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REPORT OF THE EVALUATING TEAM
ON THE
MOROCCO FAMILY PLANNING PROGRAM

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Based on national figures and evaluators' observations, it is evident that in ten years the Moroccan National Family Planning Program had almost no demographic effect. Any modest fall in the birth rate is more the result of social change than the extension of family planning. There has been slight progress; however, the basic figures are so low that it is more apparent than real. In addition, the drop-out rate is high. On the positive side, there is potential within the impressive national public health infrastructure for an effective family planning program. The principal problems are (1) a lack of priority emphasis, (2) an organizational structure which forestalls the possibility of effective management, and (3) insufficient information, educational materials, and training. The principal recommendations are: (1) that the Government of Morocco (GOM) assign a high priority to family planning within its integrated health delivery system; and (2) that only if the GOM acts quickly to increase the emphasis on family planning should AID assign a high priority to the real needs of the program. The evaluators make a total of 45 recommendations on such things as management, new methods of distribution, information and education, status of women, service delivery, reference centers, sterilization, and reduction of illegal abortions.

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EVALUATION REPORT
ON THE
MOROCCO FAMILY PLANNING PROGRAM

I. INTRODUCTION

The Evaluation Team spent 12 days in Morocco during February, 1976, reviewing the National Family Planning Program and the U.S. Agency for International Development (AID) assistance to that Program. The Team travelled into nine provinces, urban and rural, containing almost half of Morocco's 18 million people. We visited and conducted interviews in 27 health service delivery points and family planning offices, as shown on the accompanying maps. (Maps 1 and 2)

During the period that the Team was in Morocco, one can project from actual 1975 figures, or make reasonable estimates, that there were 27,500 births and 9,500 deaths in the nation which resulted in a natural increase of 18,000 in the population. The number of new acceptors of contraception in the National Family Planning Program was 2,400, but the number of persons (nearly all women) in the Program who dropped out during the period was 1,500. This resulted in a net increase of 900 in the number of couples protected by modern contraceptives, while the increase in the number of women in the fertile years, ages 15-49, was 4,000. In other words, during the Team's 12 day visit in Morocco, the National Family Planning Program lost ground. There were more unprotected women at risk of pregnancy when the Team left Morocco than there were when it arrived.

Both from the national figures and from what the Team observed in its travels through the country, it is evident that in ten years the Moroccan National Family Planning Program had almost no demographic effect. If there has been a modest fall in the birth rate, from something approximating 49 to 47, it is more the result of social change and ferment than the extension of the program of contraceptive protection to about three percent of the four million women at risk at the end of 1975.

This is not to say that there has been no progress. Since 1972, the number of acceptors of the pill, the IUD, and the condom has grown at praiseworthy rates: 34 percent in 1973, 48 percent in 1974, and 32 percent in 1975. But the basic figures are so low - 37,000 first acceptors in 1973, 55,000 in 1974, 72,000 in 1975 - that the progress is more apparent than real.

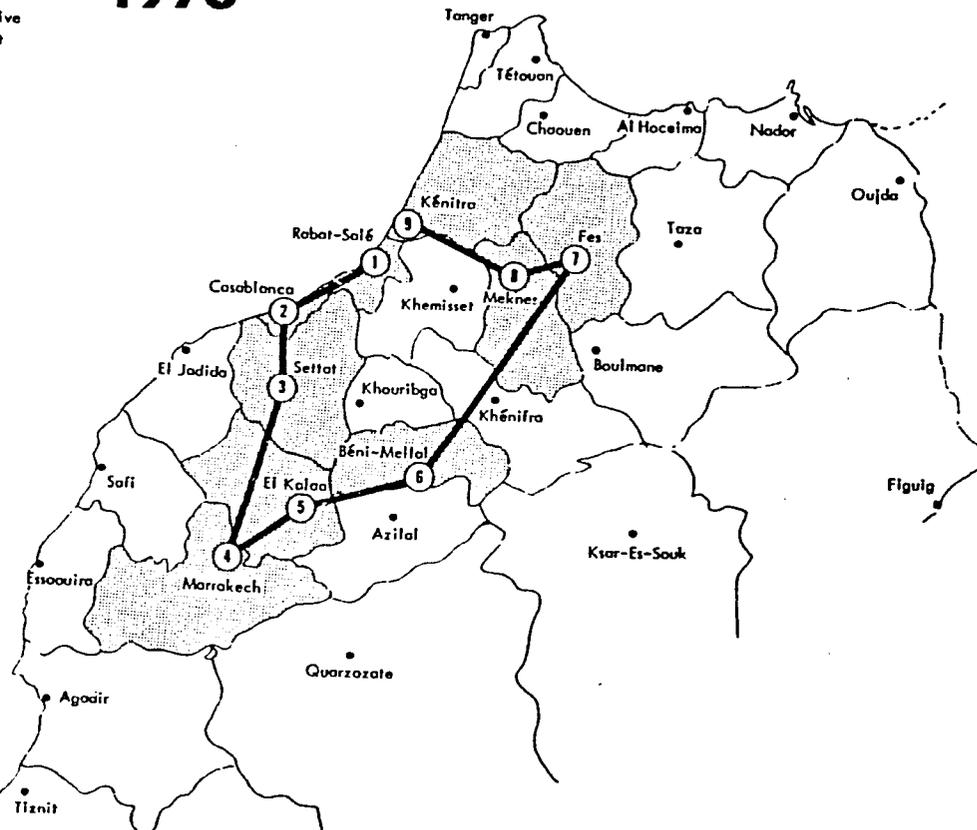
MOROCCO BY PROVINCE, Estimated 1976 Population, Women of Reproductive Age, Expected Births
 USAID Evaluation Trip, February, 1976

1976

FERTILITY STATUS

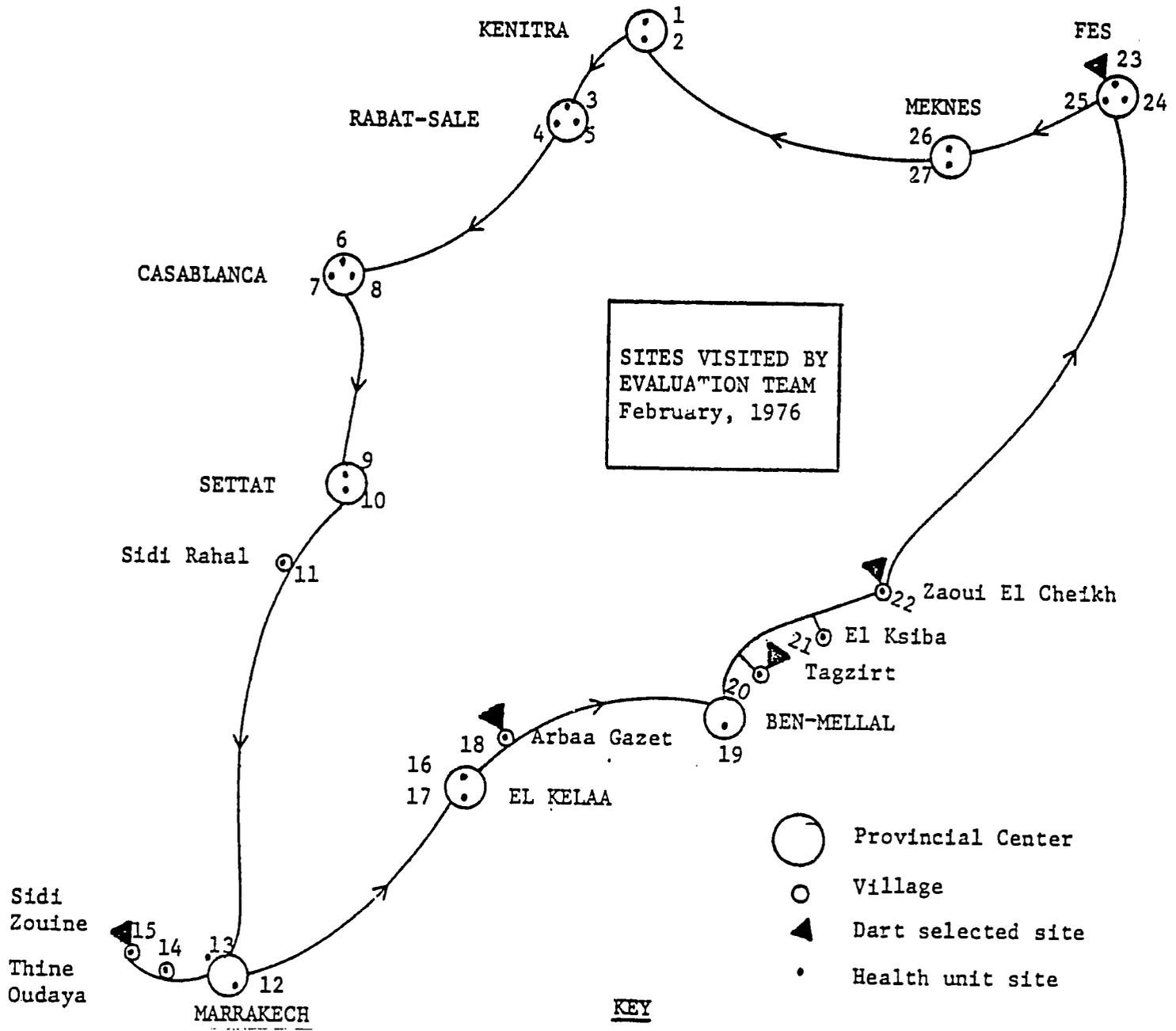
PROVINCE		CERED Projections		1976	1976	Cumulative
Rank 1)	1976-Population	Percent	Number	♀ 15-49 2)	Expected Births 3)	
2	1 Casablanca	11.92	2'140'941	476'145	98'483	30.9
7	2 Fès	6.46	1'161'073	258'223	53'409	
4	3 Marrakech	6.32	1'135'442	252'522	52'230	44.7
9	4 Kénitra	6.19	1'111'246	247'141	51'117	
	5 Agadir	5.01	899'930	200'144	41'397	66.3
1	6 Rabat-Salé	4.55	816'766	181'649	37'571	
3	7 Séttat	4.23	760'845	169'212	34'999	78.7
8	8 Meknès	3.92	704'387	156'656	32'402	
	9 Oujda	3.71	666'210	148'165	30'646	91.8
	10 El Jadida	3.70	665'493	148'006	30'613	
	11 Tétouan	3.45	620'147	137'921	28'527	98.3
	12 Taza	3.43	615'666	136'924	28'321	
	13 Safi	3.40	610'648	135'808	28'090	100.0
	14 Quarzazate	3.30	592'903	131'862	27'274	
	15 Nador	3.18	570'499	126'879	26'243	
8	16 Béni-Mellal	3.01	540'209	120'143	24'850	
5	17 El Kalaâ	2.96	531'426	118'189	24'446	
	18 Essaouira	2.24	403'275	89'688	18'551	
	19 Khémisset	2.23	401'303	89'250	18'460	
	20 Tiznit	2.20	395'388	87'934	18'188	
	21 Khouribga	2.17	390'370	86'818	17'957	
	22 Ksar-Es-Souk	2.13	382'304	85'024	17'586	
	23 Azilal	2.07	371'192	82'553	17'075	
	24 Tanger	1.82	326'921	72'707	15'038	
	25 Al Hoceïma	1.58	284'622	63'300	13'093	
	26 Khénifra	1.56	281'217	62'543	12'936	
	27 Chaouen	1.55	278'887	62'024	12'829	
	28 Boulmane	0.73	131'916	29'338	6'068	
	29 Figuig	0.52	92'843	20'648	4'271	
	30 Terfaya	0.45	80'655	17'938	3'710	
	MOROCCO	100.00	17'964'724	3'999'535	826'377	

1) Ranking by Provincial Population Size
 2) A factor of 0.2224 was applied to the Provincial Population
 3) A factor of 0.046 was applied to the Provincial Population
 Evidently, the urban-rural differential has not been taken into account in this overview summary layout.



KEY:
 ① — ⑨ USAID Evaluation Visit: 16-28 Feb. 1976
 [Shaded Area] Provinces visited

Map 1.



SITES VISITED BY
EVALUATION TEAM
February, 1976

- Provincial Center
- Village
- ▲ Dart selected site
- Health unit site

KEY

- | | |
|--|-------------------------------------|
| 1. Maternite | 14. Thine Oudaya, Dispensaire r. |
| 2. Centre de Sante Moulay Hassan u. | 15. Sidi Zouine, Dispensaire r. |
| 3. Maternite & Clinic | 16. Maternite |
| 4. National FP Center | 17. Centre de Sante |
| 5. Family Planning Association | 18. Dispensaire r. |
| 6. Maternite | 19. Maternite & Centre de Sante |
| 7. Centre de Sante | 20. Dispensaire r. |
| 8. Family Planning Association
(Clinic - Heures Joyeuses) | 21. Centre de Sante r. |
| 9. Centre de Sante | 22. Dispensaire r. |
| 10. Maternite | 23. Maternite |
| 11. Sidi Rahal, Dispensaire r. | 24. Centre de Sante Bab Boujat u. |
| 12. Maternite | 25. Dispensaire Fesgdite u. |
| 13. Quartier Industriel
Centre de Sante u. | 26. Maternite |
| | 27. Ecole d'etat,
Diplome Infirm |

u. = urban r. = rural

Further, the drop-out rate, particularly among users of the pill, is so high that the Program slips back six paces for every ten it takes forward. The 72,000 new acceptors during 1975, for example, have to be considered against the estimate, formed from a National Study of Continuation Rates conducted three years ago, of 44,000 drop-outs.

On the positive side, a potential exists within the impressive national public health structure for an effective family planning program. The principal problems seem to be a lack of priority emphasis by an organizational structure which forestalls the possibility of effective management. Our principal recommendations can be summed up as follows: 1) that the Government of Morocco, and primarily the Ministry of Public Health, take steps to assign a new, top priority to the National Family Planning Program within its integrated health delivery system; and 2) that if the Government of Morocco quickly demonstrates by its actions that it has increased the emphasis to be placed on the National Family Planning Program, then, and only then, should AID assign a high priority to the real needs of the Program.

We hope that officials of both governments, Moroccan and American, study this report and react favorably to the recommendations. We are convinced that family planning is of special importance in Morocco which has demonstrated through its health organization a real concern for its children, and through its investment in development, a promise for the future.

Finally, we want to express our thanks and appreciation to those who have helped us with our evaluation. The Team, because of the limitations on its time, proceeded at a rather fast pace. Our urgency in making appointments, meeting people, and pressing them for information must have taken aback many of those who found themselves faced with our insatiable demands for information and data. But everywhere we met the greatest of helpfulness and cooperation, and a large measure of understanding for what we were trying to accomplish. (See Appendix F).

We are particularly grateful to the staff of AID, both in Washington and in Rabat where Dr. Poulsen was our tolerant guide and mentor; and to the officials of the Ministry of Public Health of Morocco, who were uniformly and enthusiastically cooperative with our mission.

Above all, we must express our appreciation to Dr. Abdel-Kader Laraoui, Secretary General of the Ministry of health, who dealt with us with the utmost candor and tact, and with Mlle. Rachida Laraoui, Chief of the National Family Planning Service, whose charm and graciousness helped to make our entire trip a very great pleasure.

II. NATURE OF EVALUATION

Basis of Authority

This evaluation was conducted under the authority granted in the PROP for project 608-11-580-112, Family Planning Support to the Government of Morocco, as approved in April, 1975. Under "Conditions of Approval" the PROP states:

"AID/W will review the project with the Mission within the next year to evaluate the GOM's capability to support the program beyond 1977 without further AID assistance. In addition, at the time of the evaluation arrangements will be made for collection of additional data needed to measure the program's achievements."

Evaluation Team

The evaluation was conducted in Morocco from February 16, through 27, by a four-person team. The team consisted of Mr. John Robbins, consultant on the management of international fertility control programs, and former Chief Executive Officer, Planned Parenthood Federation of America, as Team Leader; Dr. Roger Bernard, Associate Director, International Fertility Research Program, and an Epidemiologist; Laurie S. Zabin, Doctoral Candidate, Johns Hopkins Population Program, and former Chairman, Information and Education Committee, Planned Parenthood Federation of America; and Dr. David Mutchler, Deputy Chief, Policy Division, Office of Population, AID.

Guidelines

A set of basic guidelines for the study were provided in October, 1975, by Dr. Niels Poulsen, USAID Population Officer in Rabat. Because these guidelines were so broad, and devoted so much attention to the much-studied history of the family planning program in Morocco, in contrast to the prospects for its future, the Team and AID authorities in Washington agreed that more precise instructions were needed. These were spelled out in a letter from Mr. Robert Grant to Mr. Robbins dated December 15. The key clauses in this set of guidelines instructed the Team to:

- 1) Consider the possibilities open to AID in supporting any type of program which will assist the Government of Morocco to translate its own population policy into reality.
- 2) Spend about half its time and effort on evaluation of the effectiveness of U.S. assistance up to the present time, and half in considering courses of action for the future.

- 3) In determining the Moroccan Government's capability to support the program beyond 1977, treat the word "capability" as implying the will and interest of the Government.
- 4) Hold its report as close as possible to a consideration of goals and objectives stated in the various PROP's covering the Moroccan program.

The letter also covered the special consideration of visits to "dart-selected" villages, which is covered in detail in Section VI.

Team Procedure

The following characteristics marked the Team's procedure:

Delays. The visit to Morocco was delayed from October to November 1975 to January, and finally to February, 1976 mainly because of the special problems which the country was undergoing in the territory that had been known as the Spanish Sahara.

Emphasis on Field Trip. Faced with limitations of time, the Team chose to put its emphasis on a trip to the field at the risk of having to give less than appropriate attention to various headquarters authorities and Ministries in Rabat.

Operating as a Unit. The Team chose to operate in the field as a unit, making joint visits to service delivery points, interviewing separately, and then consulting as a group every evening on what the individual members had learned during the day. This was particularly necessary in view of the delay in Dr. Mutchler's arrival. The Team is convinced that it chose wisely in refusing prior advice to split up and work on separate field trips.

Sacrifice of Some Investigations. Because only three members were present during most of the time in Rabat, the Team chose to abandon certain investigations it originally wanted to undertake. Chief among these were checks into the state of inventories of contraceptives, and a survey of the nature of commercial imports and sales of contraceptives.

Division of Labor. The diverse backgrounds of the Team indicated the method of operations and Team members found that their specialties dovetailed neatly. Mr. Robbins concentrated largely on management questions; Mrs. Zabin on information, education, and training; Dr. Bernard on medical methods and epidemiological data; and Dr. Mutchler on possibilities for new methods of service delivery. Since the conclusion of the visit, Mr. Robbins and Mrs. Zabin have concentrated on writing the report, and Dr. Bernard on preparing charts and tables, and editing has been done cooperatively by all.

Modification of Guidelines on Estimate of Prospects for 1977.

In respect to one important guideline the Team decided, on the basis of its experience in the field, to alter its recommendation from the mode requested by AID. This was the guideline requesting the Team to gauge the "capability" of the Moroccan Government to support the family planning program beyond 1977 without AID assistance.

As far as having an extensive network through which health services can be delivered, the Moroccan Government certainly has the "capability" to continue the program. A countervailing point is that the Moroccan Government is as restricted by shortages of funds as are most other third-world governments. It does not have a financial "capability" to automatically "pick up the bill" after 1977 for the contraceptive supplies that AID has been providing.

But the important questions, in the opinion of the Team, have to do with the "will and the interest" of the Government. In Rabat, government leaders speak of their "will and their interest" in family planning. In the field, the indications are that the "will and the interest" at the highest levels of government are lacking.

What the Team has attempted in this report, and most specifically in its recommendations, is to provide AID with a set of precise indices which can be used during the next year to measure the true "will and interest" of the Government of Morocco.

Report to Mr. Disdier

Mr. Grant, in his letter of December 15, asked the Team to produce a draft of its report before its departure from Rabat and to discuss it with the USAID Mission. We learned so much in Morocco, and we collected so much data, that it became impossible to write the entire report before leaving. We did, however, produce drafts of an outline of the report, and of the two most important sections, Summary of Findings, and Recommendations. We met with Mr. Disdier and his key associates on February 27, discussed with them our findings and our recommendations, received their suggestions, and left with them copies of our drafted material.

III. SUMMARY OF FINDINGS

In as much as this report is being submitted to officials with a basic familiarity with the Moroccan National Family Planning Program, we do not propose to repeat the general findings of the many previous reports on this Program. This section constitutes a summary of our most significant findings. In the case of nearly every finding summarized in this section, a reference is given keying the summary to a more complete description of the situation in one of the other sections of the report.

1. Basic Strength of the Infrastructure of the Health Delivery System. In visits to nine provinces, with site visits to no fewer than 20 hospitals, health centers, and dispensaries, the Team was impressed with the infrastructure which the Ministry of Public Health has established for the delivery of health services. The system has the following strengths:
 - a) It extends broadly through all settled parts of the country and into the poor, crowded areas of cities. Even in the rural villages which the Team visited through random selection, we found a dispensary with the capacity to deliver basic preventive services to all but the most remote residents of the area. (See Section VI.)
 - b) Personnel of the system appear to be young, vigorous, and interested in the service they deliver. Particularly impressive were the Provincial Health Directors whom we met in eight provinces.

These strengths were offset by the obvious shortages of resources, staff, equipment, and medicines in the system. However, the heavy investment made by the Ministry in schools to produce nurses of various levels in the provinces where they will be working is now starting to provide a flow of newly-trained personnel to complete the staffing of the system. In short, the health system has the potential to provide a means for the delivery of a high-quality, effective national family program. (See Section VIII.)

2. Failure of the Family Planning Program to Produce Results. Despite the strength of the health delivery system, the Team concluded that the National Family Planning Program has produced minimal results. Significant observations in this regard include:

- a) The cooperation on a crash basis of the National Health Statistics Service enabled us to see the final 1975 statistics on contraceptive distribution.

For the third year in a row there was a rate of increase of thirty percent or more in the number of "first acceptors" of orals, IUD's, and condoms. The continuing growth of the use of the pill in the National Program has made it the choice of five out of every six "first acceptors".

First Acceptance of Contraceptive Method, 1972-75
(In Thousands)

<u>YEAR</u>	<u>ORALS</u>	<u>% ANNUAL INCREASE</u>	<u>IUD</u>	<u>% ANNUAL INCREASE</u>	<u>CONDOM</u>	<u>% ANNUAL INCREASE</u>	<u>TOTAL</u>	<u>% ANNUAL INCREASE</u>
1972	19.3		5.3		2.9		27.5	
1973	27.3	41%	5.2	(2%)	4.5	55%	37.0	34%
1974	46.2	67%	6.3	21%	2.8	(38%)	55.4	48%
1975	59.8	29%	7.5	18%	4.9	75%	72.2	30%

- b) These "first acceptor" figures, however, are stated in gross terms, without taking into account the very high drop-out rate in Morocco. The continuation rates are low. (For every ten new acceptors there are six drop outs.) The net increase in the number of women protected by contraception during 1975 was only 28,000. (72,000 new acceptors less 44,000 drop-outs.)

- c) Because of the high proportion of youth in the population of Morocco, the number of women in the fertile years grows each year. During 1975, it grew by about 116,000, more than four times as many as the 28,000 addition to the number of women protected.

- d) At year-end 1975, by the most generous estimate, the National Family Planning Program was providing protection to no more than four percent of Morocco's four million women in their fertile years. (See Section V)

3. Special Problems of the Program in Cities. In the cities, the National Family Planning Program is plagued by some particular problems including:

- a) The health facilities, such as hospitals and health centers, tend to be old, vast, and crowded. The section reserved for family planning within a maternity hospital tends to be small and remote from the door by which all patients and potential acceptors arrive at the hospital.
 - b) With a notable exception in the city of Meknes, little emphasis within the health system is placed on the family planning program.
 - c) Women seeking family planning find themselves mingling with the sick and the old, who are seeking cures, not prevention.
 - d) The reception accorded to women seeking family planning services may be a deterrent to acceptance of the program.
 - e) The hospitals and centers are almost completely devoid of markings, direction signs, or any other information about the existence of a family planning program. It appeared that family planning services are not easily accessible to a woman who seeks them. (See Section VIII.)
 - f) No post-partum programs are conducted in hospitals. One trial program was run in Casablanca, but its results seem to be unavailable.
 - g) Frequently only one cycle of pills is extended at a time, either to a new or to a continuing acceptor.
4. Rural Problems of the Program. In the rural areas - containing two-thirds of the people - we found a high-quality management of provincial health services interested in family planning, but severely hampered by:
- a) a shortage of staff, money, and equipment;
 - b) a lack of any push toward widespread distribution of contraceptives at the community level;
 - c) a lack of sufficient guidance or management on family planning matters from the Ministry; and
 - d) a lack of encouragement in this field from the Ministry in the form of incentives, rewards, line budgets for family planning, visits to inspect family planning facilities, or even directives concerning the high priority to be given to this program.

Indeed, we believe that there is a potential here, through the use of the rural network of "health centers" and "dispensaries", to build a real, nation-wide family planning program with a distribution network reaching out into communities and households throughout the country. (For details on distribution methods, and on the possibilities of trying new methods of distribution in the cities and in the rural areas, see Section VIII.)

