recognized the importance of the private sector and initiated activities to collaborate with private sector providers in urban areas where they can play a significant role in service provision. For example, at the Mohammedia Conference in April 1993, the MOPH formed a working group to generate strategies to expand the role of the private sector. These initiatives must be supported and expanded. In addition, policies must be implemented that remove constraints and provide incentives to encourage private sector physicians to provide family planning services.

The potential market for private sector family planning services is large. In 1992, 40 percent of users of supply methods and 18 percent of users of clinical methods obtained their services from the private sector. The most significant private sector provider of family planning services is the network of pharmacies that provides over 36 percent of pill users with their contraceptives. Commercial pill distributors distribute approximately 4 million cycles annually through this network. The SOMAKC Project forecasts sales of 3.5 million cycles by 1997. This represents 20.5 percent of the total oral contraceptive market. As Moroccan women become more accustomed to purchasing pills in pharmacies and as more products are introduced that provide a broader range of prices and choices, the distribution of the pill through pharmacies will increase.

The private sector provision of clinical methods has tremendous growth potential as well. Over 50 percent of consultations for curative health care services are provided by the private sector and there are over 4000 private physicians in Morocco. The 1992 DHS indicated that 19 percent of IUD users obtained their services from the private sector and 16.6 percent of female sterilizations were performed at private sector clinics. Introducing training and other incentives to encourage private physicians to provide these services may increase these percentages significantly.

Policy Implications

The current policy environment in Morocco limits private sector provision of family planning in two ways. First, laws, regulations, and operational policies increase the cost of commodities, training and equipment to levels which make family planning services too expensive for private providers to provide. Second, availability of public sector services provided free of charge crowd the private sector out of the market for family planning services.

Policies that make the cost of providing family planning services prohibitively expensive for private providers include:

Duties: Duties of up to 40 percent are charged for imported contraceptives, as well as for the raw materials needed for the manufacture of oral contraceptives. Local manufacture of the pill was stopped because it became too costly, and imports of contraceptives by the private sector have been reduced because of this heavy tax. These duties are imposed on contraceptives distributed by both the public and private sectors. They raise the cost of commodities to a level at which private sector providers can no longer afford to provide them, and they impose a significant drain on MOPH resources.

Training: Training for medical personnel in IUD and Norplant® insertion and sterilization techniques is not readily available to physicians in the private sector. Currently, the public sector provides training for public sector physicians. There is no policy that allows private physicians to participate in these training sessions, and there is no mechanism whereby private physicians can pay to participate in this training. Also, current curricula include only training for the laparoscopy technique for sterilization. Laparoscopy requires expensive equipment and is not as efficient as mini-laparotomy. Private physicians could play a larger role in the provision of sterilization if policies were introduced to allow their participation in training and to provide training in mini-laparotomy techniques. Also, charging private sector physicians a fee for this training would provide an opportunity for introducing cost recovery into the public sector and developing administrative capabilities within the MOPH to manage funds.

Equipment: Current techniques used for sterilization in Morocco require expensive equipment. The cost of this equipment is too expensive for private physicians to purchase for their practices. There is no policy that allows private physicians to use public sector equipment and facilities to provide sterilization to private sector patients during hours in which the facilities are not needed by public sector physicians. Also, there is no mechanism whereby private physicians can pay to use these facilities.

Crowding Out the Private Sector: Private sector service provision is also limited by the availability of public sector services provided free of charge. The public sector will always need to provide services free of charge for the population that cannot pay. Policies need to be implemented that segment the market and target private sector resources to the population that can pay, reserving public sector resources for those who cannot afford to pay. Effective means testing is critical to the successful implementation of these policies. Analyzing the market to determine which family planning clients can pay and which cannot, and developing a strategic plan to target public and private sector resources accordingly, can reduce the negative impact of crowding out on private sector services. The DHS, as well as household consumption/expenditure surveys, can be analyzed to develop this plan.

Currently the MOPH develops strategic plans that establish goals for each province based on national goals. There is such diversity among the provinces in Morocco, however, that national goals do not truly reflect the potential for private sector involvement in each province. By developing objectives that better reflect the characteristics of the region or province, planning and coordination can be improved. Efforts for collaboration between private and public sector providers have begun at the provincial level. Strengthening these efforts will improve coordination, decrease the negative impact of public sector services crowding out those of the private sector, and increase the role of the private sector.

Policy Interventions

1. Analyze the laws and regulations pertaining to the private sector provision of family planning.

This analysis would review all laws and regulations that constrain the private sector from providing family planning services and identify to what extent they actually impede private sector provision. It should include an estimate of the potential increase in private sector provision which would result from reforming policies, recommended strategies for reforming policies, and the likelihood of achieving reform. The MOPH is planning to engage a Moroccan expert to initiate a legal and regulatory review. OPTIONS II plans to provide an example of a similar study conducted in Egypt as well as guidance from a legal expert who had conducted this type of analysis.

This analysis would provide a wealth of information that is essential to determining the direction of future policy reform to promote the private sector. It is not a resource intensive exercise and would have a high payoff in the long run by identifying policy activities needed

to reform policies, the potential impact of pursuing those activities, and the likelihood of succeeding to reform policies and increase private sector provision of family planning.

2. Analyze the socioeconomic characteristics and family planning practices of the population to segment the market into public and private sector target markets.

This analysis would identify the potential role of the private sector in each region or province by analyzing the socioeconomic characteristics of family planning users and the supply of potential private sector providers. This market segmentation analysis would provide important information concerning which family planning users currently use the private sector, which users can afford to pay for services and should be directed towards private sector services and which family planning services should be made more available through private sector providers. This information should then be used to support design of future private sector interventions, strengthen private sector provision of specific family planning services and develop materials to inform family planning users of the availability of services through private sector providers.

Initiatives in improving public/private sector collaboration are already underway in several provinces. Using data and information to guide the direction of these activities and target resources appropriately will improve their effectiveness as well as increase the efficiency of service delivery.

3. Train private sector physicians in sterilization, mini-laparotomy, Norplant® and IUD insertion techniques.

This would involve implementing policies that allow private physicians to participate in public sector training sessions for a fee or for free. Policies regarding the procedures, curricula and counseling techniques included in the training should be reviewed in an effort to train private sector physicians in the provision of quality family planning services that can be provided at affordable prices.

Since the public sector is currently providing training for its own physicians, the additional cost of training private sector physicians would not be excessive. Charging fees for this service would provide an opportunity to introduce cost recovery into the public sector system and develop policies and administrative systems required to manage the collection of funds.

4. Expand private sector provision of IUDs by providing training and affordable IUDs to private physicians who will provide them to their patients at a reasonable price.

In Egypt, the provision of training and low cost IUDs to private physicians triggered a dramatic increase in the provision of IUDs by the private sector. Private physicians now provide 43 percent, and PVOs 10 percent, of IUD insertions in Egypt. Increasing private provision of IUDs in Morocco would increase access to IUDs and support the MOPH's goal of increasing the use of long-term methods and private sector provision of family planning.

5. Reduce duties imposed on imported contraceptives and materials required for their manufacture.

An economic analysis of the public revenues generated by collecting this duty, and the reduction in public spending resulting from increased private sector provision of family planning that would result from its removal, could be used to demonstrate to the Ministry of Finance the advantage of eliminating the duty.

Financial and economic analyses have proven to be effective tools to advocate for additional resources for family planning programs. This analysis could result in the removal of duties which are a heavy drain of MOPH resources as well as a strong deterrent for increased private sector provision and local manufacture of family planning commodities. Currently duties are also charged on imported vaccines distributed by the public sector. Progress is underway to eliminate this duty. Removal of the duty on vaccines can lead the way to removal of duties on contraceptives imported by the public sector. This analysis could provide additional impetus for the elimination of duties on contraceptives imported for private sector use. This will be increasingly important as USAID/Rabat phases down its commodity support; demand for family planning increases; and the GOM is faced with shouldering an increasingly heavy burden for the purchase of contraceptives.

