

Morocco

**30 YEARS OF COLLABORATION BETWEEN USAID
AND THE MINISTRY OF HEALTH**

A RETROSPECTIVE ANALYSIS

Family Planning

**USAID/Morocco
Morocco Ministry of Health**

**MEASURE *Evaluation*/Tulane University
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OVERVIEW OF THE RETROSPECTIVE ANALYSIS

Purpose of the Series of Reports

This series of four reports details the productive collaboration between the United States Agency for International Development (USAID) and the Moroccan Ministry of Health (MOH) spanning a period of over 30 years. It focuses on four health areas in which USAID support has been the greatest: family planning, child survival, safe motherhood, and sexually transmitted infections (STIs)/HIV/AIDS.

Morocco has made tremendous strides in its health programs, as evidenced by steadily improving health outcomes over time. In part because of this success, USAID began a strategy of “withdrawal” from Morocco, which was slated to begin in the year 2000. Subsequently USAID decided to maintain a modest level of funding through 2004 to support the activities of a “mature program,” including sustainability and decentralization.

What was accomplished during the more than thirty years of collaboration between the MOH and USAID? This series of reports is designed to address that question. The specific objectives of this retrospective analysis are:

1. To document the evolution of the programs in family planning, child survival, safe motherhood, and sexually transmitted infection/AIDS under the Ministry of Public Health (MOH) – USAID collaboration;
2. To place the health initiatives in Morocco in a larger international context as a means of better understanding the evolution of programs in Morocco;
3. To present measurable results in health status indicators that link directly to these health initiatives;
4. To identify keys to the success of specific programs that may represent valuable lessons learned for programs in other countries; and
5. To recognize the past obstacles and continuing challenges to the implementation of health programs in the four areas.

Many factors contributed to improvements in health status in Morocco over the past three decades: improvements in socio-economic conditions, exposure to ideas from other countries, investments from other donors, among other factors. Whereas this series of reports focus almost exclusively on the MOH-USAID collaboration, other factors and other parties share in the credit for the progress made to date. Notwithstanding, this series of reports has been prepared to demonstrate the sustained investment by USAID in the Moroccan health programs and the results achieved to date.

The current report covers the period from the early 1965 (when family planning first surfaced as a concern) to 2000, when Phase V funding ended. USAID continues to provide bilateral support to the MOH through an agreement (Assistance for Family Planning and Maternal-Child Health, Accord 608-0223) that aims at expanding

the resource base and capacity for sustainable development in the period 1999-2005, but the current activities are outside the scope of this retrospective analysis of the Moroccan program.

Audience for this Series of Reports

This series provides a comprehensive overview of the major events that occurred in relation to the four health areas in question. It will serve as a reference to MOH personnel, donor agency staff, international visitors, academics, and others with the patience and appetite for a relatively detailed account.

Methodology

A team of MEASURE *Evaluation* staff and independent consultants conducted the analysis for this series of reports. Team members conducted in-depth interviews with key informants and reviewed relevant program documents. The purposive sample of key informants included the following:

- Persons with substantial experience in the management of some aspect of the four health program areas;
- Personnel from both the central and regional/provincial level;
- Personnel from both the public and private sector;
- Personnel from non-governmental organizations (NGOs);
- Representatives of donor agencies; and
- Persons outside the program (researchers, economists, sociologists, demographers).

A complete list of all persons interviewed appears in Appendix C.

Limitations

The team encountered several constraints in conducting this retrospective analysis. First, all of the in-depth interviews — especially those relating to events in the distant past — were subject to recall bias. Respondents were most gracious in attempting to reconstruct events from over a decade ago, but there is an inherent bias in doing so.

Second, the key informants included persons closely involved in the program who tended to have a favorable outlook toward these health initiatives. The team did not attempt to identify and interview persons who might have provided alternative interpretations to this set of events, given the difficulty of drawing up any type of systematic list of such individuals. The team did, however, try to solicit information on both positive and negative aspects of the program from those interviewed, and most respondents were quite forthcoming.

Third, it was difficult and in some cases impossible to obtain financial information on components of MOH activities funded by other donors. Thus, the team was not able to

assess the financial contribution made by USAID relative to the total amount of international aid for each sector.

Fourth, the existing documentation was more extensive for some programs than others and for some periods than others. Although four reports were prepared, the descriptions of the programs herein do not do justice to the many triumphs and frustrations of designing and implementing these activities.

Summary of Findings – Family Planning

This report documents the collaboration between USAID and the MOH in Morocco over the past three decades, the impressive results achieved, and the challenges ahead. Cooperation between the MOH and USAID began in the early 1970s, five years after the start of the Moroccan National Family Planning Program (NFPP). Between 1971 and 2000, five USAID/MOH projects corresponding to five phases and totaling 126 million dollars were launched. A sixth and final project covering the 2000-2004 period is intended to ensure the sustainability of the population, health, and nutrition programs.

The cooperation between USAID and the MOH evolved and adapted to the country's needs and priorities. The Moroccan NFPP benefited from focused USAID technical support in five essential areas: contraceptive logistics; continued training of health providers; development of effective Information-Education-Communication (IEC) strategies; information system; and involvement of the private sector: Project appropriations increased over time, growing from three million dollars in 1971-1977 to 52 million in 1993-2000, attesting to the mutual interests and the relationships of trust between the two parties.

Over the past thirty years, USAID supported a broad range of actions, facilitated by increased participation from both the MOH and USAID, and the involvement of institutional contractors. The Moroccan family planning program also benefited from the support of the royal family over the years as well as high levels of political support which contributed political capital to family planning as a program and legitimized contraceptive use at the individual level.

The collaboration between the MOH and USAID led to important results in family planning indicators. Contraceptive prevalence among married women of reproductive age rose from less than 20 percent in 1979-80 to 59 percent in 1997. The total fertility rate decreased dramatically from 7.0 children in 1979-80 to 3.1 children in 1997. Despite these advances, significant differences persist in family planning indicators between rural and urban areas.

While the Moroccan NFPP still faces challenges ahead, it is considered to be a success on both the national and international levels. Thanks to the commitment of political officials, the incremental approach adapted to the national context, the dedication of health care professionals, and the support of USAID, the NFPP stands today as an internationally recognized success.

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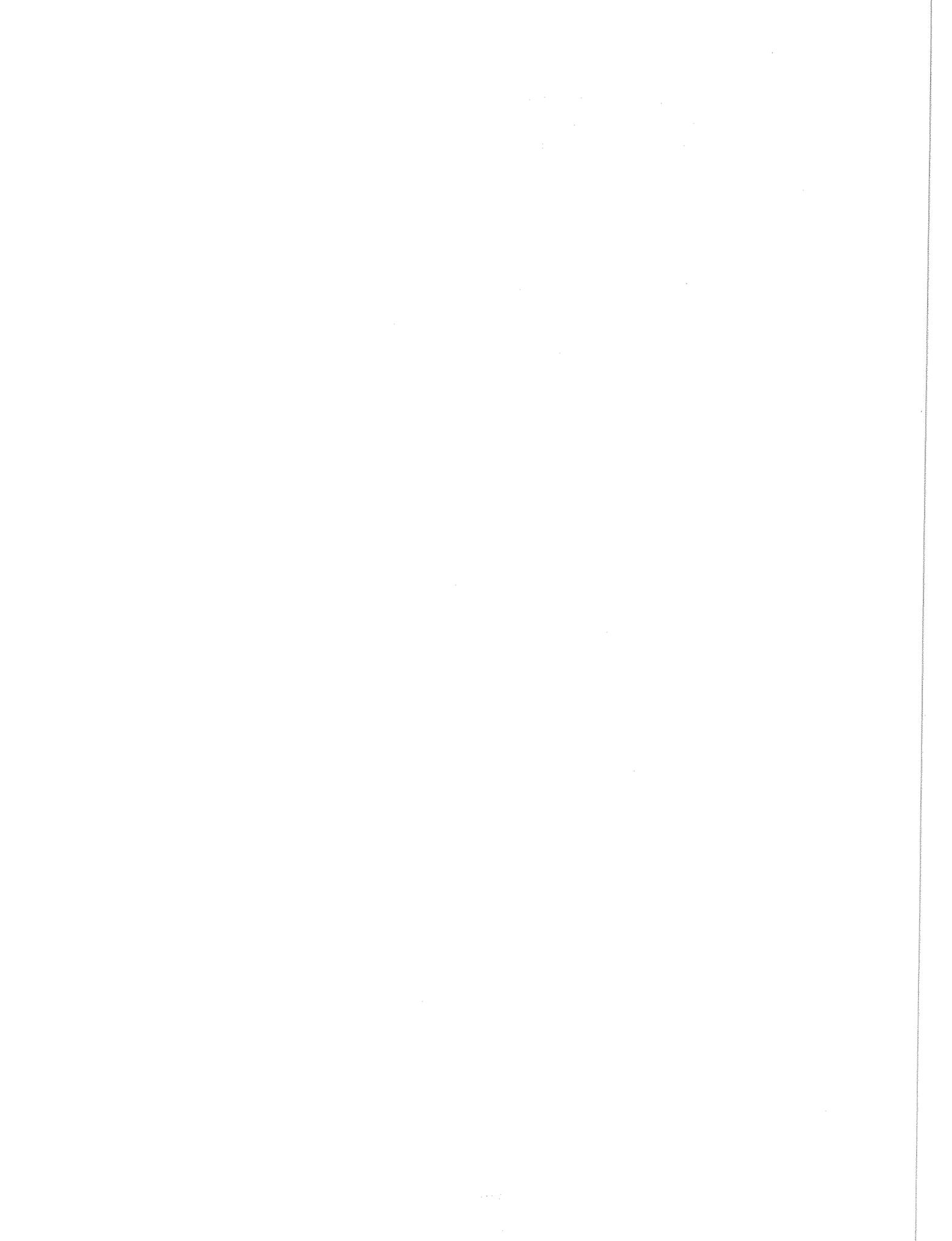
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMPF	Moroccan Family Planning Association - <i>Association Marocaine de Planification Familiale</i>
AVSC	Association of Voluntary Surgical Contraception
CAs	Cooperating Agencies
CBD	Community-based Distribution
CDC	Centers for Disease Control
CMS	Commercial Market Strategies
CSM	Commercial Social Marketing
CNFRH	National Center for Training on Human Reproduction - <i>Centre National de Formation en Reproduction Humaine</i>
CPT	Contraceptive Purchasing Tables
DHS	Demographic and Health Survey
DP	Directorate of Population - <i>Direction de la Population</i>
DPES	Office of Prevention and Health Training - <i>Direction de la Prevention et de l'Encadrement Sanitaire</i>
DPSI	Division of Planning, Statistics & Computer Science - <i>Division de la Planification, de la Statistique, et de l'Informatique</i>
ENPS	National Population and Health Survey - <i>Enquête Nationale sur la Population et la Santé</i>
EU	European Union
FHI	Family Health International
FP	Family Planning
FP/MCH	Family Planning/Maternal & Child Health
FPLM	Family Planning Logistic Management
GOM	Government of Morocco
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
IFCS	Institutes of Training for Health Careers - <i>Instituts de Formation aux Carrières de Santé</i>
IMCI	Integrated Management of Childhood Illness
INAS	Institute of National Health Administration - <i>Institut National de l'Administration Sanitaire</i>
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JHPIEGO	John Hopkins Program for International Education in Reproductive Health
JHU	Johns Hopkins University
JHU/CCP	Johns Hopkins University /Center for Communication Program
JHU/PCS	John Hopkins University/Population Communication Services
JSI	John Snow Inc.
KAP	Knowledge, Attitudes, and Practices
MCH	Maternal and Child Health

MIS	Management Information System
MOH	Ministry of Health
MPH	Master of Public Health
MSH	Management Sciences for Health
MSMP	Moroccan Social Marketing Program – <i>Programme Marocaine de Marketing Social</i>
NFPP	National Family Planning Program - <i>Programme National de Planification Familiale (NFPP)</i>
NGO	Non-governmental Organization
OCP	<i>Office Chérilien des Phosphates</i>
PACR	Project Action Completion Report
PHR	Partnerships for Health Reform
QA	Quality Assurance
RH	Reproductive Health
RTI	Reproductive Tract Infection
SEATS	Service Expansion and Technical Support Program
SEIS	Service for Research and Computer Science - <i>Service des Etudes et d'Information Sanitaire</i>
SETI	Service of Research and Communications Information - <i>Service des Etudes et Traitement Informatique</i>
SIDA	Swedish International Development Authority
SOMARC	Social Marketing for Change Projects - Futures Group
TA	Technical Assistance
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VDMS	Systematic Motivational Home Visits - <i>Visites à Domicile de Motivation Systematique</i>
VSC	Voluntary Surgical Contraception
WHO	World Health Organization



FAMILY PLANNING

I. OVERVIEW OF THIS SECTION

Family planning has been at the heart of USAID assistance to the Ministry of Health over the past three decades. This report outlines the evolution of family planning in Morocco as a result of the productive cooperation between the two partners. It gives an overview of the Moroccan situation at the outset of the partnership and the successive stages of USAID involvement in FP activities from 1971-2000.

The report describes a variety of efforts put in place over the years, thanks to the financial and technical support of USAID, which today form the basis of the Moroccan Family Planning Program. The report shows USAID's financial commitment and its evolution, as well as the general contribution of USAID to the program's success. It also highlights the impressive results obtained in Morocco during the last thirty years, as shown in representative surveys at the national level.

II. MOROCCAN SITUATION AT THE OUTSET OF THE COOPERATION BETWEEN THE MINISTRY OF HEALTH AND USAID

The mid-1960s marked the onset of widespread concern at the global level over rapid population growth in developing countries. International donor agencies (e.g., the World Bank) warned governments of the negative implications of rapid population growth for socio-economic development. Some leaders remained unconvinced of the link. Others recognized the problem, yet were unwilling to take the politically risky position of advocating population control in highly traditional, pronatalist societies. A third group of leaders took a bold stance on the issue, thus setting the stage for national family planning programs.

In Morocco, concern for rapid population growth was first addressed by the Economic Planning Department of the Government. This department recognized the threat that rapid population growth posed to rationally planning the economy through the development of a central planning authority. Their view was based on analysis of the 1960 census data that revealed a population growth rate of 3.2 percent per annum. Advisors from the World Bank confirmed these projections and pointed out that population growth was outstripping economic growth.

As a result, the Ministry of Planning prepared population projections that demonstrated the economic repercussions of continued rapid population growth on education, housing, employment and other factors; they showed that the scenario would be far more favorable if population growth were decreased to 2.5 percent by 1985.¹ It, therefore, proved necessary to establish a solid family planning program in the country.

His Majesty King Hassan II heeded the message and initiated a number of bold steps that would pave the way to a national family planning program. In 1965 he issued a royal

memorandum, explicitly linking the problem of rapid population growth with the socio-economic development of the country. In the following year, two legislative acts were passed: one that created the High Commission on Population, the second that repealed the repressive laws (dating back to the days of the French Protectorate) prohibiting the promotion and sale of contraception.²

International politics surrounding family planning were not favorable during this time. The cold war was in full force, and many viewed the promotion of family planning to be an imperialistic plot sponsored by Western countries to promote their own interest by stymieing growth in developing nations. Countries such as Morocco were caught between East and West, and the international politics of family planning made it even more difficult for local leaders to openly embrace this cause, for fear of being branded as “*esclaves des imperialistes*” (slaves of the imperialists).

During the late 1960's several groups provided technical assistance and support to Morocco to assist in the startup of its family planning program, including the Ford Foundation, the Population Council, the Swedish International Development Authority (SIDA), and the International Planned Parenthood Federation (IPPF). A National Seminar on Family Planning in 1966 was held to further promote public debate on population and family planning, to conduct a national Knowledge, Attitudes and Practices (KAP) study in 1966-67, and to support training and study tours for government officials.

The National Family Planning Program (NFPP) officially began in February 1966, under the Ministry of Health (MOH). Family planning was integrated into existing health service delivery, to avoid duplication of costs and to gain the approval of medical professionals. The MOH offered services primarily in urban areas, where it was expected the demand would be greater. Program administrators initially designated the Intrauterine Device (IUD- Lippes loop) as the method of choice.

Indeed, the five-year plan (from 1968-1972) called for the insertion of 500,000 IUDs. This number proved to be far too ambitious. Too few doctors were trained in family planning, and those who were had inadequate time to master the techniques, most notably the management of side effects. By 1970, only 40,000 women had accepted the IUD from government clinics.³ Moreover, this rapid startup — before the system was fully prepared for comprehensive service delivery, including the management of side effects — was counterproductive to the long-term acceptance of IUDs. In 1968, the oral pill was added to the method mix, and by 1970 more acceptors opted for the pill than the IUD.⁴

In sum, the bold policy statements of the King in the mid-1960s did not translate into decisive action at the operational level until a decade later. The political climate was not propitious for considering demographic issues. Political problems surfaced in other arenas that may have caused the King and his advisors to refocus their energies elsewhere (although the Royal family has never wavered in its support of family planning). Population was prominently mentioned in the five-year plan (1968-72), yet family planning did not take off in Morocco until the late 1970s.