5. Basic Reasons for Lack of Success of Family Planning Program. Against this background of a strong health delivery infrastructure, and a congeries of problems not unusual for a developing country, the Team explored the reasons for the failure of the family planning program to achieve greater results. We found:
- a) Priority Assignment. The first reason appears to be that the Government of Morocco has not assigned to family planning the level of urgency which is required if the National Family Planning Program is to get the resources and attention it deserves. Evidence concerning this lack of high priority assignment is noted throughout this report.
 - b) Management Structure. The organizational structure by which the family planning program is "integrated" into the public health system hampers the possibility of effective management. The small National Family Planning Center is not a headquarters unit at all, but a technical staff unit quite removed from the main line of control of the public health system. The Chief of the National Family Planning Service cannot, because of this organizational structure, contribute significantly to the development of objectives, budgets, policies, procedures, and/or programs. The position has no authority over personnel and no authority to impose standards on the system, to measure or to correct performance. (See Section VII.)
 - c) Management Information System. Subsidiary to the general management problems is a set of problems arising from the failure of the system to use the data it collects to guide management in making decisions. The Team found, however, that the basic system of data collection is good. Changes could be made quickly and relatively easily that would provide management with prompt reports on progress. (See Section X.)

- d) Information and Education Material. There is a glaringly apparent lack of posters, booklets, displays, and audio-visual aids of all types; even directional signs. (See Section XI.) The only new information and education material produced within the past four years consists of two items: 1) a calendar published in February, 1975, and 2) a booklet for science teachers. There is no sign that any substantial amounts of new material are being prepared. Efforts to improve this situation will require that: 1) such material is in fact specifically requested by the Ministry, 2) the reasons for family planning are conceptualized and accepted by all Ministry officials as an important component of public health, and 3) the responsibility for production is clearly assigned either to the National Family Planning Service or to the Service of Health Education.
- e) Training. Seminars in family planning have been held, one on a national basis and two covering four provinces each. These have aroused some interest and other seminars are planned. But seminars are not a substitute for rigorous in-service training of all personnel. This type of training awaits pressure from above. Family planning is at present included in the curriculum of nursing schools, but no numbers are available on persons receiving in-service training on the delivery level. (See Section XI.)
6. Supplies. The lack of supplies does not appear to be a limiting factor on the growth of the Program. In dispensaries even in remote villages, supplies of pills were on hand as well as IUD's and condoms. The problem was clearly involved in the motivation of the doctors, the "infirmiers", and the system as a whole to promote the use of contraceptives. (See Section IX.)
7. The National Family Planning Center Building. The new building of the National Family Planning Center or is completed and equipped after considerable delay. The building, on the outskirts of Rabat and in the vicinity of the future site of the Maternity Hospital and the School of Public Health, lacks any identification. Regrettably, only some 10 percent of its space can be identified as being used for a family planning function. (See Section VIII.)

8. The "Reference Centers". Judging by the status of planning and/or construction in the seven provinces visited by the Team which are to have "Reference Centers" in the first wave, progress is somewhat behind the schedule spelled out in Dr. Poulsen's memo to files dated December 9. Deeper problems concerning these AID-financed units, however, are connected to the weaknesses of the management structure that affect the National Family Planning Program. There appears to be confusion between the national headquarters and the Provincial Health Directors as to the proper function of the units when they are completed. It will be most unfortunate if these "Reference Centers", with their high potential for helping to develop the Program, are not fully utilized. (See Section IX)
9. Equipment. There is an urgent need throughout the health delivery system for simple, uncomplicated audio-visual equipment that can be used to help educate and inform potential acceptors of contraceptives. (See Section XI.) Aside from this, and although there are shortages of all sorts of medical and non-medical equipment, lack of equipment does not seem at the moment to be a limiting factor affecting the family planning program. Care should be taken that any equipment sent to Morocco is simple to operate; is compatible with Moroccan electrical power systems, i.e., that the plugs fits and that it carries with it instructions in Arabic or, at least, French language.
10. The Family Planning Association. The Family Planning Association in Morocco is small and it considers its principal function to be educational. However, it runs seven clinics in cities. Because they are providers of only the one service - family planning - and because they provide a better ambiance and more encouraging treatment than the public health clinics, they show a better record of acceptors than comparable government installations. (See Section XII)
11. The "Foyers Feminins". The Team was impressed by the program for young women outside the school system, run by the Ministry of Youth and Sport in the "Foyers Feminins". Along with learning many sorts of practical skills, the girls -- and often their mothers as well -- get a good grounding in the principles of family planning. Unfortunately, the "Foyers Feminins" are limited in number and size by budget stringencies, and reach only a tiny fraction of the girls that could benefit from the program. (See Section XI.)

12. The Commercial Sector. The Team did not have an opportunity to investigate the distribution of contraceptives through the commercial sector or by private physicians. We have no reason to question the conclusion of Dr. Jean LeComte of the Population Council: That one can accept as a good working estimate that about half the use of family planning in Morocco is through the private sector (FPA, doctors, and pharmacies) outside the National Program. (See Section XII)
13. Research and Studies. The basic capacity to collect data appears to be sufficient in Morocco to make some of the installations of the public health system attractive centers for studies of changes and trends in patient profiles. The results of such studies could be used, in turn, to stimulate the interest of doctors and government officials in the promotion of fertility control. (See Section X)
14. Sterilization. The entire fertility control effort is being held back by the discouragement evident in the Ministry of Public Health for the acceptance of sterilization. Data on this surgical form of fertility control go unrecorded, or are subtly hidden in other statistics. (See Sections V and X)
15. UNFPA Financing. After several years of negotiation, UNFPA accepted late last year a proposal from the Government of Morocco for a three-year grant for \$3.2 million. The proposal covers a broad spectrum of MCH activities and family planning. UNFPA quickly approved the 1976 segment of the grant for \$800,000. Of this, \$560,000 is allocated for equipment, most of it for information and education equipment for the "Foyers Feminins", and for medical and nursing schools. Another \$200,000 is allocated for the training of Ministry of Public Health personnel and of family planning instructors in the "Foyers Feminins". The remainder is being used to employ two foreign communications experts assigned by WHO to the Ministry of Public Health, and to produce a limited amount of information and education material. There are good prospects that the remaining \$2.4 million of the grant will also be approved.
16. Population Policy Development. Government Ministries do not possess systematic analyses of the impact of projected population growth upon education, agriculture, employment and other spheres of government activity.

Ministries should be invited to participate in research activities which assess the impact of government programs and expenditures upon fertility. Analysis should be done to measure how specific programs in population education, health care, nutrition, etc., may--in addition to the family planning program--affect fertility, mortality and aggregate population growth.

Population impact statements should be constructed evaluating the second-order implications for population growth of public sector expenditure decisions and project development in activities which are not apparently related directly to fertility, mortality and population growth.

The above analyses will require social science research (sample survey analysis, anthropological field investigations and other efforts) to pinpoint the determinants of family fertility through the analysis of household decision systems.

For all of the above, AID contracts and grants could be utilized for technical assistance and some start-up costs, including, in some cases, support of Moroccan research institutions.

IV. RECOMMENDATIONS

A. KEY GENERAL RECOMMENDATIONS

The Government of Morocco, and primarily the Ministry of Public Health, should:

1. Take steps to assign a new, top priority to the National Family Planning Program within its integrated health service.

The U.S. Agency for International Development (AID) should:

2. If the Government of Morocco quickly demonstrates by its actions that it has increased the emphasis placed on the National Family Planning Program, then, and only then, assign a high priority to the real needs of the program.
3. Accept as indications of changes in the emphasis assigned by the Government of Morocco to family planning, actions in six fields of activity:
 - a) Systems of management of the Program.
 - b) Objective setting
 - c) Management information systems
 - d) Trials of new direct methods of distribution.
 - e) Information and Education.
 - f) Management personnel.

(The actions which the Government of Morocco might take, and which the Team considers to be the most significant as indices, are outlined in the following Recommendations B through G.)

4. Pending evidence of Government intentions to revitalize the Program, AID should continue, through FY 1977, limited financial support of family planning in Morocco, and most specifically, supplies of contraceptives, maintenance of a Population Officer in the USAID Mission in Rabat to give technical assistance and advice, and such modest pilot programs of the type recommended in this report as the Ministry of Public Health proposes to undertake in an effort to strengthen the Program.

B. SYSTEMS OF MANAGEMENT

The Government of Morocco should:

1. Revitalize the High Commission on Population and involves all appropriate ministries in the development of population policy.
2. Adopt a method of its own choice of managing the Family Planning Program within the Ministry of Public Health which will involve the director of family planning in the planning and budgeting, the organizing, the leading, and the controlling of the Program. (Sections III and VII)
3. Increase the budget for the management of the Program to a level that will permit the maintenance of a staff of a size and competence suitable to the importance of the Program. (Sections III and VII)
4. Assign to the management of the Program either direct control over its information and education activities, or establish a clear-cut staff relationship with the health education section which will permit it to plan and direct the production and distribution of a steady flow of new information and educational material. (Sections III and XI)
5. Assign to the management of the Program a clear-cut staff relationship with the Provincial Health Directors (Medecins-Chefs) that will enable policy and procedure guidance, management information, and other communications to flow freely in both directions. (Sections III and VII)
6. Assign clear responsibilities to Provincial Health Directors for family planning programs within their provinces. This should include the setting of short- and long-range objectives for each province which will involve a realistic but challenging expansion of effort. (Section VII)
7. Adapt existing systems to give the Provincial Health Directors authority to exercise flexibility in the way in which they move toward their objectives. This may involve the establishment of special provincial family planning funds. (Sections VII and VIII)

8. Assign direct responsibility for and authority over the management of the Family Planning Program high enough within the Ministry of Public Health to guarantee results throughout the Ministry's highly centralized system. (Section VII)
9. Insure that the management of the Program, working closely with the Provincial Health Directors involved, establishes clear guidelines for the policies and procedures that will govern the "Reference Centers", now planned or under construction in 13 provinces. (Sections III, VIII and IX)
10. Insure that all Ministries concerned, but most particularly the Ministry of Public Health, clearly demonstrate to the Provincial Governors the high priority which they assign to the achievement of family planning goals. This activity should in each case, and most notably in the case of the Ministry of Public Health, involve overt encouragement by high officials of the family planning effort and periodic visits by high officials to health installations to review family planning activities, and rewards (such as prizes) to officials and functionaries at all levels who achieve family planning objectives.

TIMING: Straightforward action on all these recommendations should be undertaken within one year.

C. SETTING OBJECTIVES

The Government of Morocco, and most notably the Ministries of Planning and Public Health, should:

1. Revise upward the goals for the National Family Planning Program. While substantially increasing the short-term targets for new acceptors, the new goals should add a new emphasis on increasing continuation rates, both by improving the reception and care given all patients, by liberalizing the methods of resupply of the pill, and by encouragement of the use of the IUD. Appropriate goals might be:
 - a) For 1977, a doubling of the 1975 achievement of 72,000 new acceptors (to 144,000) while holding drop-outs to the 1975 level of 44,000.
 - b) For 1978, a net increase in number of women protected (new acceptors less drop-outs) equal to the annual increase in the number of Moroccan women in their fertile years, which in 1978 will be about 125,000. (Sections III and V)

2. As recommended in B(6), such new objectives should be broken down by province, and responsibility for attaining them assigned to Provincial Health Directors.

TIMING: To be effective for 1977 and 1978, new objectives should be set this year.

D. MANAGEMENT INFORMATION SYSTEM

The Ministry of Public Health should:

1. Adopt, during 1976, a system of management information which brings to the attention of public health management each quarter the up-to-date statistics showing results in the Program, measuring them against objectives, and giving to management at each level a tool to use in making decisions. By the end of 1977, this family planning bulletin should be on a monthly rather than a quarterly basis. (Sections III and X)
2. Utilize three key "Reference Centers" - Rabat, Marrakech, and Meknes - for trying out new formats for family planning tables and new data collection systems that will effectively feed into a national management information system. (Section X)
3. Call on U.S. and other foreign assistance programs for assistance in revising the present questionnaires and system of recording, analyzing, and distributing statistics, in order to arrive at a workable, high-quality management information system. This may involve the sending of a two-or three-member technical team to other countries to study and observe good systems. The experience of such a team should then be utilized to help train management at the central and the provincial levels in the use of a management information system to make better decisions. (Section X)
4. Analyze the figures on patient characteristics collected during 1974 and 1975 and now available in Rabat. Such a study can produce valuable patient profiles, as well as indications of changes and trends in patient attitudes toward and practices of family planning. (Section X)
5. Redesign the individual acceptor forms to become an integrated part of the management information system. (Section X)

6. Continue the monthly reporting and tabulation of family planning activities by Province.
7. Differentiate in reporting and quarterly analysis between the activities and performance of the "Reference Centers" and those of the remainder of provincial operations. Analyze the differences. (Section X)
8. Design an experimental monthly report on obstetrical activities in maternity hospitals backed by the Reference Centers. Recommendations Nos. 6 and 7 should enable the monthly tabulation of a local integrated fertility care profile.

TIMING: All these technical recommendations, except as noted, should be put into effect before the end of 1976.

E. TRIALS OF NEW METHODS OF DISTRIBUTION (Section VIII)

The Ministry of Public Health should:

1. Initiate, in at least three provinces (one urban and two rural) during 1976, pilot projects testing the practicability and efficacy of household distribution of oral contraceptives. Unless the results are discouraging (which seems unlikely) the number of such projects should be expanded during 1977 to at least the 13 provinces with "Reference Centers". Successful projects in the original three provinces should be expanded to cover their provinces by the end of 1977.
2. Insure, as a minimum step throughout the country, that active distribution of orals is being conducted at all dispensaries, in accordance with the guideline recently issued by the Minister of Public Health. The Provincial Health Directors should supervise and encourage such activity.
3. Insure that three cycles of orals at a time are distributed to all continuing acceptors, unless exceptions are justified. Such exceptions may be either permissions to distribute fewer or more than three cycles at a time.
4. Initiate, in provinces with interested health directors, studies in such possibly improved methods of distribution as:

- a. Increased use of female workers in family planning in dispensaries and, wherever possible, as "itinerants."
- b. Influencing husbands through the use of male "itinerants".
- c. Use of volunteers from among satisfied acceptors to participate in the instruction and in the distribution process.
- d. Distribution of orals, as well as information and education material on health and fertility care, by Ministry of Public Health personnel in or close to the traditional gathering places of women: the "Souks" (markets).
- e. Training of selected wives of rural "infirmiers" to assist in the program.

TIMING: All these technical recommendations, except as noted, should be in place by the end of 1976.

F. INFORMATION AND EDUCATION (Sections III and XI)

The Ministry of Public Health should:

1. Produce from already available funds a continuing flow of basic informational and educational material, such as posters, brochures, displays, and slides. Such material should be rapidly distributed to the provincial health services for use in hospitals, centers, and dispensaries.
2. Utilize committed funds to purchase simple, basic audio-visual equipment, such as movie slide projectors and tape recorders. Such equipment should be rapidly distributed to the provincial health headquarters for use in hospitals, health centers, and dispensaries. All equipment should be simple and easily repairable and adjustable, and should be accompanied by instructions in Arabic or, at least, in French. Priority, especially for more sophisticated equipment, should be assigned to those provinces with working "Reference Centers", so that there can be coordinated use and maintenance of equipment for maximum usefulness.

3. Plan, design, test and choose a symbolic design for family planning that will be easily recognizable throughout Morocco. (The design of the family planning postage stamp, issued in February; might be used as such a symbol.) By the end of 1977, such a symbol should be used to identify family planning material and family planning installations. Pending the selection and distribution of such a symbol, as a minimum step, clear markings showing the way to the family planning facilities should be placed outside, at the doors of, and along the corridors of hospitals and health centers.
4. Institute a campaign to inform and educate the entire health network, public and private, as to the priority assigned by the Government of Morocco to family planning. One objective of this campaign should be to alter the attitudes of health personnel so that they are not negative on family planning, or even merely passive in their acceptance of the desire for family planning among their patients, but active, positive promoters of family planning as a health measure.

TIMING: Action on all these recommendations should be underway, except as noted, by the end of 1976.

G. PERSONNEL

The Ministry of Public Health should:

1. Assign to manage this complex program, which is of so much importance to the country, a person with:
a) experience and proven abilities in the management of the delivery of health services, and b) an education in medicine, and experience and proven abilities as a public health physician.

This might seem a difficult problem in executive search were it not for the reservoir of talent that the Ministry has available among its young, eager, intelligent, energetic Provincial Health Directors.

TIMING: This recommendation should be put into effect in the first half of 1976.

H. STATUS OF WOMEN

AID should:

1. Undertake an analysis of the results of a survey taken nationally among the "Foyers Feminins"

last September in an effort to determine whether there are significant correlations between Foyer Feminin activity and changes in attitudes toward and practices in fertility regulation. At the very least, a description of the study given to the Team indicates, the study should provide baseline information that could be used in designing other studies which might measure the effectiveness of Foyer Feminin activity. Such studies might lead not only to positive conclusions concerning the desirability of expanding the now limited activities of the Foyers Feminins, but also to projects dealing with the age of marriage and other aspects of the status of women. (Sections III and XI).

The Government of Morocco, and particularly the High Commission on Population, should:

2. Take steps to insure that women of talent approach parity with men in promotion to positions of responsibility, such as that of Provincial Health Director.
3. Continue its emphasis on opening education and training to women.
4. Study the ways in which the energies and abilities of women can be used in community development in the small villages, despite the handicaps which now exist to hinder and endanger a woman trying to work in the village environment.
5. Study the problems posed for Moroccan women by current divorce law. The relationship between fertility care of various kinds of women's precarious marital status could be an important factor in understanding broad-based acceptance of family planning.
6. Explore the feasibility of raising the legal age of marriage.

TIMING: Recommendation No. 1 should be undertaken during 1976, as soon as results of the study are released. The other recommendations concerning women are relatively timeless and continuing.

I. SERVICE DELIVERY

The Ministry of Public Health should:

1. Take steps to study the attitudes and practices of its personnel toward patients, with a view to establishing measures to improve, insofar as possible, the manner in which physicians and para-professionals are widely reported to treat women seeking family planning. (Sections III and VIII)
2. Within the limits of possibilities, take steps to assure that personnel are not charging women for family planning materials intended for free distribution in this high-priority program.

TIMING: These recommendations are of a continuing nature.

J. REFERENCE CENTERS (Sections III and XI)

The Ministry of Public Health should:

1. Postpone the construction of more "Reference Centers" until the value of the first 13 has been tested. This will take at least until a year after the first three have achieved a reasonable level of operations.
2. Insure that clear guidelines on the purposes and procedures of the "Reference Centers" are available to and used by Provincial Health Directors, and that the existence of these new units is fully exploited.

K. STERILIZATION

AID should:

1. Encourage the International Project of the Association for Voluntary Sterilization (IAVS) and the Program for International Education in Gynecology and Obstetrics (PIEGO) to explore the possibility of sponsoring projects for, and sending equipment to, selected physicians, hospitals and Provincial Health Directors. (Sections V and X)
2. In parallel fashion, encourage appropriate technical assistance groups to sponsor projects through which such physicians and institutions as initiate ligation projects can turn those projects into

scientific research and use them to gain acceptability for sterilization in Morocco. The use of "Reference Centers" as the sites of such projects may well be appropriate. (Section X.)

The Ministry of Public Health should:

3. Look with a tolerant eye on such projects, and follow their evolution.

TIMING: These recommendations should be undertaken in 1976.

L. REDUCTION OF ILLEGAL ABORTIONS

The High Commission on Population should:

1. Reach a consensus on the need for new policies to cope with this national problem, which otherwise will intensify among the teeming incoming generations.

The Ministry of Public Health should:

2. Initiate a process to determine its responsibilities in "integrated health and fertility care" when faced with 800,000 deliveries and over 100,000 induced abortions for 1976, not to count the scores of women who will die as a result of such attempts.

TIMING: These recommendations are of a continuing nature.

M. EVALUATION

Prior to a decision to continue the program after 1977, AID should:

1. Assign an evaluation team in 1977:
 - a. To visit Morocco, following much of the same itinerary as this Team. (An additional week of time may be required.)
 - b. To review progress, using this study as a baseline.
 - c. To review the evidence as to whether the Government of Morocco has indeed assigned a higher priority to family planning.

- d. To assist in evaluating test projects, and particularly those dealing with new methods of distribution.
- e. To examine the status of the "Reference Center" network.

V - THE CURRENT STATUS OF FERTILITY CONTROL

The Team devoted most of its attention to investigating the status of the Government of Morocco National Family Planning Program, which utilizes oral contraceptives, IUD's, condoms, and, to a lesser extent, foams and jellies. It made an effort to assess the status of sterilization in Morocco, as well as that of abortion, although neither of these procedures comes under the Government family planning program.

This section recapitulates briefly the status of the use of each of the principal forms of contraception. It then concentrates on the total effect of the National Family Planning Program on the incidence and prevalence of protection against pregnancy in Morocco. Finally, it summarizes a few estimates concerning the private sector, sterilization, and abortion.

A. ORAL CONTRACEPTIVES

The National Family Planning Program, at its inception in 1966, utilized only the IUD as a method of contraception. The use of oral contraceptives was not authorized until 1969, but in the second year of their distribution first acceptors of the pill outnumbered those of the IUD, 14,000 to 10,000. The acceptance of orals has climbed steadily each year since their introduction while IUD's have never regained the level of acceptance they achieved in 1969 and 1970. In 1975, there were 60,000 new acceptors of pills, eight times as many as the 7,500 first acceptors of IUD's. The oral contraceptives used in the program are all provided by AID out of supplies of Norinyl (or Noriday).

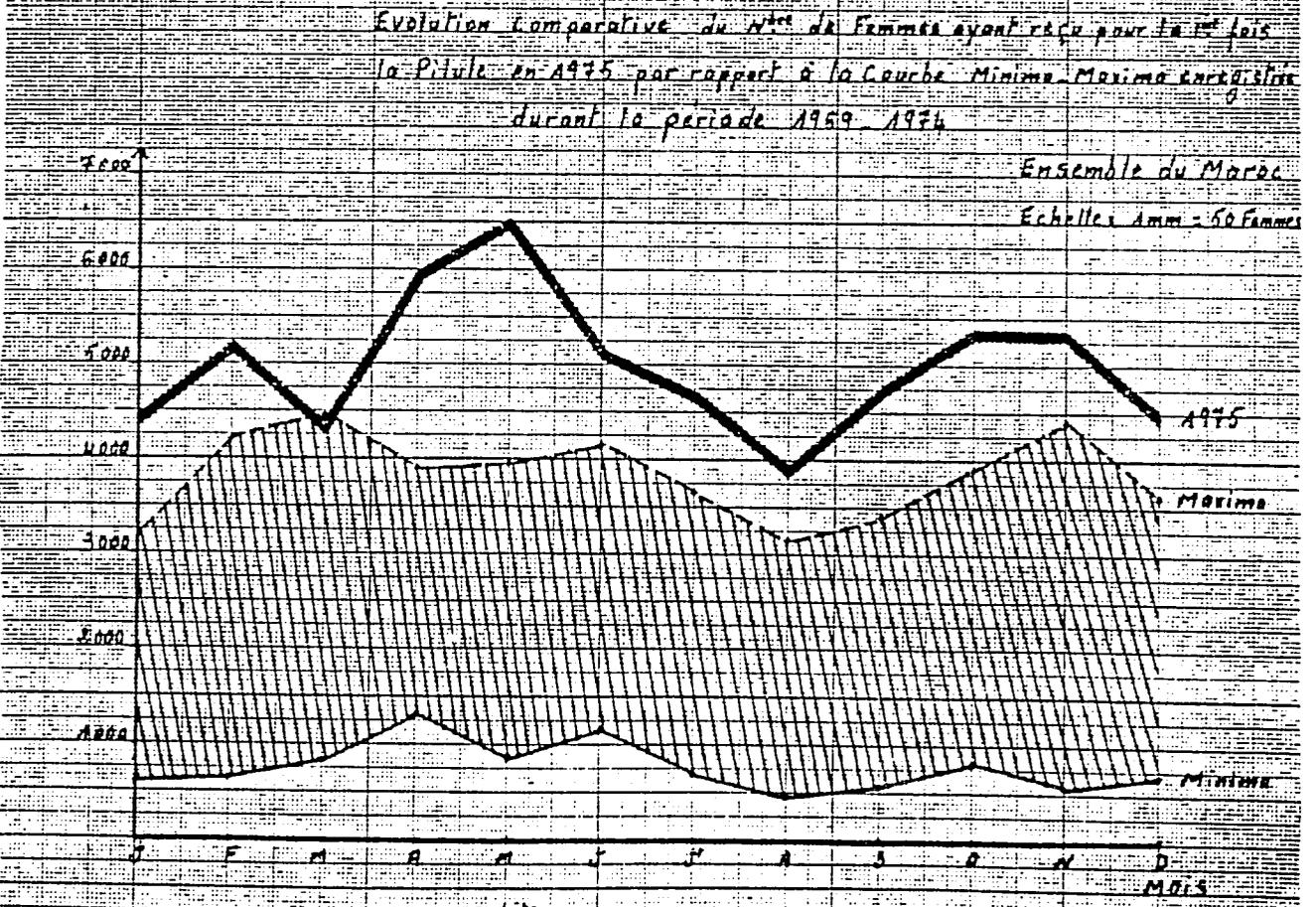
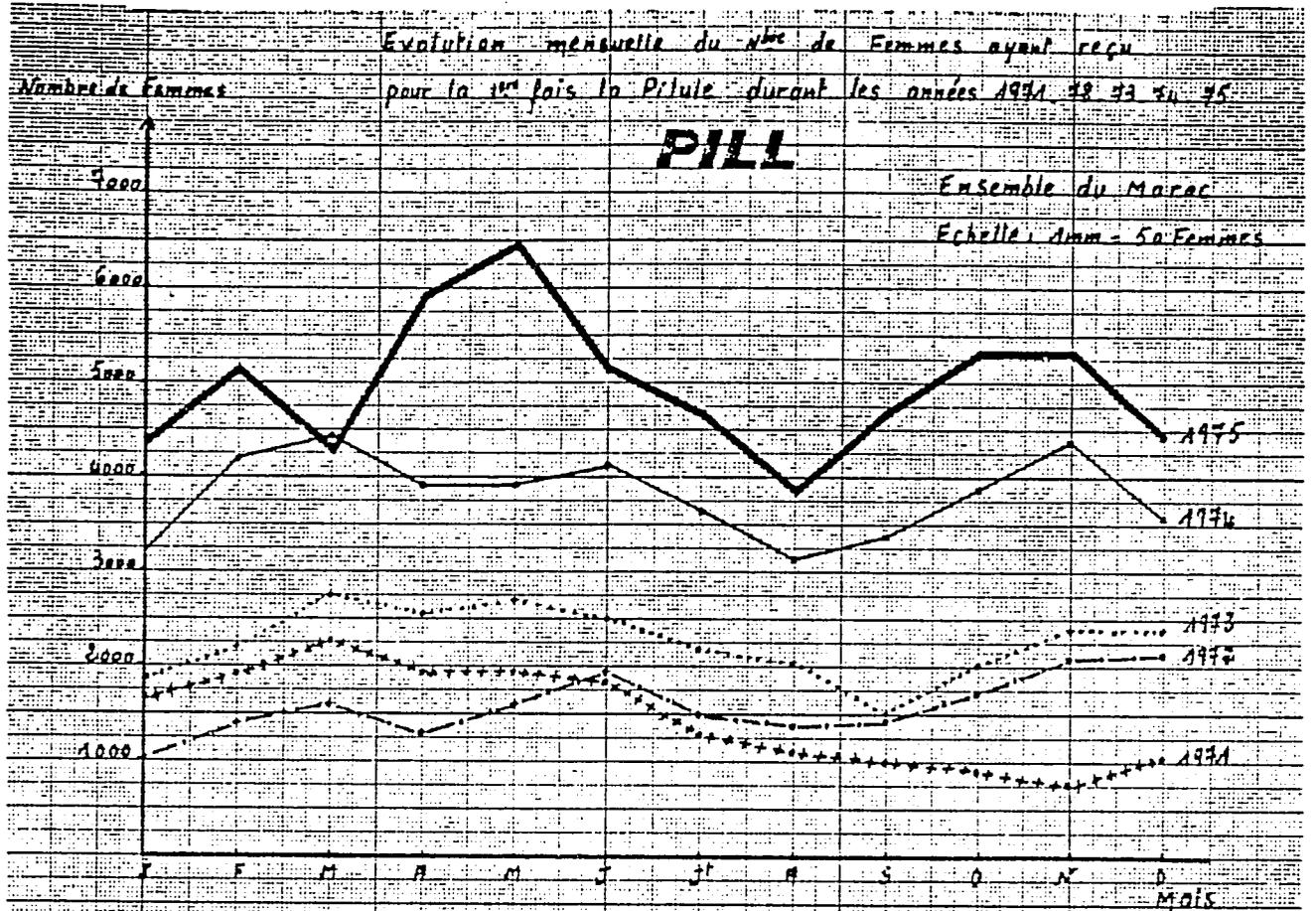
Government health officials point with pride to the steady increase in first acceptance of the pill, citing such figures as the 1974 growth rate over 1973 (67 percent) and the 1975 growth rate (29 percent). A frequently mentioned figure is the total number of first acceptors of the pill since the program began, 197,000 women. Chart 1., prepared by the Government Health Statistical Service, shows that during each month of the last year, except one, first acceptance of the pill set new records.