6. Investigate the feasibility of allowing private physicians to use public facilities to provide sterilization.

This policy reform would put in place an incentive for private physicians to increase the counseling and sterilization services they provide to their clients who have achieved their fertility desires. In the past the MOPH had conventions with private sector specialists to fill gaps in the staffing of public facilities. Using these conventions to permit private physicians to use public facilities to provide sterilization could greatly expand access to this method. In addition, these conventions could be used as an opportunity for the public sector to recover some of its costs. There is, however, significant resistance to this idea within the MOPH, both from administrators, who anticipate the difficulty of managing this exchange, and from public sector physicians. For example, one OB/GYN within the MOPH expressed serious reservations about authorizing private sector physicians to use equipment and facilities for which the MOPH is responsible as well as concern about liability issues. Additional information needs to be collected to determine the feasibility of reforming these policies and their potential impact on access and use of sterilization.

7. Convince factory managers of the advantages of distributing family planning methods at the worksite and work with them to develop a system for providing methods to their employees.

The MOPH is collaborating with the Medical School at Casa Blanca to implement a pilot project of introducing family planning services into several workplaces. The results of this pilot project will demonstrate the potential impact of introducing family planning at the work place and the benefit of expanding these efforts.

8. Convince insurance providers of the importance of including family planning in their benefit packages.

Currently health insurance providers do not cover a large proportion of the population. The impact of this intervention would also be curbed by the limited supply of family planning in the private sector. Health financing initiatives are exploring the possibility of introducing a National Health Insurance system in Morocco. As this effort progresses, it is critical that family planning be included in the health care services covered by this insurance scheme.

9. Examine the potential impact of commercial social marketing to meet the needs of family planning users who can pay and analyze the price sensitivity of demand to project the potential impact of introducing new brands and products at a range of prices.

Price is the key mechanism that can be used to shift family planning users from public to private sector sources. Analyzing the price sensitivity of demand as an outgrowth of the market segmentation analysis would provide critical information in determining appropriate prices, the potential for shifting users from public to private sources, the potential for increasing prevalence, and the need to introduce additional products at different prices into the market.

PROCUREMENT RESPONSIBILITY: IMPLEMENT A STRATEGY FOR TRANSFERRING THE RESPONSIBILITY FOR PROCUREMENT AND PURCHASE OF CONTRACEPTIVES TO THE GOM

Justification

USAID/Rabat and the GOM have agreed to transfer responsibility for contraceptive financing, procurement, management, and logistics from USAID/Rabat to the GOM. In order to ensure a steady supply of contraceptives to the program during this transfer a strategy must be implemented and policies put in place to ensure adequate funding and build the capability of the MOPH to project contraceptive needs, identify the most cost-effective sources for purchasing commodities, and manage effectively the procurement, logistics and distribution of commodities.

All contraceptives available in Morocco are imported. The majority of contraceptives available through the public sector are donated by A.I.D. Under the Family Planning and Child Survival Project (Phase IV), USAID/Rabat has financed most of the contraceptive requirements for the MOPH and the social marketing program through 1994. This costs approximately \$2 million annually.

The GOM and USAID/Rabat have agreed to transfer the financial responsibility for contraceptive purchase from USAID/Rabat to the GOM over a period of five years. The additional costs which the GOM must anticipate have been projected in the development of the Family Planning and Child Survival Phase V Project and are projected to reach \$2.3 million annually in 1999. While the GOM has introduced a line item in the MOPH budget and allocated \$221,000 to fund the purchase of contraceptives in 1994, it is imperative that this amount increase in order to continue meeting the needs of the program.

In addition to mobilizing resources to purchase contraceptives for the program, the GOM must develop the capability to forecast contraceptive needs, identify the most cost-effective procurement sources, mix of methods, and manage the logistics and distribution of commodities. Currently, forecasting is conducted by looking at past consumption of contraceptives and talking with people involved in the program to factor in potential shifts in method mix resulting from program activities and anecdotal indications of changes in demand. This process does not include a systematic review of trends in demand as indicated by the DHS and other demand surveys or review of the cost implications of various source and method mixes.

Since all commodities have been supplied by USAID/Rabat there has been no need for the GOM to identify cost-effective sources for commodities or negotiate prices with manufacturers. The GOM currently manages a logistics system which clears the commodities through customs and distributes them to a network of 2,200 fixed facilities. In general the logistics system operates effectively, and the program has not suffered from stock outages. The Family Planning and Logistics Management Project (FPLM) has developed a strategy for building capabilities within the GOM for forecasting, sourcing and procuring contraceptives. This strategy also includes assistance to improve the efficiency of the logistics system.

Policy Implications

Implementing this transfer of responsibility for purchase and procurement of contraceptives will require introducing policies for increasing the funds allocated specifically for purchase of contraceptives and for institutionalizing responsibility and capabilities for procuring contraceptives within the MOPH. The funds allocated for contraceptive purchase will need to increase as USAID/Rabat phases out its support. This will require the GOM to forecast contraceptive requirements and project financial needs accurately in order to ensure that no shortages occur. In addition, the GOM must lobby the Ministry of Finance to be certain that sufficient funds will be available to purchase contraceptives. In order to institutionalize

capabilities for conducting an international tender and sourcing contraceptives, policies must be implemented which identify the appropriate office in the MOPH to be responsible for each of the steps in these processes and endow it with necessary resources and authority.

Policy Interventions

1. Project contraceptive needs by looking at trends in demand for methods and sources.

Efforts should be undertaken to initiate work with FPLM staff and the MOPH to improve forecasting procedures and identify the most cost-effective sources for procuring contraceptives. The former can be done by analyzing demand surveys such as the DHS and applying analytical tools like the Target-Cost Model. The Target-Cost Model can project the number of users and acceptors in future years of the program under various scenarios of changes in method mix - illustrating the impact of increasing the use of long-term methods - and of source mix - demonstrating the impact of increasing the role of the private sector. In addition to projecting the numbers of users and acceptors, Target-Cost projects the resources - including staffing and commodities - required to provide services for them.

Training MOPH staff in this kind of analysis would improve planning by looking at future needs rather than past experience. Target-Cost allows program managers to conduct sensitivity analysis in order to identify the most efficient delivery strategies and method mixes for meeting the needs of the population and the goals of the program. It could also be used to determine the cost implications of obtaining contraceptives from different sources. Finally, it would allow managers to model the potential impact of specific interventions in the program such as the introduction of new methods, campaigns to promote a specific method, or campaigns to increase the involvement of the private sector.

2. Develop a presentation highlighting the important role the family planning program has played in reducing public sector expenditures for other publicly-funded services such as education and health, and disseminate it to decision makers at the Ministry of Finance in order to ensure that adequate funds are allocated for the purchase of contraceptives.

These presentations have been very effective in demonstrating to policy makers the important role family planning programs play in the economic development of a country and mobilizing increased investment in family planning programs. Often policy makers do not see the connection between slowing population growth, economic development, and family planning programs. This information together with information about the strong demand for services would convince decision makers to allocate additional resources to family planning.

DECENTRALIZATION: SUPPORT INITIATIVES OF THE MOPH TO DECENTRALIZE ITS ACTIVITIES

Justification

Morocco's national program of MCH/FP has well developed targets at the national level. It depends on the peripheral level to achieve them. Different regions and provinces will contribute more or less to these targets, according to factors such as urban/rural location and socioeconomic and cultural characteristics of the population. For example, urban areas in which the population has access to health facilities, has access to radio and TV, and has higher proportions of working and educated women may be able to contribute more to achieving these targets than rural areas. By comparison, rural areas that are thinly-populated may contribute less, due to the difficulty in reaching people and the traditional isolation of the population.

In view of this, it may be very useful to strengthen planning for expansion of family planning use, methods and providers of services at the peripheral level. This would allow leaders at the peripheral levels to use detailed information concerning supply and demand for services in their areas to set appropriate targets and plan individualized strategies. For example, plans in urban areas would differ greatly from plans developed for rural areas. In urban areas, the population may be more familiar with family planning and more willing to try long-term methods. Likewise, there may be more private physicians and pharmacies, and greater exposure to the messages of IEC and social marketing (Protex condoms; Microgynon/Minidril orals) through radio and TV. Thus their strategy might emphasize long-term methods and significant involvement of the private sector. By comparison, rural areas may be inaccessible, with little exposure to media and few private physicians. In this case, the program might emphasize methods like the pill delivered by the public sector.