III. PHASES OF USAID ASSISTANCE TO THE MINISTRY OF HEALTH AND PROJECT MANAGEMENT: 1971-2004

A. Six Cooperative Agreements

Over the past thirty years, five bilateral agreements were signed between the Ministry of Health and USAID and a Memorandum of Understanding, is currently being implemented (see Table 1). The agreements have revolved primarily around family planning assistance and secondarily around maternal and child health support. A total of US\$126 million were invested in the health and population sector over the years, making USAID the largest single donor to Morocco's health program. Projects were undertaken based on priority needs, however, certain areas were consistently programmed, such as the purchase of contraceptives and equipment, the provision of technical assistance, and the training of health professionals.

Table 1. Projects of Bilateral Donations between USAID and the Ministry of Health

Phase	Accords	Period	Total in US Dollars	Principal Components
Phase I	Project no. 608 0112: Support to Family Planning	1971-1977	3,046,000	-Contraceptives -Construction of 13 Family Planning referral centers and sites of population management -Launching of VDMS pilot project in Marrakech
	Project no. 608-01505: Management Improvement Project	1978-1984	2,185,000	-Human resources -Logistics
Phase II	Project no. 608-0155: Population/Family Planning Support Project	1978-1985	11,887,000	-Support to VDMS Program -Construction of 10 Family Planning referral centers -Contraceptives & equipment -IEC -ENPS -CNFRH -Support to AMPF
Phase III	Project no. 608-0171: Assistance to Family Planning and Demographic Issues	1984-1991	26,210,000	-Support to VDMS Program -CCV and CNFRH -ISC -Clinical family planning services -Training -Support to other organizations and ministries with regard to family planning -Contraceptives

Phase IV	Project no. 608-0198: Assistance for Family Planning and Child Survival	1989-1996	31,000,000	-Health coverage -Clinical services -Social marketing -Program of employee services -Information sub-system -Management and operational research -Training -IEC -Contraceptives
Phase V	Project no. 608-0223: Assistance for Family Planning and Maternal-Child Health	1993-1999	52,000,000	-Technical assistance -Training -Equipment/Supplies -Local costs -IEC -Contraceptives
Special Objective 7	Memorandum of Understanding Key Interventions Support Sustainability of Population, Health, and Nutrition (PHN) Programs	2000-2004	16,000,100	-Decentralization of health services in two pilot regions -Support for RH and child health activities in the private sector

1. Phase I/Project # 608-0112 (1971 – 1977): Support to Family Planning

This was the first project to formalize the relationship between the MOH and USAID. It began during a crucial period for FP activities. On one hand, there was a political desire to develop demographic activities in Morocco. But, on the other hand, the rather disappointing fact was that, after a decade of activity, the national family planning program had relatively little to show. On the positive side, the public health system did provide contraceptives in approximately 300 health centers. However, the system was highly medicalized; contraceptives were available only by prescription and after a physician's exam.

During this period, the relationship between USAID and the MOH was rather formal and distant. USAID officials were frustrated by the seeming lack of commitment to family planning, and they were unconvinced by the management capacity within the MOH. Local health officials wondered what contribution the Americans were making. And, the French still played a very strong advisory role to the MOH.

Despite a relatively small amount of donor funds (US\$3,046,000), this phase of assistance helped establish family planning activities in Morocco and marked the beginning of cooperation between the Ministry of Health and USAID. The project included the purchase of contraceptives and the planned construction of 13 Referral Centers (and the headquarters for the FP Division). In addition, the *Visites à Domicile de Motivation Systematique*, or "Systematic Motivational Home Visits" (VDMS), were launched in the province of Marrakech during this period.

2. Phase II/Project #608-0155 (1978-1985): Population/FP Support

This agreement was signed under a more favorable climate than the previous one. The late 1970s and early 1980s represented a dynamic period in the history of the Moroccan Family Planning Program. The Ministry of Health was restructured to reorient health services to address the preventable health problems affecting the largest number of Moroccans. The MOH-USAID initiatives during this period helped to desensitize family planning among policy makers, and, for the first time, the GOM included a line item for family planning in its 1983-1985 budget.

During this period, the leadership of the Moroccan family planning (FP) program had to balance pressures from USAID/Washington to be more aggressive on population with the potential consequences of advocating family planning too overtly in Morocco. Powerful political and religious groups — known for their opposition to FP — did not attempt to disrupt the operations of the MOH in providing FP as part of the national health service. The MOH leadership decided against developing an official population policy (despite the wishes of Washington), because of the potential backlash from these powerful groups. They instead invested their efforts in the “less public” activity of strengthening the infrastructure for the delivery of FP services. Similarly, Washington wanted the Moroccan program objectives to explicitly include mention of a drop in the birth rate in the NFPP and encouraged the MOH to develop more FP activity in the private sector with social marketing programs, but the MOH resisted.

Despite these differences, the second bilateral grant reinforced the commitment of the MOH and USAID to the national family planning program. This second grant covering the period 1978 – 1985, represented a more significant investment (US\$11,887,000). The project funded the startup of VDMS in 13 provinces, the construction of ten Referral Centers, and allowed for the first diversification of activities including:

- The creation of the National Center for Training and Reproductive Health (*Centre National de Formation en Reproduction Humaine - CNFRH*) in Rabat for the purpose of training health professionals in voluntary surgical contraceptive procedures (a partnership between the MOH, JHPIEGO and AVSC);
- The implementation of the first contraceptive prevalence survey; and
- The modest introduction of information, education and communication (IEC) activities by the *Association Marocaine de Planification Familiale* (the Moroccan Family Planning Association - AMPF) who were equipped with a studio capable of recording video and audio productions. (The IEC teams of the MOH were quite small at that time.)

A 1983 evaluation of this phase (while recognizing that the original project was over-ambitious) described the significant progress that occurred during this period on several important fronts.⁵

During the same 1978-1984 period, another grant was signed for the strengthening of the management capacity of the MOH through the USAID-awarded “Management

Improvement Project,” led by Management Sciences for Health (MSH). This project focused primarily on developing a system for pharmaceutical logistics as well as a computerized personnel system.

3. Phase III/Project # 608-0171 (1984 - 1991): Assistance to Family Planning and Demographic Issues

The situation in Morocco evolved markedly after the first two projects. At the political level, there was no longer a feeling of ambivalence towards family planning and its acceptability among the general population increased. The MOH continued its aggressive push forward with family planning, expanding FP activities to include the private sector.

The amount of USAID assistance for family planning during this period increased (US\$26, 210,000), and demonstrated the increasing commitment of USAID to the NFPP. This assistance covered the purchase of contraceptives (US\$7 million), expansion of the VDMS program to 10 additional provinces with the purchase of 375 mopeds for itinerant nurses, and support for voluntary surgical contraception (VSC) and IEC campaigns with AMPF. Child survival activities appeared for the first time, notably assistance for the national campaigns for vaccination and prevention of diarrheal diseases.

For the first time, a strategy involving the private sector was developed. In 1989, a social marketing program was launched for the introduction of the “Protex” condom. Initially, “Protex” was aimed at businesses through a US\$2 million project with OCP (*Office chérifien des phosphates*) and CHELCO (a textile business).

4. Phase IV/Project #608-0198 (1989 – 1996): Assistance for Family Planning and Child Survival

Phase IV was characterized by an excellent relationship between the MOH and USAID. The amount of assistance increased to US\$31 million of which US\$12 million was earmarked for contraceptive commodities. Between Phase III and Phase IV there was an overlap of activities; many activities, such as the construction of Referral Centers, refrigerated chambers, and provincial warehouses, which were scheduled to occur in Phase III (and some even earlier during Phases I and II), were delayed until Phase IV.

This phase included:

- Increased private sector involvement (for the purpose of diversifying sources of service offerings), with the launching of an oral contraceptive “Kinat Al Hilal,” as part of the social marketing program;
- Support to child survival activities aimed at increasing immunization coverage, reducing infant mortality caused by diarrheal disease, and improving the quality of prenatal consultations;

- Increased access to health services through the purchase of 44 vehicles, 400 mopeds, 775 metal cases (for itinerant nurses), and 775 helmets for itinerant nurses;
- Construction of two Referral Centers at the University Hospitals in Rabat and Casablanca as well as 20 VSC provincial units;
- Creation of nine regional family planning training centers, in order to decentralize training;
- Provision of solar power to 82 rural dispensaries and health centers, previously without electricity, to improve the quality of services provided as well as the living conditions of the health professionals;
- Significant purchase of medical and office equipment;
- Design of the health information system for the MCH-FP program and inclusion of management and research aspects in action plans; and
- Introduction to “policy” issues including hospital cost-recovery, health policy reform, and extension of health insurance with the POLICY Project.

5. Phase V/Project #608 0223 (1993 – 2000): Assistance for Family Planning and Maternal-Child Health

Assistance increased to US\$52 million during this period, which was originally scheduled as 1993-1999, but was later extended to 2000. This was the last phase of bilateral assistance between USAID and the MOH. It included two primary objectives: increased utilization of FP/MCH services and the sustainability of those services. During this phase, in 1996, a transition plan was developed, addressing sustainability and maintaining capabilities. The USAID-funded projects under Phase V were the most important in financial terms, as well as in the provision of technical assistance and equipment. For the first time, maternal health was addressed in the title of the project. The reduction of maternal mortality was given priority and two major interventions were developed as a result:

- A national communication strategy to increase awareness among policy-makers and the general population on the gravity of maternal mortality and spread the message that women need not die in childbirth; and
- A pilot project aimed at improving emergency obstetrical care in the regions of Fés-Boulemane and Taza-Al Hoceima-Taounate.

During this phase of assistance, the IEC Department was given a total of US\$5 million (in contrast to a total budget of US\$700,000 during Phase III), and expanded more than ever.

Construction of several facilities already programmed in Phase IV was also finalized, including eight Referral Centers, 19 community health centers, a warehouse in Salé, and renovation of warehouses in Casablanca and Agadir (see Table 2). A total of 180 vehicles were also purchased to strengthen the mobile strategy.

Table 2. Construction (Rehabilitations and Extensions) with USAID Support

Type of Building	Location
Family Planning Referral Centers (Built during Phase IV)	<ul style="list-style-type: none"> • Ain Chock • University Hospital Center (<i>Centre Hospitalière Universitaire - CHU</i>) Rabat • CHU Casablanca • Chaouen • El Fida • Khouribga • Larrache • Rabat (Chellah) • Taounate • Tétouan
Rural Health Centers (<i>Centre de Santé Rural, CSR</i>)	<ul style="list-style-type: none"> • Tanakoub • Jebha • Beni Arous • Rissana • Tahar-Souk • Khenis Anjra
Rural Dispensaries (<i>Dispensaire Rural, DR</i>)	<ul style="list-style-type: none"> • Béni Ounsar • Bani Gmil • Snada • Sebt Gorfet • Kariat • Boudinar • Driouch • Khlalfa • Bouarous • Bouchabel • Bab Mrouj • Ajdir • Beni Hassan
Provincial Automotive Garages	<ul style="list-style-type: none"> • Khouribga • Sidi Kacem • Taounate • Errachidia
Warehouses	<ul style="list-style-type: none"> • Casablanca (2) • Salé • Agadir

For the first time, the amount allotted by the MOH (\$108 million) was included in the total project budget. A total of 60 percent of the MOH funds covered salaries and six percent covered contraceptives. During this phase, John Snow, Inc. (JSI) was the American institutional contractor responsible for managing the project.

6. Memorandum of Understanding – Key Interventions Support Sustainability of Population, Health, and Nutrition Programs

The final phase of USAID's assistance to Morocco includes a sum of US\$16 million and covers the period 2000 – 2004. It is currently being implemented and is not discussed in this document. This agreement falls under the MOH's decentralization initiative within its strategy of developing the health sector, focusing on two regions, Sous-Massa-Draa and Tangers-Tetouan, and includes:

- Decentralization of basic health services in the two regions; and
- Provision of reproductive and child health services in the private sector at the national level.

Support activities include technical assistance and research studies. A mid-project evaluation and a Demographic and Health Survey (DHS) are programmed for 2002.

B. Evolution of the MOH/USAID Strategic Approach

The relationship between USAID and the MOH began slowly, with an initial investment of US\$3 million, but culminated in US\$52 million during Phase V. This relationship was characterized by:

1. An Expansion of Issues Addressed

In the beginning, the focus was exclusively on family planning activities. Support for child survival did not begin until Phase IV, while support for the prevention of maternal mortality started even later, under Phase V. Concern over the organizational structure of the health system and policy considerations were not a central part of USAID's assistance until Phase IV. The last agreement, however, has sustainability as its main objective and focuses on assisting the MOH to improve the health system through its decentralization initiative.

2. An Expansion of Activities

The variety of programmatic activities increased over the different phases of USAID assistance. Little by little, a complementary package of activities was developed, including: construction; purchase of equipment, office furniture, and modes of transportation; provision of technical assistance and training; support for IEC; contraceptive logistics; information systems; and research. By Phase V, the Moroccan health system was capable of providing quality family planning/maternal child health services that responded to the needs of the population.

3. An Increase in the Number of Key Partners

Most of USAID's agreements with the MOH operated under the Directorate of Population and the Director acted as the project director while the Directorate of Equipment handled all the construction aspects of the project. Over time and as project activities diversified, other departments of the MOH became involved including: the Directorate of Planning and Finance, Directorate of Epidemiology, Directorate of Hospitals and Ambulatory Care, and Directorate of Regulations and Disputes. By Phase IV, other new players became involved including representatives of the private sector, other social welfare departments within the government, associations, and professional organizations. At times, there were problems coordinating the efforts among the increasing number of partners.

4. A Change in the Programmatic Approach of USAID/Washington

USAID's concept of assistance evolved over time. At first, assistance was geared towards specific short-term projects with a set budget. By the middle of Phase V, USAID focused more on strategic objectives and measurable results. The idea of measuring results through indicators was introduced. Whereas previously project evaluations were done only at the mid-point and end of the project, data was now collected annually in order to monitor the project's performance. Washington demanded annual reports in exchange for releasing additional funds for program activities. This change in approach signified an increased understanding and greater oversight by USAID/Morocco over USAID central programs in Morocco.

C. Sustainability of Family Planning and Child Survival Activities

The issue of sustainability after USAID withdrawal of assistance has been a concern of USAID and the MOH since the beginning of bilateral support. Because of this concern, initial family planning activities were developed within existing operational structures within the MOH. During Phase V, priority was given to sustainability issues and a transition plan was developed based on the gradual withdrawal of USAID support without compromising capabilities. A list of criteria defining priority areas and interventions has been developed to better identify areas needing support in order to guarantee the continual provision of FP/MCH services. USAID continues to support limited interventions that will allow the MOH to offer basic health services with decreased donor assistance. The two partners have begun a plan of gradual transfer of financial support for health programs from USAID to the MOH. As part of the last bilateral agreement, one of the key indicators measuring sustainability was the amount of financial commitment by the MOH. The contribution by the private sector was also one of the key indicators (e.g., in 1992, 34 percent of contraceptives and 13 percent of ORS packages were provided by the private sector).

The financial transfer plan developed between USAID and the MOH included the following timeline:

- 1990: Complete transfer of VDMS expenses to the MOH;
- 1990-1995: Progressive decrease of USAID support for gas and automotive spare parts;
- 1995: Purchasing of contraceptives starts to be gradually transferred to the MOH; 1996: MOH purchases 100 percent of vaccinations and 23 percent of contraceptives; and
- 2000: MOH purchases 100 percent of contraceptives.

Present factors favoring sustainability:

- Increased access to quality FP/MCH services that respond to the population's needs;
- Improved institutional environment for FP/MCH services in collaboration with Partners for Health Reform (PHR);
- Involvement of the private sector in the provision of FP/MCH programs (including social marketing and a partnership for health project);
- Increasingly decentralized approach involving local health teams in problem solving;
- Viable basic and on-going training of health providers. In an effort to provide the most current information and best quality health care, training curricula for nurses and midwives have been updated to address RH problems. Curricula in medical schools have also been updated and a new focus placed on the health of women and children, thanks to a partnership involving the MOH, the medical school faculties from the universities of Rabat and Casablanca, USAID, and JHPIEGO. A national training strategy, adapted to fit the decentralized model, was also developed to better respond to regional and provincial training needs;
- Finally, the post-bilateral phase 2000-2004 consists of activities totaling \$16,000,000, a much lower level than that of Phase V. This phase consists essentially of actions necessary for maintaining capabilities and consolidating institutional capacities.

D. Phase-Over of Contraceptive Procurement

Until 1995, USAID was responsible for all contraceptive purchases, and contraceptives were a major component of the different projects. Then, as part of the withdrawal of USAID support, the two partners developed plans for the procurement of contraceptives solely by the MOH. This plan outlined the amount to be contributed by each partner. It was conceived in Phase II and began to be implemented in Phase IV. Key players that helped develop this strategy included the MOH, USAID, JSI, PHR, POLICY, and FPLM.