B. IUD'S

The IUD has not been a popular or successful contraceptive in the National Family Planning Program, although the Team found areas where an enthusiastic and careful

Chart 1.

MONTHLY FREQUENCIES OF NEW PILL ACCEPTORS, 1971 - 1975



doctor has persuaded numbers of women that this is the method they should choose. Chart 2., prepared by the National Health Statistics Service, shows that 1975 acceptance figures, while higher than those for the years 1972-4, is still hardly above the median for all the years of the program.

The problems which have inhibited growth in the use of the IUD are not dissimilar to those in other less-developed countries. The doctors and para-professionals who inserted the IUD's in the early years failed to warn women sufficiently of the side effects, and women were quickly discouraged by the cramps and pains. They not only asked to have the IUD removed, but also spread the word that it was a painful device.

Further, the men do not seem to approve of the IUD. The Team heard different stories in various provinces, but they added up to much the same thing: many Moroccan men are bothered by a wife's use of the IUD. This attitude on the part of men is effective in determining women's choice of contraceptives. Most rural women seem to accept that, while their general health is their affair, their reproductive organs essentially belong to the husband.

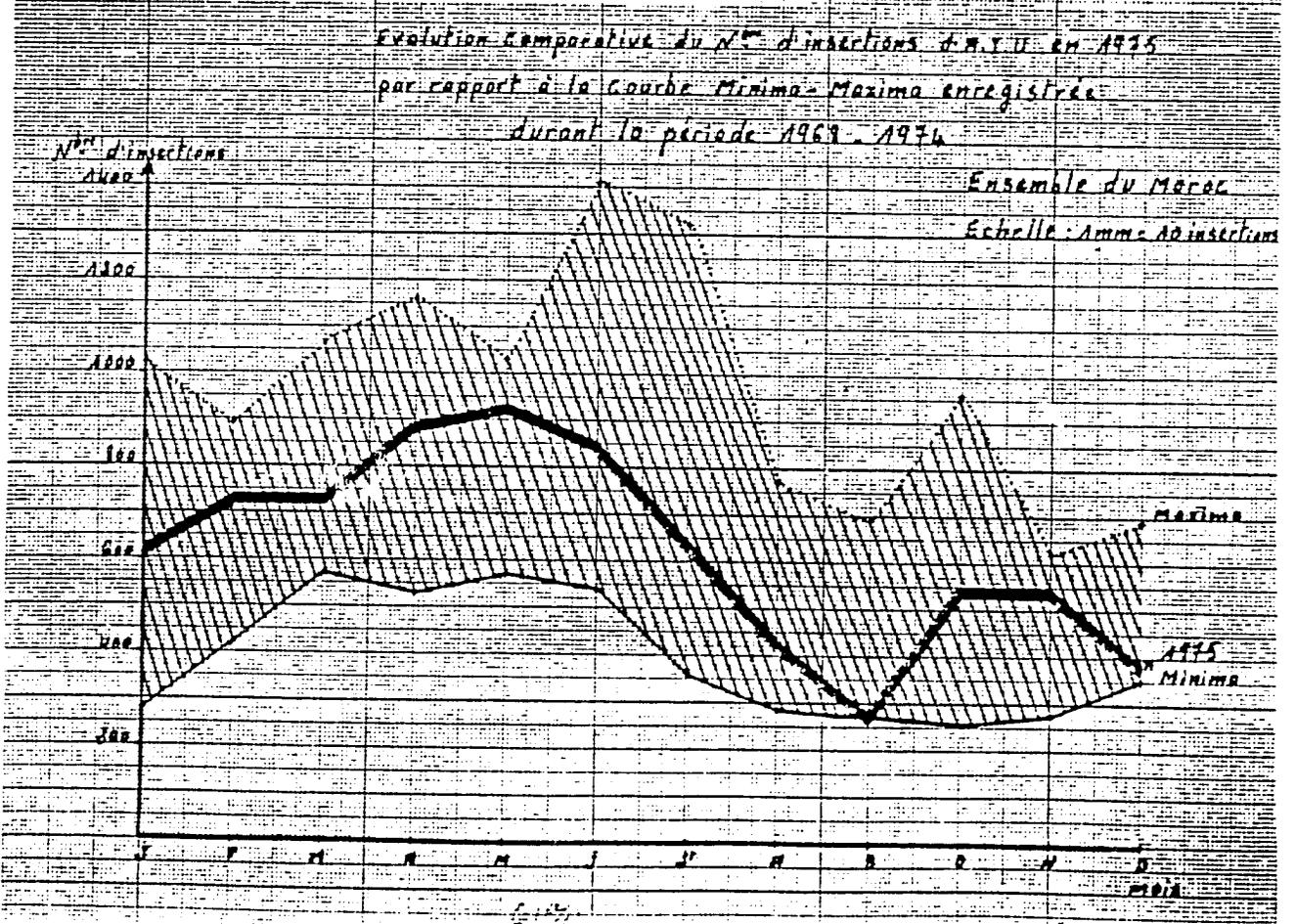
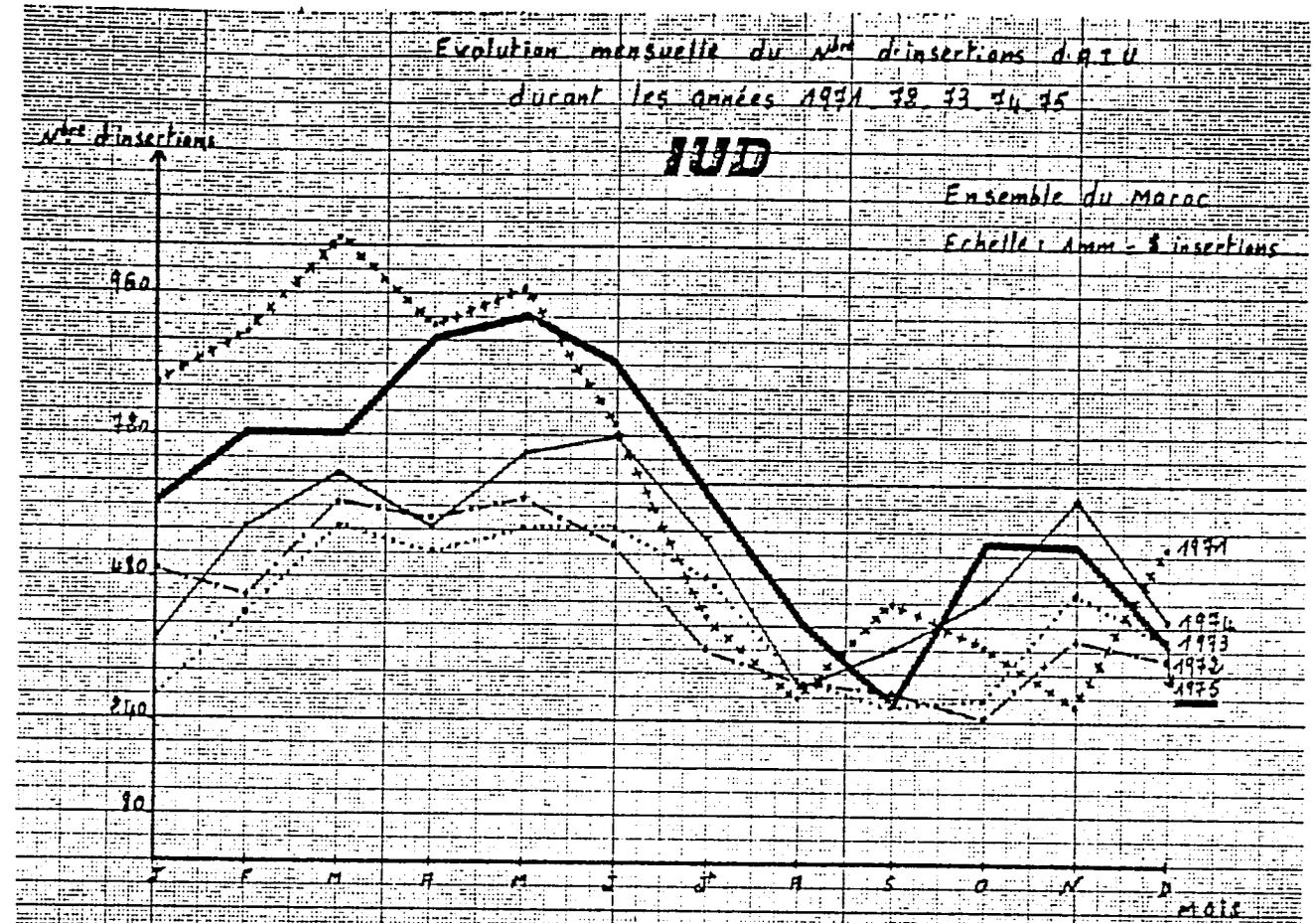
Finally, there appears to have been an oversupply in Morocco of IUD's of small sizes. After these have been inserted in the uterus of mothers of six, seven, or eight children, they have tended to slip out. Often the woman did not notice, and when she got pregnant again she helped to spread the word that "the IUD doesn't work".

C. CONDOMS, FOAMS, ETC.

The condom has not been widely accepted in the National Family Planning Program. Condoms are reported to be generally unpopular in Morocco, and there is not a great commercial sale. The Team was told several times that condoms are associated with prostitution. Whether or not it is so, it is certain that the Program does not push the condom. The facilities where family planning materials are distributed are basically facilities for women. In a dispensary, "Family Planning Day" tends to be MCH day. The building is full of women who are certainly interested in the health of their babies, and who are possibly interested in the pill or an IUD, but who have no reason to be interested in condoms. Stocks of colored condoms have begun to arrive in the field, but they have not yet had anything like a popularity test.

Chart 2.

MONTHLY FREQUENCIES OF NEW IUD ACCEPTORS, 1971 - 1975



Foams and jellies are available in health centers, but they do not form a statistically significant part of the national Program.

D. INCIDENCE OF PROTECTION PROVIDED

The National Family Planning Program has maintained a steady increase in the number of persons whom it is reaching -- nearly all women in the fertile years. But the percentage of women at risk who have chosen to accept a method of contraception remains small.

Chart 3. shows the percentages, by Province, of women in the fertile years who, during 1975, became "first acceptors" of either the pill or the IUD, the two principal methods of family planning offered by the program. The 67,000 women represented 1.7 percent of the nearly four million women categorized by W.H.O. standards as "fertile". The shadings on the map and the figures in the accompanying table show the wide distribution of penetration of the Program among the provinces. Only two provinces, urban Casablanca and rural Beni Mellal, show more than three percent of women at risk accepting one of the methods. Eleven provinces show less than one percent.

Chart 4. shows the variations among the Provinces in the growth rate of "first acceptance" of the pill or the IUD between 1974 and 1975. Eight provinces, containing about a third of the population, showed an annual growth rate higher than the national average growth rate of 24.12 percent. (A reader must deal cautiously with this chart since some of the provinces showing high rates of growth during 1975 were merely catching up ground they had lost during 1974.)

While a program growth rate of 24 percent is highly praiseworthy, the actual number of "first acceptors" is very low in comparison to the number of women in need of protection. Indeed, with its high proportion of young people, the number of young women reaching age 15 far outnumbers the number of women leaving the fertile years at 49. Therefore, the number of women in the fertile years is steadily increasing by about three percent annually, or 116,000 women in 1975. This means that, even with the relatively high growth figures of first acceptors in recent years, the number of new acceptors of the pill, the IUD, and the condom in 1975 through the National Family Planning Program was less than the growth in the number of women at risk. (See Appendix G).

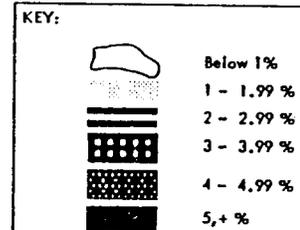
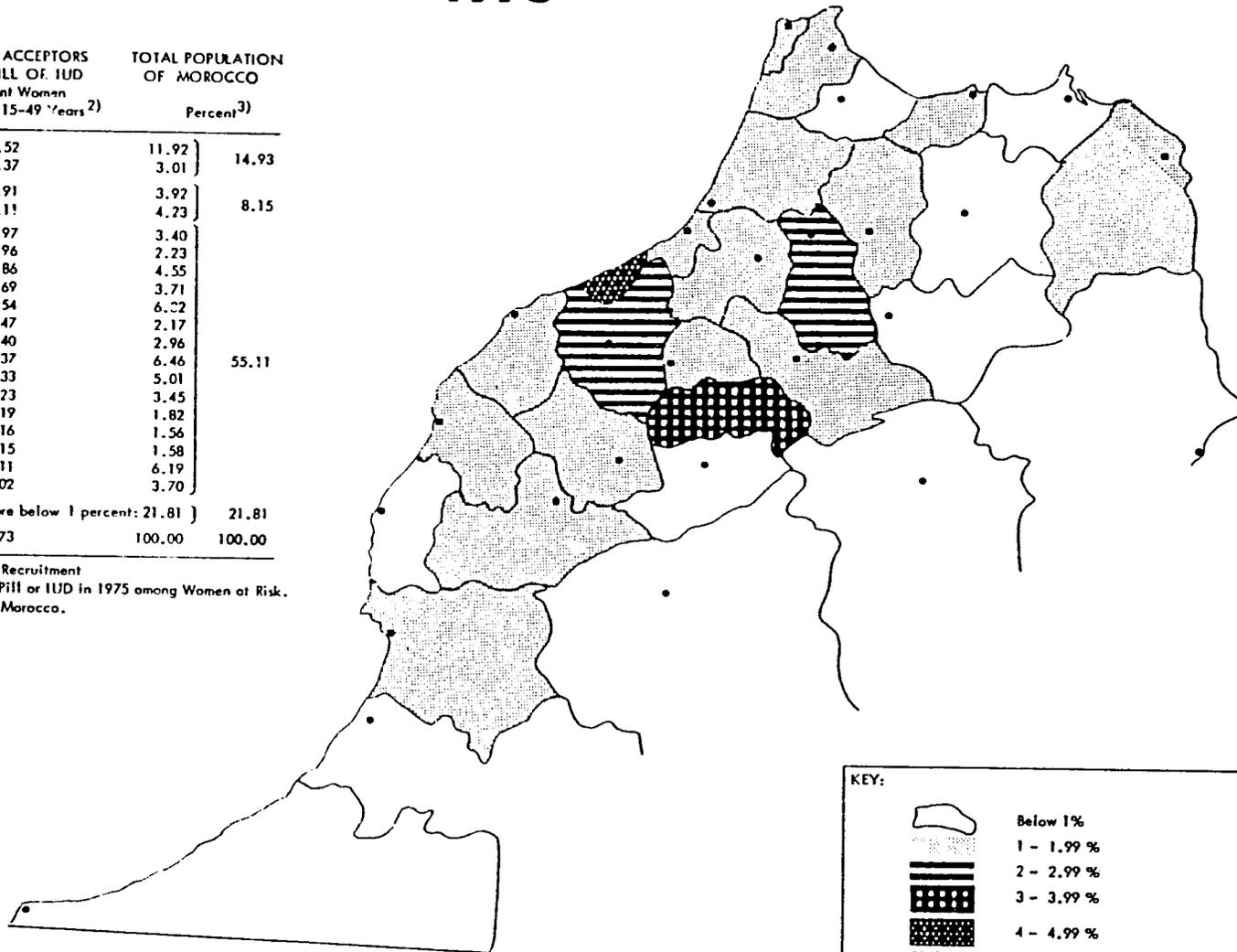
RATE OF PRIMARY ACCEPTANCE OF PILL or IUD per 100 WOMEN AGED 15-49 YEARS
BY PROVINCE, YEAR 1975
Government of Morocco Family Planning Program, Rabat

1975

NEW ACCEPTOR STATUS

Rank ¹⁾	PROVINCE	NEW ACCEPTORS OF PILL OF IUD Percent Women Aged 15-49 (year ²⁾	TOTAL POPULATION OF MOROCCO Percent ³⁾		
1	Casablanca	4.52	11.92	14.93	
2	Béni-Mellal	3.37	3.01		
3	Meknès	2.91	3.92	8.15	
4	Settat	2.11	4.23		
5	Safi	1.97	3.40	55.11	
6	Khémisset	1.96	2.23		
7	Rabat-Salé	1.86	4.55		
8	Oujda	1.69	3.71		
9	Marrakech	1.54	6.22		
10	Khouribga	1.47	2.17		
11	El Kalaâ	1.40	2.96		
12	Fès	1.37	6.46		
13	Agadir	1.33	5.01		
14	Tétouan	1.23	3.45		
15	Tanger	1.19	1.82		
16	Khénifra	1.16	1.56		
17	Al Hoceima	1.15	1.58		
18	Kénitra	1.11	6.19		
19	El Jadida	1.02	3.70		
20-30 Remaining 11 Provinces are below 1 percent: 21.81			21.81		
MOROCCO, 1975		1.73	100.00		100.00

1) Provincial Ranking by 1975 Recruitment
2) Percent New Acceptors of Pill or IUD in 1975 among Women at Risk.
3) Percent Total Population of Morocco.



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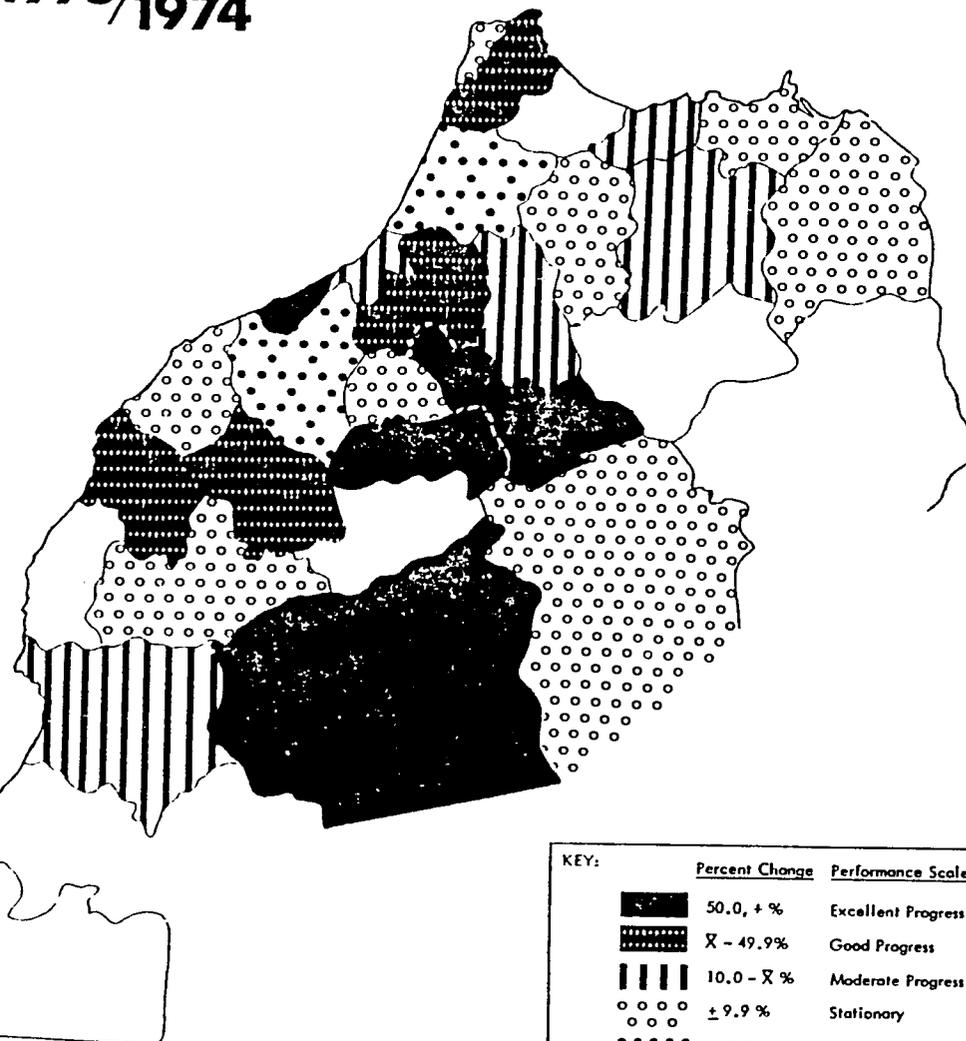
PERCENT CHANGE OF PRIMARY PILL or IUD ACCEPTANCE RATES PER 100 WOMEN AGED 15-49 YEARS
FROM 1974 to 1975, BY PROVINCE OF MOROCCO
Government of Morocco Family Planning Program, Rabat

1975/1974

NEW ACCEPTOR TREND

Rank 1)	PROVINCE	PERCENT INCREASE IN 1975 over 1974 NEW PILL/IUD USERS per 100 Women Aged 15-49 Years. 2)	TOTAL POPULATION OF MOROCCO Percent 3)	
1	Beni-Mellal	+106.93	3.01	} 19.8
2	Khénifra	+75.45	1.56	
3	Casablanca	+74.07	11.92	
4	Quarzazate	+71.94	3.30	
5	Safi	+39.35	3.40	} 12.0
6	El Kalaa	+37.66	2.96	
7	Khemisset	+36.14	2.23	
8	Tetouan	+25.46	3.45	
\bar{x}	ALL-MOROCCO	+24.12	100.00	100.00
9	Meknes	+17.57	3.92	} 18.5
10	Agadir	+17.56	5.01	
11	Al Hoceima	+17.21	1.58	
12	Rabat-Sale	+13.86	4.55	
13	Taza	+11.27	3.43	} 28.8
14	Oujda	+8.66	3.71	
15	Ksar-ès-Souk	+7.85	2.13	
16	Marrakech	+4.91	6.32	
17	Fes	+3.95	6.46	} Stationary ($\pm 10\%$)
18	El Jadida	-1.07	3.70	
19	Nador	-1.87	3.18	
20	Khourilga	-3.49	2.17	
21	Tanger	-5.87	1.82	} 10.4
22	Settat	-19.80	4.23	
23	Kénitra	-39.65	6.19	
24-30	Remaining 7 Provinces: either new or data not yet available (minimal activity)		10.50	10.5

- 1) Provincial Ranking by 1975 Progress in Recruitment over 1974
 2) This is a comparison of 'Calendar-Year specific Rates', implying availability of estimates of Women at risk in both years (CERED-rb)
 The dynamics of progress by province has been scaled into five classes (rb)
 3) Percent Total Population of Morocco, by Province (CERED).