Strengthening planning at the peripheral level would support decentralization in a number of ways: by making the services more sensitive to local needs; by using the vision and knowledge of peripheral program managers; and by giving the periphery more responsibility for setting and meeting appropriate targets. It would also support current efforts of the MOPH to improve quality of services at the regional level.

This approach also complements policy objectives to increase private sector provision and introduce new methods. It would make use of intersectoral groups to increase dialogue, create venues for collective planning, and more actively engage the private sector. Over time it may improve the cost-effectiveness of contraceptive procurement by bringing planning closer to the client.

Policy Implications

Strengthening planning capabilities and increasing responsibilities at the peripheral level has several policy implications. First and foremost is defining the roles and responsibilities of the central, regional and peripheral levels. Administratively, at present there is no viable structure at the regional level. Steps are being taken to revitalize a regional structure that existed previously. But careful attention will have to be paid to defining the roles and responsibilities of the regional level vis-a-vis the provincial level in terms of the delegation of authority, budgeting, etc. Finally, the central level will continue to play a critical role by supporting the activities of the regional and provincial levels through the provision of training, supervision and coordination; and by collating peripheral targets into the national plan and ensuring that the aggregated peripheral targets correspond to the national targets.

Planning at the regional level can make use of the DHS, which is representative at the regional (but not the provincial) level. Regional planning should be scrutinized to make sure that it is not blurring large provincial differences (as national data blur regional and provincial differences). It will be important to use data to inform decisions about provincial implementation since it is the provincial level that is closest to the client and must take initiative to respond to local needs.

Decentralizing planning implies that a policy is made (at least for the pilot areas) to endow the peripheral level with authority and autonomy to set objectives and implement programs based on its more informed understanding of local needs, problems, and available resources. But to be effective, the central level would need to transfer authority and control over resources, both financial and staffing, to the peripheral level. The central level would need to accept that, over time, the programs, as implemented in each province and region, would begin to look different as they respond to local needs. Central policies determining uses of funding and deployment of staff would have to be implemented through effective, results-oriented monitoring systems. Other policy implications that would need to be decentralized over the long term include staffing policies such as hiring, firing, staff profiles, and performance rewards.

Policy Interventions

1. Training staff at the peripheral level in data analysis to strengthen program planning.

This intervention could be introduced into pilot prototypical areas and expanded into additional provinces. It would include:

- Collecting supply data by mapping public and private service points, including private physicians and pharmacies, to illustrate those areas that are saturated with service providers or with provision of particular methods and those that are not adequately covered.

- Conducting a workshop to analyze demand at the provincial and regional levels, drawing on the experience of provincial managers, service statistics and other existing data at the provincial level. Regional computer analysis of the DHS could be used to show fertility preferences, knowledge and use patterns, and socioeconomic characteristics of the population.
- Conducting a workshop with the intersectoral group to develop decentralized quantitative targets for methods and sources of services based on a market segmentation analysis of supply and demand.
- Planning strategies to achieve the targets. This would mobilize initiative at the provincial level, make good use of its ideas, and increase its responsibility. Innovative strategies might be developed including, but not limited to, training in family planning skills for private physicians and meeting expressed demand for particular methods such as the demand for injectables in the North.
- Building consensus for the strategy, developing timeframes, and defining roles, responsibilities, and resource needs at both the central and peripheral levels.

This approach has the advantages of being practical, interesting to participants (both to the central level in its role of providing vision and to motivated, participating peripheral units), and being a modest first step in decentralization. It not only sets in motion a process, but also transfers the skills and tools necessary to support the decentralization process from the central to the peripheral levels.

The disadvantage of this approach is that its success will be limited if the central level does not endow the peripheral level with the authority and responsibility it will need to make the process succeed.

SERVICE DELIVERY SYSTEM: IMPROVE THE EFFICIENCY OF SERVICE DELIVERY BY EXAMINING THE ROLES OF THE DIFFERENT FACILITIES AND PERSONNEL IN THE DELIVERY OF SERVICES AND STREAMLINING SERVICE DELIVERY

Justification

The GOM is undertaking initiatives to improve access to quality family planning and maternity services. It is implementing strategies to increase use of effective clinical methods as well as reduce disparities in the utilization of clinical family planning and maternal care between rural and urban areas. Currently, use of prenatal services and deliveries assisted by trained medical personnel is low. The 1992 DHS showed that only 31 percent of pregnant women used prenatal services and only 32 percent of deliveries were assisted by trained health personnel.

Cultural factors may affect demand for these services. Increasing the number of female health care providers may help to mobilize demand. But limitations in the supply of appropriate health care personnel, inefficient use of MOPH personnel and limited entry points into the health care system present significant obstacles to meeting existing demand. Policies are in place which require women seeking MCH/FP, and sterilization services in particular, to make numerous trips to health care facilities. MCH/FP services are not effectively integrated at the service delivery point. For example, postpartum family planning services are not readily available. Typically health care systems are designed in a pyramidal structure in which each category of lesser trained staff is more numerous than that above and has a specific role to play in the provision of health care. This ensures an efficient use of personnel and resources. The FP/MCH service delivery system needs to be streamlined in order to improve access to quality services and efficiency of resource use.

The case of the *sage-femme* provides a good example of this situation. According to the "Safe Motherhood Strategy", only 147 *sage-femmes* work in the public sector. Both the 1992 DHS and the 1987 NPS showed that women were seeing physicians more often than *sage-femmes* for prenatal care, despite the fact that it is easier and less costly to train *sage-femmes* than physicians. Partly because of this scarcity, *sage-femmes* are not able to play the role they are intended to play in the delivery of MCH services. Women seeking prenatal and maternity services often receive care from physicians or *infirmières accoucheuses*. Using the costly time of a physician to provide these services is not an efficient use of resources. Using an *infirmière accoucheuse* to provide these services, on the other hand, does not provide access to sufficiently trained health care providers who can intervene in cases of high risk.

Sage-femmes fulfill an important role in the provision of maternal health care and are widely used in other countries such as Tunisia. According to the "Safe Motherhood Strategy", the public sector needs at least one trained *sage-femme* per health center, and the private sector needs additional *sage-femmes* in order to meet the maternity needs of Moroccan women. This goal is based on the *sage-femme* worker filling the niche, not only of assisting normal deliveries, but being able to attend to high risk pregnancies as well.

Ensuring that sufficient numbers of *sage-femmes* can be trained has important implications for the curricula and provision of training of *sage-femmes* and *infirmières accoucheuses*. The *sage-femme* certification requires at least three years training. *Infirmières accoucheuses* receive training in basic care for two years. Currently, much of the training is provided as in-service as opposed to pre-service training. In-service training is not always the most cost effective type of training. Systematic review of both training needs and the cost-effectiveness of providing training is essential to improving the efficiency of the MOPH system.

Policy Implications

There are a number of policy implications in resolving the lack of sufficient trained staff to provide maternal care. Policy analysis and adoption of a policy is needed regarding the roles and responsibilities of each level of trained staff. This would clarify the GOM's policy as to the need for workers trained at the level of sage-femme compared to infirmière accoucheuse. On the basis of this analysis, policy decisions would be made to train required numbers of staff at appropriate levels.

If the policy adopted put priority on the sage-femme category, subsequent policy implications and actions might include greatly increasing enrollment from the qualified waiting list and revamping the curriculum to make the training continuous, without a break for a lengthy practicum. This policy commitment would likely require immediate allocation of additional resources to the training centers. The marginal additional costs of employing sage-femmes compared to infirmières accoucheuses would also have to be anticipated and funded.

Policy Interventions

1. Analyze the numbers of sage-femmes and infirmières accoucheuses needed to improve access to maternal care.

A new module of the Target-Cost Model could be used to project required numbers of staff at each level and estimates of training needs. The results generated by the Target-Cost Model could be incorporated into a presentation about the type and volume of maternity care needs, as well as in-country and international experience, to inform decision making regarding staffing needs for maternal care and corresponding training requirements.

There are no disadvantages to conducting this analysis. Its success, however, hinges upon taking the following steps to address critical issues:

- Plan for training of maternity care staff. Review the number and capacity of training sites to assure that they can provide this supply.
- Review the criteria for recruiting sage-femmes into training programs to assure that the profile (education and experience) of women recruited is appropriate to the demands of the training. Implement the criteria.
- Make the sage-femme training program continuous with no lengthy practicum to break up the training.
- Allocate required funding.
- Encourage private practice sage-femmes in rural areas. This will also further progress towards increasing private sector participation.