Several studies and tools were developed to ease the transfer of this procurement responsibility:

- Development of advocacy materials aimed at increasing awareness among policy makers for the need to dedicate sufficient funds to the national FP program;
- Conduct of a marketing segmentation study to evaluate the demand for FP and estimate the needs of the program;
- Reduced customs and taxes on contraceptives (thanks to advocacy efforts);
- Marketing research on contraceptive availability in Morocco that revealed that the MOH would not get the same discounted prices on these supplies as did USAID (based on its larger-volume multi-country purchases);
- Study on contraceptive purchasing options which allowed the MOH to effect many purchases during this transition phase;
- Set-up of a system to estimate contraceptive needs based on Contraceptive Purchasing Tables (CPT);
- Conduct of a workshop on consolidating RH programs workshop in Marrakech in September 1998. Participants at this intersectoral workshop unanimously recommended that an adequate budget be included in the government five-year economic plan to cover the needs of the family planning program. With FPLM assistance, the MOH was able to calculate necessary annual budgetary needs, keeping in mind the contributions from USAID, the EU and UNFPA; and
- Conduct of a final intersectoral conference in July 2000 to examine how to determine the costs of the RH/MCH program, how to reinforce partnerships, and how the new financial mechanisms should work. The Directorate of Population (DP) is now responsible for the purchase of all vaccinations and contraceptives and this comprises the majority of its budget. This will affect other program support activities handled by the DP.

The gradual transfer of contraceptive procurement occurred as scheduled. (Since the initial groundwork began early, in 1994, it was likely to succeed.) The MOH fulfilled and even surpassed its original commitment. As of the year 2000, 100 percent of all public sector contraceptive procurement was done by the MOH and forecasting needs have been projected until the year 2004. However, it must be noted that the actual financing for the purchase of contraceptives is assured due to a loan from the World Bank. Increased advocacy efforts by those in charge of FP are necessary to ensure sufficient funds for contraceptive procurement post-2004.

Many key players are concerned about this arrangement. Will the MOH have sufficient financial resources to cover future contraceptive needs? Will the MOH be able to continue to provide contraceptives free of charge to the general population? May it instead need to limit free contraceptive distribution to the needier segments? What role can the private sector play in fulfilling contraceptive needs? Thus far, the MOH has had problems procuring a homogeneous product offering, in particular for the pill. These changes have caused confusion for a public that has become accustomed over the past decades to certain methods (and brands).

E. Management of USAID Projects

1. Key Management Players

During the thirty years of cooperation between USAID and the MOH, the management of USAID-funded projects has evolved in relationship to the importance of these projects. There have been many key management players: the MOH, USAID/Morocco, USAID/Washington, Cooperating Agencies (CAs), and institutional contractors.

◆ USAID/Washington

In the beginning, the role played by USAID/Washington was significant because projects were centrally funded by Washington and managed by CAs such as the CDC-managed FPLM project for contraceptive commodities, JHPIEGO and AVSC for VSC services, and MSH for management assistance. Other projects included The Future's Group OPTIONS, RAPID, and POLICY Projects for policy aspects, and SOMARC for contraceptive social marketing. Gradually, bilateral projects became more important and the role played by USAID/Washington was more one of monitoring the activities developed by USAID/Morocco.

◆ USAID/Morocco

Each bilateral accord has an initial financial budget. Implementation is based on pre-set conditions for making funds available and letters of implementation which detail the activities to be carried out and the budgets allotted thereto. These are official documents signed by the two parties. There is a great deal of flexibility in managing the programs; budget adjustments are possible as long as both the MOH and USAID are consulted and approve any changes. USAID/Morocco plays an essential role in the day-to-day management of USAID-funded projects. Along with its MOH counterparts, USAID/Morocco monitors the planning, implementation and evaluation of activities. USAID/Morocco is responsible for verifying that all activities conform to USAID policies and procedures and communicates with USAID/Washington on financial matters and project implementation.

In the beginning, much of the expertise in budgetary and management matters came from USAID/Washington. Over time, however, the Mission office had increased funds that they then managed directly according to the needs of the program.

◆ The Ministry of Health

Within the Ministry of Health, the Directorate of Population (DP) is USAID's key partner. The DP has been the recipient of the grants and the entity responsible for their implementation. The Director of the DP has always been the official director of the projects.

As already mentioned, other MOH departments became involved in USAID-sponsored activities as the projects expanded; the Directorate of Hospitals and Ambulatory Care for quality assurance-related activities, the Directorate of Human Resources for training activities, the Directorate of Regulations and Disputes for legal and institutional aspects, and the Directorate of Epidemiology for STI/HIV/AIDS activities.

The DP has played a fundamental role in the management and coordination of health activities. The DP's administrative team has accomplished a colossal amount; for example, this team was responsible for the payment of 4000 VDMS promoters and the monitoring of all official documentation related to the collaboration between USAID and the MOH.

◆ **Institutional Contractors**

During the first four phases of USAID assistance, projects were managed mainly by the MOH and USAID/Morocco teams, with frequent short-term visits by institutional contractors and consultants. The number of such visits was often very high; for example, during Phase III, 50 different consultants worked in Morocco and a total of 430 consultant days were charged during 1987 and 1988. This did not always facilitate the management of project activities.

The MOH and USAID, often with only small local teams, were faced with an enormous amount of project-related work. Therefore, as the funding for USAID-sponsored projects increased, it became necessary to establish more practical operating structures. An American institutional contractor was recruited to facilitate the management of USAID-sponsored projects during Phase V and during the Special Objective 7 Phase (with the exception of contraceptive procurement).

RONCO began training assistance to the MOH during Phase III through short-term consultancies. SEATS was the first contractor to be based in Morocco, managing a modest portion of the PHASE IV project. JSI has been the largest resident contractor, managing the Phase V project as well as the current post-bilateral project.

The responsibilities of the institutional contractors have included:

- Assisting the MOH and USAID in planning, implementing, and evaluating the programmatic and operational aspects of the project;
- Managing project funds;
- Supporting the MOH in the acquisition and distribution of project equipment and materials;
- Providing technical assistance and technology transfer to the MOH teams; and
- Facilitating coordination among the MOH, USAID, and other CAs.

This type of technical assistance has been useful in many ways:

- Since the contractor is based in Morocco, it has a long-term vision for the project and has had a greater understanding of the Moroccan context – which was not necessarily the case with previous consultants who came only for short-term assignments;
- The contractor's flexible management style facilitated rapid implementation of certain activities;
- The institutional contractor provides significant assistance in purchasing despite occasional delays; and
- Finally, the Phase V institutional contractor provided technical assistance in the areas of contraceptive logistics and the health information system, and IEC. (A resident IEC expert and the support of JHU-PCS helped the MOH develop large-scale FP and safe motherhood campaigns, strengthening institutional capacity in IEC.)

There have also been some negative aspects associated with use of institutional contractors in Morocco:

- The institutional costs have been high, consuming up to 30 percent of the project's total budget;
- Contractor teams were sometimes perceived as replacing those of the MOH, which has caused some coordination problems. Provincial offices have occasionally complained that the contractor was going beyond its supporting role and becoming too much of a major player;
- The MOH and the consulting personnel had different administrative systems, which favored the consulting teams. These inequalities hindered teamwork; and
- According to the MOH teams, transfer of technical expertise was insufficient in some cases.

2. Management Procedures

Management procedures for the cooperation between the MOH and USAID were defined over time. By Phase IV, specific entities were established to work in a complementary fashion with the different missions:

◆ Managing Committee

The committee deals with the overall planning and monitoring of projects. It is a forum for discussions among the MOH, USAID, and their partners. Its members are representatives of various areas of the MOH, USAID, the private sector, and other organizations involved in the projects. Meetings are held annually, led by the Minister or the Secretary General. These meetings usually include the presentation of new projects, action plans, and the evaluation of various efforts. The committee is responsible for managing project implementation, reviewing results as compared to original objectives, and recommending necessary changes.

◆ **Project Management Unit**

The unit's principal responsibility is the coordination and monitoring of the project. Members include the managers of the MOH divisions and offices responsible for project activities, representatives of USAID, the project head, and representatives or any consultants involved. In certain cases, international experts, and CA representatives involved in the projects are invited to the meetings when they are in Morocco. Bi-weekly or monthly meetings, of two to three hours in length, are led by the Director of Population. The agenda is jointly agreed upon between the MOH and USAID and is sent to participants a few days before the scheduled meeting date. The generally friendly and frank discussions focus on the operational aspect of program activities, the raising of problem situations, and the proposal of solutions which will allow the action plans to be carried out in a timely manner. The sessions can also be a forum for presentations on a specific effort, evaluations, or sub-projects. Minutes of the meetings, including the principal decisions, are sent to the members. This process facilitates coordinated planning among the partners and others involved.

◆ **Organization of Periodic Group Retreats**

Once or twice a year, the MOH and USAID organize meetings for planning new projects, preparing action plans, and evaluating the status of projects. These retreats are usually held outside Rabat.

IV. THE PRINCIPAL COMPONENTS OF THE NATIONAL FAMILY PLANNING PROGRAM

Over the years, the NFPP has evolved and been continually reinforced. The administrators have systematically developed new program components in order to offer quality service according to the needs of the population. Many complementary strategies and activities have been established in a wide range of areas.

The attitude and perceptions of the general public toward FP have been taken into consideration since the start of the program. FP leaders have been careful not to provoke those who are more traditional and conservative as well as certain religious and political groups. The program has evolved smoothly, in step with the evolution of attitudes toward more openness and greater acceptance. All these considerations have been taken into account in the program initiatives.

A. An Innovative Start-up Strategy: VDMS

This innovative strategy, based on regular home-visits, marked a high point in the history of the NFPP (see Box 1). It was designed to increase the availability of family planning services directly at the household level and it helped to strengthen ties between the community and health professionals. Start-up was not easy, occurring during a period of temporary tension between MOH and USAID representatives. Based on experiences in

other countries, USAID pushed for community-based distribution of services (CBD), while MOH officials were skeptical about the acceptance of such a strategy in a rather traditional Muslim society. The partners finally reached an agreement and a pilot project was set up in Marrakech to study this approach from July 1977 to December 1980. The objective was to test the acceptability and usefulness of the direct distribution of contraceptive services and products.

1. The VDMS Model

Itinerant health workers (MOH nurses) visited families, collecting data on women of reproductive age. They gathered information on their fertility history, screened them for contraindications for contraceptive use, and took care of the women who wished to follow one of the methods. Based on each individual case, a nurse gave contraceptive advice, distributed pills or condoms, or referred the woman to the closest health center for the insertion of an IUD. Scheduled quarterly follow-up visits allowed the health professionals to see new women and to monitor existing clients, providing them with three cycles of pills or 20 condoms.

2. Results

The pilot project showed two things: that family planning was widely accepted and that the health agents were able to provide efficient service without generating complaints from either women or the community in general. Nurses, rather than doctors, were able to offer such services without risk to their clients because of the checklists they followed.

Box 1. Contribution of VDMS to the National Family Planning Program

- VDMS was the first mutually-agreed-upon family planning effort between the Ministry of Health and USAID, and it marked the beginning of a productive working relationship between the two partners.
- The Marrakech pilot test showed that the Moroccan population accepted family planning.
- Government officials made a stronger commitment and were more confident in developing FP activities. This was the true take-off of the FP program. The success in this phase led to feelings of pride and accomplishment within the MOH in the area of FP.
- The strategy was successful in “paramedicalizing” family planning; moving it beyond a clinic-based, physician-dominated service and establishing it as an important component of government health services.
- It reinforced the value of the itinerant health worker and the mobile strategy
- It contributed to building a better knowledge of the population and in defining areas of coverage.
- It led to the development of an integrated maternal and child health package for an isolated, mostly needy population.
- Because of VDMS, Morocco became internationally known as a country willing to try innovative strategies which produced promising results.

3. Expansion of VDMS

Due to the success of this initiative, it was gradually expanded to other provinces: 16 under Phase II, 49 under Phase III, and to 51 of Morocco's then 60 provinces under Phase IV. The expansion not only increased geographic coverage, but also better targeted segments of the population, orienting services toward the more isolated and needy groups. The range of services also increased. The expanded VDMS project included family planning as well as several maternal and child health (MCH) interventions such as breastfeeding promotion, immunization referral, iron and vitamin supplements for pregnant or lactating women, and distribution of Actamine 5 (a locally produced weaning food).

4. VDMS Cost

It is difficult to measure the exact cost of this activity because of the nature of the work and the personnel. USAID was the principal backer and its funds allowed for the purchase of mopeds, along with their maintenance/repair expenses and gasoline. The funds also covered the purchase of contraceptives and Actamine 5, the training of the health agents, and their per diem allotments (*indemnités*). The MOH paid for the health agents' salaries. To a lesser degree, two other donors participated in the program, UNFPA and UNICEF. In 1988, the annual cost of VDMS was estimated at DH 83,603,749 (US\$ 10,251,964) divided as follows: 46 percent salaries, 20 percent debt repayment, 20 percent FP and MCH products, 11 percent per diem allotments, 3 percent gasoline, and less than 1 percent for training.

5. Difficulties Encountered

A mid-term evaluation identified several problems. Some outreach workers had incomplete or inaccurate knowledge about family planning and lacked the ability to solve problems on their own. Training programs were put in place to improve their capabilities. Certain areas were not readily accessible due to rugged terrain, bad weather and/or frequent moped breakdowns. The information system was inadequate (but has since been revised).

6. Evolution

Since 1990, the VDMS system has gradually diminished in importance, although it has not disappeared entirely. The MOH withdrew VDMS from urban areas and cut back on household visits in areas served by MOH fixed facilities or the private sector. The ranks of itinerant health workers thinned, as a new generation of nurses aspired to a higher level of clinical training and greater job opportunities. Two major elements for the motivation of the health agents were gradually reduced: the monthly per diem payments and the gas coupons. The model, which was essential in gaining widespread acceptance of family planning in Morocco, was no longer needed to pursue the goals of the program.

Indeed, the current strategy to reach remote areas with the mobile teams can be seen as a spin-off of VDMS; it serves the same outreach function but at a lower cost-per-client. (Mobile teams visit predetermined locations where people congregate on specific days to receive health services.) The mobile strategy was an important component of Phase IV and received subsequent financial support from USAID during Phase V.

Newer strategies have emerged to meet the needs of a better informed and more demanding clientele. Currently, the MOH is re-evaluating its mobile health strategy in terms of sustainability and appropriateness.

B. Policy and Strategies Adapted to the Moroccan Population

After the startup of FP activities in Morocco, the administrators wished to develop service offerings within pre-existing organizational structures and to integrate family planning services with those of maternal and child health.

VDMS was very innovative from the family planning point-of-view, but it in fact was based on a model already in existence: itinerant health workers in the fight against tuberculosis and malaria. The program allowed health workers access to isolated communities, so that they could provide not only contraceptives but other health services as well.

The Moroccan and Tunisian models of FP service delivery are frequently compared. Like Tunisia, Morocco could have put in place a separate parapublic organization that dealt solely with family planning. Instead, it preferred to adopt a different model, one in which family planning was an integral part of programs targeting maternal and child health. The idea of integration has been a fundamental concept in the establishment of FP activities and has certainly contributed to the sustainability of the NFPP at a time of decreasing funding.

At the start of the Moroccan-American cooperation, USAID/Washington feared that such "integrated programs" were a way for uncommitted countries to raise funds and use them to develop the more popular MCH activities. In the case of Morocco, commitment to family planning has not wavered and this element has been key to the MCH/FP programs of the last twenty years.

The MOH has done an excellent job of integrating service offerings at the local level. Clients use the FP and child health services at one center and are seen by the same personnel. Management information systems are also integrated; for example, all routine service statistic forms include both MCH and FP. IEC campaigns cover FP, safe motherhood, and, to a lesser extent, the prevention of STI/HIV/AIDS.

These days, it is viewed as desirable to integrate family planning with other MCH and reproductive health services. At the outset of the partnership, Moroccan officials had to fight for a general integration model, holding out against pressure from Washington that favored a more vertical approach to FP service delivery. Ironically, 20 years later in the

post-Cairo period, we are asking the reverse question: Are all components of the program sufficiently integrated?

C. Diversified Infrastructure to Increase Access to Family Planning

1. Multipurpose Health Centers

In parallel with the ground-breaking VDMS effort, several buildings were renovated or constructed in both urban and rural areas (See Table 2), with the cooperation of USAID, the World Bank, and MOH funds. The quality of the Moroccan health service network facilitated the establishment of the FP program greatly. FP services thus became available in dispensaries, health centers, birthing centers, and urban and rural maternities.

2. Specific FP Units

In the course of the collaboration between the MOH and USAID and as the NFPP evolved, it was deemed necessary to build specific FP units. In order to give the program broader coverage, regional training centers, Referral Centers, VSC units, and contraceptive warehouses were funded under bilateral accords.

◆ CNFRH

The *Centre National pour la Formation en Reproduction Humaine*, CNFRH, (National Center for Training in Reproductive Health) was founded in Rabat in 1982 to train health personnel in FP. Several types of professionals were trained: gynecologists, general practitioners, and nurses. The training focused mainly on VSC techniques and the insertion of IUDs. The center also trained health professionals from many sub-Saharan African countries.

The establishment of this national center of excellence in the provision of long-term clinical methods complemented the community-based approach of VDMS. Because it trained hundreds of doctors and nurses from Morocco and other francophone countries, the center helped Morocco gain international recognition for its leading role in clinical contraception.