KEY:	Percent Change	Performance Scale
	50.0, + %	Excellent Progress
	\bar{x} - 49.9%	Good Progress
	10.0 - \bar{x} %	Moderate Progress
	± 9.9 %	Stationary
	-10.0 and less	Regression

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Within the past ten years, the number of women aged 15 to 49 has increased from three to four million. Because of the age curve, the annual percentage increase will remain above three percent for the next 15 to 25 years. In the next eight years (to 1984) the women at risk of pregnancy will climb to five million. Six years later (1990) there will be over six million women at risk. Five years later (1995) there will be over seven million women aged 15 to 49. A conservative estimate generates eight million women at risk of pregnancy in the year 2000, double the number of today.

The annual increase in women aged 15 to 49 becomes a key denominator when studying the annual number of new acceptors. Evidently, "doing as well as last year" means regressing in performance as the women at risk increase at three percent compounded annually. In other words, year after year the National Family Planning Program produces a protection deficit as the total number of unprotected women increases. A real growth in protection cannot be reached until the number of new acceptors equals the increase in the number of unprotected women at risk. Chart 5. shows graphically the problem which the Program faces, and indicates the rate which would be necessary to achieve parity on an "index of national coverage".

Clearly, the Moroccan Program faces an uphill struggle. To achieve parity in 1976, the number of new acceptors would have to increase from the 72,000 in 1975 to 122,000. This is a far higher figure than the 1976 goal set in the Five-year Plan for 85,000 acceptors, or the 1977 goal of 98,000 acceptors. The Team concludes that the achievement of 122,000 acceptors in 1976 or 1977 is not really attainable under the present assignment of priority to the family planning program.

E. PREVALENCE OF PROTECTION PROVIDED

1. The Problem of Low Continuation Rates. Gaining new acceptors is not the full measure of the success of a program in providing protection. The program in Morocco has to cope with a very high drop-out rate among those who accept family planning. The drop-out rate is particularly high among users of the pill, the method of choice of most Moroccan women who have entered the Program.

Table 1., reprinted (in French) from an official Government of Morocco publication, summarizes the results of a National Study of Continuation Rates conducted by the

NEW PROTECTION VERSUS NEW RISK 1969 - 1975

[IUD, Pill, Condom] [Increase in]
 Acceptors ♀ 15-49 Yrs

Government of Morocco Family Planning Program, Rabat

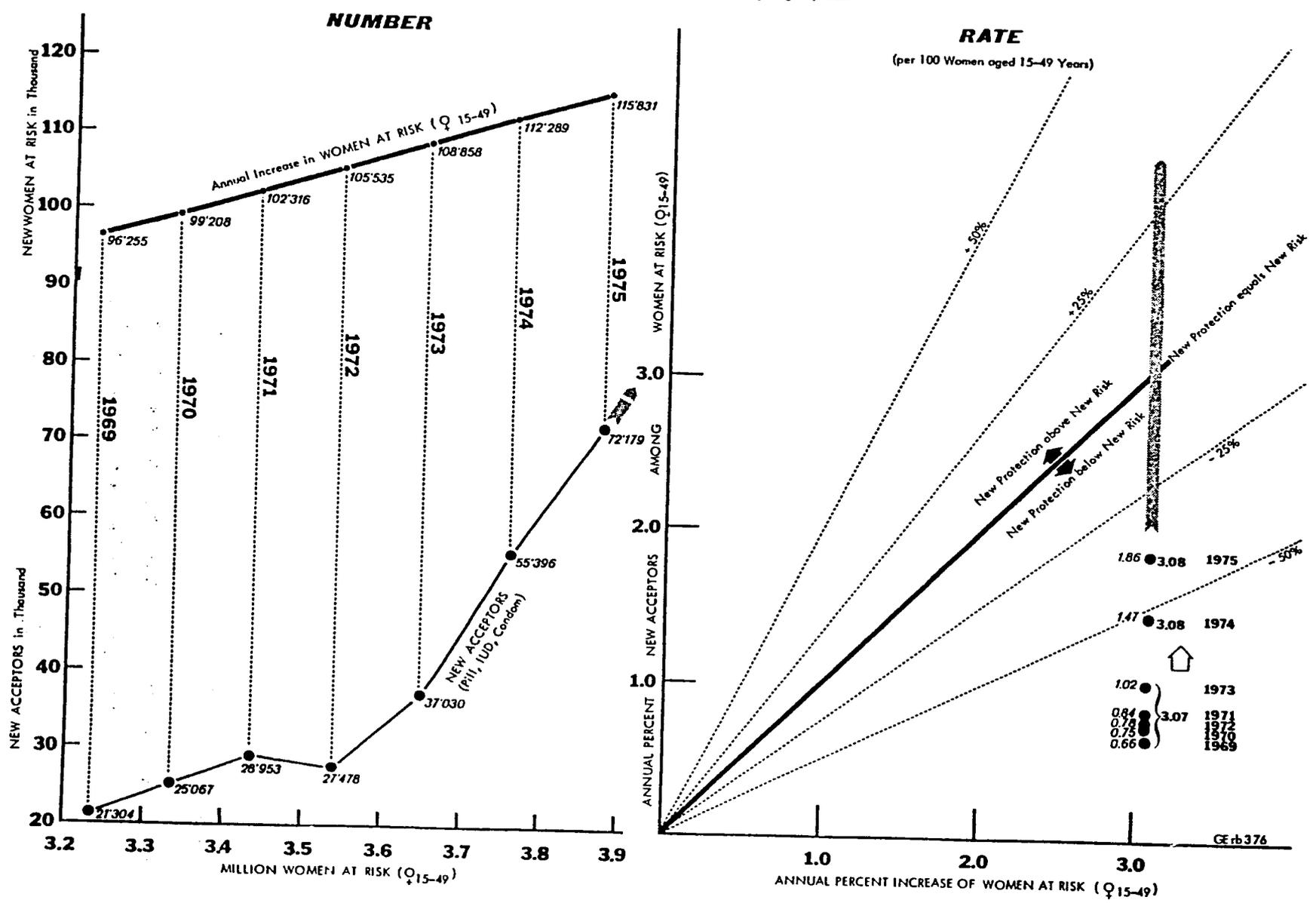


Chart 5.

Table 1.

National Follow-up Survey, 1972 & 1973

L'acceptation d'une méthode contraceptive ne suffit pas à assurer une protection contre une grossesse indésirée. Pour être efficace, la méthode adoptée doit être utilisée de façon régulière ou permanente. Cette continuation dans la pratique de la contraception est mesurée par différents taux :

- 1) Taux de continuation première méthode
- 2) Taux de continuation toute contraception
- 3) Taux de protection.

1) Taux de continuation première méthode :

Il se rapporte au temps écoulé entre la première acceptation et l'arrêt définitif de l'utilisation de cette méthode ou la date de l'enquête si la première méthode est toujours utilisée à ce moment.

Comme le montrent le tableau 1 et la figure 1, l'A.I.U. est de toute évidence la méthode utilisée avec le plus de succès du point de vue continuation. Alors que une femme sur deux utilise toujours l'A.I.U. 30 mois après son acceptation, au bout de 10 mois une femme sur deux a abandonné l'usage de la pilule.

Méthodes	Durée en mois					Nombre acceptrices
	6	12	24	36	48	
A.I.U.	81,9	71,3	55,3	45,9	38,7	553
PIL.	63,2	45,1	26,6	16,1	-	448
A.I.U. + PIL	73,5	59,5	42,7	33,9	28,1	1001

Tableau 1
Taux cumulés de continuation 1ère méthode

2) Taux de continuation : toute contraception :

Il a trait à la durée d'utilisation d'une méthode contraceptive quelconque. C'est donc un taux qui tient compte du ou des changement(s) de méthode éventuel(s). Il représente la proportion des premières acceptrices qui après avoir adopté une méthode ne sont pas tombées enceintes et utilisent toujours celle-ci ou une autre.

Douze mois après la pose d'un A.I.U.; 77 % des acceptrices utilisent toujours une méthode, contre 55 % seulement des acceptrices de pilule (tableau 2, figure 1).

Tableau 2
Taux cumulés de continuation toute contraception

Méthodes	Durée en mois					Nombre acceptrices
	6	12	24	36	48	
A.I.U.	85,4	76,9	65,5	57,0	48,8	553
PIL.	68,5	51,6	34,4	22,9	-	448
A.I.U. + PIL	77,8	65,5	50,9	42,3	35,2	1001

3) Taux cumulé de protection :

Ce taux est défini par la proportion des premières acceptrices qui après leur acceptation ne sont pas tombées enceintes, qu'elles utilisent ou non une méthode contraceptive au moment où elles ont été interrogées.

Douze mois après s'être fait poser un A.I.U., 88 % des acceptrices ne sont pas tombées enceintes. Au bout de 48 mois, 62 % n'ont toujours pas eu de grossesse. Il n'en est pas de même pour les premières acceptrices de pilules. Un an après l'acceptation, 70 % ne sont pas tombées enceintes, deux ans après 47 % et 3 ans après 37 % (tableau 3, figure 1)

Méthodes	Durée en mois					Nombre acceptrices
	6	12	24	36	48	
A.I.U.	95,7	88,3	74,9	66,6	61,5	553
PIL.	85,7	70,1	47,0	37,2	-	442
A.I.U. + PIL	91,2	80,1	63,7	55,2	51,3	1001

Tableau 3
Taux cumulés de protection

Ministry of Public Health in 1972-73, with technical and financial assistance from the Ford Foundation and Population Council. Lecomte and Laraqui summarized the findings as follows: "Three years after acceptance, 57% of IUD acceptors are still using some method as compared with 23% of pill acceptors." Further... "67% of IUD acceptors and 37% of pill acceptors have managed to avoid pregnancy for three years."

2. The Prevalence of "New Protection" in a Given Year. Drop-out rates are so high that even during the year of "first acceptance" of a method, a significant portion of the acceptors fail to achieve protection. Chart 6. shows the comparison between annual new incidence of acceptance of the pill and the IUD and the corresponding "new protection prevalence" at the end of the year. As one might expect, the protection decay is much greater for pill users than for IUD users. In 1975, the end-of-year additional protection prevalence among primary pill acceptors was 1.32 percent of the women at risk against 1.54 percent new acceptance incidence during that year. For primary IUD acceptors, the corresponding values were .18 vs. .19 percent. (See Appendix H).

The figures indicate that the Ministry may want to reconsider the emphasis it has been placing on the pill as compared with the IUD.

3. Protection Prevalence Calculated from Recruitment over Four Years. Given the protection decay for Moroccan women, as indicated by the National Study of Continuation Rates, one can calculate for primary pill and IUD acceptors as far back as four years -- but no farther -- the national protection prevalence conveyed by the National Family Planning Program as of the end of each of the four years. Appendix I shows the method of calculation -- in essence a "backward extension" of the technique used to calculate the "end-of-year additional protection prevalence".

Chart 7. shows, with its heavy lines and shading, the protection prevalence at the end of 1975 resulting from new acceptance of the pill and of the IUD during 1972, 1973, 1974, and 1975. It also shows the protection prevalence at the end of 1972, 1973, and 1974 resulting from new acceptance of the pill or the IUD in each of the preceding four years.

Chart 6.

ANNUAL NEW INCIDENCE OF ACCEPTANCE OF PILL AND IUD AND CORRESPONDING
 NEW PROTECTION PREVALENCE AT END OF YEAR, BY METHOD, 1969 - 1975, MOROCCO.
 Government of Morocco National Family Planning Program, Rabat

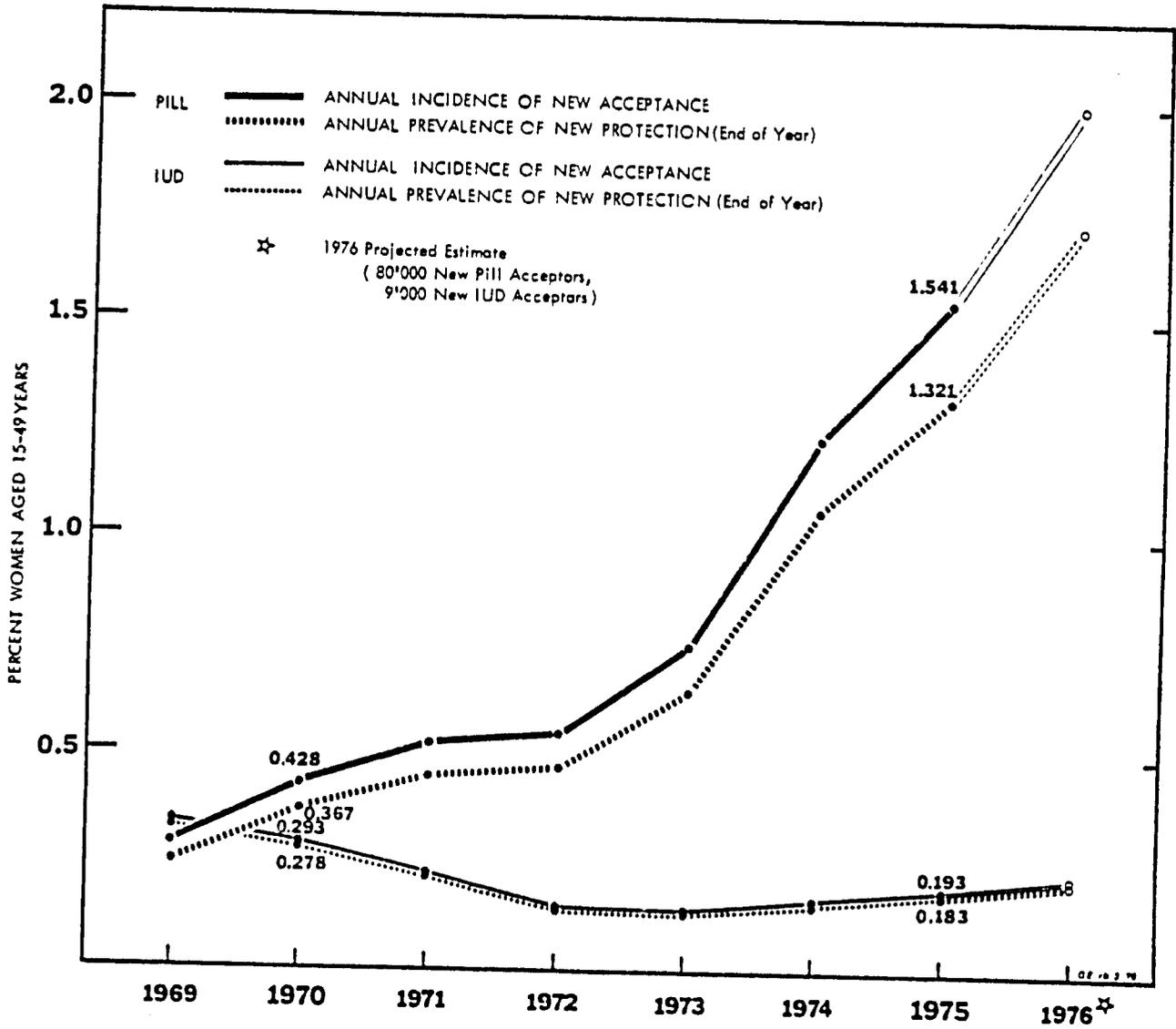
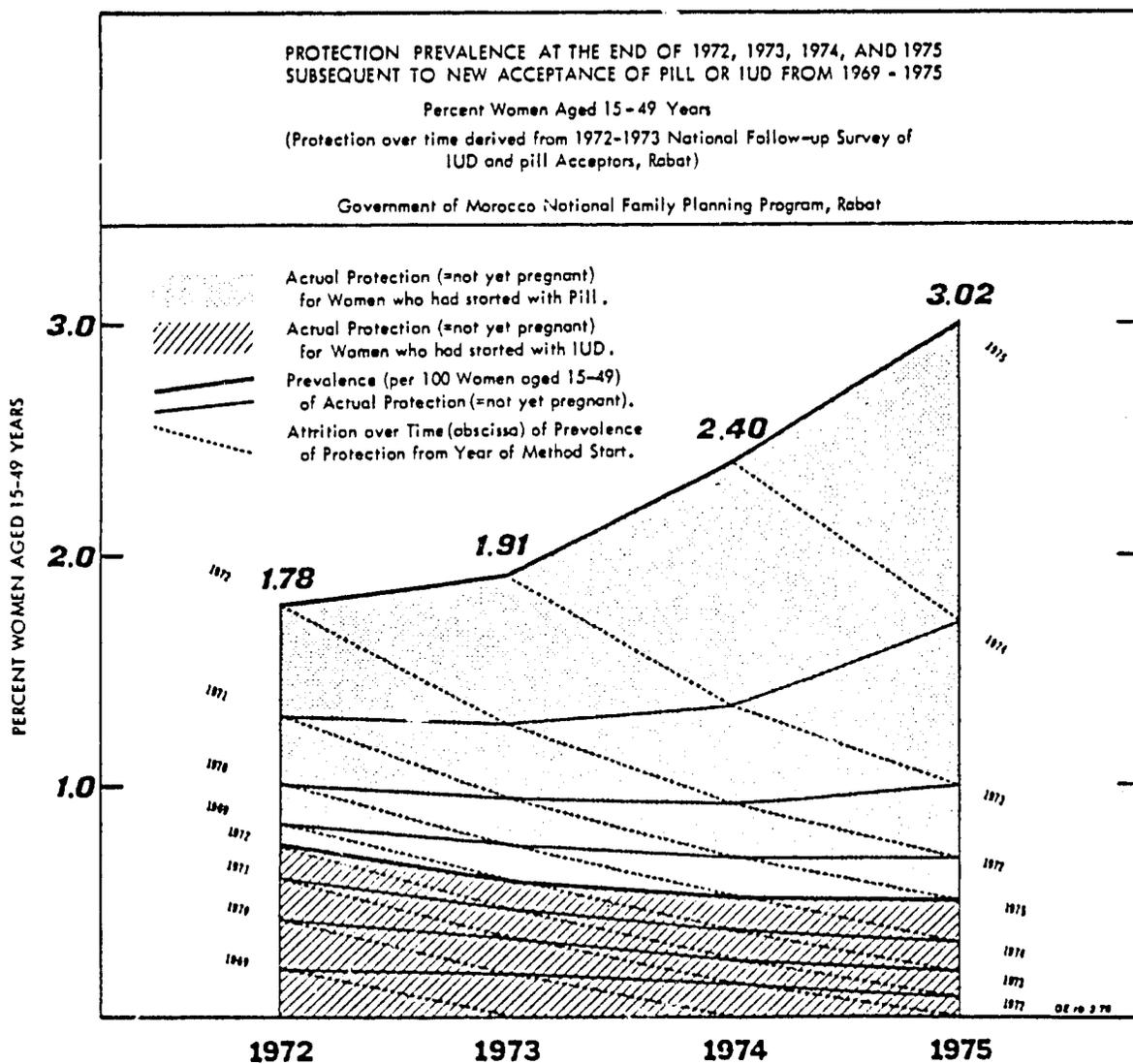


Chart 7.



Consider primarily the results of the four most recent years, 1972 through 1975. During those years a gross number (ignoring possible duplications) of 153,000 women accepted the pill for the first time through the National Program and 24,000 the IUD, for a total of 177,000. These women represented at the end of 1975 some 4.56 percent of the women at risk. But because so many of them had dropped out of the Program (and from use of a contraceptive) the percentage of women at risk protected by the Program as of the end of 1975 was only 3.02 percent. This is the equivalent of about 117,000 women.

F. CONCLUSIONS

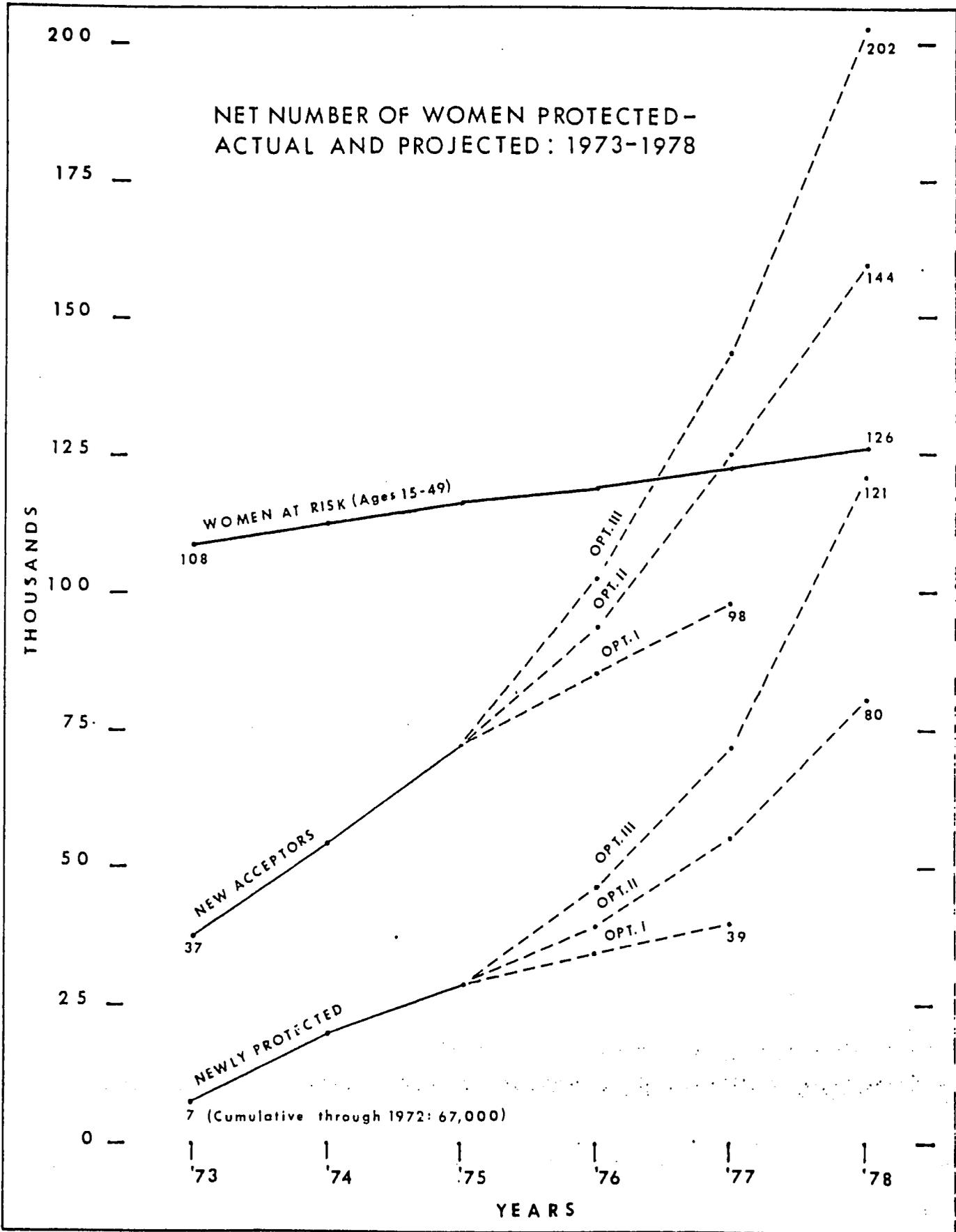
1. Options for New Goals. Chart 8. attempts to sum up the findings in this section on one year acceptance of the pill, the IUD and the condom, in the National Family Planning Program (incidence of acceptance), and goes on to estimate the annual increments to the total level of protection (prevalence of protection), as compared with the annual growth in the number of Moroccan women in the fertile years. The lines extended for the years 1976, 1977, and 1978 represent a graphic statement of options open to the Government of Morocco in setting goals for those years.

Using the percentage figures from Chart 7, and adding an estimate of the small number using the condom, one can conclude that the total number of women protected as of the end of 1972 was on the order of 67,000. During 1973 there were 37,000 new acceptors, but there were also (based on the National Continuation Study) 30,000 drop-outs. The net addition to the number of women protected, therefore, was only 7,000.

There has been some improvement in 1974 and 1975. In 1974 there were 55,000 new acceptors, and one can estimate that there were 36,000 drop-outs, leaving an increment of only 19,000 women newly protected. In 1975, against a total of 72,000 new acceptors, one must set 44,000 drop-outs, leaving an increment of new protection of 28,000. In other words, for every ten women (or couples) becoming new acceptors in a year, six drop out of the Program. The increase in the number of women protected by the Program during 1975 was only one-quarter as large as the increase in the number of women in the fertile years.

The National Family Planning Program, viewed in terms of increases in the number of women protected each year, is not making progress, indeed, it is falling

Chart 8.



behind. In order to correct this situation, the Program must achieve two types of goals: 1) increasing the number of new acceptors at a considerably higher rate, and 2) cutting down on the number of drop-outs.