SUPPORT OF LEADERS: DEVELOP AN EFFECTIVE POLICY COMMUNICATION STRATEGY TO SUPPORT PROGRESS IN EACH OF THESE POLICY REFORMS

Justification

The Moroccan Government continues to recognize the importance of demographic trends for development and to build consensus and support for MCH/FP services. Recent activities to solicit broad-based support for family planning objectives among policy makers, planners, and leaders at the national level include the Mohammedia Conference (March, 1993), and, at the international level, the Maghreb Conference on the benefits of family planning (April, 1993). Currently, according to Division of Family Planning (DPF) staff, the DPF is receiving an unprecedented number of requests to make presentations on the family planning program to a variety of private and public sector institutions and organizations.

Initiatives in institutional reform will require a well-organized plan for building consensus among the many ministries, organizations, and individuals who will be involved in their implementation at both the national and local levels. The DPES recognizes the need to develop a policy-level communication strategy whereby activities are clearly linked to specific reform issues. General IEC activities, which have been delineated in a three-year plan entitled "Strategie d'Information, Education & Communication en Planification Familiale" (July 1992), focus on key service delivery issues, but primarily target providers and families rather than policy-level audiences. As the policy reform agenda begins to take shape, the selection of target audiences and the systematic development of information and messages aimed at implementing those reforms will be critical. Equally essential is the need to develop an institutional capacity and to establish mechanisms that help ensure long-term policy communication efforts.

Policy Implications

The DPES is already convinced of the need to enact a number of the institutional reforms discussed throughout this report. Ultimately, the success or failure to implement change, and the rate at which change takes place, may rest with the ability of the MOPH to enter into meaningful policy dialogue at the national level and to build a solid consensus among key decision makers at all levels. Each reform activity should include a thoughtful review of potential obstacles or constraints and ways in which information can serve to surmount them.

Although the MOPH sponsors seminars and conferences for leaders and the media on FP/MCH issues, policy-level communication activities occur on an *ad hoc* basis. The DPES staff remarked that materials and tools to communicate to policy makers, as well as to a wider range of decision makers and opinion leaders, are not adequate. This situation can be improved by using the wealth of data, the high level of analytical skills, the availability of selected technical expertise and equipment within the Department of Health Education (DES), and the interest of DPES staff in reaching policy audiences, to establish a policy communication strategy which promotes the policy reform agenda. High priority should be

given to enhancing this institutional capacity by building on existing initiatives and local talents.

Policy issues requiring significant policy dialogue and consensus building include the following:

- **Convince the GOM to increase financial resources allocated to the family planning program.** DPES staff are expressing concern and raising questions regarding presentation strategies. Issues include the timeframe required to gather critical information regarding contraceptive costs; the best format to use in presenting needs and demonstrating long-term benefits; and identification of the most appropriate individual(s) to deliver presentations.

- **Develop support for diversifying the family planning program financial base through the private sector.** Morocco's private sector, comprised of hundreds of pharmacies and over 4,000 private physicians, is loosely organized. Although the DPES is working with selected influential leaders and associations representing private sector interests, a systematic, coordinated strategy at both the national and provincial levels is needed to establish networks and ongoing communication mechanisms.

- **Build a consensus and reinforce the implementation of policies aimed at shifting from temporary to long-term and permanent contraceptive methods.** Translating new policies and service standards into provider practices and client preferences may be one of the most difficult challenges that the DPES staff faces. For example, the MOPH recently issued new, less restrictive eligibility requirements for tubal ligation. Staff in all MOPH facilities have been notified of the new criteria, and many facilities have them posted on the wall. During a recent field trip, however, MOPH staff in these facilities demonstrated varied understanding of the eligibility criteria for tubal ligation - few provider responses corresponded to the new mandate, and all responses implied more restrictive criteria than the new regulations.

Changing provider practices will require ongoing communication efforts on a number of different fronts. Moreover, significant policy dialogue and widespread dissemination of the characteristics, contraindications and benefits of each method may be necessary to prevent negative repercussions associated with the introduction of new methods such as injectables and implants.

- **Raise the priority of FP/MCH programs among influential national, provincial and community leaders.** The DPES has a rich and growing body of data emerging from the 1992 DHS, as well as from numerous other surveys and studies. The DHS analysis in particular is occurring at an opportune time. Morocco has a newly-elected parliament and DPES staff is interested in bringing the DHS results and their policy implications to the attention of these high-level policy makers. DHS findings

reinforce the need for several key policy reforms, such as accelerating the provision of quality prenatal and maternal services; supporting treatment and IEC activities aimed at reducing diarrheal-induced mortality and morbidity; addressing the gaps between levels of knowledge, demand, and use of modern contraceptives; and increasing the role of the private sector in the provision of FP/MCH services.

Statistical staff are also conducting in-depth analyses of regional- and provincial-level DHS data, which could be presented to local leadership groups and used to help local managers develop decentralized action plans.

Policy Interventions

1. Develop a policy-oriented communication strategy (action plan) in which the objectives and activities are clearly linked to key institutional reform issues.

The plan could include actions at two levels:

(1) **internal communications** within the MOPH to: (a) determine current levels of understanding; (b) inform personnel of new research findings, policies and strategic planning options (e.g., decentralization approaches, changes in eligibility criteria); and (c) evaluate use and effectiveness of communication approaches; and

(2) **outreach communications** to both national- and local-level audiences (top ministerial officials, parliamentarians, civic leaders, private sector providers, religious leaders, media, professional associations, women's organizations, and other influential leadership groups) designed to build consensus and facilitate acceptance and implementation of policy reforms.

It would also include identification of organizations and key players who can play a role in disseminating information to target audiences (INAS, AMPF, SOMARC, university departments, DES, the media, professional associations, etc.). Once the key groups are identified, appropriate staff should establish links and collaborative mechanisms. The number and type of collaborative organizations will depend on the policy area to be addressed. The official National Committee for IEC could serve to provide oversight and feedback, monitor activities, and act as liaison between the DPES and the various ministries and organizations it represents.

Strengthening DPES skills in conducting audience research and in pretesting materials will be essential to the success of these interventions. Brief surveys of representative audiences should be performed prior to any major policy communication activity. Pretesting of surveys and materials does not need to be extensive or require significant resources.

The action plan should incorporate the following interventions to support priority areas of policy reform:

a. Develop a computer-generated, interactive storyboard presentation highlighting the health and economic benefits provided by family planning programs. Developing the capacity to create the presentation and manipulate data inputs would give the DPES staff a valuable communication tool that could be revised to accommodate the informational needs of a variety of national-, regional-, and provincial-level decision makers. The visual presentation should be accompanied by a brief, attractive booklet that underscores key population trends, their impacts on selected sectors, policy implications, and required future actions.

b. Implement a series of private sector strategic planning activities that build on current national-level initiatives. Interventions could include: (1) identifying private sector informational needs concerning public sector policies and reforms, laws and regulations pertaining to private sector provision of services, training, availability, costs of contraceptives and equipment, and service/commodity pricing; (2) developing a private sector distribution list based on those available from private agencies (e.g. SOMARC) and professional associations; and (3) ensuring that relevant studies are summarized in simple, useful formats and disseminated to target audiences in a timely manner.

At the provincial level there is a need for information and materials to help facilitate local-level public/private collaborative efforts. Current public sector initiatives to organize "*journées de réflexion*" and to provide information to private sector providers should be reinforced. An additional suggestion from provincial delegates includes increasing the opportunities for interprovincial (regional) conferences to share ideas and experiences regarding public/private collaboration.

c. Reinforce provider compliance with the new VSC eligibility criteria. These directives should be immediately integrated into both pre- and in-service training modules. Field notification follow-up strategies include regular reminders over the first year; the distribution of new eligibility criteria on cards (laminated) to each facility; and the dissemination of attractive, one-page desktop fact sheets on voluntary sterilization (e.g., method mix examples from other countries where tubal ligation rates are higher, anticipated change in method mix ratios given new criteria, etc.).

d. Exploit existing databases and communications initiatives. DHS results and its policy and program implications for both MCH and family planning services can be presented in a variety of innovative formats including one page fact sheets; feature newsletter articles; a summary booklet; a leaflet series; or a wall chart depicting national and regional results, international comparisons, policy implications, and essential future actions. In addition, the existing VDMS success story could be expanded to cover the greater FP/MCH program including future challenges

(institutional reforms) and next steps. In booklet form, the case study could be used for local high-level audiences as well as for distribution at the 1994 World Population Conference.

e. Enhance DPES staff ability to access data and policy-related information by improving the organization of the DPES documentation center materials, and centralizing data resources in one bank. As a focal resource for health and population information, the center could serve multiple purposes in supporting MCH/FP policy reforms.