For USAID, the establishment of the center was an essential first step in strengthening Moroccan capabilities so that VSC services could be expanded to regional hospitals throughout the country. However, clinical methods, including VSC, continue to be under-utilized in Morocco vis-à-vis the pill. Although the CNFRH as a "center of excellence" has brought prestige to the country, it has been unable to make long-term methods more popular.

Between 1983 and 1991, the center completed a broad range of training programs and VSC procedures. It was also successful in establishing high-quality VSC services in 34 provincial hospitals.⁶ However, barriers to service delivery continued to exist, one of which was the number of visits a woman had to make simply to get the service.

◆ **Regional Training Centers**

Nine regional training centers were set up in the principal provinces of the kingdom (Agadir, Marrakech, Casa-Anfa, Casa-Ain-Sebaa, Tétouan, Fes, Kénitra, Meknés and Oujda). The idea was to decentralize FP training, especially for IUDs. The centers did not have a legal status but rather were administrative in nature. Three types of entities collaborated in the training: the Referral Centers, health career training institutes, and the provincial obstetric and gynecological services. The centers trained many thousands of health professionals and are still in operation.

◆ **Referral Centers**

In the first phase of the project, it was planned that 13 provincial centers would be built, with an additional one attached to the maternity section of the University Hospital Center in Rabat (see Table 2). The centers' mission was to acquaint the public with the issues of family planning and to develop FP activities appropriate for postpartum women. The centers also were meant to handle any complicated cases (including the management of side effects) and refer difficult cases to the Rabat center. In practice, each provincial health officer had a different idea on the exact functions the centers should serve, and staffing was not always adequate for them to perform all the functions cited above. A total of 27 referral centers were built over the phases of USAID assistance, of which 10 were built during Phase IV.^{7,8}

◆ **Construction and Refurbishment of Contraceptive Warehouses**

To improve the management and distribution of contraceptives, Phase IV of the MOH/USAID project called for the renovation of the Casablanca national warehouse and the construction and equipment of a satellite warehouse at Salé. This latter unit is a regional warehouse serving the north of Morocco. Another regional warehouse was renovated in Agadir to stock both contraceptives and other medications. It will be tested during the post-bilateral project and will provide coverage for the southern part of the country.

A great deal of equipment was purchased: four forklifts, maintenance equipment (palettes and shelving), and the computerization of inventory management. The project also improved conditions for the distribution of contraceptives and vaccines through the purchase of six trucks and a refrigeration chamber at the Salé warehouse.

D. A Wider Range of Contraceptive Methods and a Logistics System

1. Different Methods Offered by the NFPP

Over time, the NFPP ensured the availability of all contraceptive methods at its urban as well as rural health centers.

◆ The Pill

The NFPP was put in place officially within the Ministry of Health in February, 1966. The pill was the second product to be introduced, in September 1968, after an inconclusive experience with IUDs. The number of users of the pill grew very rapidly, and surpassed those of the IUD by 1970. Since then, its popularity has continued to increase and the number of users has grown progressively, beyond all expectations. Today the pill is the most popular and best-accepted method among Moroccan women. It is the leading method in Morocco, representing over 60 percent of total contraceptive usage.

Two major initiatives at the outset of the program contributed to this dominance: efforts of the IPPF affiliate, AMPF (founded in 1971), and the VDMS strategy.

- Because of AMPF's contacts with the international network of IPPF affiliates, this private organization introduced the first community-based distribution effort in 1974. A few years after its creation, AMPF had a greater clientele than that of the government establishments. Subsequently, AMPF diminished in importance in both the policy and service realms; this was partially due to policies that favored the investment of resources in the public sector.
- The VDMS strategy, which was based on the distribution of the pill and condoms by paramedical personnel in both urban and rural areas, is largely responsible for the knowledge and acceptance of the pill by Moroccan women.

The dominance of the pill has often been felt to be a negative factor in the NFPP, and major efforts have been approved to shift the range of products toward longer-term methods.

◆ The IUD

The IUD was the first contraceptive method introduced in Morocco. The five-year plan covering the period from 1968 to 1972 called for the insertion of 500,000 IUDs. This number proved to be far too ambitious in relation to the efforts made on its behalf. Too few doctors were trained in family planning and the ability to manage side effects was insufficient. As previously mentioned, only 40,000 women had accepted the IUD from government clinics by 1970.⁹

Progress proved difficult. Although over 1,300 physicians and nurses were trained in IUD insertion, the proportion of users opting for the IUD barely rose between 1987, 1992, and 1995 (from 8 percent in 1987 and 1992 to 9 percent of all users in 1995).¹⁰ Similarly, the percentage of users that chose female sterilization remained fairly stagnant: 6, 7, and 8 percent of all users on these same three surveys.¹¹

The Referral Centers, which were originally set up to improve the availability of IUDs and sterilization at the provincial level, ended up duplicating the services available at the health center.

Phase V prioritized activities aimed at increasing the acceptance and usage of longer-term methods. During this period, more advanced medical-technical equipment was purchased and a qualitative study on the attitudes of women toward the IUD was performed, in collaboration with the EVALUATION Project. The goal was to try to identify the factors leading to resistance to the IUD.

In 1999, several training sessions were conducted at nine regional training centers on the insertion of IUDs and IEC counseling. Over 450 service providers were trained, and follow-up supervisory visits were made to determine the impact of training on service delivery. IEC produced training materials, in particular a counseling video "Sahel Mahel," for use by health workers. During the same period, the Social Marketing Program "Al Hilal" released television spots on long-term methods. The MOH conducted an evaluation to measure the extent of "early withdrawals," which proved to be lower (8 percent) than expected (15 percent).

◆ **Condoms**

Condoms were introduced in Morocco in 1969. In spite of the known resistance of men to using condoms, the acceptability of this method grew over time, thanks to the Social Marketing Program for the promotion of contraceptives and the efforts of the STI/HIV/AIDS prevention program. Usage became increasingly less taboo, especially among young people.

◆ **Injectables**

Injectables were introduced in September 1994, at 12 centers, and, by 1996, in all provinces. Training sessions were organized to make health workers aware of this new method. Booklets on the methodology and side effects were distributed widely in all the health centers. Nevertheless, the acceptance of injectables by Moroccan women was relatively limited and health professionals, especially doctors, resisted this method.

There remains a great deal of work to be done to make the public aware of injectables and to provide counseling to increase their acceptance. There needs to be an improvement in the ability of health professionals to deal with side effects. Since this is a decidedly different method, a specific strategy needs to be developed to establish it within the NFPP. With this in mind, the MOH and Commercial Marketing Strategies

(CMS) are working on improving the brand image of injectables. A study on injectables showed a discontinuation of 64 percent (compared to the expected level of 50 percent) of women, who failed to return for the third injection and were presumed to have discontinued.

◆ **Norplant**

In order to broaden the range of methods available, Norplant was first introduced to Morocco in November 1992, in six centers in collaboration with AVSC, the Population Council, and JHPIEGO. Expansion of the method to 12 other centers was done in 1994. In spite of the training given health workers, problems arose due to the fact that the program generated greater demand than could be supplied. Trained personnel were lacking, especially for removal.¹²

In 1996, an evaluation of Norplant activities was conducted, with inconclusive results. For mainly financial reasons, the MOH decided to remove Norplant from the method mix.

◆ **Voluntary Surgical Contraception**

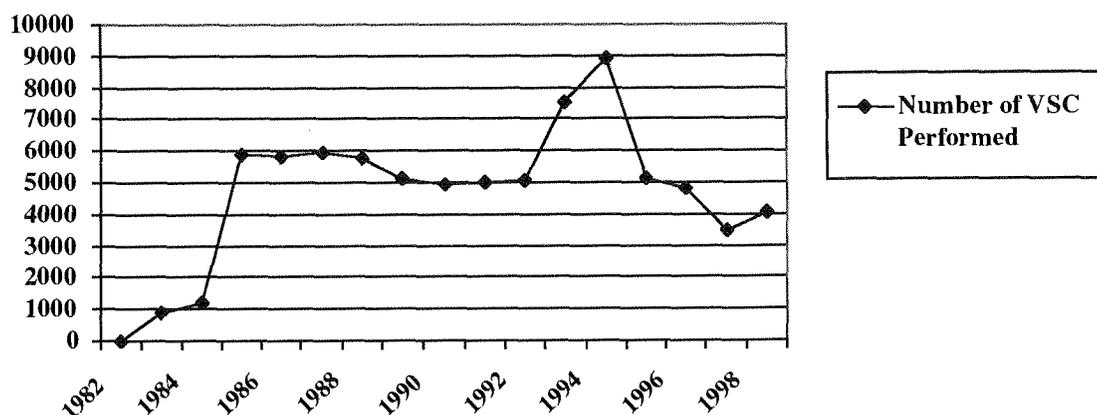
This method was introduced to Morocco in 1982 by the CNFRH in Rabat. The center was able to establish high-quality VSC services based on the efforts of university trainers who were well-known to health professionals at the local level.

The introduction of the method was based on several components:

- The training of multidisciplinary teams (doctors, anesthetists, nurses) to do VSC using laparoscopy, and to maintain the relatively sophisticated equipment;
- Team visits by trainers and NFPP officials to inaugurate the new VSC units; and
- Supervisory visits to monitor the management and quality of the services provided by the units.

The number of VSC recipients increased gradually from 1982 to 1995 with a peak in 1994-95, coinciding with the launch of the national FP media campaigns. After that time, however, there were difficulties with VSC activities and the number of users stagnated (see Figure 1).

Figure 1. Number of VSCs Performed Annually - 1982 - 1998



Several reasons can be cited for the under-utilization of VSC:

- Religious considerations. Since it is irreversible, VSC is condemned by Islam. In their speeches on the method, health professionals always emphasize that it will protect the health of the mother. This aversion to female surgical contraception on religious grounds is manifest in the lack of interest among key medical personnel in “popularizing” the mini-lap procedure. It is instructive that no Muslim country except Iran has high levels of female surgical contraception (including Indonesia, which has been extremely aggressive in its promotion of family planning using other methods);
- The complete withdrawal of USAID (AVSC and JHPIEGO) support from the VSC program in 1996. Today this program does not have a solid source of funding. The transfer of this activity to the MOH has not been successful;
- The dominance of the use of laparoscopy. Health professionals are accustomed to this technique that was developed at the start of the program. As a result, they have shown great resistance to using mini-lapotomy, in spite of strong recommendations by USAID over the course of various visits. University professors consider mini-lapotomy to be a less advanced technique. The Moroccan program has favored laparoscopy over mini-lapotomy since the start. It appears that it will be extremely difficult to change course after over 13 years of using laparoscopy almost exclusively;
- The relatively long lag time between the first client visit and actual surgery. Many appointments are missed, for various reasons. This discourages women who may have to travel long distances for the visits. In addition, communication between the more distant centers and the VSC unit is often difficult;
- The turnover of trained personnel, who go to other governmental entities (which do not offer VSC) or who join the private sector.
- The lack of supplies and adequate maintenance of equipment, all of which has been imported and is not available on the Moroccan market; and
- The introduction to Morocco of alternative methods, such as the IUD and injectables.

Attempts have been made to refocus VSC activities through a system of monitoring by NFPP officials and CNRFH professors, but with no tangible results.

2. Contraceptive Logistics

The smooth functioning of the contraceptive logistics system is a crucial element in sustaining FP activities. To streamline the process, it was essential to put better stock procurement and management systems in place. Under Phase V, the MOH, with input from the Family Planning Logistics Management Program (FPLM) of USAID/Washington, greatly strengthened its contraceptive logistics system. The old "push" system (orders handled by a central office) has been replaced by the "pull" system (orders placed by users based on past usage and available inventory). Thousands of health professionals have been trained in the new system, and have been given manuals and other material for ordering and monitoring stock.

Procedures have been standardized and institutionalized, thus assuring the flow of commodities to all levels of the MOH service delivery network. The system has considerably improved the forecasting, purchasing, and warehousing of products. Two trucks acquired under the USAID projects have noticeably improved contraceptive distribution. The consistency of contraceptive supplies and the virtual lack of gaps in inventory have been of great benefit to the NFPP.

Despite its success, some have criticized the vertical nature of the program. In fact, a separate Directorate in the Ministry manages the provision of essential drugs using a different system. The chronic problem of stock-outs of basic medicines in public health facilities is a key issue facing the MOH for implementation of Integrated Management of Childhood Illness (IMCI), STI/HIV/AIDS prevention, and other important programs. It is doubtful that the FP program would have achieved the current levels of contraceptive prevalence if it had relied on the general distribution system used for other medicines. This vertical approach may prove difficult to absorb into a more integrated system, without weakening program performance. The important thing to remember is that the MOH today has its own institutional capabilities for managing and purchasing contraceptives.

E. Information, Monitoring and Evaluation Systems

Morocco has a long tradition of collecting and using data for policy purposes and programmatic actions. In the early days of the policy debates over family planning, results from surveys provided the necessary evidence of high fertility levels in Morocco that threatened to reduce the achievements in socioeconomic development. Over the past 30 years and with strong support from USAID, the Ministry of Health has produced an impressive amount of data that has allowed program managers to document progress as well as identify areas for further work. National level surveys on fertility and family planning include the World Fertility Survey (1979/80), Contraceptive Prevalence Survey (1983/84), the DHS (1987 and 1992), the mini-DHS (panel study) in 1995, and the PAPCHILD Study in 1997. Data from large-scale national surveys are supplemented

with the routine service statistics that reflect service utilization in the different programmatic areas.

Prior to 1986, the MOH capacity for computerized information and statistics resided in the *Service d'Exploitation Mécanographique*, which was part of the General Secretariat of the Ministry. Information was sent regularly to the Head of the DP, who was responsible for FP activities. As of 1986, the Minister divided this office (which was still part of the General Secretariat) into two services: the Service for Research and Health Data (SEIS) and the Service for Research and Computer Science (SETI).

During the mid-1980s, SEIS collaborated on two activities: conducting surveys and providing regular data services. They were the host-country implementing agency for the 1983-84 Contraceptive Prevalence Survey, done in collaboration with Westinghouse. The extensive training of SEIS personnel for the DHS improved the technical capacity of this group for data collection, entry, cleaning, and processing. Moreover, this technical know-how has been exploited on a regular basis, with the conduct of subsequent DHS and other surveys. In addition, in 1988 SEIS participated in the design and implementation of a health information system that replaced the previous "accounting approach."

In the 1990's, the MOH, with input from USAID-funded consultants, redesigned the health information system for the MCH-FP program. Key activities included reviewing the indicators, changing the forms, and training personnel throughout the country in their use.

During this same period, the MOH worked with the EVALUATION Project to further improve the use of survey data and service statistics for program decision-making. The collaboration began with a study of quality of care in 1992, but branched out into numerous other activities. Morocco was one of the few countries in the world in which it was possible to measure the impact of the FP program through linking of data from the household DHS and facility-based survey. It was also the only DHS ever to attempt a "panel," that is, to re-interview the same respondents in two subsequent rounds of DHS data collection (1992 and 1995).

With USAID's collaboration, the MOH has developed a state-of-the-art interactive computerized system that tracks service statistics across all programs and provinces. In addition, the MOH periodically conducts special studies on key topics of interest (quality of care, market segmentation, legal regulations, among others) to further supplement their understanding of program dynamics. Qualitative research has also been done to improve the targeting of programs (e.g., the public's perceptions of FP, the IUD, and men's attitudes regarding FP).

F. Training to Strengthen Technical Capacity

Training health professionals has been a key component of all the phases of the MOH/USAID partnership. It has had several forms, according to the needs of the

projects. Subjects have included the technical aspects of family planning, contraceptive logistics, IEC counseling, management, information technology, and monitoring/research. Both pre-service and ongoing training programs have been improved.

Most training sessions have been held at the MOH in Rabat, especially those for instructors, but many sessions were also held at the provincial level. Data on the sessions is incomplete, but Tables 3-5 give an idea of the importance assigned to training.

Table 3. Number of Doctors and Nurses Trained, 1983 - 1992

Personnel Trained	FP/IUD	Laparoscopy	Anesthesia	Other	VDMS
Doctors	158	145	0	15	98
Nurses	251	113	92	19	683

Table 4. Number of Doctors and Nurses Trained in IUDs, 1991 - 2000

Personnel Trained	IUD Training
Doctors	1,128
Nurses	1,842
Total	2,970

Table 5. In-Country Training in Family Planning, January 1997 – September 2000

Training Area	1997	1998	1999	2000	TOTAL
Clinical Skills	780	903	595	60	2338
IEC	497	271	996	336	2100
Management Skills	455	548	1326	227	2528

According to a 1983 project evaluation summary, the training component was one of the most successful elements of USAID's assistance to the MOH.¹³ The MOH was continually pleased with the quality of USAID technical assistance to support in-country training activities and to successfully incorporate a skills-based approach in both its formal nursing curricula and in-service training programs. By 1984, trained nurses offered IUD insertion in over 500 health facilities.¹⁴

The Moroccans recognized early on that it was essential to develop a strong base of managerial and technical skills to support their growing family planning program. The Moroccan leadership, in collaboration with USAID/Morocco, opted to systematically develop a strong cadre of leaders and managers who would insure the growth of the program over the years.