The Program today seems to pay relatively little attention to the needs of women who have already accepted a form of contraceptive. These women (and the small number of men who accept condoms) should be a primary interest of the Program, because they have clearly demonstrated their motivation to space or limit births.

The dotted lines at the right of Chart 8. show some of the options open to the Government of Morocco in setting goals for 1976 and 1977. For "New Acceptors" and "Newly Protected" the lines indicated as option I are based on a maintenance of the goals accepted by the Government in the current Five-Year Plan: 85,000 new acceptors in 1976 and 98,000 new acceptors in 1977, with a maintenance of current continuation rates.

Those lines indicating Option II represent a maintenance of the rate of growth of new acceptors in 1975, and an increase in the continuation rate of contraceptive users which would bring the net annual increase in number of women accepted to half the gross number of new acceptors by 1978.

The lines marked Option III represent a challenging objective. It calls for reaching a number of new acceptors in 1977 twice as high as the actual 72,000 reached in 1975 -- 144,000 -- and continuing in 1978 at the same 40 percent annual growth rate to reach just over 200,000 new acceptors. It also calls for improving the continuation rate by an amount that would bring the net annual increase in number of women protected to 60 percent of the gross number of new acceptors by 1978. Option III would bring the Moroccan National Family Planning Program in 1978 to a level of net new protection of women during the year substantially equal to the increase in the number of women at risk during the year, about 125,000.

2. Total Levels of Protection Current in Morocco.
The figure of 3.02 shown in Chart 7. represents the percentage of women in the fertile years protected as of the end of 1975 with the pill or the IUD, based on recruitment and continuation rates over the previous four years. This figure is as far as one can proceed

with precision, but one can estimate the effect of three other factors: 1) recruitment before 1972, 2) use of the condom, and 3) acceptance of contraception outside the Program. Thus, one can arrive at an estimate of the total number of, or the proportion of, women at risk, who are protected by modern contraception, inside and outside the National Family Planning Program.

While one cannot calculate precisely the protection prevalence resulting from the Program activities more than four years before the end of any given year, one can estimate that the total carry-over effect from these earlier years, plus the prevalence resulting from the limited use of the condom, is unlikely to amount to more than one percent of the women at risk. In other words, even building into the protection prevalence rate a factor to cover those women still using the IUD and the pill who entered the Program in the years 1966-71, and the small number of couples relying on the condom, the protection prevalence would not reach more than four percent of the women aged 15 to 49.

If the Program achieves the same ratio of growth in 1976 as it did in 1975, the protection prevalence at the end of this year, based on new acceptors over the four-year period 1973-76, will be 3.93 percent. Adding to this computation the generalized estimate of one percent to cover all those women who accepted the pill or the IUD in the Program before 1973, and all the couples using the condom, one comes to an imputed total of five percent of the women in the fertile years who would be protected at the end of this year.

G. FERTILITY CONTROL OUTSIDE THE NATIONAL PROGRAM

1. Non-Surgical Methods of Family Planning. The Team did not have an opportunity to investigate the state of the private family planning sector other than the Moroccan Family Planning Association. The most recent estimate, made in March, 1975 by Dr. Jean Lecomte, Population Council Resident Advisor, was that the total activities of the private sector (the FPA, private doctors, and pharmacies) involved a number of couples approaching the number reached by the National Program.

If this estimate remains valid (and the Team has no evidence on which to base a judgment) one can infer that as of the end of 1975, approximately eight percent of women in Morocco aged 15 to 49 were regularly utilizing a modern method of contraception.

2. Sterilization. The Team discovered many physicians who are interested in the field of sterilization, particularly in modern methods of tubal ligation. Some expressed a desire to learn and practice the techniques themselves. Others expressed a belief that the method should be added to the family planning methods used within the Program. But the Team found no evidence that tubal ligations are statistically significant. Judging from what we heard, the number of vasectomies performed must be at a level approaching zero.

3. Abortion. Physicians were often reluctant to discuss the subject of abortion, and figures on numbers of abortions were difficult to determine. However, in two cities the Team was given figures on abortion which had a ring of reliability. Building on these figures, one might infer a rate in urban Morocco of some 225 abortions per 1000 live births.

By imputing to rural Morocco a very low rate (less than 100), which seems reasonable based on the available evidence, one arrives at the conclusion that the number of abortions throughout the country in 1975 may well have approached 100,000, or a national rate of about 120 abortions per 1000 live births.

VI. THE STATUS OF FAMILY PLANNING IN FIVE LOCATIONS

A. INTRODUCTION

A distinctive feature of this evaluation process was the method used to select the five sites in Morocco which the Team visited. The method, preliminarily suggested by Dr. R. T. Ravenholt during an early AID/W briefing of the Team, involved throwing five darts at a map of Morocco. Those sites literally pinpointed by the darts, or the nearest village, constituted the places selected for site visits by the Team. The Team believes that this method, which started as little more than a light hearted suggestion, worked out very well in practice.

B. GENERAL FINDINGS

The site visits to the four villages and the one urban quarter, selected by the dart-throwing process, are described in Appendices A through E, which discuss: 1) Sidi Zouine, a village in the arid plain outside Marrakech, a possible model of how family planning services might be extended; 2) Arbaa Gazet, a village in the prosperous, irrigated province of El Kelaa Des Sraghnas; 3) Tagzirt, a mountain village in the province of Beni Mellal; 4) Zaouia Cheikh, a village in the foothills of Beni Mellal, where venereal disease turned out to be present in epidemic proportions; and 5) Bab Boujat, a poor quarter of Fes, and its sector dispensary of Fesgdite. Our key findings from these visits -- aside from what they added to a general understanding of the Moroccan scene -- can be summarized as follows:

- 1) The Moroccan public health system, to a surprising extent, reaches out into very remote areas.
- 2) Family planning services, as part of the national public health system, are available at each of the sites visited.
- 3) Shortage of supplies of oral contraceptives is not a limiting factor affecting the National Family Planning Program. Each dispensary visited had supplies adequate to its current needs.
- 4) In none of the sites had the Ministry of Public Health assigned a high priority to family planning. Only in one village, Sidi Zouine, did the young couple in charge of the dispensary treat family planning as one of its important health services.

- 5) No site had equipment to help it promote family planning.
- 6) No site had any but the most rudimentary information and educational material.
- 7) A potential exists at all sites to expand the use of the dispensaries as a form of community-based distribution of contraceptives, and to encourage the "itinerants" who visit houses throughout the sector to try new systems of household distribution.

VII MANAGEMENT PROBLEMS

A. INTRODUCTION

To a student and practitioner of the art of management, the absence of management in the National Family Planning Program lies at the heart of its failure to "get off the ground." This is not to say that theories and practices of management can somehow supply all the missing elements that are needed to turn the Program into a success. The Program has to be considered within the total framework of the public health system, since there is no practicable alternative means of delivery of service. The management of the public health system is based on traditional models, which seem over-centralized, inelastic, and cumbersome. Nonetheless, the public health system has achieved some remarkable results in Morocco. The top levels of the Ministry of Public Health clearly know how to use their system to achieve agreed objectives. The system must have strengths, however serious its defects appear to be.

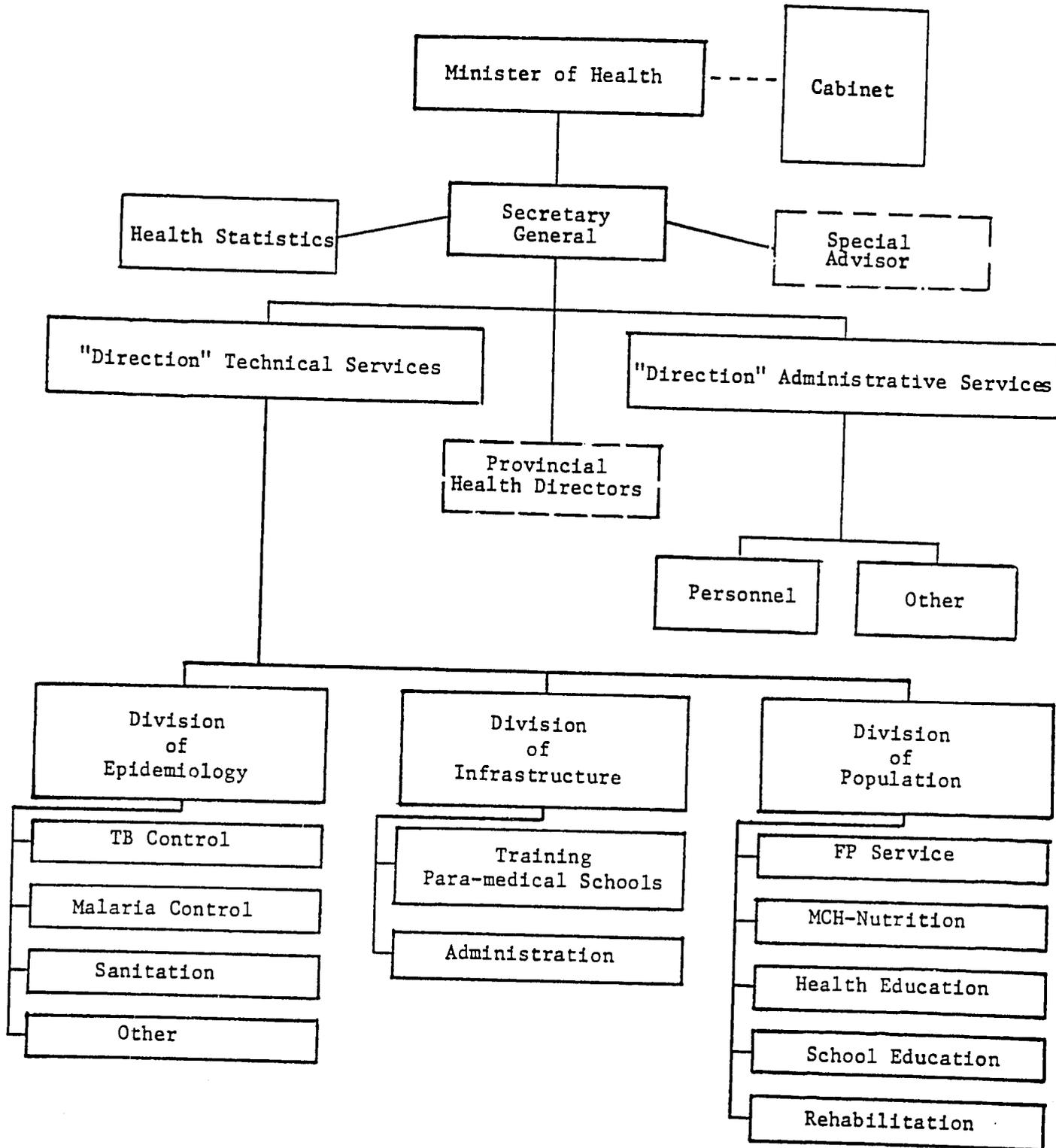
But within this system of management of the public health system, the family planning program seems singularly cut off from the main stream of responsibility and authority. Even within the framework of the present system, it would appear that there are ways in which it could be tied more closely into the main currents of management. In the opinion of the Team, the program should be more effectively managed if it is to grow and achieve success in delivering to the people of Morocco the means to space and limit the births of their babies.

This chapter represents conclusions based on a brief ten-day effort to analyze the missing elements in the management of the family planning program and to suggest, in hardly more than outline form, ways in which reforms could be accomplished within the present system of management of the Ministry of Public Health.

B. THE NATURE OF THE PRESENT MANAGEMENT SYSTEM OF THE MINISTRY OF PUBLIC HEALTH

1. Organizational Structure. The basic organizational structure of the Ministry of Public Health appears to be of a European pattern. The Government has, of course, made numerous changes in the structure since securing independence. Chart 9. was prepared by the USAID Mission in Rabat to show the Team

Chart 9.
Proposed Reorganization of the Ministry of Public Health



the latest organizational changes made in the Ministry last fall. The chart has been amended by the Team to show two aspects of the Ministry structure which it considers important; i.e., the link between the Ministry and the Provincial Health Directors (Medicins Chefs), and the maintenance of a French advisor on public health matters.

The chart shows the Minister of Public Health as a member of the Royal Cabinet, having a one-over-one relationship with the top "civil service" official, the Secretary General, to whom the rest of the Ministry in principle reports. Two main headquarters groups report through directors to the Secretary General; one for Technical Services and one for Administrative Services. The Health Statistics Center and the remaining French advisor also report to the Secretary General.

Finally, the Secretary General represents the formal link between the Ministry and the nearly 30 Provincial Health Directors. This theoretical link is, in practice, doubly complicated by the line responsibilities which each Provincial Health Director has to the Governor of his Province, and the almost inevitable direct interest which the Minister must take in events in the province.

2. Population Division. In the latest reorganization a Division of Population was established. At the time of the Team's visit, a director of this Division had been appointed but had not yet taken office. The Division contains not only the Central Family Planning Service and the section governing Maternal and Child Health, but also sections dealing with Health Education, School Health, Rehabilitation, and a subsection on Nutrition within the MCH section. Indeed, the title "Population Division" should not be permitted to convey a semantic implication that the Ministry is concentrating on the problem of population growth. The Division of Population is merely a grouping of sections dealing with a variety of continuing health problems.
3. Method of Operation. The chart fails to show a major characteristics of the management system; the lack of delegation of authority through the Secretary General to "middle management". Even what appeared to be minor decisions had to be submitted to the Minister for his approval and signature. An example is a fairly routine schedule of subjects of proposed weekly radio and TV programs. Without the Minister's signature, nothing moves.

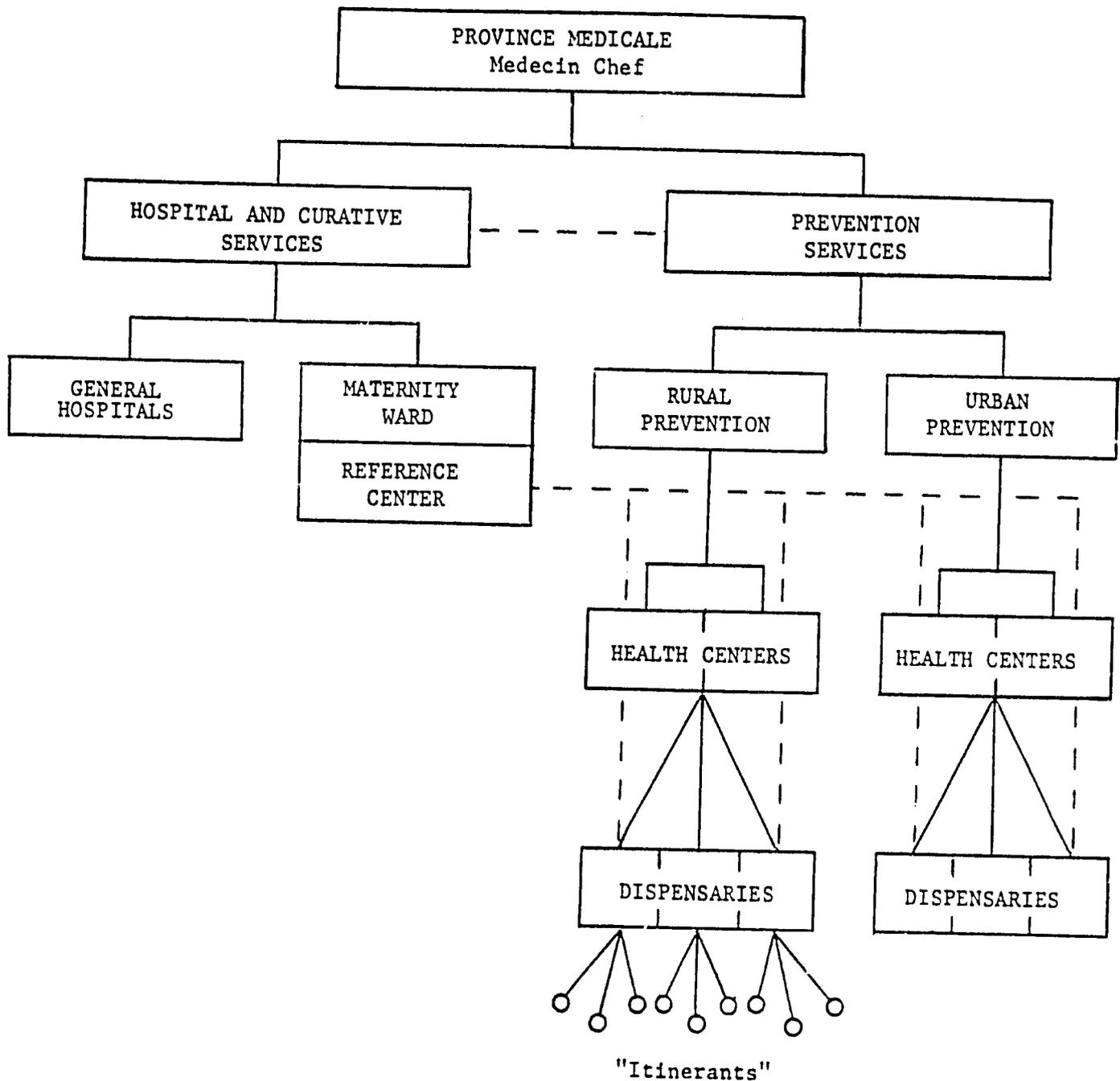
We gathered, from our interviews, that the Technical Services group -- and perhaps this is typical of comparable units throughout government departments -- operates to a considerable extent by consensus. The heads of all the sections meet regularly (normally weekly) and each manager is encouraged to submit his or her problems and proposals to the group for general discussion. The meeting works out solutions, making such compromises as are necessary, and the results are submitted as recommendations through the Secretary General to the Minister. The system requires a great deal of teamwork, and seems to reduce the importance of individual energy and initiative.

4. Budgets. As with any government, budgets for a department are arrived at through a process involving the entire Government. In the case of Morocco, budgets are tied to objectives, and to revenue and expenditure estimates included in a Five-Year Plan prepared by a Ministry of Planning. The Team had no opportunity to observe the interplay among the Ministries in the preparation of the Plan or the annual budgets. One rather curious aspect of the management of the Moroccan system was reported to us from various sources. Even after a budget for the Ministry has been approved, the Ministry of Finance may not, and often does not, release the funds to undertake programs or projects included in the budget. According to Dr. Poulsen, during the 1968-72 Five-Year-Plan period the Ministry of Public Health ended up spending only 45 percent of the total budget that had been allocated.

5. Provincial Health Departments. Chart 10 shows the standard organizational pattern of a Provincial Health Department, with its hospital or hospitals, its health centers, and its dispensaries. The box labelled "FP Reference Center", and the dotted lines connecting it with other sections, appears to be someone's -- perhaps Dr. Poulsen's -- impression of how these "Reference Centers" may fit into the structure. There seemed, however, to be no general agreement among Provincial Health Directors and the chief of the National Family Planning Service as to just how the new units would fit into the system.

Chart 10.

PROVINCIAL HEALTH SERVICES



NOTE: Solid lines indicate chain of command or supervision. Interrupted lines indicate the interchange of services between the Family Planning Reference Centers and Urban and Rural "Prevention" health centers and dispensaries.

Provincial Health Directors play key roles in the management system. In some aspects of management they are locked into an inflexible system. They have no control, for example, over their budgets, and little control over the assignment of personnel to their provinces. From a practical point of view, however, they have great power to mobilize such personnel as they have within the province as they see fit. No two Provincial Health Directors, for example, organized their services in exactly the same fashion. Within broad limits, Provincial Directors can decide where to place emphasis in meeting the health problems of their provinces.

But the Team got a clear sense that each director makes such decisions on the basis of how he interprets the real objectives of the Ministry. The provincial office receives quantities of paper from Rabat expressing the desires of the Ministry to have the provinces cope with all manner of health problems. But the Provincial director has limited resources and must decide which messages are real. In making this decision, he appears to downgrade the formal communications and to size up the Ministry's real priorities on the basis of the actions of Rabat rather than its mere words. In the case of family planning, directors in province after province told us that they had received little or nothing from Rabat in the way of family planning services, visitors interested in family planning or inspecting family planning service delivery, direct messages on family planning from the Minister, or encouragement of any kind to push family planning. Hence, they concluded that Rabat was not much interested in this particular campaign, despite the Ministry's public statements.

6. Prospects of Change. It was reported that a management consultant had been sent to Rabat by the U.N. to review the entire system of government. The Team, on the basis of its brief visit, can only offer its thoughts on how the management of family planning can be improved within the framework of the present system.

C. MANAGEMENT AND THE FAMILY PLANNING PROGRAM: GENERAL

The Chief of the Family Planning Services (FPS) is, as a manager, in an unenviable position. She is told that she is "in charge" of a high-priority health program

within the Ministry. She is assigned a staff of only four professionals, not all of whom are full-time. She has no clear authority beyond this small staff, and her responsibilities are unclear. Her line of communication upward through the Director of the Division of Population, to the Director of Technical Services, and beyond him to the Secretary General and the Minister, is clear enough, but she is just one of a number of section heads. Her relationship with these section heads is a bit ambiguous, although she must depend on some of them, such as the Chief of Health Education for such services as the production of informational material. Her lines of communication to the Provincial Health Directors are very fuzzy indeed. For example, guidelines on the policies, procedures, and authorities that will govern the 13 "Reference Centers", three of which are already nearing completion, are either non-existent or not agreed to by the Provincial Health Directors concerned. A "management of the family planning program" simply cannot be said to exist.

Furthermore, the Chief of the FPS is utterly without experience in management. She has been placed in a network of career health professionals who are skilled in making the system work. However, she lacks the seasoning that would enable her to fit into the team, and she needs help.

The following sections represent a very preliminary analysis of how the role of the management of family planning within the Ministry of Public Health might be clarified. The analysis consists of a brief look at each of the component parts that make up the art of management, and how it might be altered within the Moroccan system. There are several excellent such categorizations of the component parts of management; this particular one happens to be that of the American management consultant, Louis Allen. Mr. Allen divides the roles of management into four parts: Planning, Organizing, Leading, and Controlling. Each of these divisions includes a variety of activities, which provide the next four sections with their outline.

D. MANAGEMENT AND THE FAMILY PLANNING PROGRAM: PLANNING

1. Forecasting. Any good plan must rest on a set of assumptions as to the conditions that will prevail during the period being planned. The Moroccan Five-Year Plan contains such forecasts, but there

is no evidence that the Family Planning Center had a part in preparing the forecast that concerned the social and economic conditions under which its program would operate. The manager of family planning should be tied in with this process on a continuing basis.

2. Developing Objectives. The current Five-Year Plan and the last Five-Year Plan each stated family planning objectives, but the current Chief disavows any responsibility for arriving at these objectives. Indeed, the objectives are stated merely in terms of numbers of new acceptors per year, with no clear indication that the Ministry of Planning was aware of the very high drop-out rate. Since the manager of family planning, whatever the title, is bound to be held responsible for the achievement of the objectives, the incumbent should have an important role in setting and regularly reviewing them. Indeed, participation of the manager of family planning in the objective setting process should improve the nature of the objectives.
3. Programming. In the case of family planning in Morocco, programming would mean such elements of planning as breaking the objectives down by province and setting provincial objectives. There are no provincial objectives of which any Provincial Health Director is conscious. The manager of family planning should be in the ideal position to pay a leading role in such programming.
4. Scheduling. Scheduling is difficult in Morocco because of the prevalence of delays. The chief of Family Planning Services has apparently had a hand in such elements of scheduling as the setting of completion dates for the National Family Planning Center Building and the "Reference Centers". Suffice to say that scheduling should be improved.
5. Budgeting. The Chief of Family Planning Services reports that she has never participated in the budgeting process. Given the nature of the Moroccan governmental system, it is hard to see just how a family planning manager could be tied into the budgeting of family planning funds, but some move in this direction seems essential to insure that adequate funds get appropriated for the program.

6. Developing Procedures and Policies. The Chief of FPS does appear to have a hand in the preparation of such procedures and policies as do govern the delivery of services. The coverage of such policies and procedures, however, is limited.

E. MANAGEMENT AND THE FAMILY PLANNING PROGRAM: ORGANIZING

1. Developing an Organizational Structure. If what the Team observed concerning the "Reference Centers" is any test, the Chief of FPS has been trying to participate in the development of organization structures, but without much effect. Six weeks before the forecast opening date of the "Reference Center" in one province, the Provincial Health Director appeared to have no concept of how the "Reference Center" would fit into his organization. All of the provincial directors of whom we asked the question thought that the Chief was seriously understating the need for personnel in the "Reference Centers" if they were to achieve anything like their stated objectives. There should be a way within the present management system by which the manager of family planning services, whoever the incumbent, could have an influence on the structure of service delivery in the provinces.
2. Delegating. Under the present organization, the Chief has so little authority herself that she has nothing to delegate.
3. Developing Relationships. This sounds, on the surface, like an aphorism. Indeed, however, it is essential that the manager of the family planning program, whoever the incumbent, be able to develop the sort of relationships that make him or her part of the "team", and able to function effectively in a system which relies so heavily on teamwork and consensus. The Evaluation Team believes that the position requires someone with successful experience as a manager within the system.

F. MANAGEMENT AND THE FAMILY PLANNING PROGRAM: LEADING

1. Decision Making. Within the structure of the Ministry of Public Health, the management of the family planning program is not now placed at a level where it can make significant decisions.