SERVICE DELIVERY SYSTEM: INTEGRATE FAMILY PLANNING INTO PRIMARY HEALTH CARE SERVICES

Justification

The Morocco national FP/MCH program is continually seeking to improve coverage, extend services to hard-to-reach populations and operate efficiently with scarce resources. Family planning services and maternal and child health services are routinely offered in the public health system and are, therefore, integrated in a general sense. At the point of delivery, however, entry into a system of complete FP/MCH care at any point in time is not necessarily guaranteed when a client arrives for a particular problem or need. For example, clients are not routinely referred for family planning when they seek prenatal or maternal services. Due to a lack of postpartum family planning services, a woman does not leave the hospital following delivery with any type of contraceptive. Health providers are not polyvalent in that they are not all similarly trained and supervised to deliver all aspects of FP/MCH care. Although the MOPH has issued new, streamlined referral directives for VSC in an effort to reduce the number of women lost in the system, facilities lack referral and follow-up mechanisms linking fixed and outreach services and linking services within the same facility.

Developing a holistic approach to meeting the needs of women and children is essential for ensuring high-quality services. Operations research projects in Burkina Faso demonstrated the synergistic effects of increased use of both maternal/child and family planning services when offered in an integrated setting. In addition to the benefits of having one health care provider familiar with all aspects of their care, women also gain from the direct and indirect cost savings resulting from reduced transportation and waiting time.

Policy Implications

Efforts to establish integrated services will require the revision or the introduction of policies aimed at: (1) ensuring that all health providers are truly polyvalent; (2) instituting mechanisms to strengthen follow-up and referral linkages between services; (3) strengthening postpartum family planning services; and (4) allocating the resources necessary to fully equip and maintain additional integrated delivery points. It is unlikely that increased service integration will be achieved at the local level unless greater efforts are expended toward coordinating program activities between services at the central level. Donor policies that support vertical service goals, particularly those policies mandating centrally-funded projects, continue to promulgate in-country vertical program approaches.

Policy Interventions

1. Analyze the organizational and administrative structures at each level to determine the most efficient approach to achieving service integration.

- Central level. Strengthen coordination and unify program objectives and budgets for FP/MCH. These activities should be carried out in tandem with efforts to resolve questions of funding approaches from donors.

- Service delivery level. One approach to testing and establishing integration would be through progressive development of service integration, leaving the exact mechanisms and structures to the judgement of provincial managers according to the needs of their areas and the capacity of their staffs.

2. Initiate an operations research study to test different approaches to the establishment of postpartum services.

This study would provide a wealth of information that would be useful for the development of new job descriptions; contraceptive distribution and inventory systems; revised supervisory roles; reporting procedures; client follow-up and tracking systems, etc.

3. Develop a strategy to help managers achieve their objectives in integrated service delivery, that is, by setting priorities and performance targets, and monitoring performance through regular data collection mechanisms and Total Quality Management exercises.

RANGE OF CONTRACEPTIVE METHODS: EXPAND THE METHOD MIX AND APPROPRIATE USE OF CONTRACEPTIVES

Justification

According to the 1992 DHS, family planning clients are heavily dependent on the pill (80 percent of modern contraceptive use) for which there is a high discontinuation rate (37 percent) within the first 12 months. Between 85 and 99 percent of married women surveyed were aware of IUDs and sterilization, and 62 percent had knowledge of injectables. By contrast, only 9 percent had ever used IUDs, 3 percent had selected sterilization, and less than 2 percent had used injectables. The DHS also indicates a high demand for family planning, with 49 percent of married women stating that they did not want more children, and 24 percent stating that they did not want a child within the next two years.

Morocco's method mix relies much more heavily on supply methods than that of other countries. This indicates a need for greater emphasis on long-acting and permanent methods. Promoting the use of more highly effective, long-term contraceptive methods will help the MOPH achieve its stated objectives of increasing contraceptive prevalence from 41.5 percent (1992) to 54 percent (1999) and improving the sustainability of the program in meeting the needs of a growing population. At the same time, reducing restrictions to access and availability can lead to increased service quality and client satisfaction. Decreasing the dependence on supply methods will also reduce the recurrent expenditure requirements of the program, freeing up financial resources to be directed toward other needs.

Policy Implications

In many countries, key officials or influential leaders play a pivotal role in setting program directions. Prior to the introduction of new methods or changes in current method policies and procedures, MOPH planners must assess the political climate to determine the potential for opposition to the introduction of new methods. For example, concerns about ensuring the quality of the provision of voluntary surgical contraception (VSC) and regulating the private sector can limit the private sector provision of this method. In Morocco, where VSC has been provided in the public sector under rigorous oversight, influential leaders may resist extending similar privileges to the private sector.

The introduction of new long-term methods, such as injectables and Norplant[®], can also be accompanied by rumors and misinformation that seriously impede the implementation of program policies and protocols and greatly reduce demand. For example, during the OPTIONS team field visit, a provincial hospital administrator stated that Norplant[®] suppresses fertility for up to two years following its removal. (Injectables can suppress ovulation for 6 to 12 months following the last dose; there is no delay in return to normal fertility following the removal of Norplant[®]). Identifying these misperceptions through audience research and disseminating correct information will help reduce misinformation and negative reactions and support program expansion.

Other key policy issues affecting the expansion and appropriate use of contraceptive methods are described below.

Decentralized Planning:

Due to regional variations, overall demand for long-term methods, as well as demand for particular methods, will increase more rapidly in some provinces than in others. Current central-level planning policies, however, impose national-level target objectives for each method upon the provincial levels. Given the heterogeneous nature of Morocco's cultures, differences in exposure to methods (large existing clientele for injectables in the Northern provinces owing to European influences), variations in the availability of private sector services, etc., it will become increasingly important for each province to be able to set objectives for method and source mixes that are appropriate for the local context.

Client eligibility:

Injectables: Introductory trials for injectables are planned for 1994. Prior to the establishment of trial client eligibility criteria, MOPH officials should review international experiences and standard policies. Currently, standard indications for injectables include women who: (1) present with contraindications regarding estrogen therapy; (2) are breastfeeding and need or want a contraceptive; and (3) want long-term birth spacing or have the number of children they want but do not want surgical contraception or are not appropriate candidates for sterilization. There are no age or parity limitations.

Norplant®: Introductory Norplant® trials are underway. Regulatory requirements for expanding Norplant® nationally will include establishing official eligibility and provider criteria and developing national protocols. Currently, trial eligibility guidelines in Morocco, including weight and age restrictions, are unnecessarily prohibitive. Standard international indications suggest that a woman may be a candidate if she wants long-term birth spacing or has the number of children she wants but does not want surgical contraception or is not an appropriate candidate for sterilization. There are no age, weight, or parity limitations.

Case studies from other countries indicate the adoption of broad, internationally accepted standards. In Senegal, the age of Norplant® users varies from the early 20s to late childbearing years. A program in Zaire found that a significant number of young women (secondary-school level) preferred Norplant® as their method of choice so as to help ensure completion of their education without risk of pregnancy. In Mexico, Norplant® users are mainly women who have reached their ideal family size but do not want tubal ligation. The method also appeals to women who want a long-acting, highly effective reversible method with few contraindications, and who do not like IUDs.

Voluntary Surgical Contraception: In May of last year, the Minister of Health issued new eligibility criteria. Key changes in the eligibility requirements include the client must be less than 40 years (as opposed to greater than 30); and have more than two children (instead of

four with one boy). Other former conditions, such as the need for the youngest child to be at least two years of age, and the need for a woman to have her husband's consent, appear to have been dropped (see Attachment A). While these new directives were established to improve the quality of services and better meet the needs of clients, systematic follow-up strategies or mechanisms were not put into place to ensure provider compliance and monitor policy impacts.