In 1982, USAID Morocco awarded a contract to MSH to improve management capacity. This contract did not focus on family planning per se, but took a wider approach to the improvement of health services in general.

The creation of the National School of Health Administration (*Institut National d'Administration Sanitaire*, INAS) in 1989 was a further demonstration of commitment to improving the management of health programs throughout Morocco. The primary function of this institute has been to provide two-year training to the provincial health officers (primarily physicians) who will serve as Delegates, the leading administrative post at the provincial level for health service delivery. The INAS training is similar to a Master of Public Health (MPH) in the United States, and it has produced an impressive group of individuals with the requisite managerial and technical skills.

In Phase V, the PRIME project funded by USAID worked with the Directorate of Human Resources as well as the Directorate of Population to improve the quality and content of reproductive health training for nurses, both pre-service and in-service. While working to improve the skills of trainers, both at the national and regional levels, PRIME helped the MOH develop a national strategic plan for in-service training to prioritize and make more effective the large volume of in-service training they conduct every year. In this context, they also piloted a distance-learning approach for use by INAS to reach provincial health staff in a more efficient manner. While access to the Internet is still limited in many provincial health offices, this is a promising approach for the future.

Pre-service training was also an important aspect of USAID's assistance in Phase V. Interventions of the JHPIEGO Project resulted in the introduction of family planning training in the two Medical Faculties in Rabat and Casablanca. In addition, JHPIEGO provided training in teaching techniques for the faculty and provided a range of training materials for them to use.

The training efforts have ensured that the MOH has highly competent upper and mid-level managers, who are largely responsible for the success of the program.

G. Information, Education and Communication Activities (IEC)

IEC efforts developed slowly under the USAID-funded projects. The program administrators showed a historic aversion to putting family planning in the spotlight. They also feared drawing unwanted negative press through the promotion of social marketing. But, these reasons alone do not completely explain the late start-up of IEC. The administrators were cautious with regard to IEC because they did not wish to create public demand for services that the health system was not ready to supply. The evaluation of the MOH/USAID project at the end of Phase III emphasized the gaps in IEC in contrast to the impressive strides made in other areas. It was clear that it was time to give IEC the attention it deserved.

During the 1990s important changes were made in the area of communications for all the key MOH health programs. With USAID financing, the MOH entered into a contract with Johns Hopkins University (JHU) from 1990-1991. In 1990, a national strategy on information was formulated and a national seminar to reach consensus on FP was organized in 1991 (for the first time) in Mohamadia; it was attended by all partners as well as representatives of other social ministries, NGOs, and the press. Output included a

training curriculum for interpersonal communication and the preparation of written, audio, and TV material. The JHU contract was extended in 1993-1996.

1993-94 were important years for FP. For the first time in its history, the NFPP was center stage as “National Family Planning Weeks” were organized three years in a row, with the help of USAID. These media campaigns mobilized politicians, health professionals, and the various partners around a theme that, until then, had been developed only for health workers within their organizations. The campaigns emphasized the importance of FP and this encouraged other partners.

During Phase V, the highest priority was given to IEC, with a USAID budget of \$5,000,000. The MOH received technical assistance from a full-time international IEC expert, under the partnership with JSI and JHU-PCS. Parallel and complementary IEC activities were developed related to FP and the reduction of maternal mortality. The MOH teams acquired skills in the creation, production, and distribution of audio-visual and written material.

Thanks to the project, the IEC Division received “state of the art” technical equipment. This enabled the production of a great deal of material at low cost, for both FP and other MOH programs. Good relationships developed between MOH representatives and members of the Moroccan radio and television media which encouraged them to work together on broadcast productions.

New subjects were addressed during this phase such as men’s role in FP decision-making and the importance of dialogue between couples. For the first time, a qualitative survey was done on men’s behaviors and attitudes toward the family, FP in general, and some FP methods in particular.

A new area for the IEC Division that ended up being an important media event was the filming of a play addressing maternal mortality and family planning. This Moroccan film illustrated the dynamics of FP decision-making within the couple and was distributed nationwide. Of particular note, the film was designed in the “enter-educate” style that JHU has promoted worldwide.

In July 2000, the MOH sponsored an open house, at which it displayed the products of a decade of effort on the IEC front. The display was large and the quality of the materials high. Given that a decade earlier, IEC had been labeled the weakest part of the national program, the collaboration between the MOH and USAID since then deserves a great deal of credit for the impressive display of IEC materials.

H. Collaboration between the Public and Private Sectors

1. Social Marketing

The launch of social marketing was a real turning point in the life of the NFPP. Program administrators had for a long time strongly resisted the promotion of FP methods through social marketing. However, once the success of the VDMS model proved the public's acceptance of FP, the administrators were ready for a new challenge. Under Phase III, the Futures Group under SOMARC, worked with a local research firm ALCO. They laid the foundations for developing the Moroccan Social Marketing Program (MSMP).

The program was launched in 1989 under Phase IV, as an active partnership among manufacturers, pharmacists, and distributors. The goals were to:

- Find other financial support for the FP program, until then solely supplied by the public sector;
- Involve the private sector in FP services;
- Make low-cost, quality contraceptives available to needier populations;
- Increase the national contraceptive prevalence (just 36 percent in 1987); and
- Ensure long-term financial autonomy for the project.

◆ First Stage

Condoms were the first contraceptive launched by the MSMP. It was a great challenge, since condoms were considered a taboo subject. Up to that point in time, the primary targets of the NFPP had been women, but now men were targeted for the first time. The PROTEX radio campaign developed the slogan "Family planning is also the responsibility of the man." The campaign used marketing techniques, including:

- A communication strategy highlighting the role of men in choosing a contraceptive method;
- A public relations campaign targeting governmental decision-makers, opinion leaders, and prescribers (as special role was reserved for pharmacists); and
- A pricing policy that included a 3-condom package for DH6 (\$0.50).

A large-scale training program for 14,000 pharmacy sales personnel and 1,000 pharmacists accompanied the launch. Protex is one of the NFPP's great success stories. Though originally financed by USAID, it became self-supporting in 1993 due to the 30 percent tax on sales revenue.

◆ Second Stage

In December 1992, in a country where oral contraceptives were well-known and widely used, the social marketing program launched the pill "Kinat Al Hilal." The MSMP added new goals to its program: improving women's knowledge about the pill and its use, and

reducing the number of “drop-outs.” The effort, which benefited both the government and private sectors, was developed under a solid partnership among various groups:

- The National Federation of Pharmacists’ Unions, which trained pharmacists and their assistants in the technical and counseling aspects of oral contraceptives; and
- The Moroccan Association of Pharmaceutical Industries that advertised and distributed the product, and monitored sales.

The launch included a major training program for 1,200 sales people and 1,000 pharmacists. Various educational materials were produced and distributed. Spots about the pill were aired for the first time on national television. Research was conducted to examine the public’s perceptions and attitudes about the program and to adapt the communication strategies accordingly.

At DH8 (\$0.66) per pills’ pack, success was immediate. Sales exceeded forecasts in the first year. Other pill brands also benefited from the communication campaign. Thus, Kinat Al Hilal created new demand and broadened the general market for the pill.

Due to a 10 percent reserve created from sales revenue for further promotion, the project, which was originally funded by USAID, became self-supporting in 1996.

◆ **Third Stage**

Having been so successful in the first and second stages, the social marketing program decided to launch long-term methods, at a time when the MOH was also interested in promoting them. One of the key goals was to broaden the array of methods offered by the private sector. The injectable was introduced in 1997, priced at DH 34.40 (\$3.00) and the IUD in 1998 at DH 50 (\$4.50).

The climate was less favorable for these two methods than it had been for the pill and condom campaigns, in terms of the public’s knowledge and acceptance. Doctors were reticent to use injectables and did not know how to manage side effects since many had not been trained in their use. Under Phase V, however, 600 pharmacists and 150 general practitioners and gynecologists were trained in injectables and 1,000 private doctors in FP and IUD insertion. The training was done by the medical faculties at Rabat and Casablanca. Campaigns were organized to increase awareness and educational material was distributed and TV spots aired. Doctors received cue cards on managing the side effects of injectables and a poster on how to insert IUDs.

The introduction of these methods was not very successful. The sales of injectables increased, but often clients gave them up because of the side effects. In spite of the tremendous amount of training and the affordable price, the number of IUD insertions by private doctors did not increase significantly. Some of the reasons for the difficulties were the lack of experience of the private sector, competition from the public sector, negative rumors about IUDs, and the lack of involvement of gynecologists at the start of the project.

Since 1999, the Commercial Market Strategies Project, CMS, which is managed by a consortium of American CAs, is continuing the project. In addition to ensuring the maintenance of present capabilities, the primary mission of CMS is to strengthen the positioning of long-term methods in the private sector. The goal is to increase the participation of that sector in providing FP products and services. A broad action plan has been agreed upon with the MOH to meet that challenge.

2. Partnership for Health Project

Given the success of social marketing, an ambitious project was launched under Phase V to strengthen the role of the private sector in preventive services. The strategy called for a partnership among the MOH and various members of the broadly-defined private sector: doctors, nurses, midwives, professional associations, local communities, industry, other governmental departments, and private citizens.

The goal was to involve these different partners in developing an FP/MCH healthcare package. Several attempts at developing micro projects were ineffectual and had problems. Goals were too ambitious, the private sector was not ready, and legal considerations complicated the situation. Based on an evaluation done in 1996, it was decided that only general practitioners would be involved – through the development of a network. At the same time, MSMP launched the IUD and needed these doctors to support it. Many activities were developed: training, marketing of preventive services, examination of the sector's service quality, attempts at improving the organizational climate, research and evaluation.

These activities had a relatively limited impact because of the problems the sector was experiencing. The development of an effective partnership was hindered by various constraints: financial, tax, geographical divisions, competition, limited consumer purchasing power, and insufficient social service coverage. Evidence demonstrates that any strategy involving the general practitioner needs to bear these constraints in mind, which the MOH/CMS project is now trying to do. The GP's role needs to be radically recast if he is to be a major partner in developing health services, be they for prevention or treatment.

I. Improvement of Healthcare Quality

Improving the quality of FP services has always been a priority for the Moroccan MOH, which has tried to integrate it into all program activities. However, quality of care only truly came into the spotlight at the MOH in 1992, with the "Integrated Quality Management" initiative. Launched in five provinces, this initiative expanded to 14 sites by 1996 and to 53 sites by 1999.¹⁵ In parallel fashion, a number of different quality initiatives were undertaken during the 1990s by different groups within the MOH or in other Ministries: team problem-solving exercises, the development of FP standards (guidelines), the IMCI approach for child health, procedure manuals for nurses, procedure manuals for labs, among others. To institutionalize Quality Assurance (QA),

the Directorate of Hospitals and Ambulatory Care initiated the URC Quality Assurance Approach with support from USAID, in collaboration with multiple partners within and outside the MOH. These activities included: evaluating and capitalizing on the QA experiences in Morocco to date, awareness-raising at the regional level (1997), development of a manual and implementation of a training course for “training of trainers” in QA, two regional workshops to develop norms and standards, and the elaboration of a strategic document on the National Program for Quality Assurance (1999).¹⁶

J. Strengthening the Institutional Environment

Although policy reform was not identified as a separate element in the original MOH/USAID project, it has been a key activity. It gained in importance during Phase IV and was further emphasized in Phase V due to concerns about the sustainability of the FP/MCH activities. With the help of the OPTIONS project, a study entitled the “Legal and Institutional Policy Study of the Practice of FP in Morocco,” was conducted.

OPTIONS II also trained MOH personnel in techniques for advocacy and policy dialogue (PowerPoint, equipment, and color transparencies), provided TA in decentralization issues, and developed a simple approach for tracking host country contribution.

V. INDICATORS OF PROGRESS

Three sources of data are available for tracking progress in family planning in Morocco:

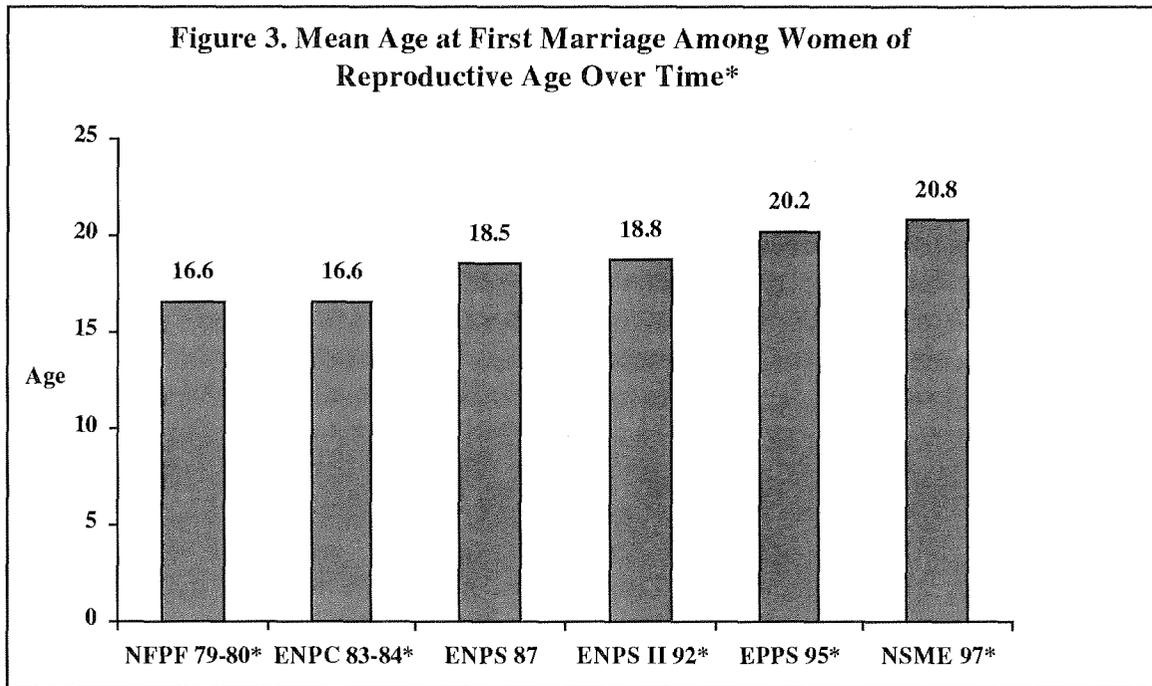
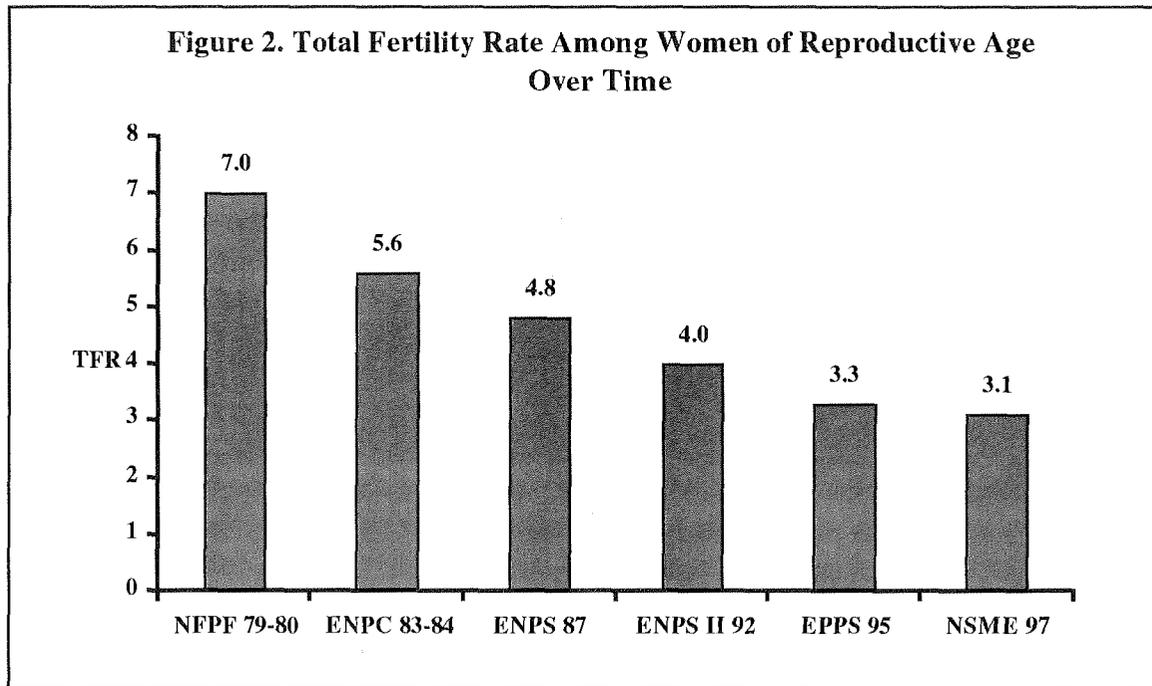
- (1) The nationally representative surveys that were carried out in 1979, 1983-84, 1987, 1992, 1995, and 1997;
- (2) The Family Planning Program Effort Index, developed by Berelson, Lapham, and Mauldin,¹⁷ and continued by Ross and Stover;¹⁸ and
- (3) Service statistics that measure different aspects of service utilization.