2. Communicating. This also sounds like an aphorism. The Evaluation Team believes, however, that it is particularly important that the manager of the family planning program be in a strong position to communicate effectively with the Provincial Health Director.
3. Motivating. The present Chief of FPS has clearly put much effort into areas of motivation. By her own conviction she has furthered the program, but there is no regularized or institutional system whereby personnel are all encouraged to promote planning. The design of such a system is not under discussion, and no personal conviction can take its place.
4. Selecting People. Within the structure of the Ministry of Public Health, the management of the family planning program is now placed at a level where it can select only the personnel of the small staff of the Center.
5. Developing People. The system appears to have been developing people whose training includes elements of family planning, although the family planning management has not been directly involved.

G. MANAGEMENT AND THE FAMILY PLANNING PROGRAM: CONTROLLING

1. Developing Performance Standards. This is an obvious function for a manager of family planning, even if the status of the position remains unchanged. No one seems as yet to have started to develop standards of performance of even the rudimentary type.
2. Measuring Performance. This subject is discussed more fully in Section IX of this report. The possibilities of developing a solid management information system in family planning are very real. Using the management information system to measure performance is an obvious role for a manager of the family planning program.
3. Evaluating Performance. Same comments as above.

4. Correcting Performance. Within the framework of the Ministry's system of management, this is probably an impossible assignment for a manager of one categorical program. The manager of family planning, however, should have the means to recommend to line management which actions to take on personnel as a result of the measuring and the evaluating of performance.

H. CONCLUSIONS

If the Government of Morocco and the Ministry of Public Health intend to assign a higher priority than they have in the past to the National Family Planning Program, one type of action they should take is to make the management of the program more effective.

The Ministry has precedents that it can use in designing an improved management structure for family planning. The Ministry has conducted an apparently successful campaign against malaria. The team did not have time to learn all of the ways in which the Ministry went about assuring that Provincial Health Directors assigned a high priority to malaria, however it is understood that there was a Malaria Commission, which received the direct attention of the Minister, and which was able to focus the attention of the public health system on the malaria campaign.

Certainly if the family planning campaign is to be more effective, its management group must have greater status than it now possesses. It should be: 1) increased in size, 2) given clear-cut staff authority to communicate with Provincial Health Directors and to speak for the Ministry, and 3) permitted and encouraged to participate in the management of the program along the lines suggested in this discussion. Responsibility for the management of the program should be assigned to someone with two important qualifications; i.e., 1) experience in management within the health system, and 2) the ability to deal with the Provincial Health Directors on the basis of experience in the practice of medicine, and the possession of a medical degree.

Finally, the true test of the desire of the Government of Morocco to assign the highest priority to the extension of family planning services will be the personal time, attention and effort the Minister of Public Health assigns to overseeing the program, and an increase in direct delegations of responsibility and authority to family planning and health personnel at lower levels.

VIII THE DELIVERY SYSTEM

A. INTRODUCTION

Primary findings in the area of patient service can be summarized as follows:

1. The health delivery system of Morocco, which has developed rapidly in recent years, has reached a level of coverage which makes it possible that adequate family planning medical service could be supplied as an integral part of its program.
2. Exceptions to this finding are still numerous, including such specific problems as:
 - a. Locations in which only male personnel are available.
 - b. Locations in which the cadres of health personnel are too far below strength to handle this prevention service, without either inordinate inconvenience to the patient or a kind of special treatment which sacrifices other services, and which therefore tends to cast suspicion upon family planning.
 - c. Locations where either pressure or lack of orientation make the personnel unsympathetic to family planning patients.
 - d. Locations in which distances to dispensaries are too great to resupply patients with ease unless new methods within the system are adopted.
3. Remaining within the structure of the widespread health system, there is ample room for innovative delivery techniques, which need in no way weaken the professionalism of the department or the medical safety of the program. The administrative design of the Service places real limits on experimentation and creativity in this regard, but there is no over-riding reason why the excellent field personnel involved could not devise and launch such programs, given sufficient encouragement and emphasis from the Ministry.
4. The fact that the delivery of service can be adequate within the polyvalent health service should not be construed to indicate that patient education, outreach and motivation can also be accomplished by that department acting alone. This confusion has been a serious

deterrent to innovative programming which should involve a wide range of government departments and agencies. There have been a few exceptions to this monopoly, and they have demonstrated the usefulness of interdepartmental cooperation in family planning communication, however a great deal more is needed. Perhaps this is a suitable role for the High Commission on Population. It certainly must extend beyond the reaches of the Ministry of Public Health, however determined the GOM is that the medical service itself remain focussed within that department.

B. THE HEALTH SYSTEM

Because family planning is thoroughly integrated in the health delivery system, it is important to understand the format- both in theory and in fact- of the Ministry of Public Health. It is organized as a tight chain of command, with cadres reaching out to touch every home and family in Morocco. The central policies that dictate action plans at the top government level are reflected in the schedules, reports, and day-to-day activities of the smallest village dispensaries. The principle of integration, of "polyvalance", can be highly effective, but by the same token, unless stimulated from the highest level of authority, a program easily can be drowned in the sea of pressures on the nationwide system. So far, family planning has been submerged.

Line officers in the chain of command are the Medecin-Chefs du Province who in turn subdivide their provinces into Circonscriptions, the Circumscriptions into Secteurs, the Secteurs into Sous-secteurs (sub-sectors) with small enough populations to be visited monthly by an itinerant nurse. Corresponding with each provincial center is a hospital, including a Maternite; within each Circumscription of about 45,000 is a Centre de Sante (a Health Center); within each Sector, a dispensary serving about 15,000, and in each sub-sector of approximately 5000 an itinerant, male nurse with a bicycle or a mule. (See Chart 10). This organization is plagued by shortages of funds, doctors and medical paraprofessionals, and may be lacking in its projected cadres by up to 40 percent. But, in general, the system is in place, and even in random visits we discovered no areas that were completely unmanned.

Personnel are assigned and paid by the Ministry. Requests by the Health Officers for personnel are met, to the extent that they can be, by yearly graduates from schools that are mushrooming in response to the everpresent need. This process means that: 1) the Health Officer is limited, by and large, to present personnel, and may

therefore have trouble launching new and original initiatives; 2) the process of budgeting requires a delay and another year's application for permanent additions to staff; 3) most of the new personnel are without field experience, and since little selectivity has been involved in those trained, their quality is very uneven; and 4) any emphasis from above which requires local delegation of manpower means removing staff from some current assignment. With the importance placed on all-purpose training, this kind of juggling is possible, but means that special expertise for a categorical program is rarely available.

Furthermore, since all programmatic and budget control is centralized, the system is well-equipped to respond to government initiatives, but it is not able adequately to encourage creative experimentation. The cultural variety of the population, even within provinces, makes such local projects essential in developing a strong program. In many provinces, description of the population included differentials which are well-known to be closely correlated with family planning attitudes and/or usage; i.e., differentials in traditionalism, religiosity, schooling, work patterns, accessibility to service, male dominance, initiative. There is no single strategy in this field--no "standard operating procedure" as in the case of the GOM's highly successful struggle against malaria--but rather a need to adapt to the cultural demands of a highly varied and individual people. If family planning is to succeed, means must be found to give the dedicated Medecin-Chefs du Province some leeway in designing individual delivery initiatives, without detriment to their already strained resources or the administrative integrity of the Ministry. If the Ministry is willing to design the mechanics of such a program, we strongly suggest that USAID cooperate in their funding.

1. Professional and Paraprofessional Staff. The GOM several years ago made courageous and forward-looking decisions to invest in the future of its people through the development of staff and facilities for health service. Their long-range investment in staff education as a first priority is paying off with numbers of trained personnel, achieving almost as many per year as there were in the whole country a few short years ago. They have made a wise emphasis, one that so many countries have failed to make, on certificate nurse (Infirmiers Brevete); on both the number and geographical distribution of these practical nurses and the opening of their schools in each province. So far, 23 provinces

are covered where only two were in 1956. From these graduates (approximately 500-600 per year) cadres of local services are filled each year, and distributed also to the provinces not yet training their own.

It is understood that standards for admission to the schools will be raised. Total numbers of Brevete in 1975 were 6068; of Diplome d'Etat (Registered Nurses) about 1313; of Specialists, 119; and "other", 1716, making close to 10,000 health workers in the public health system in addition to medical doctors. And there is not the acute distribution problem which plagues so many countries. The nurses are placed where they are needed and serve where they are placed.

Basic positions seem to be filled; each sector having a "Chef du Secteur", although the quality of these nurses is extremely uneven. But neither the dispensaries nor the itinerant positions are fully-manned, and even when the rosters indicate two-out-of-three positions filled, one or two were frequently away for training, vacation or other temporary assignment. The tremendous variations that statistical reports show in service rendered by month, especially in vacation periods, indicates how sensitive the system is to the vagaries of the staffing mechanism. As training permits, clearly the projected rosters themselves will have to increase if a good level of service delivery is to be achieved on a year-round basis.

The amount of education the nurses receive in family planning in their regular curriculum has apparently been augmented recently, and although they are all "polyvalant", or multi-purpose generalists, there seems to be enough in their present training to make them able to handle the program. In the field, as well as in conversation with the director of one of these provincial schools, it seemed clear that what is lacking is not the technical know-how, but the kind of in-service orientation to family planning that gives them a real understanding of their special role in human, family and national development.

It is our understanding that with graduates of the new provincial schools swelling the ranks, it will not be long until the rosters of the provinces are filled to presently-projected strength. That in itself could remove the last deterrent to delivery of family planning service within the system if the GOM is serious in its effect.

One area that needs investigation is the question of specialized training, which is at present in low repute in the health system. The numbers of registered nurses equipped to handle jobs previously done by doctors could not be determined; it is apparently not increasing rapidly, and could well be important in the face of shortages of medical personnel. Only a few of the 18-20 graduates of the highest level Ecole de Cadre in Rabat become midwives each year. RN's, graduating at about 120 a year, are generalists, except for a few specialists which does not include midwifery.

The problem of doctors is, at present, more recalcitrant. There are far too few. Too many are in private practice, and they are far too concentrated in Rabat and Casablaza. After medical school they are required to give two years to the Public Health Service, but the exodus to private practice and its lucrative income is a subject of commentary throughout the country. Steps are being taken to redress the serious imbalance in income scales, but it cannot be overcome completely. There are hopes that in that way more doctors will be induced to stay within the Service on a full-time basis.

The shortage of doctors affects patient service directly in many ways. While triage relieves some of the burdens on physicians, they continue to work under tremendous pressures. They are underpaid and overworked. The Medecin-Chefs, describing their staffs, emphasized their doctors' problems and their "lack of motivation," although those we met seemed dedicated and concerned. The pressures under which these doctors work was blamed for many problems, including charges that have at times been made for services that should be free, and the rude treatment of patients whom they may be seeing at a rate of up to 150 per day. After frequently long and uncomfortable waits for service, the patient may be seen by a doctor too harrassed and tired to communicate with her, even if he is equipped to converse with her in her local dialect.

The lack in growth of IUD insertions was often blamed on this physician shortage as well. The original, frequently mentioned IUD program in the late 1960's failed, one is told, because of its problems in the hands of ill-trained practitioners. Now IUD's are still limited because there are not enough doctors to handle them or, in our observation, not enough who want to handle them. Furthermore, we heard from at least three Medecin-Chefs, from hospital directors, and even "animateurs" that there is a growing demand

for tubal ligation which is frequently refused because there are no doctors to perform them. This often means no doctors "willing" to perform them, but time pressures on those who are willing is an important factor. One Maternite director claimed that he could do 10 a day for those who requested them if he had the doctors to perform them. An "animateur" told us that women seeking help want ligations because "their greatest fear is getting pregnant with contraception." But he has nowhere to refer them. Clearly, the prejudice of Moslem women against sterilization is not absolute. If those demands could be met, not only would a valuable health service be performed, but future strain on the dispensary level would be removed when a permanent method of choice replaces the constant need for continuing service.

A second medical school was opened in Casablanca in the fall of 1975, and Rabat is graduating 70 to 100 a year. Other schools are projected, with Marrakech high on the list. A healthy proportion of the students are women. The Ministry is well aware of the need to reverse the movement into private practice. Education in family planning is now included in their training; tubal ligation procedures need to be included in future. It is to be hoped that funding will be extended to permit some of this training to take place in the United States and elsewhere and/or to send training teams into Morocco where they are invited. But the dedication of the medical people we met is apparent; the use of paraprofessionals is sensible, and interest in new medical techniques of fertility management is growing. And so, serious as these shortages may be at present, they cannot be seen as long-term deterrents to family planning service.

2. The Structure of Client Service. The framework outlined above gives little image of the physical facts of the health hierarchy; the individual portraits of service areas in Appendices A through E may amplify the picture. Clinics range from urban Centres de Santes (66) through urban dispensaries (163); from rural Centres de Santes (120) through rural dispensaries (520). These numbers have almost tripled since 1956. The urban Centers are generally large, multi-roomed quarters, often in old buildings with sufficient space, but little or no attempt being made to make the space attractive or comfortable. They frequently serve many more than the 45,000 people they are supposed to serve. In Casablanca we were shown one facility that probably serves at least 100,000 in

a crowded and growing part of the city. There appears to be less leeway for urban flexibility in services than in rural, and, despite growing staffs, these clinics are very overstrained.

The larger Centers have separate family planning clinics and women at the local dispensary (often a part of the same building or complex) are referred there. It is our impression that in urban areas, women from other dispensaries are also referred, because those we saw had responsibility for their entire Circumscriptions. They are often not very active, and we got the feeling that women could easily be lost in the referral, despite the proximity of the services. They were frequently hidden in remote parts of the buildings, and nothing indicated their general availability. Urban dispensaries performed the triage- the allocation of patients by their needs for service- and the simple treatments which practical nurses could deliver.

All of the dispensaries we observed were connected with Centers, but they rendered a valuable function of their own. The large numbers of women with babies and small children clustered around the gates and entries of these Centers indicated not only the length of wait and delay that these visits must entail, but also illustrated their importance to the families they serve. In most Centers there did not seem to be a way of moving directly to the family planning unit without going through the standard triage procedure. It does not seem that "integration" in the total health system need imply that women who desire a specific service should have to wait for referral with the entire collection of the days' applicants. Of course, the admission procedure may turn up many more potential acceptors, but those who have made the choice should be able to move directly into facilities that are equipped to handle them.

Rural Centers were also large and apparently well-staffed but crowded. The family planning unit was often integrated with the Protection de la Sante d'Enfants (PSE) thus complicating and often overloading the service problems, but aiding, no doubt, in the exposure of more women to family planning workers. The disappointing numbers served, relative to the numbers involved in PSE, indicated how a preventive service can be submerged in the priorities of medical care. Most Centers and even dispensaries had programs in Nutrition running concurrently with regular hours where mothers could bring and feed their babies under the guidance of nutrition specialists.

The Ministry is obviously well able to implement strong educational programs within the context of its clinic structure. But the numbers necessarily involved in these specialized programs indicate that they are not adapted to deliver family planning on a broad scale.

On the local, rural scene, small and unpretentious dispensaries varied greatly in atmosphere, appearance, staffing and accomplishment. In a few rooms, with or without electricity, practical nurses conduct triage and basic services unassisted. They have access to professional assistance either in weekly visits by a doctor, by ambulance, by telephone, or by referral to the nearest Center or Hospital which is often a considerable distance away. From these fundamental units of the health hierarchy, itinerants move into the sub-sectors. In these dispensaries a more personal and direct relationship is apparently established by nurses who reside among the people they serve. Where this works well - especially where a female nurse has the chance to establish a relationship with her patients - this level of care holds out hope for a strong, natural kind of clinic-based distribution, and as a headquarters for creative extension into community based distribution, never needing to move too far from its dispensary base.

The next step seems clear. Itinerant nurses are of the same level of certification as dispensary nurses, and are equally equipped to handle the screening that permits dispensaries to be primary distributors of the pill. Almost every Medecin-Chef interviewed by the Team was anxious to try some kind of experimental program using these itinerants, although the details of such programs varied. We respect the importance which the government places on orienting an unsophisticated and often illiterate population toward the professionalism of the clinic setting, but submit that for continuing service, such as family planning, that interest can well be served by permitting health workers to bring the possibility for contraception to their patients on their regular rounds. In the home there is the potential to reach both husband and wife. There is an established routine of regular visits and there is in place a staff of the kind of paraprofessionals most countries have to dream up. This seems to us to be a classic setting for intelligent, well-monitored programs in community-based distribution and, if the government is interested, we strongly recommend their funding.

The health hierarchy which we have described is of necessity highly uneven in the level of its service. As one Medecin-Chef said of his Centers' involvement in family planning, "ca ne marche pas du tout." Where one doctor serves over 30,000 patients, and no time is available for this preventive service, that is to be expected. Kenitra province, with one of the finest programs in family planning education and recruitment we saw anywhere located in its capital is far down the list in provincial achievement. Since the same health officer is involved, this is clearly not a matter of his interest, but a condition of the realities of a strained system. It must be stressed that only the government can decide whether it is willing to wait for relief of the entire system before implementing greater ease of access to family planning; or whether it believes that, in the long run, relief to the system can only be achieved with access to family planning. If the decision is the latter, there are many procedures open to them without violating the progressive, long-range plans within the Ministry of Public Health is operating.

3. Delivery of family planning through Maternite. While there have been some experiments in post-partum family planning, the results of these efforts seem to have been lost to follow-up and will not be discussed here. What was observed in the many provinces visited will be reported, and some observations given on the potential of this kind of service. Hospitals are under construction throughout Morocco. Numbers of maternity beds are not large, and ob-gyn sections are being juggled back and forth between new facilities and the older buildings they replace. While several are in unattractive buildings with large clusters of women around their entrances, there are notable exceptions and a real attempt is being made to improve them.

The vast majority of births takes place outside the hospital, which is located at the provincial capital and is used for both local deliveries; when the mother prefers institutional care, and for more difficult deliveries brought in from surrounding areas. Home deliveries are not attended by medical personnel and any potentially difficult delivery may be brought in even when the resulting birth is normal. In El Kelaa des Straghnas we were told that about six or eight out of 25 births in January in the Sector of Arbaa Gazet were taken into the hospital and that only

a few were problem deliveries, although each was ambulated to the hospital at the request of the local Infirmier. Only in Beni Mellal were we informed of beds for delivery in Centres de Sante. If they exist elsewhere we did not see them. There was a considerable variety in the hospital deliveries, with stay ranging from two days down to four hours. At most of the wards visited there were two mothers, each with new-born, in each bed, despite stays averaging 24 hours. Only in Beni Mellal, where stays were reduced to four hours, was there only one mother to a bed. And in Settat, the maternity ward was almost empty with no satisfactory explanation available for this rare phenomenon.

The short stays and the numbers of women who are not in a position to return to the hospital for postpartum service make their accessibility as family planning centers limited. We were informed in El Kelaa that the majority of the cases brought in from the surrounding country-side are first births. They are less likely to respond, therefore, to the family planning message. We were further informed by a nurse attending deliveries that they tried to discuss contraception with women in labor: "They hurt so they are likely to agree." The long-term results of such a message do not seem positive.

The family planning clinics connected with such hospitals were among the most under utilized facilities we saw. In no case was there any indication to the patient that such services were available. No sign or posters were in evidence until one was in the room provided. (In fact, the only posters observed were in the hallways and were from milk companies suggesting the use of commercial products as an alternative to breast-feeding). Numbers, where they were available, indicated usage of these facilities by a very small percentage of the women delivered.

In Fes, where we were informed in the Centre de Sante that all IUD patients were referred to the Maternite, there were nonetheless 6-month periods without a single IUD inserted. If these are the settings in which so-called "problem cases" are now being handled, there is little evidence that they are doing their job. And with the dearth of medical practitioners, they may not be able to do so. (Statistics do not reflect surgical procedures in this regard). But even routine con-

traception does not seem to have much success here, and it is dubious, in view of the infrequent returns to the Maternite setting in later months, that they could be the suitable measure of a post-partum educational program.

Since very few women return for post-partum visits, even to their local urban clinics and maternities, the educational job of bringing them back when they are ready for contraception is a difficult one. We were told of the traditional 40-day seclusion of the mother after delivery, and see that as a potential means to promote a postpartum family planning visit on the fortieth day by those delivered in hospitals and at home alike. A national campaign to tie such a visit to the mother's first outing is the sort of education initiative that the program needs. The Maternite, although it serves such a small percentage of births, might be a good place to begin such a promotion, and the new Reference Centers, in their proximity to the Maternites, could be extremely useful in that regard.

4. Women and the System. From the point of view of the patient, then, family planning is but one of the services available and must be associated with all the problems surrounding any clinic visit. Long periods of waiting, the atmosphere of crowding and illness, and the pressured staff are endemic. In addition, particularly in urban centers, there are the kinds of special indignity for woman that Dr. Fatima Mernissi reports in December, 1975 Studies in Family Planning. Her "Obstacles to Family Planning in Urban Morocco" (Vol. 6, No. 12, pp 418-425) details the reaction of the lowest class, bidonville women to clinics in which their treatment is often rude, their questions unanswered, and their ignorance ridiculed. Their resistance to the city is hardened by their introduction to the health system, often their first most brutal encounter with urban institutions. But, Dr. Mernissi indicated to the team that the health department had "done miracles" for the child, that its nutrition program worked well within the traditional communal life of the women involved. There is little reason that their family planning program could not do the same. Treated in the framework of women's traditional interdependence and mutual trust and their solidarity, especially in times of child-birth, family planning need not be scarred by association with either the institutional problems of a pressured health system or the male-female tensions of long and complex history.

Women may be forced to suffer certain indignities in the treatment of disease, theirs or their children's, and will do so however unjust or unnecessary. They are free to reject, however, a purely preventive service if it entails these same indignities. Therefore, many do reject family planning. Several steps could be taken to improve treatment, some related to the enormous time pressures upon the medical staffs, but some require changes in the training and attitude of those who deal with women patients. Illiteracy is not ignorance, and methods could be devised to give unlettered women greater understanding and control over their own health treatment. Men, doctors and the others who model their behavior on that of doctors, could be trained to treat women with the respect due all their patients. Nurses could be required to model their treatment on the best they might expect, not on the undignified service they see in crowded urban clinics. Where physicians may not be able to speak the language or the dialect of patients, nurses could be taught to serve as a bridge in communicating.

As long as the Program integrates family planning, it will not only be plagued by the general problems of the system, but complicated by male-female tensions and the ability of patients to reject the preventive service. In all parts of the country we were told of the "mauvais accueil"- the "bad welcome"- greeting women who seek this service. It was stressed as one of the fundamental problems of this program, in urban areas especially. Only in a few rural settings and in the Family Planning Association (FPA) was this problem overcome. It is too serious to ignore because it affects not only the patients who are hurt, but the very reputation of family planning in Morocco.

Another female problem is the precarious position of Arab women in their marital situation which make fertility-related decisions infinitely complex. Both Dr. Mernissi and Mme Therab of the FPA emphasized the divorce law, which permits renunciation of a wife by her husband for no provocation, as a serious drawback to the power of women to control their own fertility. As one Medecin-Chef explained it, a woman will give him permission to conduct suggested surgical procedures for any other part of her body, but will insist upon her husband's decision whatever her health status if her reproductive system is involved. It is, in large measure, his. His education and attitude then may play a major part of her health treatment.

This suggests still another complicated finding; i.e., the problem of male nurses in rural dispensaries and itinerant positions. There are a limited number of married couples who are both nurses, and several Medecin-Chefs are trying hard to locate them in rural dispensaries where they are unwilling to place single women alone. (Unfortunately, there is the additional problem that such service is arduous and places young families away from the cities in which they would prefer to serve. The reward for their excellence is frequently more years away from the setting in which they would wish to raise their families!) Therefore, there are still large numbers of women who see only male representatives of the health system.

We were also given the following conditions, and they lead to several alternate conclusions:

1. Many male nurses are uncomfortable with the subject of family planning and do not discuss it with their patients.
2. Women will not bring up family planning with male nurses.
3. Itinerant nurses, almost always male, cannot see the women in the homes they visit. The largely traditional nature of the scattered rural hamlets make it unlikely that the man of the house will permit his woman to speak directly to a male visitor.
4. "Tradition" is a more usual bar to family planning than is "religion." It is rural traditions and economics that lead men to oppose child limitation.
5. In the most traditional settings it may be more important to reach the men than the women. While female attitudes to family planning may be positive, there is little likelihood of continuing contraception unless the male is equally convinced. (It should be noted that all statistics given by the Ministry for new acceptors show nothing of their continuation rates. The last survey, in 1972-3, showed excessively low rates, which explains the miniscule impact of the Program. Continuation rates could be affected by male attitude and a study of this relationship is needed.)

If these observations are largely true, there is particular importance to the travelling family planning workers who move through as many as 10 rural dispensaries a week. The numbers will have to be multiplied greatly if dispensary-level contraception is to grow. Also, these observations lead to several problems encountered in the field: 1) the need for female infirmiers on the local dispensary level, and 2) alternatively, the special role for male infirmiers vis-a-vis Moroccan husbands attitudes toward family planning- a role which we see no evidence that they are playing at the present time. Our suggestions on the role of "gender" in these delivery questions then would include:

1. An orientation of male nurses in this special function which they can provide to their male patients.
2. An orientation for male and female nurses so that both may speak confidently to women about their reproductive problems.
3. Experimental projects in which selected male nurses or visiting family planning nurses choose a few village women, satisfied acceptors who have the confidence of their neighbors, to help them in recruiting, explaining and giving acceptability to family planning, and to help assemble small group so that the time of the visiting nurses is well-spent.
4. A brief, specific training course for wives of selected male nurses in rural villages, so that at a minimal additional cost they might assist in family planning outreach, although they are not nurses.
5. The training of more family planning "animateurs" and field workers is a necessity. Once engaged in full-time work in family planning, both male and female nurses seemed highly successful at communicating their positive story. "Polyvalance" is an excellent back-up, but not a substitute, for this special expertise.