Policies affecting provider eligibility, access to training, constraints on the types of settings, and levels of use:

Injectables: Currently, injectables are not available in the public sector, although anecdotal evidence from several MOPH clinics in the North indicate that increasing numbers of women are requesting injectables as their preferred method, purchasing Depo-Provera from the pharmacy and bringing it to the clinics to receive the injection.

Policies specifying the level of providers to be authorized to give injectables, and establishing standard protocols with subsequent incorporation into pre- and in-service training programs will be critical to the successful introduction of this method. An additional policy implication concerns the impact of adding injectables to the forecasts of future method mix ratios.

A DHS comparison of countries with a history of public sector provision of injectables found that, in general, they are less widely used than sterilization, oral contraceptives and IUDs. However, in Indonesia, injectables are the third most popular method, used by 12 percent of married women and accounting for 25 percent of all modern contraceptive use. Injectables are also important in Botswana and Kenya where they account for about one-fifth of use, and in Thailand where they account for about 15 percent of use of modern methods. Although it is difficult to project potential levels of use for injectables in Morocco, its popularity in the Northern provinces indicates significant potential for this new method with gradual spillover into other parts of the country.

Voluntary Surgical Contraception. While there are 34 official sites (CCVs) equipped to provide laparoscopy or mini-laparotomy, only 6000 procedures are performed annually. Although reasons for low voluntary sterilization rates are complex, two significant policy-related deterrents have been: referral system barriers and restrictive eligibility criteria.

According to research studies on barriers to VSC conducted in two provinces in 1990-1991, major problems exist regarding the number of visits to a health center a client must make in order to obtain services. These include visits to obtain consent and pre-operative laboratory and radiology examinations as well as visits for the procedure itself. In addition to the complicated referral system, client access is further compromised by the limited availability of beds and trained personnel. In one province, a sample selection of women seeking VSC indicated that more than 50 percent were lost in the system and did not receive services. The MOPH's May 1992 announcement of new VSC eligibility criteria also included

directives outlining a new, more streamlined referral system. However, mechanisms for monitoring and evaluating the system have not been established.

The above-mentioned studies on VSC barriers also reported a steady decline in mini-lap use over a five-year period. In Marrakesh, use dropped from 12 percent in 1986 to less than 3 percent in 1990. This trend may signal a need to review current in-service training policies, particularly given the MOPH's stated desire to establish postpartum services and to expand VSC in the private sector.

The major advantage for increasing the availability of mini-lap services in Morocco's program is that it is the safest sterilization method in the postpartum period and requires only simple, inexpensive, easily maintained equipment. Thus mini-lap involves lower start-up and continuing costs than laparoscopy services. Physicians initially trained in laparoscopy, however, frequently prefer this procedure because it is slightly quicker and easier to perform than mini-laparotomy, causes less discomfort to the patient, and can also be used for diagnostic and therapeutic procedures. (See Table 1, Comparison of Mini-lap and Laparoscopy).

In Kenya, voluntary sterilization is the most widely used form of contraception among women over age 30. The numbers of women receiving the procedure jumped from 68 in 1982, to more than 11,000 in 1990. The local family planning program credits the increased acceptance and demand for VSC to the training of over 200 doctor-nurse teams in mini-laparotomy with local anesthesia. Kenya's training program includes both public and private sector providers.

Policies for follow-up and resupply of oral contraceptives:

The high discontinuation rate for pill users is a serious problem. Although in-service training addresses client follow-up, and clinic staff appear to be very conscientious about establishing and maintaining client tracking systems, many clients continue to be lost. Follow-up procedures and method supply policies may need to be revised to ensure client continuation. Research findings from the VDMS program indicate a low oral contraceptive discontinuation rate among clients served by itinerant agents. This is believed to be due to flexible protocols regarding the number of pill cycles supplied at each visit (6-12 months), as well as regular home visits.

Policy Interventions

1. Analyze the central- and local-level policy climate with regard to the introduction and expansion of new methods (e.g., injectables and Norplant®), and the promotion of private sector provision of long-term and permanent methods, especially VSC.

This analysis could document rumors or misinformation, concerns about the safety record of contraceptives, and general fears about expanded use.

Comparison of Minilaparotomy and Laparoscopy for Female Sterilization

Source: Adapted from WHO & AVSC

Table 1.

| <i>Consideration</i> | <i>Minilaparotomy</i> | <i>Laparoscopy</i> |
|--------------------------------------|---|--|
| <i>Instruments and equipment</i> | Requires a few inexpensive, standard surgical instruments and two special instruments—a tubal hook and a uterine elevator. | Requires delicate and expensive endoscopic equipment. Ongoing maintenance required. Spare parts must be available. |
| <i>Electricity</i> | Not necessary. | Necessary. |
| <i>Surgical skills and expertise</i> | Can be performed by any physician with basic surgical ability and skills after special training in the technique. Nonphysicians can be trained in this technique. | Restricted to specially trained surgeons and gynecologists. |
| <i>Setting</i> | May be performed in maternity centers and basic health facilities with surgical capacity. | Requires hospital or health facility with an anesthetist and general anesthesia backup available. |
| <i>Surgical time</i> | Usually performed in 10 to 20 minutes. | Performed in 5 to 15 minutes. Useful for services with large daily case loads. |
| <i>Contraindications</i> | Pelvic scarring, adhesions, and obesity make the procedure difficult. Acute pelvic infection is an absolute contraindication. | Not recommended for postpartum procedures or in women with previous lower abdominal surgery. Acute pelvic infection is an absolute contraindication. |
| <i>Risks and complications</i> | Low complication rate. Slightly higher rate of wound infection than with laparoscopy. Injury to broad ligament may require additional surgery. Slight risk of bowel or bladder injuries, uterine perforation. | Low complication rate. Severing the fallopian tube or injury to broad ligament may require additional surgery. Slight risk of vascular injury, bowel injury, and insufflation accidents. |
| <i>Postoperative pain</i> | Postoperative abdominal pain may occur. Slightly longer recovery than with laparoscopy. | Postoperative chest and shoulder pain resulting from abdominal insufflation may occur. |

Thoughtful preliminary research, using focus group formats or brief interviews with key officials, would provide critical information regarding potential obstacles or negative repercussions once policies are established. Analysis results, supplemented with DHS demand data and examples from other countries, could subsequently be disseminated through a variety of channels in a manner that would help allay fears and dispel rumors.

2. Develop a training program designed to address provincial-level forecasting and objective-setting needs.

The training program could include the use of instructional, interactive computer models, such as Target-Cost, and an analysis of both demand and supply-side variables. Training plans should be incorporated into regular in-service planning and management modules. These efforts could help improve local program efficiencies, encourage the use of long-term and permanent methods, support decentralization, and strengthen local capabilities to develop objectives that better reflect the characteristics of the province.

Decentralized planning and target-setting will also require a rethinking of central-level strategic planning policies. The MOPH's current practice of establishing goals for each province should be reviewed and possibly revised within the context of national decentralization plans. To ensure quality control, the MOPH may want to phase-in decentralized strategic planning training and subsequent delegation of authority, allowing each province to set and carry out its own family planning objectives.

3. Develop client and provider eligibility criteria for Norplant® and injectables based on a careful review of international standard indications and the experiences of other countries.

MOPH staff could conduct a secondary analysis of existing data from other countries to examine the impacts of different criteria on client use. Disseminating the analysis results to policy makers in the early stages of Norplant® and injectable trials may result in less restrictive regulatory policies.

4. Reinforce provider compliance with the new VSC client eligibility criteria.

These new directives could lead to increased service use if they are well disseminated and family planning providers are trained and encouraged to implement them on a regular basis.

Another priority intervention would be the systematic follow-up testing of the new VSC referral system in a limited number of provinces. Criteria for the selection of provinces could include the presence or absence of reference centers, variations in urban/rural populations, and the presence of one versus two or more local physicians trained in tubal ligation. The study would allow central staff to observe referral problems firsthand and to document ongoing problems with strategy implementation, including continued client loss. Test results should be analyzed to determine if additional changes in service roles and

provider responsibilities are indicated, and to identify the best approaches for ensuring that these new directives are implemented.