Because of changes in the measurement of certain indicators over time and lack of universal reporting, service statistics are not particularly useful in tracking progress over a 25-year period. Thus, this section focuses on the results of the national level surveys and the Family Planning Program Effort Index.

A. National Level Surveys

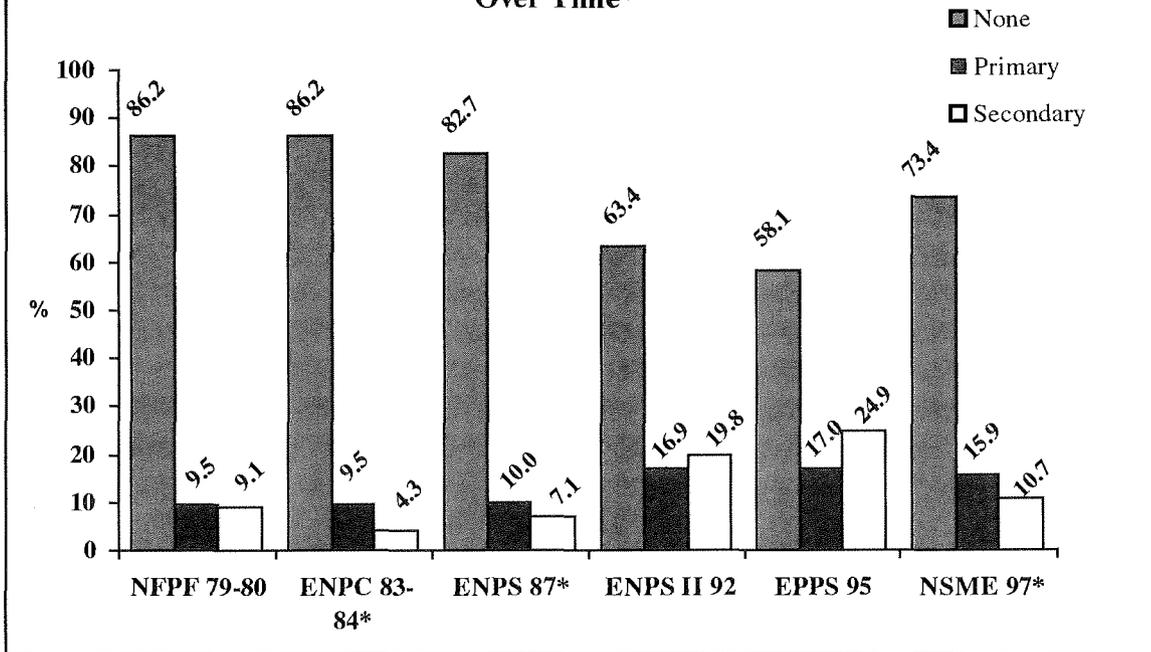
The data in Figure 2 indicate a dramatic decline in the total fertility rate (TFR), from 7.0 children in 1979-80 to 3.1 children in 1997. It is important to recognize that factors other than the national family planning program have also contributed to this decline. Figures 3 and 4 illustrate the dramatic shifts in two key variables that are reflective of this trend: the

mean age at marriage and the percent of women with a secondary education (both on the rise).



* Only among married women
 All surveys are among women aged 25-49 except ENCP '83-84, which is among women aged 20-49

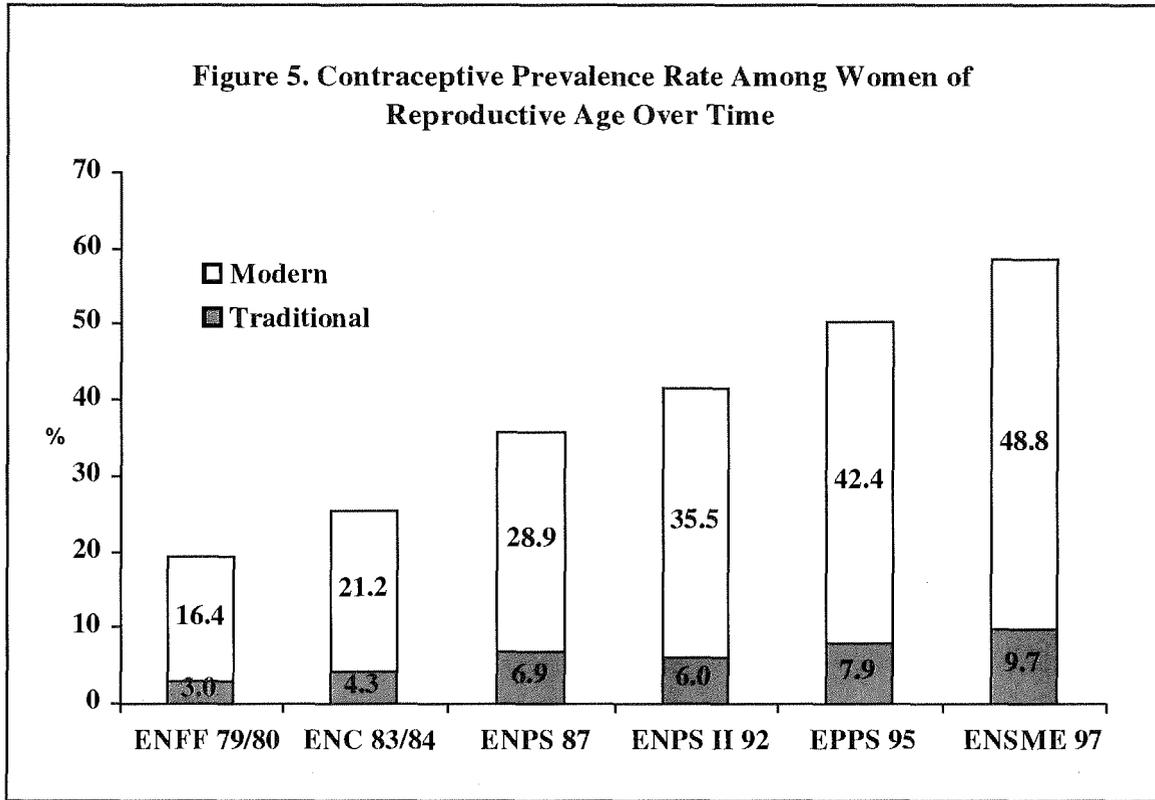
Figure 4. Educational Level Among Women of Reproductive Age Over Time*



* Only among married women.

The success of family planning in Morocco is best illustrated by the steady increase in contraceptive prevalence at the national level over time: from 19 percent in 1978-79 to 58 percent in 1997, as shown in Figure 5. This level of contraceptive prevalence puts Morocco in the category of “family planning success stories,” although the most successful countries worldwide have now reached levels of prevalence in the high 60s or low 70s.

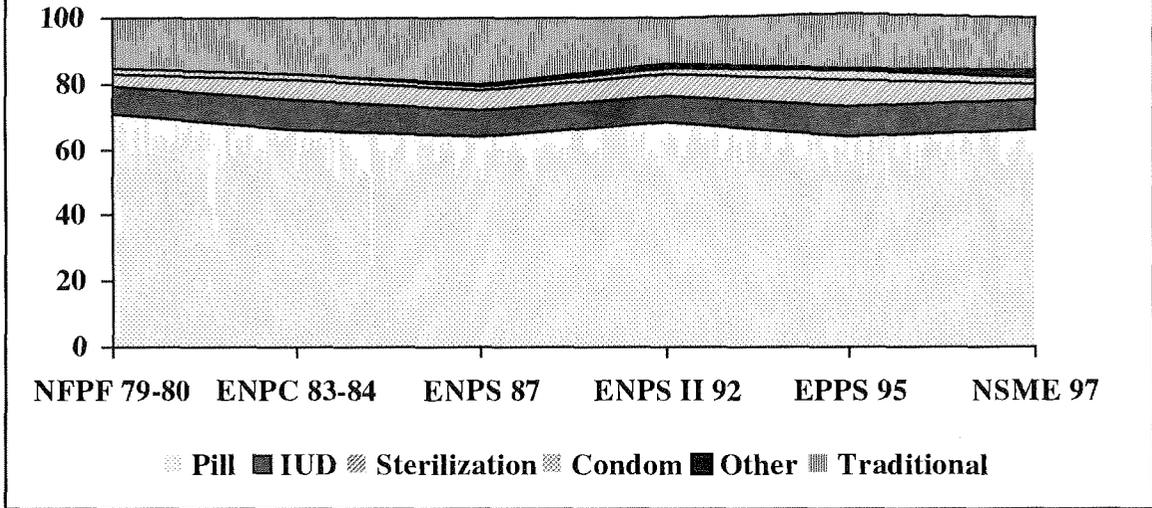
Figure 5. Contraceptive Prevalence Rate Among Women of Reproductive Age Over Time



Note: Modern methods consist of the pill, IUD, injections, vaginal foams, condoms, and female sterilization. Traditional includes all other methods. The total CPR for 1997 adds up to 58.5% when disaggregated by modern vs. traditional methods.

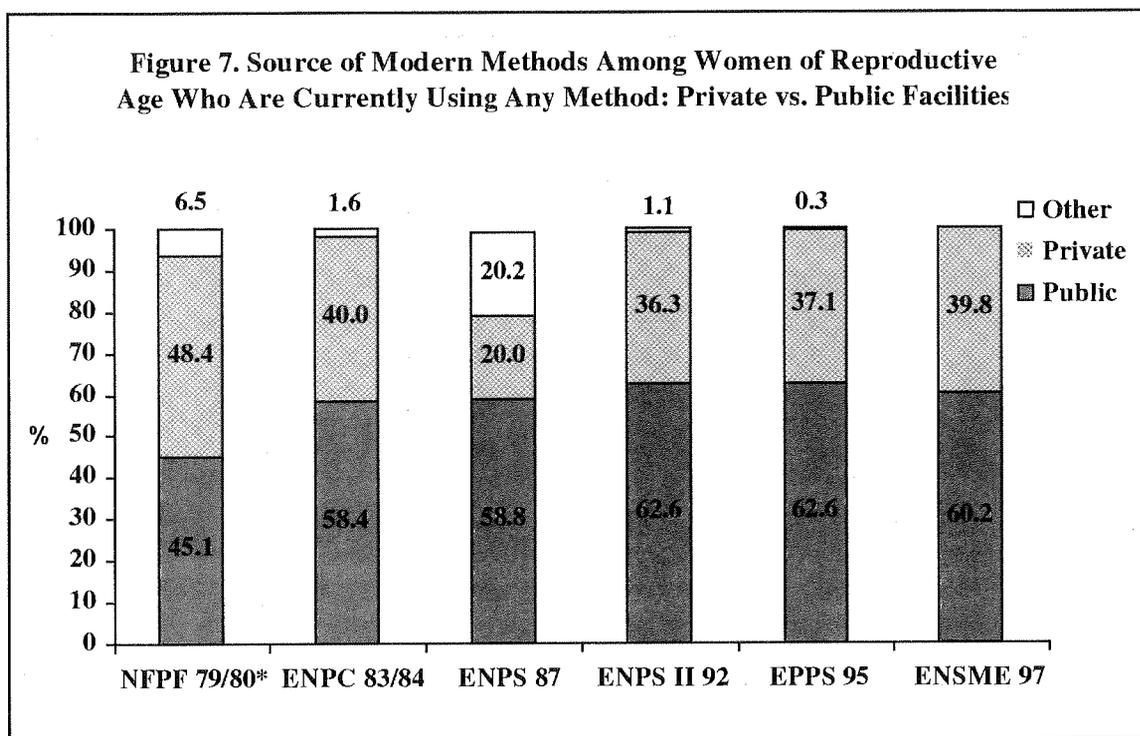
Method mix has remained highly consistent over the past 20 years, as shown in Figure 6. At every survey, the pill has dominated the method mix, constituting over 60 percent of all use at every survey. Traditional methods are second most prevalent (ranging from 14 - 20 percent of use), followed by the IUD and female sterilization. Other methods have had low levels of use in Morocco.

Figure 6. Method Mix Among Women of Reproductive Age by Survey



Morocco is one of the few countries with the necessary data to measure the impact of the family planning program on contraceptive use using “linked data” from household and facility-based surveys. Morocco had two surveys in 1992 and 1995 that allowed for the linking of household (individual) data with data on the family planning facilities available in the same clusters. The results of this analysis provided evidence that changes in the family planning supply environment during the three-year study period, in particular increased presence of nurses trained in family planning and the level of infrastructure at public clinics, played a significant role in the increased use of modern contraceptives.¹⁹ In retrospect, this methodology might have been more powerful in demonstrating program effects, had the time interval between surveys been greater than three years. For example, many of the changes in the program may have occurred before 1992 and would not have been captured in this analysis with a “window” of 1992-95 only.

The majority of users (58-63 percent) in the past five national surveys obtained their contraception from the public sector, including hospitals, maternity clinics, health clinics, mobile outlets and home visits (VDMS) as shown in Figure 7. This percentage has remained relatively constant over time (if one assumes the 20 percent “other” for ENPS 87 is a methodological artifact). Among those using the private sector, the percent obtaining their method from the pharmacy increased from 9 percent in 1987 to 31 percent in 1992, and continued to increase thereafter, reflecting the role of social marketing.



Public facilities include: hospitals, maternity clinics, health clinics, mobile outlets, and home visits.

Private facilities include: AMPF, private clinics, pharmacies, and doctors.

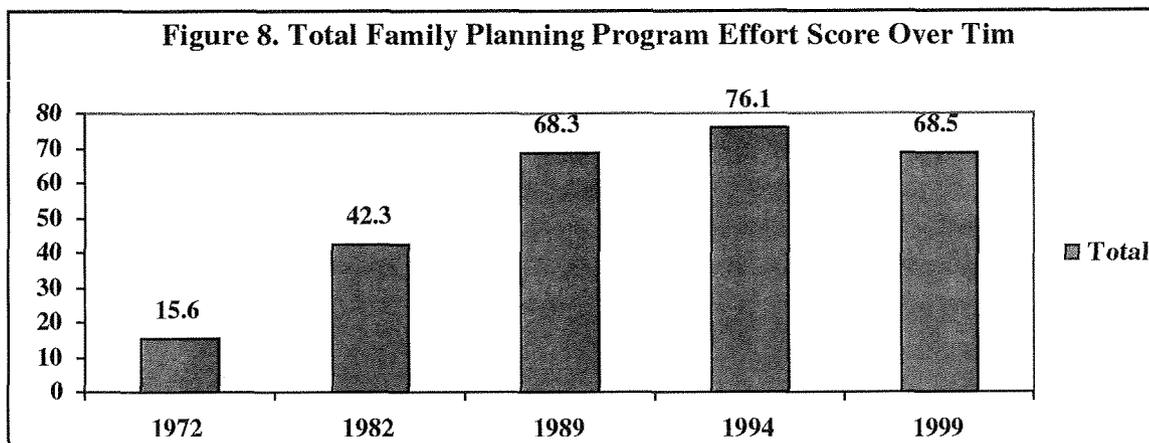
Other includes friends, family, and unknown

*This is the source for the pill only

B. Family Planning Program Effort Index

This index is designed to measure the strength of a national family planning program in four areas: policy, service delivery, record keeping, and methods. The data are based on information provided by 4-12 key informants per country. The 30 items on the instrument yield a possible score of 120, which is then reset to a scale of 100.

Data are available for Morocco at five intervals: 1972, 1982, 1989, 1994, and 1999, as shown in Figure 8. The total score for Morocco increased steadily between 1972, 1982, 1989, and 1994 (from 16 to 76), consistent with the steady progress described in this retrospective analysis. However, in 1999 the total score for program effort dropped back slightly (to 69). It is surprising that the overall FP program effort score actually decreased in 1999 after a steady rise over the previous 15 years. The decrease can be tracked to one (and only one) of the four components of the index: service delivery.



Nevertheless, the family planning program effort score – despite the dip in 1999 – captures the essence of a dynamic program that gained strength over time. It should be noted that some of the most successful programs in the world, such as Korea and Singapore, have also “lost ground” during their mature stage, when the momentum of popular demand takes over to sustain contraceptive use levels.

VI. COST OF THE NATIONAL FAMILY PLANNING PROGRAM

A. USAID Funding

During the 30 years of FP cooperation, USAID has been the most important source of external funding. The total amount invested by USAID was \$126,000,000 (see Table 6). Financing increased steadily from \$3,000,000 under Phase I in 1971 to \$52,000,000 in 1999 under Phase V. The post-bilateral assistance approved by USAID, of \$15,000,000, is not included in the present analysis. Currently in the implementation phase, it covers the period of 2000-2004 and is designed to ensure sustainability of FP/MCH activities and to consolidate capabilities in the public and private sectors.

Table 6. USAID Contribution by Phase		
Phase	Years	Contribution
Phase I	1971-1977	\$3,000,000
Phase II	1978-1985	14,000,000
Phase III	1984-1991	26,000,000
Phase IV	1989-1996	31,000,000
Phase V	1994-2000	52,000,000
Total	1971-2000	126,000,000

It is difficult to calculate the annual budgets allotted to FP/MCH activities because of the overlap of grant periods and their respective disbursements. Some activities have been

transferred between Phases III and IV (e.g., construction requiring a long time period or supplies needed quickly). At the end of Phase IV, \$1,000,000 was returned to Washington since the Phase V had already begun.