It must be emphasized that no program, however well conceived, can stand the bad reputation that any service receives if the poor attitudes of all medical personnel toward their female patients, especially in urban centers of heavy population concentration, are not radically improved.

C. REFERENCE CENTERS

Now under construction or nearing completion are 13 provincial Reference Centers, free standing units in or adjoining the Maternites hospitals in the provincial capitals. There is agreement that as a focus to the family planning work of each province, as a visible symbol of the government's concern, and as a coordinating and managing mechanism, the Centers will be extremely useful. A Reference Center has been defined as an information and education center, as a headquarters for rural outreach, as a base for post-partum programming, and as a training location for all health staff moving into the province. There is less agreement on a fifth "function" that is listed by the Program; that of handling "difficult cases", because it is not clear how much service delivery the Centers can perform and how much they will depend upon the usually adjacent Maternites for clinical back-up. They have not been designed as clinics on any large scale, and could not accommodate that service. But they could handle some highly selective out-patient procedures, and several health officers saw that as a real and valuable purpose.

It is difficult to know where to locate the Reference Centers within the delivery system because: 1) none of them are in operation at present, 2) no single authoritative statement has been made on their intended functions, 3) each Provincial Health Officer indicates a different potential role for the Center in his province- the range of options is not defined and almost any function named seems acceptable to the current program director, and 4) the projected staffing of the Centers is well below the number required to perform in any of the suggested patterns.

The fact that they are behind in their construction schedule has been noted elsewhere. That there is still some confusion about the location of a few Centers that were scheduled for completion this year is discouraging, as is the fact that the Casablanca and Rabat Centers, at least, will not be adjacent to Maternites as was planned when the construction of new hospital buildings is completed. The latter may not present problems, except possibly to post-partum work, but as an indication of the looseness of the plan it is nonetheless significant.

The health officer in each province will be expected to delegate two or three staff from their present allotment to the new Centers. Future years may give them additional staff, either to take places left empty or to supplement the Centers, but no priority has been placed on training staff specifically for this function as an addition to the resources of the provinces involved. Even where a Center was to open in six weeks, as in Marrakech, there had been no planning as to the function of a building that is rising immediately adjacent to the health officer's office and the hospital. There is so much else to do. Once again, only high priority emphasis from Rabat will breathe life into these potentially exciting Centers. Several health officers see the Centers in the immediate future as requiring staffs of at least nine persons, not two or three as planned, and suggest generally some distribution of an administrator, a social worker, a doctor, educators, registered nurses, mid-wives, a maid or janitor, and a chauffeur. (It seems unlikely that there are enough midwives to spare for the projected Centers.) But headquarters has indicated no such assignments. They should be urged to consider the staffing suggested by their Medecin-Chefs as soon as graduates are available.

Within the health delivery system these Centers could be ideally suited to collect the data on which future planning of the Program could be based. They could also pioneer in the delivery of certain carefully controlled services such as tubal ligation and terminations, when they are approved, which are apparently difficult to fit into the present delivery structure. They are also logical places to train physicians in all new and specialized services, and to coordinate the work of adjacent Maternites with the provincial family planning network. Their potential is unlimited and, as one officer said, "In two years we will have an 'Institut de Planification'!" If the imagination of these officers is permitted some leeway, and some budgetary support, these could be unique centers of service, education, and management control. If not, they could remain just outside the hierarchy of health delivery, and serve little purpose in the overall scheme.

D. SUMMARY

The Government emphasis on preventive medicine, multi-disciplinary service, and community-level health delivery and health education make Morocco a suitable location for a comprehensive test of family planning as an integrated

element in the total health system. So far the demonstration has had negligible results. But a rapid acceleration in filling health cadres, and the very recent approach of the system towards some of its immediate objectives, make it particularly important to observe the program for another year. If, despite the comprehensiveness of the delivery system, there is insufficient emphasis on family planning to accomplish wide distribution, then no matter how intelligent the experiment it must be deemed a failure. We suggest that it need not fail, and that one more year is sufficient to make a preliminary judgment.

IX USAID ASSISTANCE

A. NATURE OF THE U.S. INVESTMENT

Since 1969, AID has invested in or committed to the Government of Morocco family planning program a total on the order of \$2.5 million. AID has reported a total of \$2.35 million in assistance between FY 1969 and FY 1975. (World Population Growth and Response, Pop. Ref. Bur., Apr. '76). The PROP Revision, dated 9/30/74, shows a total, starting from FY 1971 and reaching through FY 1976 and the interim quarter, of \$2.3 million.

Judging from the text of AID reports on 1969 and 1970, money spent on the Moroccan program in those years was for general support. The PROP gives the following breakdown of the functional distribution of funds committed between FY 1971 and FY 1976 (excluding \$35,000 shown for FY 1978).

Technical Services	\$98,000
Participant training	36,000
Commodities	1,539,000
Construction and Renovation	
National Family Planning Center	300,000
Provincial "Reference Centers"	325,000
Support to Seminar, and Other	<u>25,000</u>
	\$2,323,000

B. STATEMENT OF OBJECTIVES

The objectives of the U.S. support for the Moroccan family planning program have been stated in different ways in different documents. The Evaluation Team was asked to pay special attention to the objectives as stated in the PROP covering the current projects. These are in three forms:

- 1) The cover letter sent with the PROP dated April 11, 1975, summarizes the objectives as "The proposed grant to the GOM will supplement an earlier grant made in 1971 to assist the government in establishing its national family planning program as part of an integrated health system. The objective of the program is to make family planning services available to the three million couples of child-bearing age in Morocco with the overall goal of reducing the population growth rate from 3.2% in 1972 to 2.9% in 1977."
- 2) The formal "Project Design Summary - Logical Framework" which formed the final page of PROP. (Appendix J)
- 3) An output table included as page 14 of the PROP. (Appendix K)

The Project Design Summary and the output table offer a number of relatively precise targets which the Morocco program was expected to achieve, or which the U.S. investment was specifically intended to assist. These include:

- 1) Reduction of the growth rate of population from 3.2 percent in 1972 to 2.9 percent in 1977.
- 2) Reduction of birth rates from 49 per thousand in 1972 to 45 in 1977.
- 3) A total of 391,000 acceptors "introduced" to family planning between 1973 and 1977.
- 4) Establishment of 220 Health Centers and 300 Dispensaries, staffed to deliver family planning services, by 1976.
- 5) Establishment of 18 "Reference Centers" by 1976.
- 6) Training of 425 doctors and 4,500 para-medical personnel in family planning techniques by 1976.
- 7) Holding 13 seminars by the end of 1976.

This section of the report attempts to evaluate the results of the U.S. investment, and, necessarily, of the Government of Morocco program which that investment was intended to support. It seemed appropriate to attempt this evaluation

in two forms: 1) evaluating the U.S. investment by observing the results of the functional allocation of the money, and 2) evaluating the program against the objectives established in the PROP.

C. EVALUATION BY FUNCTIONAL ALLOCATION OF FUNDS

1. Technical Services. A Public Health and Population Officer has been maintained in Rabat. We approve heartily of the concept of maintaining a Population Officer in a country in which the United States is investing large amounts of money.
2. Participant Training. We observed, to the best of our knowledge, the activities of only one recipient of participant training. This represents too small a sample to permit us to criticize this small expenditure of \$36,000.
3. Commodities. Of the \$1,539,000 in commodities, shown in Table IX-2 of the PROP as having been committed between FY1971 and FY 1976, the PROP gives a breakdown on only the \$1,156,000 proposed for commitment between FY 1974 and FY 1976. The Team cannot comment on the nearly \$400,000 worth of commodities apparently sent to Morocco in FY 1971 through 1973. The \$1,156,000 breaks down as follows:

Contraceptives

Orals (6.1 million monthly cycles)	\$717,000
Foam and IUD's	125,000
Condoms (Appx. 8 million gross)	<u>19,000</u>
Sub-total contraceptives	861,000
Audio-Visual and Medical Equipment	45,000
Equipment for "Reference Centers"	<u>250,000</u>
Total	\$1,156,000

4. Contraceptives. Smaller quantities of contraceptives have been shipped to Morocco by AID than were foreseen in the PROP. Instead of the roughly five million cycles of pills that the PROP calls for by the end of

calendar 1975, Dr. Poulsen's report cites the distribution during that year of .9 million cycles to the field, and warehouse stocks at year-end of 1.2 million cycles. If the whole proposal of 8 million gross of condoms (1,152,000,000) had been shipped, there would be available in Morocco about 7,000 condoms for each of the 15,300 "first acceptors" of the method over the past four years.

However, the investment that has been made in oral contraceptives and IUD's has been of very great use to the program. The flow of contraceptives into the field seems smooth and adequate to the present demand. We did not understand Dr. Poulsen's report that one shipload of IUD's mysteriously failed to arrive, but its loss has had no noticeable effect on the program at the point of delivery.

5. Audio-Visual and Medical Equipment. We saw little sign of the \$45,000 worth of audio-visual and medical equipment which has apparently been sent to Morocco since FY 1974. What small supply of equipment we did see was old. Some projectors were of the wrong type, and some were too complex for the typical Moroccan teacher or nurse to use. We kept running into discouraging tales about "The Choice" and the Walt Disney film, which had arrived before the departure of Dr. Robert Castadot, Population Council representative, in 1971. In centers where we found the films, we were told that women have grown tired of watching them over and over again.
6. Equipment to Reference Centers. Since no Reference Center had been completed the equipment had not yet been put to use.
7. Construction and Renovation. The National Family Planning Center building in Rabat has been completed and, with the assistance of a UNFPA grant, equipped. Most of its offices seem now to be occupied. AID first committed 1,517,000 DH (\$300,000 in local counterpart funds) toward this project in May, 1969.

Only about 10 percent of the building, at a generous estimate, is being used for purposes directly connected with family planning. The National Family Planning Service headquarters occupies seven offices, most of them approximately 8' x 13', and has (although we are

unsure of its use) a storeroom for contraceptives. The Health Education Service occupies 30 offices, many of them as large as 20' x 20' and used by several employees. As pointed out elsewhere, however, the Health Education Service is spending a minimum amount of its time and effort on family planning.

The National Health Statistical Service occupies five offices, four big workrooms, five large spaces where the punching and sorting of computer cards is carried out, a meeting room, and a file room. Some portion of the Statistical Service time and effort is, of course, devoted to family planning. There is also generous space in the building for a library, which is not yet equipped, and for two classrooms. The Chief of the National Family Planning Service identified the library and the classrooms as being assigned to family planning. The blueprints, however, show them as assigned to the Health Education Service. Certainly the Family Planning Service has no staff to man the library and to teach courses in the classrooms. The building itself is a structure of concrete and stone, with few windows looking outward, and is built around a succession of courtyards on several levels. It is not identified, outside or inside, as having a connection with the National Family Planning Service -- or with any part of Ministry.

- 8. Provincial "Reference Centers". According to the PROP, the Reference Centers were to be completed (mostly by renovation of existing facilities in maternity hospitals), equipped, and staffed with three persons each according to the following schedule:

	<u>Per Year</u>	<u>Cumulative</u>
CY 1975	11	11
CY 1976	7	18
CY 1977	7	25

The 1975 cost was projected at \$20,000 for each of the three to be constructed, and \$5,000 for each of the eight renovations, with an average cost in addition of \$9,000 for equipment. The total included in the PROP was \$325,000 for construction and \$250,000 for equipment. Eight months after the PROP was signed in April, 1975, the National Family Planning Service notified USAID/Rabat of a change in the plan, because fewer sites than they had expected had space available for renovation, and because construction

costs were going up. The revised plan called for a reduction in the number of Reference Centers to be built and equipped out of the grant from 25 to 13, at a total cost of \$492,000. Under a schedule reported by Dr. Poulsen in a memo dated December 9, 1975, a new schedule for completing these 13 proposed Centers during 1976 was as follows:

	<u>Cumulative</u>
Completion by February	3
Completion by April	7
Completion by June	10
Completion by September	13

On the basis of site visits, the Team must conclude that even this schedule appears to be falling behind. The Rabat installation, scheduled for February, was uncompleted and unequipped. The Marrakech installation, scheduled for March, was a concrete shell. No ground has been broken for the Fes installation, scheduled for April, or the Casablanca installation, scheduled for June. But far more serious problems are involved in the Reference Center project than this arrant failure to meet construction and cost objectives. The Team hopes that the 13 Reference Centers will not merely degenerate into small, freestanding annexes to the hospitals or centers near which they are being built, with no special usefulness to the family planning program. In particular, it seems important that the first three to be completed -- Rabat, Marrakech, and Meknes -- be used as pilots in the development of a number of important projects, such as an improved management information system.

9. Support to Seminar, and Other. The "national seminar" was held, at a cost to AID of \$10,000, and, judging by reports, it was adequate and an improvement over nearly any other educational project developed within the Program. The Team did not try to trace the \$15,000 presumably spent on "Other".

D. EVALUATION BY OBJECTIVE AS STATED IN THE PROP

In trying to compare what has happened in Morocco with what the PROP projected, the Team discovered just how insufficient the objectives in that document had been. The objectives suffered from the following weakness:

1. Stated in Wrong Terms. The PROP picked up from the Government of Morocco its tendency to state objectives in terms of population growth: from 3.2 percent in 1972 to 2.9 percent in 1977.

Morocco's own intensive public health campaigns, added to the steady shift toward a young age distribution, are almost inevitably going to bring the death rate down faster than the Moroccan Five-Year Plan anticipated. Therefore, a cut in the population growth rate is a poor short-term target. Indeed, even the drop in the birth-rate from 49 to 45 per thousand, which is stated as the subsidiary objective, is a poor measure of the success of the family planning program because social and economic changes are having their own effects on the birth rate.

2. Stated in Imprecise Terms. One objective is stated as: "To establish an institutional capability to provide FP services...." One can not really evaluate the success of Morocco in achieving "institutional capacity" without a clearer definition than is given of the meaning of the term.
3. Overly Modest Objectives. Apparently affected by their failure to achieve anything near the number of acceptors set as objectives in their first Five-Year Plan, the Ministry of Planning used figures for the 1973/78 plan which represented little or no challenge. The 1975 objective of first acceptors, 75,000, represents only 1.9 percent of the women in the fertile years. When the exceptionally high drop-out rate of the pill is taken into account, such a low-level objective is not really moving the program forward.
4. Evaluation of Assumptions. The success or failure of that family planning program in Morocco rode on one stated assumption: "That the Ministry of Health will give substantial priority to the program and receive the necessary cooperation from other Ministries (Plan, Interior, Information, Education, Youth and Sport). This assumption proved to be over-hopeful.

The assumptions concerning the drop in the birth-rate, the Government's willingness to provide "timely completion of construction", and the Government's ability to assign "qualified staff" to the National Family Planning Center, appear not to have been justified.
5. Comparison of Actual "Outputs" with Objectives. Against the above philosophical background, and in the light of the lack of validity of key assumptions, the Team has analyzed actual progress of the family planning program in Morocco against the "Output table" included in the PROP.

- a) Establishment of a National Family Planning Center in Rabat. Accomplished, without a communications unit and with minimal cooperation from the Health Education Service, in CY 1976 rather than in CY 1974 as shown on the chart, or in CY 1971 as originally planned.
- b) Staffing of Central Family Planning Service. Six persons, the objective for 1976, are in place.
- c) Establishment of Clinical Family Planning Training Center in Casablanca. The Team saw no trace of such a Center. It simply does not seem to exist.
- d) Number of personnel completed Family Planning training in Rabat Center. The PROP states that a "small Pilot Family Planning Center" was established in 1967 in the University Maternity Hospital in Rabat. Family planning services are still given in the Hospital, but there is no indication of the existence of a "Center" doing special training.
- e) Number of Health Center... "providing MCH-FP services 6 days a week". The stated objective for number of Centers in 1976 was 220. According to the Secretary General there are now operating 186 such Centers-66 urban and 120 rural. This is close to the target number. The problem, of course, is in the phrasing of the objective which connotes a vigorous, active, full-time, six-day-a-week family planning program. The amount of family planning that most of the Centers provide among their other public health service delivery projects is very small in proportion to the need.
- f) Number of dispensaries... "Provid(ing) part-time FP services". The objective number for 1976 was 300. The actual, according to the Secretary General is 683, of which 163 are urban and 520 are rural. The expansion of this network is a public health triumph for Morocco, but the Team's finding is that they are not at present accomplishing much in the way of family planning, although they are "equipped and staffed".

- g) Cumulative number of medical and para-medical personnel trained to provide family planning. The objective for 1976 is 425 doctors and 4,500 paramedical personnel. The Team could get no figures on numbers trained. Furthermore, as the section on Training points out, figures would mean little since there is no evidence of any significant amount of in-service training in family planning techniques. What undoubtedly does exist -- to the credit of the Ministry -- is a family planning component in the medical schools and in the growing number of schools for nurses and paramedics of various levels. Recent graduates have entered the field with some background in family planning. Further, one might say that an "infirmier" in a rural dispensary who has been taught the list of questions to ask a woman seeking the pill in order to determine if there are contra-indications, is "trained".
- h) Establishment of Family Planning "Reference Centers". The objective was 11 during 1975, and a total of 18 by the end of 1976. As this section has already noted, there have been massive delays. One (Tangiers) apparently had been established on some sort of basis by the end of 1975. There may be 10 in operation by the end of 1976.
- i) Inclusion of Family Planning in curricula of "Foyers Feminins". This program is excellent. The objective called for the inclusion of the program in 370 Centers in 1976, and for 400 Girls Club teachers to have been trained. As far as could be determined, instruction in family planning is included in the class-work of all the Foyers Feminis throughout the country. The limitation is that this is essentially a small program for a few fortunate girls. There are on the order of 150,000 girls, mostly between the ages of 12 and 18, attending classes regularly. This is less than 10 percent of the girls in this age bracket.
- j) Cumulative number of mobile units in the Family Planning Association. The objective was four such units by 1976. The Association reported the existence of one unit, in Rabat/Sale, which it reported "made sorties with a rhythm of one per week" during 1975.

- k) Establishment of Seminars. The objective was to have held four provincial seminars by the end of 1975 (in addition to the national seminar held in 1974), and four more provincial and one more national seminar in 1976. Two provincial seminars had been held by the end of 1975. The Chief of the National Family Planning Service say she is going to hold seven more during 1976.
- l) Establishment of an Analytical Demographic Research Unit. The Team had no time to check the state of this objective. We certainly heard nothing about the existence of such a unit. It did appear that the National Health Statistics Service and CERED were capable of doing satisfactory fertility planning and demographic analysis.

X THE STATUS OF STATISTICS - A KEY POTENTIAL FOR PROGRESS

A. INTRODUCTION

The Team was pleased by what it learned about the general system of collection and collation of health statistics in Morocco, including family planning statistics. With only relatively few exceptions, there was a meshing of statistics from the levels of the smallest village dispensary, through the provincial headquarters, to the National Center for Health Statistics. There is, indeed, a wealth of statistics on which one can reasonably build.

On the other hand, there are some glaring weakness in the system, especially insofar as it affects family planning and maternal and child health. The integration of family planning into the total health system has, until now, deprived the statistical system of an appropriate emphasis on what is supposed to be a high priority part of the program. The basic form used to collect figures on the characteristics of visitors and acceptors is out of date. It must have been designed during a period when the designer contemplated that the IUD would be the most widely accepted form of contraception. Managers, furthermore, do not use the wealth of statistics to learn about changes occurring with the passage of time which should affect decisions. And no one appears to analyze the family planning figures for informed decision making. But because the basic collection and collation system is strong, it should be relatively easy and inexpensive for the Ministry to adapt its system and to turn it into a strong and modern family planning management information system.

Although the changes should be relatively simple and inexpensive, they could have a profound effect on the extension of family planning services throughout Morocco. If the top levels of the Ministry choose to make these changes, they can use the management information system as a tool for themselves and for provincial management in making decisions. The figures themselves will suggest paths to improvement of delivery methods. The growth of figures, and the competition for success among the provinces can serve as an incentive that will help to establish the proper priority of family planning within the total health system.

Finally, there are a number of health officials, and a few key Ob-Gyn. specialists, who appear to be interested in making use of modern statistical methods to turn their current endeavors to perform tubal ligations, and in a few cases even early abortions, into projects of scientific research. Such research should be encouraged and coordinated.

B. THE SYSTEM

The statistical system is controlled by the Ministry on a centralized basis through the National Health Statistics Center. This unit happens to be located in the building of the National Family Planning Center, although family planning represents only a tiny portion of its interest and functions. The statistical unit turns out a quarterly report on health developments in Morocco consisting of some 20 separate tables. One of these is devoted to family planning. (Appendix L)

Family planning is fortunate in that the director of the statistical center, Dr. Ouakrim, happens to be interested in family planning figures. He was very cooperative with the Team, and he appears to work well with the current family planning management. The quarterly booklet, including the family planning form, is usually produced for distribution three or four months after the end of a quarter. Final figures for 1975, for example, were available to the Team before its departure from Rabat on February 28, although they were not available when the Team arrived in Rabat on February 16. The national system is pragmatic; when it can not get figures from a province for a particular month for a function, it forges ahead with the report, picking up the missing month in the next quarterly report. The figures cannot be absolutely depended on, therefore, by quarter, but the discrepancies are rounded out over the year.

It appears to the Team that there is little likelihood of persuading the Ministry to change its basic system and to break out a separate family planning statistical system. The whole health network is thoroughly integrated, and the highest officials with whom we spoke are committed to integration of family planning within the system. Family planning can consider itself fortunate that Dr. Ouakrim is interested in this particular field of health and fertility care.

Typically, the para-professional at even the most remote village dispensary is aware of the importance which his superiors place on the collection of figures. Informiers spend a considerable portion of their time tabulating in notebooks the statistics which record their activities. At the end of the month, they are trained to produce totals quickly, and to send them to the health center of the circumscription (region), which assembles the figures from the sectors, collates them with its own, and forwards them -- typically by the 5th of the next month -- to the provincial health headquarters. In all but one of the nine provinces visited, we found the Provincial Health Director to be in good command of the statistics for his province through the last month, and to be able to lay hands on records with ease. The exception was a provincial health director who, although intelligent and energetic, seemed to have no flair for or interest in figures and statistics.

The national center, to which the province forwards its figures, has available to it the use of an IBM computer in the 360 Series. Card punch equipment is located in the National Family Planning Center building. The statistical group uses the computer for processing data. We do not know how much use it makes of the computer for analysis of data in fields other than family planning, but it does not appear to have engaged in much analysis in our special field.

C. DRAWBACKS OF THE SYSTEM

Within this relatively strong system of data collection and collation, there are a number of flaws that affect the family planning program. These include:

1. Integration. The Ministry of Health makes a good case for the continuing integration of family planning into the public health network. But one loss to family planning is evident from the general forms which are produced. Within these forms, which are the ones to which all levels of the system ascribe the most importance, no statistics concerning family planning or maternal health are recorded. The basic forms which each "infirmier" fills out as of the highest priority, and which each Provincial Health Director uses to show the results of his team's work, contain no hint of a family planning program. This illustrates the priority really assigned throughout the health system to family planning.
2. Consumption of Time. The para-professionals in particular, but all levels of the provincial health system, complained of the amount of time they have to spend on paperwork. The Team did not try to evaluate the justice of this criticism. Since our own bias was toward reliance on statistics, we tend to think that it is fortunate that the system does force even the simplest "infirmier" to record his activities so thoroughly.
3. Basic Family Planning Form. The basic form used throughout the country to record the number of family planning acceptors is outmoded. The emphasis is on a breakdown of IUD acceptors, although the IUD has declined in importance over the past four years. The result is that one can learn a relatively great deal about a very few acceptors, and not much about the relatively large numbers of pill acceptors. The figures on first acceptors seem to be more reliable than those on on continuation visits and resupply.

4. Analysis of Data. At no level of the system, from the dispensary to the national statistical headquarters, did anyone seem to have analyzed the wealth of family planning statistics that have been collected. The worst example was reported by Dr. Jean Le Comte, Population Council representative, in his final report last year, and confirmed by the Team. It is that thousands of acceptor questionnaire forms (the second basic family planning form) have been forwarded over six years to the national statistical headquarters. Information from them has been recorded on computer cards, but no one has taken the time to analyze the information. A treasure-trove of data on patient profiles, and the change in that profile over six years, has been ignored. One might easily, in an analysis of all this data, discern a trend which should affect decisions made about the future of the Program.
5. Use of Statistics by Management. Although management at all levels seems to have possession of reasonably good statistics, no manager seems to use the data in making decisions. From the local dispensary to the National Center, the data are treated only as records, to be collected and then ignored. (Appendix M)
6. Communication. The distribution of data seems to be limited. Provincial Health Directors have little awareness of what goes on in neighboring provinces, at least in family planning and perhaps in other health activities. The ignoring of family planning results can be contrasted with the system now used in Tunisia, where each month the family planning representatives from all the provinces are summoned to Tunis to present their record for the past month, and to have their progress compared with that of their neighbors.
7. Lack of Understanding. At no level of management did officials in the Moroccan health system seem to have an understanding of how they might put family planning statistics to use. Dr. Bernard's brief presentations, developed in simple terms from the population and acceptor figures which showed the small percentage of women at risk in a catchment area who have accepted contraception, came as nearly as much of an enlightenment to Provincial Health Directors as to the least well educated paraprofessional in a rural dispensary. Even these brief presentations seem to give personnel at all levels a fresh insight into the magnitude of the job that lies ahead of them.