In addition, in preparation for the establishment of postpartum services and the expansion of VSC in the private sector, the MOPH may want to reintroduce and increase the number of in-service training programs for mini-laparotomy. Moroccan public and private physicians could be sponsored to go on mini-lap study tours as part of an effort to make mini-lap more available.

5. Train local staff to track, analyze, and interpret discontinuation data as a management and planning tool.

Simple interventions, such as adding a "client diary" to existing client record forms and interviewing a sample of no-shows, can provide a wealth of information regarding reasons for discontinuation. Training should include steps for calculating discontinuation rates by method, analyzing data, and taking effective action to reduce the number of no-show clients. Delegating the authority to make decisions regarding follow-up and supply policies, and strengthening local capabilities to diagnosis and correct problems may lead to higher continuation rates for all supply methods.

DECENTRALIZATION: ESTABLISH INSTITUTIONAL REFORMS FOR THE DECENTRALIZATION OF MOPH STRUCTURES AND FUNCTIONS

Justification

The MOPH is moving to decentralize activities, in parallel with the GOM's overarching strategy to increase local participation and decentralize services. The MSP is currently approaching this from two directions:

1) Inside the MOPH. Within the MOPH, the aim is to reduce dependence on the center, to strengthen peripheral functioning, to delegate more decision-making authority to local levels, and to improve responsiveness to urgent, local needs. Two initial steps have been taken: the development of regional training centers; and (it is reported) the delegation of increased planning flexibility to the provincial delegate for program budgeting, although implementation in the field has been variable. Full implementation in this area would require autonomous peripheral units, like the SEGMA hospitals. Thailand is an example where the provincial level has complete control over how to serve the populace (provided jointly-negotiated targets are met) and considerable control over the resources to conduct the services.

2) Outside the MOPH. In external relations, the emphasis has been on increasing the participation of collectivités locales (CLs), in order to share responsibility with these parallel structures and reduce dependence on the central MOPH structure. The Philippines is an example where the Local Government Code is now formally assigning all the budget,

personnel and accountability functions, which previously had been in the Ministry of Health, to local governments.

Achieving full decentralization, either within the MOPH or by sharing responsibility with outside organizations, requires an enormous, multifaceted and complex undertaking in Morocco. The political will to function under a fully decentralized system has to be present, along with the legal codes; administrative systems for decentralized planning, budgeting, staffing, and monitoring personnel; and an information dissemination plan. For Morocco, a major question concerns whether there is a need to establish a regional structure in the new decentralized system. The resource requirements of a decentralized system must also be determined. The timeframe to develop and implement full decentralization would be lengthy.

Policy Implications

The policy implications of moving to a fully decentralized system are enormous. For decentralization within the MOPH, a policy decision would be required committing the GOM to undertake the myriad of steps to fully decentralize. Some of the required steps are: defining roles and responsibilities at each level; allocating appropriate resources so that each level can perform; deciding about the need for a regional structure; modifying codes and regulations to bring them into line with the revised roles and responsibilities of each level; giving the peripheral level control over budgets; allowing the peripheral level to hire, fire, determine staffing patterns, and establish incentives for good performance; relinquishing prospective target setting at the central level; and substituting retrospective monitoring of results.

For initiatives outside the MOPH (e.g., the *collectivités locales*), there are policy implications in two directions. The MOPH would like the CLs to be a more effective partner in meeting community health needs (given their proximity to the communities) and would like to give them resources for this purpose. Second, the MOPH would like to get resources from the CLs (given their ability to tax) to expand MOPH initiatives.

The legal codes and regulations and patterns of interaction are not sufficiently developed in either direction. Within the *collectivité locale* structure there are three areas that need development before MOPH decentralization initiatives can bear fruit: 1) the exact role and authorities of the collectivités locales are poorly defined both legally and in practice, and the functioning of the CLs varies enormously; 2) within the CLs, the Bureaux Municipaux d'Hygiène (BMH), which is charged with health matters, is also poorly defined, codified and implemented; and 3) relationships between the Ministry of the Interior (to which the *collectivités locales* respond and which employs the health staff assigned to the BMHs) and the MOPH are also highly variable.

Strengthening these three areas will require enormous policy reform backed by deep political commitment. But without it, the CLs are not going to be a major source of revenue for the

MOPH, are not going to be an effective service partner in meeting communal health needs (by fulfilling their present charge), and are not going to be able to take over more tasks and commensurate funding from the MOPH to expand their role.

Policy Interventions

- 1. Disseminate the state-of-the-art paper on decentralization in a user-friendly format, in French, to policy audiences.**
- 2. Assemble information about the status of decentralization in the GOM.**

This would include examination of experience in other GOM entities such as the Ministry of Finance and Gendarmerie Royale, as well as experience in the MOPH in the regional training centers. This information would be disseminated to selected policy audiences.

- 3. Identify the most problematic aspects of centralized structure, and begin to systematically develop steps for decentralized reorganization.**

Interventions should be based on in-country experiences, needs and priorities, with application of international theoretical and practical experiences in decentralized public administration. The systems should be designed to suit Morocco. Finally, a time-phased plan identifying the objective, the responsible entities, steps to completion, and resources needed would be developed.

DIVERSIFY RESOURCES: INTRODUCE COST RECOVERY STRATEGIES

Justification

Cost recovery strategies can include strategies for introducing fees for services; charging fees for support services such as training, use of facilities, and production of IEC materials; and developing strategies for obtaining resources from other entities such as other ministries or collectivités locales. Pursuing any of these strategies will require extensive policy reform.

The fact that 36 percent of Moroccan family planning users obtain their services from the private sector demonstrates that Moroccans are willing to and do pay for family planning. It is critical, however, that any strategy for introducing fees for service in the public sector address the needs of the population that cannot pay. To date, the MOPH charges nominal fees for curative care services with exemptions for those who are indigent. These fees are not collected in a systematic fashion because the MOPH lacks the administrative capacity to manage fee collection and an effective mechanism to ensure equitable access for the poor. Introducing fees for preventive health care services or for family planning alone into a system that does not effectively charge for curative care services could have serious negative impacts on the perception and utilization of preventive services.

The introduction of a fee structure for those who can pay is a very important long-term objective for the MOPH. It will increase the resources available to the health sector, support improvements in the quality of care, facilitate the transfer of public sector users to the private sector, and ensure that public sector resources are targeted towards those who cannot pay. In addition, implementing cost recovery strategies that allow facilities to retain their revenues can dramatically increase staff productivity, quality of care, and morale. The MOPH has begun to strengthen the collection of fees for service in its hospital system and is planning to strengthen these efforts in all levels of curative service. The MOPH is concerned, however, that until the demand for preventive health services is well developed, adoption of a fee for service will decrease service utilization. Consequently, efforts to introduce fees for preventive health care services should be pursued after fees for curative care services are effectively collected and demand for preventive services is well established.

Obtaining resources from other groups, such as private physicians or collectivités locales, by charging for support services such as training, use of facilities and materials development, could provide opportunities for introducing cost recovery strategies, developing administrative mechanisms for collecting funds, and implementing policies which direct collected revenues back into the provision of services at the facility level. The MOPH has attempted to collaborate with the collectivités locales to build new facilities. The lack of policies defining roles, responsibilities, and authority for decision making, however, has limited the success of this undertaking.

Policy Implications

The policy implications for introducing cost recovery strategies are complex. In order to introduce fees for services, fees must be introduced for curative care services and capabilities for managing and administering fee collection developed at all levels of the MOPH. This is an enormous and costly change that will have to take place over a long period of time. Introducing fees for support services could be a first step in introducing cost-recovery strategies. It would provide an opportunity for introducing policies and procedures for managing and handling monies within the central level and hospital facilities of the MOPH. Ensuring that collected fees are retained at the facility level will be fundamental to the success of this initiative. Similarly, obtaining resources from the collectivités locales will require establishing administrative mechanisms for transferring resources and will require modifying legal statutes to allow revenues to be kept at the local and facility level.

Policy Interventions

1. Analyze feasibility of mobilizing resources from collectivités locales.

This would include an overview of the potential areas for collaboration, policies that limit this collaboration, and policy reforms that would increase collaboration and ease transfer of resources.