It is also hard to provide a breakdown of cost by individual activity since some areas, such as MCH or quality of management, affected several programs and funding came from various sources.

In addition to the bilateral grants, USAID financed FP activities through centrally-managed projects with American CAs: FPLM, MSH, AVSC, JHPIEGO, to name a few. This type of effort was the basis of USAID support during the first years of cooperation with Morocco. We do not have accurate budget numbers for those projects.

B. USAID Funding as a Percent of International Assistance for Family Planning

In the area of family planning, USAID has been the predominant source of international assistance in Morocco over the past 30 years. UNFPA has also provided funding although more limited in scope. The World Bank contributed with the construction of health infrastructure (that benefited but was not specific to family planning). Likewise, the World Health Organization has provided technical assistance on a number of activities, which has tended to be broader than family planning alone. Other sources of international assistance have included the European Union, the Canadian International Development Agency (CIDA), and GTZ.

C. Contribution of the MOH Toward the Total Costs of the FP Program

Since the start of the NFPP, the MOH has always been responsible for:

- Personnel salaries and benefits;
- Basic training costs;
- General expenses (water, heat, electricity, telephone, telex);
- Land purchases for construction;
- Rent;
- Building construction and renovation (except for certain projects under grants);
- Depreciation of buildings, vehicles and equipment;
- Purchase of medications (except some specific grant expenses);
- Purchase of accessories for medical equipment and office furnishings;
- Purchase of fuel and parts for vehicle maintenance (except where specified under grants); and
- Insurance payments.

USAID took care of the remaining programmatic costs (e.g., contraceptives, training, transport, fuel, some buildings, technical medical supplies, information systems, technical assistance).²⁰

However, the exact contribution of the Ministry of Health was never calculated. It was only during Phase V, due to concerns about FP/MCH sustainability, that the MOH contribution appeared in the project budget as a formal commitment. It was estimated at \$108,500,000, vs. \$52,000,000 from USAID. Tables 7 and 8 below give an idea of the Phase V budget details for USAID and the Moroccan government.

Table 7. Phase V: MOH Contribution (Initial amounts in \$000)		
Expense	Amount	Percentage
Personnel	66,494	61.3
Training	0	0
Equipment/Furnishings	0	0
Local Expenses	35,326	32.5
Project Management	0	0
Evaluation, Audits, Research	0	0
Unbudgeted & Inflation	0	0

Table 8. Phase V: USAID Contribution (Initial amounts in \$000)			
Expense	Sub-Amount	Amount	Percentage
Technical Assistance		6,982	13.4
Training		940	1.8
Equipment/Furnishings			
Vehicles	5,000		
Electronic Equipment	750		
Technical Equipment	3,500		
Furnishings & Other	1,250		
Audio-visual Material	750		
Total Equipment/Furnishings		11,250	21.6
Local Expenses			
Research & Studies	1,500		
Training & Seminars	3,000		
IEC Support	5,000		
Service Support	1,000		
Private Sector Support	1,500		
MIS Support	750		
Local Expense Outsourcing	1,928		
Total Local Expenses		14,678	28.2
Project Management		6,483	12.5
Evaluation, Audits, Research		640	1.2
Unbudgeted & Inflation		2,838	5.5
Contraceptive Products		10,077	19.4
Grand Total		52,000	103.6*

* Adds up to more 100%.

For the present and final accord (Special Objective 7), the budget clearly specifies the responsibility of the MOH for all expenses related to the purchase of contraceptives and vaccines, as stated in the transition plan.

The MOH has honored, and even surpassed, its commitments with USAID. These have grown steadily through increasing budget allocations. As a result, the MOH has had sole responsibility for the purchase of contraceptives and vaccines since 2000. This may, however, pose problems for the MOH and have a negative impact on some of its other activities. At the present time, there is no budgetary provision for corollary FP/MCH activities. The budget of the Directorate of Population is almost entirely designated for these purchases.

VII. 10 KEYS TO THE SUCCESS OF THE NATIONAL FAMILY PLANNING PROGRAM

1. High Level Political Support

In Morocco, the launch of family planning enjoyed support from the highest levels. His Majesty the King Hassan II established population control as a priority in 1965 and reinforced his position with the repeal of the antiquated French laws opposing the sale and distribution of contraceptives in 1966.

During the late 1960s and early 1970s, the King and his advisors became less vocal about population issues, possibly to avoid confrontation with powerful interest groups during a politically turbulent period. Moreover, the early support from the King did not translate into commitment to implementing FP services at the operational level for over a decade. Notwithstanding, the words of the King are interpreted as law in Morocco, and his early, sustained support for this cause played a key role in suppressing the opposition that would otherwise have surfaced from political and religious groups.

Family planning has benefited from the support of members of the royal family since its inception. This commitment has been shown by their appearance at national rallies. HRH Princess Lalla Meriem, daughter of the King and President of the *Association Marocaine de Soutien à l'UNICEF* (Moroccan Association for the Support of UNICEF), has been of great assistance on MCH issues. As head of the *Union Nationale des Femmes Marocaines* (the National Society of Moroccan Women), Princess Lalla Meriem has served as patron to many social and cultural events. The royal family support over the years has contributed political capital to family planning as a program and has legitimized contraceptive use at the individual level.

2. Sustained Initiative to Increase Access to Services in Rural Areas: VDMS

Without a doubt, the VDMS program was the gem in the family planning crown in Morocco. This program effectively served to both educate a large percentage of the Moroccan population about family planning and child survival issues, as well as to provide immediate access to contraceptive products and selected child health interventions (oral dehydration salts, referral for immunization, nutrition surveillance, among others). Despite the relatively low levels of education of VDMS itinerant workers, they became the “family physicians” to many rural families benefiting from

their services. The confidence they instilled and the trust they garnered from the community allowed them to approach controversial subjects such as family planning in a way that was acceptable to the local population. At the height of VDMS, the system covered more than 80 percent of the Moroccan population, including a substantial portion of rural areas.²¹ Although it is hard to say which of the factors on this list is most responsible for the success of the Moroccan program, the increased access to services that VDMS provided certainly is among the keys to the success of the Moroccan program.

3. Building the Program on Existing Structures and Integrating FP with MCH Services

Since the start-up of FP activities, Moroccan officials insisted on developing these services within existing structures.

Morocco is often compared to Tunisia in terms of family planning. It might well have followed the Tunisian model of developing a separate para-statal organization that dealt exclusively with family planning. Instead, Morocco adopted a model whereby family planning remained an integral part of its MCH/Family Planning program, thus increasing its sustainability in the period of shrinking funding for family planning.

In the early days of family planning, USAID Washington often feared that such “integrated programs” were just a ruse for non-committed countries to accept family planning funds that would then be diverted to more popular MCH activities. In the case of Morocco, the commitment to family planning remained strong, and if anything, family planning drove much of the MCH/Family Planning agenda over the past 20 years.

The MOH has done an excellent job of integrating services at the local level. Clients have access to FP and child health services at the same center and are seen by the same personnel. The management information system is also integrated (e.g., all routine service statistics forms include both FP and MCH). IEC media campaigns cover FP, safe motherhood, and, to a lesser degree, the prevention of STI/HIV/AIDS.

Although there are still cases where integration of family planning with other MCH and reproductive health services could stand improvement, the general model of integration has proven highly effective in the Moroccan context.

4. Strategic Approaches to Enhancing the Acceptability of Family Planning

Whereas family planning is a household word in Morocco these days, it certainly was not when the program was first initiated over 30 years ago. The Ministry of Health has been very strategic in its promotion of family planning, as the following examples indicate.

- The integration of family planning with child survival interventions under VDMS greatly enhanced the acceptability of the family planning component in rural areas of Morocco, where families faced multiple health problems.

- During the early years of the program, those in charge took the conscious decision to avoid media attention. They focused their efforts on strengthening healthcare, training health personnel, and emphasizing the benefits of FP to furthering MCH. In this way, they avoided negative reactions from political and religious groups.
- Similarly, decisions that could have caused discontent among MOH staff have been introduced gradually rather than abruptly to minimize disruption to the program. This was the case for phasing out gas coupons and indemnity payments for VDMS workers. In this way, program personnel, both in Rabat and at field level, were able to more gradually adjust to these changes in program activity without major disruption to the ongoing efforts.

5. Availability of Free Contraceptives

A key factor in the success of the NFPP is that it made free contraceptive services available at its health centers since the beginning of the program. In spite of the fact that an array of methods is offered, women continue to choose the pill. Attempts at diversifying the method mix toward a greater use of long-term methods have not been successful. Well-trained health professionals counsel clients so that they can make better-informed choices. Unfortunately, these services are not as readily available for men, which means that FP is still mainly a woman's responsibility.

6. Committed Leadership and Capable Team Management

Those in charge of the NFPP, both at the Head Office and in the field, have been completely committed to their tasks. They have contributed to the success of the program because of their dedication and desire to defend an often-controversial cause. It is clear from the international family planning literature that fledgling family planning programs fare best under high quality, sustained leadership, as in the case of Morocco. This drive to succeed influenced field personnel who worked diligently to achieve the program's objectives.

Since the launch of the program, the program administrators have always viewed training health workers as a key component. Since both USAID and the MOH were convinced of its importance, training was an important part of the partnership. The program also benefited from the presence of capable multi-discipline teams that played a basic role in inculcating and maintaining expertise.

7. Constructive Collaboration between the MOH and USAID

Both the MOH administrators and the USAID representatives who have worked with the NFPP have maintained a deep involvement with FP activities and have demonstrated a strong will to succeed. The administrative entities that were established, such as the Managing Committee, Project Management Unit, and the periodic retreats, facilitated project management as it became increasingly complex. The two partners worked well as a team, and proved adaptable and flexible in implementing plans. International multi-discipline teams were often asked to do evaluations, which were used as a basis for

continual adjustments in the FP efforts. These experts were also able to provide access to extensive research on different aspects of issues under discussion. The great flexibility and openness that have characterized the two partners' working relationship has been a major factor in the program's success. This close collaboration fostered the development of friendly relations and promoted an open dialogue among participants, both in Morocco and in the United States. USAID/Washington has an informal group known as "Friends of Morocco."

8. Adequate Funding

During the last 30 years, the NFPP has not suffered from insufficient funding. The Moroccan government has always covered basic expenses, sometimes helped by loans from the World Bank. USAID has made major financial contributions to the program that have allowed the development of many and varied activities geared to the needs of the public. Between 1971 and 2000, USAID invested \$126,000,000 in FP/MCH programs. Funds administered centrally from Washington, which were very important at the beginning of the working relationship, are not included in this amount. Thanks to USAID support, the NFPP has matured sufficiently that it should be able to overcome difficulties resulting from the ending of American aid. The benefits of FP are no longer questioned and the indisputable results of the NFPP will allow Moroccan administrators to argue their case for the necessary budgets.

9. Use of Data to Inform Programmatic Actions

Morocco has a long tradition of collecting and using data for policy purposes and programmatic actions. In the early days of the policy debates over family planning, results from surveys provided the necessary evidence of high fertility levels in Morocco that threatened to reduce the achievements in socioeconomic development. Over the past 30 years and with strong support from USAID, the Ministry of Health has produced an impressive amount of data that has allowed program managers to document progress as well as identify areas for further work. Few countries in the developing world compare to Morocco in terms of quality and quantity of data available on family planning programs.

10. Involvement of the Private Sector in FP Activities

As in many developing countries, the major thrust for family planning in Morocco came from the public sector. From the early days, government took the lead in establishing policy and programs through the Ministry of Health. At that time, it was not deemed advisable to involve the private sector. Officials adopted a "grass roots" strategy with VDMS. They also preferred to develop FP activities within existing public health structures.

Social marketing was only launched in 1988 under a partnership with SOMARC and ALCO. This approach, hitherto unknown in Morocco, started with the condom, which was considered a difficult product, likely to create resistance among the public. The

social marketing campaign, with its slogan "It's a man's concern as well," yielded the double benefit of bringing the discussion of condoms out into the open and markedly increasing condom sales in pharmacies. The involvement of the private sector, which started with the condom campaign, was further strengthened in 1992 in campaigns for the pill, IUD, and injectables.

VIII. ONGOING CHALLENGES

Despite the notable success of family planning in Morocco, several issues must be addressed in the years to come:

1. The Predominance of the Pill in the Moroccan Method Mix

From the early days of the program, the pill has represented over 60 percent of all method use in Morocco. Several factors explain this phenomenon. The VDMS system delivered pills and condoms (only), although they made referrals to the Referral Centers for IUD insertions. Thus, thousands of Moroccan couples were introduced to contraception in the form of the pill. It became synonymous with family planning, and its continued popularity appears to be a somewhat self-perpetuating process. (Women know about it from sisters and neighbors; they come to the clinic asking for it.)

Given the level of pill usage, it is imperative to improve the way it is used, reduce the number of women who give it up, and better identify clients for whom it may be contraindicated. In the post-Cairo period, service providers try to accommodate clients' wishes for a particular method, and this has further strengthened demand for the pill.

IUDs have gained ground over the years, but very little in comparison to the pill. A 1996 study indicated that rumors, fear of side effects, and service provider attitudes contributed to the lack of acceptance of the IUD.²² Service providers complain about the lack of means to deal with secondary effects of contraceptives, especially IUDs and injectables.

NORPLANT was introduced but later withdrawn for logistical and financial reasons; officials considered this a failure. Female sterilization is not widely practiced, for reasons outlined in section IV.D.

Is the predominance of the pill a problem? In many developed countries (e.g., France), the pill is the contraceptive method most used by women. In a country like Morocco, with a high percentage of illiteracy, problems arise such as women forgetting to take the pill or doing so incorrectly, which can lead to a rise in unwanted pregnancies.

Members of the international reproductive health community raise the question of provider bias, when any one method takes such dominance in the method mix.²³ Others argue that as long as clients are getting what they want, no problem exists. However, evidence suggests that there is substantial demand for female sterilization, which the MOH is unwilling to actively promote on religious grounds and/or for fear of political

backlash. In short, women in Morocco do not always have access to the full range of desired methods, and the program is constrained in expanding services in elective female sterilization, much less elective male sterilization (vasectomy).

2. “Drop-out” Rates

As contraceptive use increases, “drop-outs” become a problem for FP programs. Forty percent of those who use the main four methods (pill, IUD, traditional, and other modern methods) give up contraception in the first year.²⁴ The “drop-out” rate reaches 59 percent by 24 months. Traditional methods have the highest rate (51 percent and 69 percent respectively), while the IUD has the lowest (just 17 percent at 12 months). A total of 39 percent of women give up the pill after less than a year of use. The average usage period for the IUD is 34 months, but only 17.7 months for the pill. Since pill “drop-outs” occur generally during the first months of usage, health professionals should question why this happens and adjust treatment to the needs of the client, especially at the start of usage.

3. Quality of Care in Health Facilities

Despite concerted programmatic efforts during the 1990s to instill a “culture of quality” in the MOH health facilities, the MOH has not yet succeeded in developing a client-focus to the delivery of its FP services.

Because nurses and doctors are often overwhelmed by the sheer numbers of mothers and children to be seen for a variety of ailments, it is not surprising that many service providers have retained a traditional way of dealing with clients who come to health facilities. This problem is not unique to Morocco, and happily there are exceptions to this generalization (i.e., caring health professionals delivering services in the MOH system). Yet the hierarchical approach that characterizes social relations in most aspects of Moroccan life is also present in provider-client interaction.

Is the level of technical competence adequate? Many women and their husbands were introduced to family planning through the VDMS system, in which their primary contact was with one of the lowest ranking members of the health service hierarchy, whose level of competence was shown by several studies to be lacking.²⁵ Some have argued that this historical circumstance has resulted in low expectations of health workers by members of the target population, with the result that there is little public demand for improved services.

Since VDMS, the MOH has developed various programs that have affected the public’s perceptions. As a result, the general population knows more about health issues and is better able to express needs and demand quality health care.

At present, we have no “measure” of technical competence of service providers, and thus this concern may be overstated. A recent study (still in the analysis phase) will shed some light on provider performance in the delivery of FP services at the national level.²⁶

In a program that has been so successful in improving access, the MOH will do well to continue to focus on improving quality.

4. Lack of Access in Some Areas and Unsatisfied Demand

Again by no means unique to Morocco, access to family planning services remains problematic in rural areas of the country. According to the latest DHS (1995), unmet need for family planning was higher in the rural (20 percent) than urban areas (11 percent).²⁷ The MOH faces the challenge of increasing access to services among populations that are hard-to-reach geographically and that may feel less need to use contraception, at a point when USAID has reduced its support for family planning.

5. The “Vertical Nature” of Certain Program Components

The MOH argued strenuously in the early 1980s to integrate family planning into its MCH services (and won), despite pressures from Washington to maintain a more vertical approach to FP service delivery.