Several studies of collectivités locales have been undertaken and efforts pursued to initiate collaboration. The results of these efforts need to be reviewed and ideas for new strategies for collaboration developed. As the movement towards decentralization within Morocco progresses, the role of collectivités locales will change and opportunities for collaboration will evolve.

Bibliography

Journée Régionale d'Information et de Coordination des Activités de Planification Familiale
Casablanca, Morocco: Ministère de la Santé Publique, March 1993.

Projet de Stratégie Nationale de Réduction et de Prévention de la Morbidité et de la Mortalité Maternelles et Périnatales dans la Cadre de la "Maternité sans Risque" Rabat, Morocco: Ministère de la Santé Publique, April 1992.

Revue de Programmation avec l'USAID: Rapports des Groupes de Travail Mehdiya, Morocco: SEATS Project, February 1993.

Raymond, Susan; Yahya Farag
Private Sector Health Development in Morocco, Back to Office Report, March 1990.

Planning Familiale et Entreprises Privées au Maroc Rabat, Morocco: Enterprise Program, April 1987.

Colloque National sur la Santé, Realités et Perspectives Ouarzazate, Morocco: Ministère de la Santé Publique, July 1992.

Enquête Nationale sur la Population et la Santé au Maroc, ENPS-II 1992 Columbia, Maryland: Demographic and Health Surveys, September 1992.

Hurley, Suzanne and Walter Proper
Draft Trip Report, Atlanta, Georgia: FPLM Project, May 1993.

Morocco Private Health Sector Study: Findings and Project Design Recommendations
Arlington, Virginia: John Snow Inc., September 1991.

Possibilities to Expand the Private Health Sector in Morocco Arlington, Virginia: The Enterprise Program, January 1991.

Halpert, Peter and Carl Hawkins
Strategy for USAID Contraceptive Phase-down Arlington, Virginia: Family Planning Logistics Management Project, May 1993.

Saaf, Abdallah and Ahmed el Hariti
Etude sur la Participation des Collectivités Locales aux Soins de Santé de Base au Maroc
Rabat, Morocco.

Journées d'Etude sur la Collaboration entre les Collectivités Locales et le Ministère de la Santé en Matière de Salubrité et d'Hygiène Publique Rabat, Morocco: Ministère de la Santé Publique, November 1989.

Chiavaroli, Eugene et al.

Evaluation of A.I.D. Child Survival Programs: Morocco Case Study A.I.D. Technical Report No. 1 Washington D.C.: Agency for International Development, December 1991.

Jewell., Norine, et al.

Morocco Options Analysis Report Washington D.C.: Poptech Project. May 1993.

Etude de la Décentralisation de la Gestion des Ressources Humaines et de l'Organisation des Structures Centrales et Péripheriques Rabat, Morocco: IMEG Consultants, August 1992.

Lecomte, Jean DR.

Mission d'Evaluation des Centres de Reference Washington D.C.: SEATS Project, May 1993.

Graeff, Judith and Philippe Langois, Elaine Murphy, and Ron Parlato

IEC Strategy Plan for USAID Assistance in Family Planning, Maternal Child Health, and Policy Communication: 1994-1999 Washington D.C., January, 1993

Ministère de la Santé Publique

Manuel Des Méthodes Contraceptives Rabat. Morocco, June, 1992.

Belouali Radouane Docteur

Etude du Système d'Orientation Recours Pour les Services de Planification Familiale Rabat, Morocco, Institut National de l'Administration Sanitaire (I.N.A.S.), February, 1991.

Rabat, le 25 MAI 1992

MINISTRE DE LA SANTÉ PUBLIQUE

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MESSIEURS LES DÉLÉGUÉS DU MINISTÈRE
DE LA SANTÉ PUBLIQUE AUX PROVINCES
ET PEFECTURES

OBJET : Amélioration de la prise en charge des demandes de contraception Chirurgicale Volontaire (C.C.V)

L'étude réalisée sur le système de référence des clientes (dit système d'orientation et recours) dans le programme de Contraception Chirurgicale Volontaire, a permis de dégager les principaux résultats suivants :

- Les candidates à la C.C.V sont tenues d'effectuer inutilement plusieurs visites à différents niveaux du système sanitaire
- Insuffisance d'information et de maîtrise en matière de conseil en Planification Familiale
- Insuffisance de coordination entre les formations sanitaires et l'unité C.C.V

La prise en charge des demandes de C.C.V au niveau des circonscriptions sanitaires nécessite une collaboration planifiée avec l'unité C.C.V qui doit :

- Fixer de façon permanente les rendez-vous (jours et matinées de la semaine) et les respecter,
- Avoir une bonne coordination avec toutes les formations sanitaires en vue d'un meilleur suivi et
- Informer les formations sanitaires à temps de tout changement de programme.

Afin de faciliter et d'améliorer la prise en charge des candidates à la C.C.V et de pallier à ces insuffisances les directives suivantes doivent être observées :

DIRECTIVE I : LES INFORMATIONS SUR LA C.C.V

- Les informations à donner doivent préciser obligatoirement :
 - Le consentement éclairé du couple
 - L'irréversibilité de la méthode
 - Les conditions d'éligibilité : La cliente doit :
 - être âgée de moins de 40ans ;
 - avoir plus de 2 enfants
 - Le médecin jugera en toute conscience de l'opportunité de l'acte eu égard aux considérations sociales médicales
 - La technique employée et le type d'anesthésie
 - Les conditions d'obtention du service : Formulaire à remplir, rendez-vous etc...
 - Le suivi opératoire
- Ces informations doivent être données par le personnel à tous les niveaux :
 - Dispensaire médicalisé ou non,
 - Centre de Santé et
 - Centre de Référence

Aussi le Centre de Référence demeure le pivot de L'information, de l'accueil et de l'orientation des clientes vers l'unité CCV.

DIRECTIVE II : LES SERVICES ET LES RESPONSABILITES sont en rapport avec :

- Les niveaux intermédiaires
- L'unité C.C.V et
- Le suivi post-opératoire

38

1. LES NIVEAUX INTERMEDIAIRES :

Pour réduire le nombre de passages des clientes au niveau des différentes formations sanitaires et un va-et-vient inutile, il est nécessaire d'intégrer l'activité C.C.V au sein de toutes les structures de base et de définir les tâches structure comme suit :

1.1 NIVEAU ITINERANT ET DISPENSAIRE NON MEDICALISE :

- Informer la cliente sur :
 - . Les conditions d'éligibilité
 - . Les conditions d'obtention du service : Dates, Heures, Lieu, Examen
 - . Les formulaires exigibles : Fiche de consentement
- Donner une fiche de liaison vers le centre de santé ou le centre de référence selon le cas

1.2 DISPENSAIRE MEDICALISE ET CENTRE DE SANTE :

- Information de la cliente (comme indiqué précédemment)
- Interrogatoire poussé permettant l'orientation de la cliente
- Examen médical général
- Examens de laboratoire de routine exigés par l'unité C.C.V si besoin est
- Signature de la fiche de consentement
- Pré-rendez-vous vers le centre de référence avec une fiche de liaison sur la base des jours de semaine fixés au préalable pour l'activité C.C.V

1.3 CENTRE DE REFERENCE :

Il peut soit prendre en charge les clientes qui se présentent directement, soit recevoir les clientes référées leur dispenser les prestations suivantes :

- Information
- Signature de la fiche de consentement si non signée
- Examen médical général si non fait
- Rendez-vous pour la C.C.V

2. L'UNITE C.C.V : Veille à essentiellement sur :

- L'admission de la cliente,
- L'examen de la cliente,
- l'acte C.C.V pour lequel il doit être précisé :
 - le jour,
 - l'horaire et
 - l'équipe qui doit procéder à l'acte.

3. LE SUIVI POST-OPERATOIRE : il doit être organisé et se fera soit au centre de référence soit au centre de santé, soit à l'unité C.C.V si les conditions de travail le permettent.

- La 1ère visite systématique aura lieu : 1 semaine après l'intervention pour l'ablation des fils
- Les autres visites auront lieu :
 - . le 1er semestre pour le contrôle post-opératoire
 - . et par la suite, en cas de besoin

J'attache une grande importance à ce que ces directives soient scrupuleusement observées et transmises de manière claire à tout le personnel concerné.