The MOH scores high points for the integration of service delivery at the field level; clients can get FP and child health services from a single facility. The management information system is also integrated (e.g., the set of routine service statistics forms includes both MCH and FP) and IEC campaigns have covered FP, safe motherhood, and (to a lesser extent) HIV/AIDS prevention.

By contrast, the contraceptive logistics system is not well integrated into the ongoing operational systems of the MOH. The FPLM project assisted the DP in developing a well functioning system for forecasting, purchasing, storing and distributing contraceptive products nationwide. Without question, the FP program has greatly benefited from the consistency of supply.

However, a different Directorate in the Ministry manages the provision of essential drugs using a different system. The chronic problem of stock-outs of basic medicines in public health facilities is a key issue facing the MOH for implementation of Integrated Management of Childhood Illness, HIV/AIDS prevention, and other important programs.

MOH regional and provincial managers have identified reducing stock-outs of basic medicines as a priority activity, and will be studying ways to bring the regular distribution system closer to the standard set by the FP program.

6. Lack of Female Personnel in the Program

It is not uncommon to attend a FP workshop in Morocco in which 80-90 percent of the participants are male. Women traditionally do not hold jobs outside the home, although change is occurring rapidly. At the administrative level, the number of women holding responsible positions is limited. Women have held key positions within the program, but unfortunately their number has declined in recent years.

At the field level, female doctors are in short supply (despite the expressed preference of many clients for a female doctor for FP services). This problem is by no means unique to family planning. Of the 62 Delegates (the top-ranking medical officer at the provincial level) in Morocco, none are women. Improving the number of women in positions of responsibility within the program remains a major challenge.

In addition, with an aging nursing staff, many are retiring and not being replaced. New recruiting is relatively less than before.

7. Sustainability of the Family Planning Program

Can the MOH maintain the same upward trajectory in contraceptive prevalence in light of the significant cutback in USAID funding? Some would argue that once a program has achieved a certain level of prevalence, it becomes self-sustaining, based on the creation of demand that remains high even as international assistance for the program dwindles. One could point to Colombia and Thailand as examples of this phenomenon.

Yet the reduction in USAID funding for family planning as of 2000 has created concern for the following reasons:

- Although the MOH routinely covered salaries and the physical infrastructure for service delivery, USAID funding facilitated many of the support activities for a program: training of personnel, development of IEC materials, applied research studies, to name only a few. Can the program maintain the same level of dynamism without this influx of supplemental funding?
- Technical assistance from outside experts over the years helped to introduce state-of-the-art technology and programmatic innovation that greatly stimulated progress for the program. Several of the persons interviewed opined that the loss of technical assistance was as problematic, if not more so, than the reduction in USAID funding to the MOH.

The MOH must now rely on the usual governmental channels to obtain funding for family planning activities, and this change could well impact negatively on the program.

8. Predominant Role of the Public Sector

In spite of the immense efforts spent on incorporating the private sector, it still does not occupy its proper position in offering FP services. In fact, its position has stagnated in recent years. Doctors and pharmacists need to be involved to a greater degree. Long-term methods need particular attention, since their percentage usage is very low. The desired role of general practitioners needs to be evaluated at the highest level, as part of the development of a preventive MCH action package to be provided by these doctors.

9. Untargeted Segments of the Population

The NFPP has almost exclusively targeted married women of reproductive age. Unmarried women of the same age bracket have not had sufficient attention. This is of particular concern given the later age at which women are marrying and the fact that more and more women are remaining single.

In spite of recommendations from the Cairo conference, there is a decided lack of policy and programs focused on the youth segment. Men have been targeted to some degree lately, after years of neglect. Activities directed at men should be further emphasized, given their increasingly evident role in the couple's FP decision-making, especially relative to long-term methods.

10. Lack of a Broader Program Vision Including all Reproductive Health

For a long time, the development of FP activities took focus away from MCH efforts. The construction of FP buildings (Referral Centers, VSC units) took precedence over new birthing centers to the public's chagrin. It was not until Phase V that maternal mortality was included in the MOH/USAID projects.

There is still much to be done in order to respond to the Moroccan public's reproductive health needs. Problems like cancer, menopause, infertility, among others are not included in the Ministry's preventive programs. It should be noted that there have been offers of help on these issues from other countries and international organizations.

11. Decentralization

Achieving success at decentralization is a major challenge for the MOH. During the last 20 years, FP/MCH activities have been highly centralized. Given the evolution of both the programs' performance and the country's political environment, it is essential that health matters be decentralized.

In 1996, a national political decision was made to decentralize and to create a regional structure in the country. This approach represented a radical departure from the past. Regional and provincial teams are increasingly involved in identifying needs and planning activities, thus providing more focused responses to the public's needs. Decentralization is a major topic of discussion at the MOH, and various models and methods are being studied in different departments. Decentralization calls for significant preparation on the part of the regional teams as well as support from the MOH. As part of the effort, USAID is assisting the MOH through a post-bilateral project covering the 2000-2004 period. Numerous activities are directed to two pilot regions, Sous-Massa-Draa and Tanger-Tétouan, where management and decentralized planning methods are being tested.

12. South-to-South Collaboration

Morocco was a founding member and an active partner in the consortium of developing countries, who put together the South-to-South Collaboration. These countries have successfully implemented reproductive health programs and have decided to strengthen their relations with other countries of the South that have had difficulty with theirs. The South-to-South partnership is now organized to provide technical assistance to other developing countries. The success of the NFPP makes it an important source of lessons learned of technical expertise for other countries in Africa and elsewhere. This partnership should be further strengthened so that Morocco can truly share its experiences with other countries.

IX. CONTRIBUTION OF USAID TO THE SUCCESS OF THE MOROCCO FAMILY PLANNING PROGRAM

- (1) To what extent did the family planning program “cause” the increase in contraceptive prevalence in Morocco?
- (2) What was USAID’s contribution to this process?

Some might argue that prevalence would have increased due to changes in social and economic conditions or from influences of urbanization and modernization, independent of the FP program. Others would counter that such impressive program efforts must have contributed to the increase. A socioeconomic analysis based on the Bongaarts model was done on different factors related to fertility, using data from two national surveys, one in 1979-80 and one in 1995.²⁸ In Morocco, the use of contraceptives is the largest factor in the decline in fertility. In fact, 52 percent of the decline is due to contraception and 44 percent to the higher age at the time of marriage. Between the two surveys, contraception is the most important factor in the decrease in fertility among women of all subgroups, with the exception of those with at least a secondary education for whom marrying at a later date is the most important element. Post-partum infertility did not contribute to the decrease in fertility during this period. Rather, changes in breast feeding practices would have increased fertility if other variables had remained constant. This statement is valid both at the national level and among different socioeconomic groups.

The various analyses conducted in developing countries worldwide to answer this question have concluded that contraceptive prevalence increases as a result of **both** program initiatives and contextual factors and that the two factors act in complementary fashion. Presumably the same can be said for family planning in Morocco.

As to USAID’s contribution to the national FP program in Morocco, there is no sample group that would allow us to evaluate how FP would have developed without USAID funding. It is virtually impossible to quantify with precision. We know that USAID contributed \$126,000,000 in funding for family planning between 1971 and 2000. This assistance went to support such vital aspects of the program as management and

supervision, training, logistics, IEC, research and evaluation, policy/advocacy; in short, almost every aspect of a functioning FP program. The steady, substantial flow of inputs into the system over these years coincides with the period of rising contraceptive prevalence. While one cannot demonstrate cause and effect, there is a strong case for “plausible attribution.”

As of 2001, USAID/Morocco has drastically reduced its level of funding to Morocco in the area of family planning and reproductive health, and it has channeled this funding into two regions as part of the decentralization initiative. While recognizing the validity of this new approach, a number of key Moroccan health professionals have expressed the desire to continue some form of partnership with USAID that goes beyond the traditional donor/recipient model. Indeed, a number of the persons interviewed for this retrospective report echoed this request, which appeared independent of the funding issue. This interest in further collaboration is a testament to the value accorded to the MOH-USAID partnership over a 30-year program. It speaks to the mutual respect between the two parties, as well as the benefits that it yielded for both.

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APPENDIX A. KEY CONTRIBUTORS TO THE NATIONAL FAMILY PLANNING PROGRAM - MOROCCO MINISTRY OF HEALTH

MOH

- Pr. Moulay Tahor Alaoui, *Directeur des Affaires Techniques*, 1978 – 1987
- Dr. Abdelhay Mechbal, *Directeur de la Direction de la Prévention et de l'Encadrement Sanitaire*
- Dr. Drissi Abdeslam, *Directeur de la Direction de la Population*, 1993-1995
- Dr. Mostafa Tyane, *Directeur de la Direction de la Population*, since 1995
- Dr. Mohamed Zarouf, *Médecin Délégué à Marrakech, Responsable du NFPP*, 1980 – 1993
- Dr. Najia Hajji, *Responsable de la Division de la PF*, 1995 – 2000
- Dr. Wafia Lantry, *Chef de Service de Programmation PF*
- Dr. Mohamed Abou-Ouakil, *Chef de Service de la Collaboration et Coordination Intersectorielle/ou Chef de la Division de la PF*
- Mr. Oucherif Brahim, *Administrateur Divisionnaire Principal et Principal Gestionnaires des Projets USAID*, since 1984
- Mr. Ali El Khedri, *Administrateur des projets USAID et FNUAP*
- Mr. Mohamed Hamane, *Cadriste, Division de la PF*
- Mme. Malika Bouaachra, *Sage Femme, Division de la PF*
- Dr. Rahmani Abdelhafid, *Médecin, Division de la PF*
- Mr. Housni El Arbi, *Démographe, Division de la PF*
- Dr. Cherkaoui Maanaoui Keltoum, *Médecin, Division de la PF*
- Mme. Sefiati Naima, *Assistante Médicale, Division de la PF*
- Mr. Jamal Tekni, *Cadre, Division de la PF*
- Dr. El Amrani Selma, *Médecin, Division de la PF*
- Mme. Oumghar Amina, *Cadre, Division de la PF*
- Mr. Lakssir Abdelylah, *Cadre, Division de la PF*
- Mr. Lotfi El Khyati, *ASB, Division de la PF*
- Mme Selouaci Khadija, *ASB, Division de la PF*
- Mme. El Haouate Fouzia, *Secrétaire, Division de la PF*
- Mme Said Fatiha, *Secrétaire, Division de la PF*
- Mme Tyari Touria, *Secrétaire, Division de la PF*
- Mme Alaoui Mrani Zoubida, *Secrétaire, Division de la PF*
- Mr. El Ouardi Abdelali, *Chauffeur, Division de la PF*
- Mme. Jamil Jemaa, *Agent de Service, Division de la PF*

APPENDIX B. KEY CONTRIBUTORS TO THE NATIONAL FAMILY PLANNING PROGRAM - USAID

USAID

Phase I

William Trayfors, Head of Population and Health
Thomas Harriman, Head of the Population, Health, and Nutrition
Vinnie Jabbar, Project Assistant
Elizabeth Tassé, Secretary

Phase II

Gerry Bowers, Head of Population, Health and Nutrition
Thomas Harriman, Health Program Officer
Eilene Oldwine, Head of Population, Health and Nutrition
Zohra Lhaloui, Project Management Specialist
Marion Van Derhoek, Secretary
Paul Ehmer, Health Program Officer
Ursula Nadolny, Nutrition Officer

Phase III

Dale Gibbs, Head of Population, Health and Human Resources
Carl Rahman, Health and Nutrition Officer
Zohra Lhaloui, Project Management Specialist
Najia Tourougui, Secretary
Paul Ehmer, Health Officer

Phase IV

Joyce Holfeld, Head of Population, Health and Human Resources
Carl Rahman, Health and Nutrition Officer
Zohra Lhaloui, Project Management Specialist
Amal El Hilali, Administrative Assistant
Bouchra El Omari, Secretary
Carol Payne, Health and Nutrition Officer
Michelle Moloney-Kitts, Health Officer

Phase V

Bill Jansen, Head of Population, Health, and Strategic Objective (SO) Team Leader
Ursula Nadolny, Health Officer
Michelle Moloney-Kitts, Head of Population, Health and SO Team Leader
Nancy Nolan, Technical Advisor
Zohra Lhaloui, Project Management Specialist
Helene Rippey, Technical Advisor
Susan Wright, Technical Advisor
Bouchra El Omari, Program Assistant
Amal El Hilali, Administrative Assistant

APPENDIX C. KEY INFORMANTS INTERVIEWED

This list contains all the key informants that were interviewed for the retrospective analysis reports (family planning, child survival, safe motherhood, and STI/HIV/AIDS).

USAID/Morocco

Ms. Susan Wright, HPN Officer
Ms. Helene Rippey, Senior Technical Advisor
Ms. Zohra Lhaloui, Project Management Specialist

Ministry of Health (MOH)

Direction de la Population (DP)

Dr. Mostafa Tyane, Director
Dr. Najia Hajji, Chief of Family Planning Division
Dr. Hamid Checkli, Chief of Child Health Division
Dr. Ali Bensalah, Chief of Maternal Health Division
Dr. Mohamed Abouakil, Service Delivery
Dr. Tsouli, Maternal Health Division, INAS Laureate
Mr. Abdelylah Lakssir, M&E Specialist
Dr. El Arbi Rjimati, Child Health Division
Dr. Mohamed Braikat, Head of National Immunization Program
Mr. Mohamed Bigmegdi, National Immunization Program
Mr. M. Brahim Ouchrif, Administrative Services
Ms. Rerhryaye Touria, Secretary, Child Health Division

Direction de la Planification et des Ressource Financières

Service d'Etudes et d'Information Sanitaire (SEIS)

Dr. Mohamed Laziri, Director
Mr. Mustapha Azelmat, Chief Engineer and Survey Specialist

Direction de la Epidémiologie et la Lutte Contre les Maladies

Dr. Jaouad Mahjour, Director
Dr. Ahmed Zidouh, Chief of the Epidemiology Surveillance
Dr. Kamal Alami, Chief of STD/AIDS
Dr. Hamida Khattabi, Epidemiologist
Dr. Abderrahmen Filali Baba, Chief of Leprosy (former Chief of STD/AIDS)

Direction des Hôpitaux et des Soins Ambulatoires

Dr. Saida Choujaa-Jroni, Director
Dr. Darhkaoui, Chief Ambulatory Health

Direction des Ressources Humaines – Division de la Formation

Mr. Achaati, Chief of the Training Division
Ms. Temmar, Midwife Trainer and Responsible for Basic and Continuing Training Program

Dr. Mohamed Zaari Jabiri, Head of Continuing Training Program

Institut National d'Hygiène

Dr. Rajae El Aouad, Chef of Immunology

Sefrou Region

Dr. Riouch, Sefrou Delegate

Marrakech Region

Dr. Mohamed Ben Chaou, Regional Coordinator

Dr. Moulay Lakkir Alaoui, Chief Doctor of SIAAP, Marrakech-Menara

Mr. Mohamed Aniba, Major of SIAAP, Marrakech-Menara

Dr. Zenjali, Physician, El Massira I Health Center

Ms. Ben Jebli Feturio, PSGA Educator

Casablanca Region

Dr. Jaafar Heikel, Delegate, Casablanca – Anfa

Médecin Privé

Dr. Mohamed Zarouf

JSI/Morocco:

Dr. Theo Lippelveld, Chief of Party

Ms. Boutaina El Omari, IEC Program Manager

Dr. Redouane Abdelmoumen, Public Health Specialist

Ms. Malika Lassri, Private Sector Program Manager

FNUAP

Dr. Belouali, Coordinator

CNFRH

Prof. Alaoui, Director

Institut Pasteur Maroc

Dr. Abdellah Benslimane, Director

Dr. Souad Sekkat, Immunology Unit

Ligue Marocaine de la Lutte Contre les MST/SIDA

Dr. Sekkat, President (also former Chief of STDs at the Military Hospital)

ALCS

Dr. Hakima Himmich, Chief of Infectious Diseases

Dr. Amine Boushaba, Prevention Program Coordinator

Dr. Adib Baakly, AIDS Care Program Coordinator

Ms. Sara Garmona, Prevention Program with Prostitutes Coordinator

AMSED

Dr. Malak Ben Chekroun, President
Dr. Issam Moussaoui, Project PASA Coordinator

OPALS

Dr. Nadia Bezaoui, President (former STD/AIDS Chief)

Union Européenne

Mr. Massimo Ghidinelli, Technical Assistant, STD/HIV/AIDS Program

Association Marocaine pour la Planification Familiale (AMPF)

Mr. Graigaa, Director
Ms. Bennamar, Board Member

Commercial Market Strategies (CMS)

Dr. Mohamed Ktiri, Country Director
Ms. Houda Bel Hadj, Chief of Program
Mr. Mohamed Jebbor, Country Manager

Catholic Relief Services (CRS)

Ms. Fouzia Soussi, Administrative Chief

USAID/Washington

Ms. Michele Moloney-Kitts
Dr. Miriam Labok
Mr. William Trayfors
Mr. Carl Abdou Rahmaan
Mr. Gerald Bowers
Ms. Joyce Holfield
Ms. Dale Gibbs

John Hopkins University/Center for Communication Programs

Ms. Sereen Thaddeus

WHO/Egypt

Dr. Mechbal, Representative