8. Hiding of Figures. Three types of figures important to an understanding of the fertility control situation are, by the nature of the system, buried or hidden. They are:
- a) Child loss. Death figures are collected only in gross numbers, and no effort is made to identify the age of the deceased. There is no way, therefore, that one can extract from the statistics the rates for infant mortality or other child loss. Studies have shown that infant mortality is one of the prime health problems of Morocco. The Team got a sense, by vigorously questioning Provincial Health Directors, that the rate has been falling rapidly in recent years. But since no health official is faced with the figures on infant mortality each month in his forms, no one seems much interested in reducing the rate. No Provincial Health Director cited child loss or infant mortality as one of the health problems he faced.
 - b) Tubal Ligation. Tubal ligation is legal in Morocco. There is, however, a deep reluctance on the part of people to discuss it. Only our interest and our vigorous questioning turned up doctors who perform the operation, or who would be interested in performing it, and guesses as to the number of women accepting the operation. There is space on no form produced within the health system to record the number of tubal ligations. Figures are buried within other records of surgery.
 - c) Abortion. The legal status of abortion is relatively clear: Therapeutic abortions are permitted, and the term "therapeutic" is carefully defined. But both legal and social pressures seem to make abortion a difficult subject for most Moroccan health officials to discuss. And the statistics on number of abortions, or even the number of women with incomplete abortions who come into the health system for help, are non-existent. There is no way in which a doctor could record them on the present forms, even if he or she wanted to do so.

D. WHAT MIGHT BE DONE

Each of the noted deficiencies could be corrected. Nor are the corrections so difficult or so expensive as to constitute a barrier to the Ministry. Here are some of the possibilities which the Team considered:

1. Integration. Since there is no practical possibility of developing a system of family planning statistics separate from the national health statistics, the best course of action would be to try to turn a weakness into a strength. If the Ministry really believes that family planning is a high priority program, it should take steps to alter its basic forms so that health officials at all levels are required to record developments in family planning and maternal and child health along with their figures on diseases. Family planning figures could replace those on some diseases, such as malaria, which are no longer of such importance in Morocco.
2. New Family Planning Forms. As a minimum sign of interest in family planning, the Ministry should take steps to alter the existing standard family planning report forms so that they place emphasis on the pill rather than the IUD.
3. Development of a Management Information System. While changing the forms, the Ministry should seize the opportunity to turn its family planning reports into a modern management information system. The forms should be revised to take into account what has been learned in recent years around the world about reporting. It would appear that any of several AID contractors could be of considerable assistance to the Ministry in providing the needed help to design such a system, and in training a team to install and use it. Such a management information system probably could not, and perhaps should not, be installed quickly throughout the country, despite the centralized nature of the reporting system. A test of such a management information system should be made in the first three of the Reference Centers. Not only would three Centers provide a test of an appropriate size, but the project would give the Centers some useful activity in which to engage. When the faults are out of the system, it can be transferred to the national health network.

4. Understanding and Using Figures. In one step we cannot repair the apparent lack of understanding and use of figures which characterizes the health system in Morocco. However, one can envision the development of a family planning management information system as a breakthrough with implications for the health network as a whole. It would seem clear that to get a management information system designed and operating in three Reference Centers, a team would have to be sent outside Morocco for training. The same team could be trained to understand the significance of data and the use of data in making management decisions. The team could then be used in Morocco to train Provincial Health Directors in understanding family planning data and using the data in solving problems.
5. Removing the Taboos. It would improve the understanding and the management of fertility control and maternal and child health programs in Morocco if the clouds were dispelled that hide the figures on child loss, tubal ligation, and abortion. The forms involved should be changed.

E. SPECIAL POSSIBILITIES

The Team found a certain number of individuals who expressed a deep interest in sterilization and abortion, and particularly in tubal ligation. It is clear that some specialists are already performing ligations, and others, including doctors within the public health network, would be interested in performing them.

Dr. Bernard mentioned to several such doctors the possibility of their keeping accurate records of the patient characteristics and other aspects of tubal ligations they perform; collating the figures and submitting them for analysis. In effect Dr. Bernard told them that they could turn their project into a form of scientific research. It was fascinating to watch the manner in which the doctors listened and expressed interest in this possibility. Those who are on the staffs of medical schools seemed particularly interested in the potential for using such project as material for doctoral candidates.

This latent interest on the part of doctors seems to fit well with the type of program which IFRP has introduced in other countries of collating and analyzing data on patient characteristics. The Team thinks that IFRP should be encouraged to pursue the leads turned up in Morocco.

XI INFORMATION AND EDUCATION

A. INTRODUCTION

For the family planning program to have any health and demographic impact, a concentrated communications program must be mounted that legitimizes family planning, motivates professionals to provide and the general population to use all reliable methods, and alters attitudes leading to discontinuance. This is not a function for one department alone, but a responsibility of the Government and the High Commission on Population. The following describes the current information and education program and the conditions under which it can be made to work.

B. DEPARTMENT OF HEALTH EDUCATION

In keeping with the integrated health system that serves the entire country, primary responsibility for information, education, communication and training in the field of family planning rests with the Service d'Education Sanitaire, the Department of Health Education. Under the direction of Mme. Zhor Laiziri this service creates and produces almost all the posters, brochures, radio and television programs and professional publications on any health subject. It also provides in-service medical and para-medical specialized training - whatever is not a part of the regular school curriculum for physicians and nurses. Ideally, it operates in close cooperation with specific programs to develop a unified approach. In fact, there seems to be some risk that responsibility for a categorical area may fall somewhere between the Service and the health program in question.

This appears to have happened for a number of reasons in the family planning field. Clearly, with the breadth of responsibility that falls on the Service, emphasis is placed as the Ministry chooses, and the emphasis has not been strong on family planning. It has a place in the program; there is a weekly television program for health education and twice a year the subject is family planning. Health Educators, "animateurs", at the local level are responsible to the Service, and their instructions include regular presentations on contraceptive methods. But on the other hand, no new posters have been produced in years, no patient level materials have been printed, and the Family Planning Calendar, the only recent publicity item, was apparently handled largely by the family planning department.

Two experts are currently serving in the field under contract with UNFPA; neither is in close contact with Mme. Laizire, and there is great question on her part as to the usefulness of such assistance. They are, therefore, cooperating with the Family Planning staff and do not have the benefit of Moroccan counterparts who can benefit from months of work together. The Service, in the meantime, is clearly not equipped to perform the difficult and professional job of conceptualizing the family planning story in terms acceptable to the professional and lay public. It is, in part, that sense of inadequacy that has retarded production of materials. But more importantly, it is the lack of direction from above that has made it unnecessary for this busy Service to rise to the task.

Wherever the responsibility lies, it must be noted that there is little if any publicity given to the family planning program. No posters or directional signs point the way to clinics, no notices of available service are in evidence, no written materials are given to patients. Indeed, it is not a part of Moroccan custom to use educational campaigns of that sort, and no clinics post hours, services or information of any kind. We were assured that it is not necessary; that "everyone knows." Since family planning is simply one of the integrated services offered, it can well be argued that specific publicity is not indicated. This point of view reflects the assumption that family planning is just like other health services, whereas it is actually one involving a great deal more personal motivation and decision-making than most. While the medical aspects may well be integrated in total health care, information aspects need separate consideration.

It is important to mention that in almost every province visited, the local health personnel interpret the lack of such materials as evidence of a lack of concern on the highest level with problems of family planning. It was stressed by local Medecin-Chefs, health educators, and others that if there was concern in the Ministry, the materials would be forthcoming. Furthermore, such materials ranked either first or second for every Medecin-Chef when asked, "What is the greatest need you have for your family planning program?" Everyone with whom the matter was discussed expressed a need for patient-level pamphlets, despite high illiteracy among men and women. They indicated that some pictorial information would be particularly significant to people without much printed material in hand. On the local, service level there appeared to be more understanding of the special nature of family planning education and its peculiar needs.

C. CREATIVE PROGRAMMING

The business of family planning education in Morocco must be seen as at least a threefold endeavor, and each area falls to the responsibility of different sectors of the government and private leadership. First is legitimating for all citizens the idea of family planning and the ideal of the planned family. Second is educating leaders of the government, the media, academia, and the professions about the significance of the demographic impact on development, health and the well-being of the Moroccan people. Third is informing the people themselves of the availability of the service and the importance their chosen leaders place upon its use.

The first area requires a cooperative effort probably best coordinated at the level of the High Commission of Population, including the religious leadership as well as the lay, to expose to public view recent progressive fatwahs on family planning in Islam, to stress the ideal from the highest level of government, and to also build it into the work of each department that has influence over the lives and principles of the people of Morocco. It also requires that the Commission address itself to the legitimate concerns of those who stress traditional solutions; i.e., concerns for old age, the status of women in marriage, and the economic well-being of the rural family. Attending to serious concerns is a necessary part of communication if it is to be trusted at all.

The second area is primarily the job of the Department of Population-using data from the Service of Health Statistics-maintaining a high level of current information, interpreted by the best minds that can be enlisted. (In this the Family Planning Association (FPA) could be an intelligent partner.) It is essential if the first initiative- legitimating the idea for all Moroccans- is to succeed, because only leadership with thorough understanding can be expected to promote what it believes.

An aspect of this campaign which can affect public policy on the highest level and serve to stimulate the program is the collection and publication of relevant statistical and demographic materials. The well-executed battle against malaria was marked by this kind of effort. A monthly collection of relevant data was published in concise and available form and its success is widely acclaimed. From the statistical material that is to be collected in the future, a regular publication,

by province, of the new acceptors, numbers of unprotected women of fertile ages, percentages reached, etc., should be made available to local and national administrators so that they can have a constant measure of achievement. Such a regular publication should also be brought to the attention of all representatives of the media and the government so that a better understanding of the demographic issues is achieved. Its educational value can hardly be overestimated.

The third problem is clearly the function of the Department of Health Education, although there too the FPA can be effective. The flow of materials, posters, brochures, signs that will make family planning visible should come from that department. But the department will need the help of outside experts - from the universities, the media and the educational field - to conceptualize family planning and to assist in the design and even the execution of materials which they produce. A single symbol which appears throughout the country would help Moroccans visualize this service, and the exposure which tells everyone that this is indeed as open and acceptable a subject as the Government of Morocco intends it to be.

Once this framework is in place, larger initiatives can be assigned. A postpartum education program such as that mentioned above (linking contraception to a 40th day visit), programs in hammans and souks, wherever people congregate, meetings in factories, such as the FPA has pioneered, all these can follow from a rational division of the labors ahead.

Other suggestions for informational programming include references to the language of broadcasts, with an emphasis on the need for transmissions in local Arab or Berber dialect, not in classic Arab. There seems to be general agreement that the quality of the few airings that have been made is not appropriate to the audience. There was an expressed need for new films; the Walt Disney and The Choice are known "by heart" wherever they are shown. Health Educators are anxious to try more creative settings for their showings, but need new material. The appearance of local spiritual leaders on radio broadcasts was suggested frequently, and some asked for appearances in the Mosques with the same message. The advisability of specific approaches must, of course, be made in Morocco and by the appropriate people.

D. EDUCATIONAL HARDWARE

There is a clear difference of opinion on the need for and employment of the hard materials for education; i.e., projectors, mobile units, etc. We observed an almost tragic need on the part of highly motivated field workers who wanted projectors for dispensary use. There are 683 dispensaries and 186 Centres de Sante (with some overlapping) and most are without such equipment and some without the electricity to run them. We observed a dispensary session in Settat in which family planning was discussed with about 15 women using a projector and slides. We observed another in a rural dispensary of the same province for about 25 women, without the use of equipment. This latter seemed to encourage better discussion and personal reaction, but that was a function of the "animateur" and should not be generalized. We saw a highly motivated nurse who had saved a set of slides for years in hopes of some day having a projector. There is only one set of slides generally available at the moment, and the proliferation of equipment for so limited a repertoire seems excessive. Mme. Laaziri expressed disapproval of the requests of other departments for more equipment (the Minister of Cooperation had included such materials high on his list;) because she feels that one mobile unit with equipment is enough for an entire province. But Provincial Health Educators and Health Directors disagree. They cite months of difficulty while their vehicles are in Casablanca or Rabat for repair, and they clearly are limited in new initiatives.

Our conclusions must be general: 1) without more creative design of educational material, projectors should be located only where local staff have shown a real desire to use and ability to handle them; 2) more care must be exercised to see that the correct equipment with proper electrical connections and Arab or French instructions is delivered when such orders are filled; 3) some rigorous control should be exerted to see that equipment is getting maximum usage; (No new requests for such hardware should be made until there is provision for the creation of more soft materials and evidence of a plan for the scheduling and the maintenance of equipment for maximum effective use) and 4) a great deal more training will be necessary to develop skills in communicating family planning. With or without equipment, those skills are paramount.

Finally, it should be emphasized that we were unable to obtain any information on the number of professionals and para-professionals trained, or re-trained, in family planning. The Seminars are arousing considerable interest, but they should not be considered a substitute for sound in-service training.

F. FOYERS FEMININS (A Study in Excellence)

A program of the Ministry of Jeunesse et Sports, the Foyers Feminins, are a network of local institutions for the education and training of young women who have either left school by the age of twelve or have had no formal education. The Ministry is responsible for boys until their early twenties, and for their athletic opportunities in early manhood, but in the case of women it maintains its involvement in their lives as long as it is needed. In some areas women avail themselves of the Foyers into old age, but the basic mission is to train young women between twelve and the early twenties to find work and to maintain their homes at a level of achievement that is an inspiration to see. The spirit and warmth of the Foyers appears to be a credit to the dedication of a unique collection of women who run the program.

Classes in sewing, embroidery, baking, and other home-making skills and marketable skills are alternated with basic reading for those who need it, and with some measure of physical activity, dance and entertainment. An advanced school is maintained in Casablanca for the best graduates of the city's Foyers, where selected girls get further job skills. In every case observed, however the level of accomplishment appears to be amazing. The atmosphere in which they learn is unique, and the attitude of their teachers is most likely to reach them with a message of concern for their futures. In this setting, it is not surprising that family planning is communicated intelligently and sensitively to the girls and their mothers alike. We were invited to ask questions of a class that had discussed family planning. They knew immediately the day of the month on which fertilization is most likely, and were eager to share their understanding of the reasons for child spacing for the health and well-being of the family.

At a center in Fes, we observed a group of mothers being shown the Walt Disney film, and discussing its message. Once again the atmosphere was open and warm. It is no wonder that we were told in advance by an outside observer that if we wanted to see family planning well-communicated in Morocco, we should see it in the Foyers.

E. PERSONNEL

There is a Health Educator position in the cadre of each province, and most are in place. They are charged with integrated education, and are in frequent motion all over their areas on the entire range of health issues. While some show considerable expertise in handling family planning, their jobs are clearly too broad to give it the time it requires. Some include presentations in the Foyers Feminins schools and other non-health settings, as well as covering the range of their rural and urban dispensaries and Centres de Santes. The most successful communicators, with the exception of a very few highly motivated nurses, seem to be those with some specific responsibility in the family planning field.

M. Mohamed Kartout, Animateur d'Education Sanitaire en Planning at the Centre Moulay Hassan in Kenitra, has been exceptional in his ability to reach, motivate and enlist a higher percentage of the women in his area. His dramatic approach in combination with projector and slides, larger and more accessible quarters than any other program observed, and intense conviction, make him not only a fine worker but a trainer for the nurses that move through the local schools. He has apparently carried out role playing sessions for them, and will be used in future seminars. We mention him because he emphasizes the need for highly motivated, trained educators within the system whose prime obligation is to tell the family planning story. This does not seem to interfere in any way with the government conviction that the service remain an integrated part of the total health scheme.

It is suggested that consideration be given to the training of health educators for family planning who have not had the benefit of nurse's training. At least at present when nurses are in such high demand- and perhaps even in the future- there is good reason to believe that training in education and motivation may be more important than nursing to bring this message into the schools, Foyers, clinics and wherever else the story may be told. We understand that the government reluctance to do this is a part of its effort to professionalize health education, but the question may be more importantly what kind of professional skills are really required for the task at hand?

What should be emphasized is that many of the same people are used to tell the story here as in the health department. The Health Educators have this as one of their tasks. But it is the atmosphere of the institution that makes the difference, and anything that can be done within the health setting to recreate that warmth and concern will necessarily do wonders to increase receptivity of Moroccan women to the idea of family planning.

Unfortunately, these excellent establishments reach a miniscule proportion of the girls and women that might benefit from them. In Fes, a province of well over a million people, there are five centers, each serving about 160 a week, or 800 a year on a continuing basis. Approximately 1200 lives are touched in one way or another by the program. Nationally, about 100,000 are touched, even once a year; but just 30,000 on a regular schedule. We were told that lines form in the early hours of dawn on registration days, and only the first lucky registrants are accepted. There is evidently no problem in communicating the importance of this training to the recipients; they know how valuable the Foyers can be. But out of about 2,000,000 girls in the relevant age group, only about one and one-half percent are receiving this exposure.

The Team concluded that there could be great value in cooperating with the Foyers, both as a source of important data, some of which has only recently been surveyed, in the effects of this kind of training on the future lives and fertility of the young women involved, and also as a direct means of assisting the GOM in reaching more of the population in question. Both avenues should be explored.

One additional conclusion was solidified in visits to the Foyers. The opportunity to use settings other than the health department for distribution of contraceptives was explored with many professionals. It was agreed that having a representative of the health department available for individual consultation at the Foyers with mothers or young women after these educational sessions would be of great value. It was felt that there is too much compartmentalization of social services, and the convenience of the acceptor is often sacrificed as she is expected to seek each service separately. The ideal of settings which combine several social and health services was hailed by those with whom it was broached. In the meantime, individual initiatives could attempt to bring together education and service by judicious cooperation between departments of government.

XII FERTILITY CONTROL OUTSIDE THE NATIONAL PROGRAM

The means by which individuals in Morocco can control their fertility without recourse to the National Family Planning Program are limited. They consist essentially of the following:

- 1) The organized program of the Moroccan Family Planning Association (FPA).
- 2) The supply of contraceptives through private doctors and through commercial channels, such as pharmacies.
3. The performance of abortions by private doctors and by non-medical personnel.

The activities of the FPA, and what little is known about the private, commercial sector, are included in this section.

A. THE MOROCCAN FAMILY PLANNING ASSOCIATION

The Association Marocaine de Planification Familiale (or, in this report, Moroccan Family Planning Association, abbreviated to "the Association") is a voluntary, private organization, founded in 1969, and affiliated with the International Planned Parenthood Federation. Founded and operated by interested doctors and women eminent in Moroccan society, it provides information and education programs, maintains seven clinics in four cities and one rural setting, and generally promotes family planning in any way it can. Its organization, objectives, and activities are not atypical of IPPF affiliates of a comparable size around the world. Expenditures for the past two years, and its budget for this year are:

(US\$ 000)	Expend <u>1974</u>	Expend <u>1975</u>	Budget <u>1976</u>
Allocated by the IPPF in cash	\$ 82	\$110	\$101
Raised from other sources	5	11	25 (proj)
Total Cash	<u>87</u>	<u>121</u>	<u>126</u>
Commodities	13	6	14 (proj)
Total	<u>\$100</u>	<u>\$127</u>	<u>\$140</u>

1. The Team's Visit. The Team had two points of contact with the Association -- a visit to the national headquarters in Rabat, and a visit to the headquarters and principal clinic of the Casablanca Chapter.

Unfortunately, the President of the Association, Mme. Doukkali, was out of the country at the time of our visit. She formed part of an official Moroccan delegation to Japan headed by the Prime Minister. She is said to be a woman of great energy and devotion to the cause. It was she, for example, who designed the Moroccan Family Planning postage stamp, which was issued only a few days before our arrival.

The Association's very cooperative Administrator, Abdul Llatif, supplied us with the information we sought, and sent us copies of the 1975 Annual Report, which, at the time of our interview with him, had not yet been published.

In Casablanca, we met with Mme. Therab, President of the Chapter, and with members of her Board and her staff. We visited the attractive clinic known as Heure Joyeuse, located with the Chapter headquarters in a former mansion in a relatively prosperous residential area. Mme. Therab is also energetic, intelligent, and devoted to the cause.

2. Activities of the Association. The Association looks on itself as closely linked with the National Family Planning Program. It considers its principal function as providing information and education to potential acceptors. Indeed, of the small number of family planning posters that we saw, even including the few in Government health clinics, at least half were products of the Association.

Although the Association does not report publicly on the activity, it is clear that Mme. Doukkali, Mme. Therab, and other Association leaders from the highest stratum of Moroccan society, do their best to promote family planning in all their contacts with the leadership of the nation.

Projects which the Association undertook in 1975 include holding a seminar in Casablanca attended by 70 persons; promoting and engaging in radio broadcasts; sponsoring Family Planning Week, and celebrating it with banners and displays wherever the Association has chapters; manning a booth at the Casablanca International Fair; promoting the family planning postage stamp; printing booklets; making home visits; and sending out its mobile I & E unit in Rabat/Sale "on a rhythm of once a week".

The Casablanca Chapter undertook, in addition, two special pilot projects underwritten by the Ford Foundation: 1) a trial project in which acceptors were issued "membership cards" to see if the cards improved continuation rates; and 2) a project which involved the use of satisfied acceptors to visit the "hammams", or Turkish baths where women gather, to persuade other women of the value of family planning. The first project was given up as inconclusive. Everyone seemed enthusiastic about the "hammam" project, but it seems to have run into financial difficulties since the Ford/Population Council representative was withdrawn.

Association representatives downplay the importance of their clinics, but their record of "first acceptors" is impressive. (Their tables do not break down first acceptance by method.) There were 446 in 1972; 4,170 in 1973; 7,333 in 1974 and 6,652 in 1975. In 1974, their total was 14 percent as many as the first acceptors in the National Program, and even in 1975 their total was nine percent. It must be remembered that their services were offered in only six clinics, where the National Program operates through hundreds of outlets throughout the country. (Association figures are reported to the National Family Planning Service headquarters, but are not included in the National Program figures on acceptors.) It was generally agreed, even among officials of the Health Ministry, that a woman seeking family planning gets a better reception at an Association clinic than at a Government hospital, center, or dispensary.

The Association leaders believe that many women in Rabat and Casablanca abandon the Government operated service and shift to Association clinics. It is quite usual around the world for voluntary organizations to maintain higher standards of courtesy and service in their clinics than government health centers, but the difference in Morocco seems more than normal. Part of the reason is very simple; the Association clinics offer a categorical service where the women seeking family planning are not required to mingle with the sick, the old, and the crowds of women seeking other services for themselves and their children. It may be that the Association clinics are located in areas of cities that draw to them a more educated and affluent class of women than the government centers.

3. Conclusion. It seems clear that the Association is a strong element in furthering the cause of family planning in Morocco. But there appears to be a rift in the lute. We could not avoid learning more than was wanted about differences between the Association's national headquarters and its Casablanca Chapter. Again, differences between national headquarters and local chapters are far from unknown within the Planned Parenthood family, but this rivalry seems to have a particularly virulent quality to it. Mme. Therab, when asked the question of what she thought, philosophically and hypothetically, would do the most to advance family planning in Morocco, replied, in effect: "Get the national headquarters of the Association off our backs here in Casablanca!" She proposed that the IPPF make a separate grant to her chapter. We did not meet Mme. Doukkali, and so we heard only one side of the question. It seems a pity that the family planning movement has to be weakened by this sort of internal strife.

B. PRIVATE AND COMMERCIAL CHANNELS

Limited by time, the Team did not make an investigation of the amount of contraception extended through private doctors and through commercial sources, such as pharmacies.

Many public health officials through the country told us that women, after getting the pill first from a government health center or dispensary, commonly avoid red tape by getting resupplied from pharmacies. We did not investigate this. Certainly, many village women do regularly visit the "souks" in the cities, even if the trip consumes a whole day in travel. But it takes a relatively large city in Morocco to support a pharmacy. In the reasonably prosperous province of El Kelaa des Sraghnes, for example, we were told that there were no pharmacies or other commercial outlets for oral contraceptives, even in the provincial capital.

Dr. Poulsen informed us that several brands of orals are imported. It was his impression that one pharmaceutical manufacturer is considering setting up a plant in Morocco to compound oral contraceptives. The current retail price of the oral, we were told, is three Dirhams, or \$.75, per cycle.

Our decision was to rely on the studies of Dr. Lecomte, the Population Council representative, who concluded that about half the family planning in Morocco is extended through the National Program and half outside the Program -- through the Association and commercial and other private channels.

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DART-SELECTED VILLAGE NO. 1: SIDI ZOUINE

Field Visit: February 21, 1976

Place: Sidi Zouine sector, Marrakech Province.

Population of Catchment Area: 10,000.

Women 15-49: 2,200.

Personnel: Mr. Ibrahim Malik and his wife Mrs. Zineb Soukmani. (This was the only married couple among the Infirmiers we met or heard of. They seem to work well together and to represent a good model.)

Social and Economic Conditions: Rural village depending on agriculture. However, Marrakech is close enough that, according to the Infirmier, most of the villagers, including the women, often attend the markets in Marrakech.

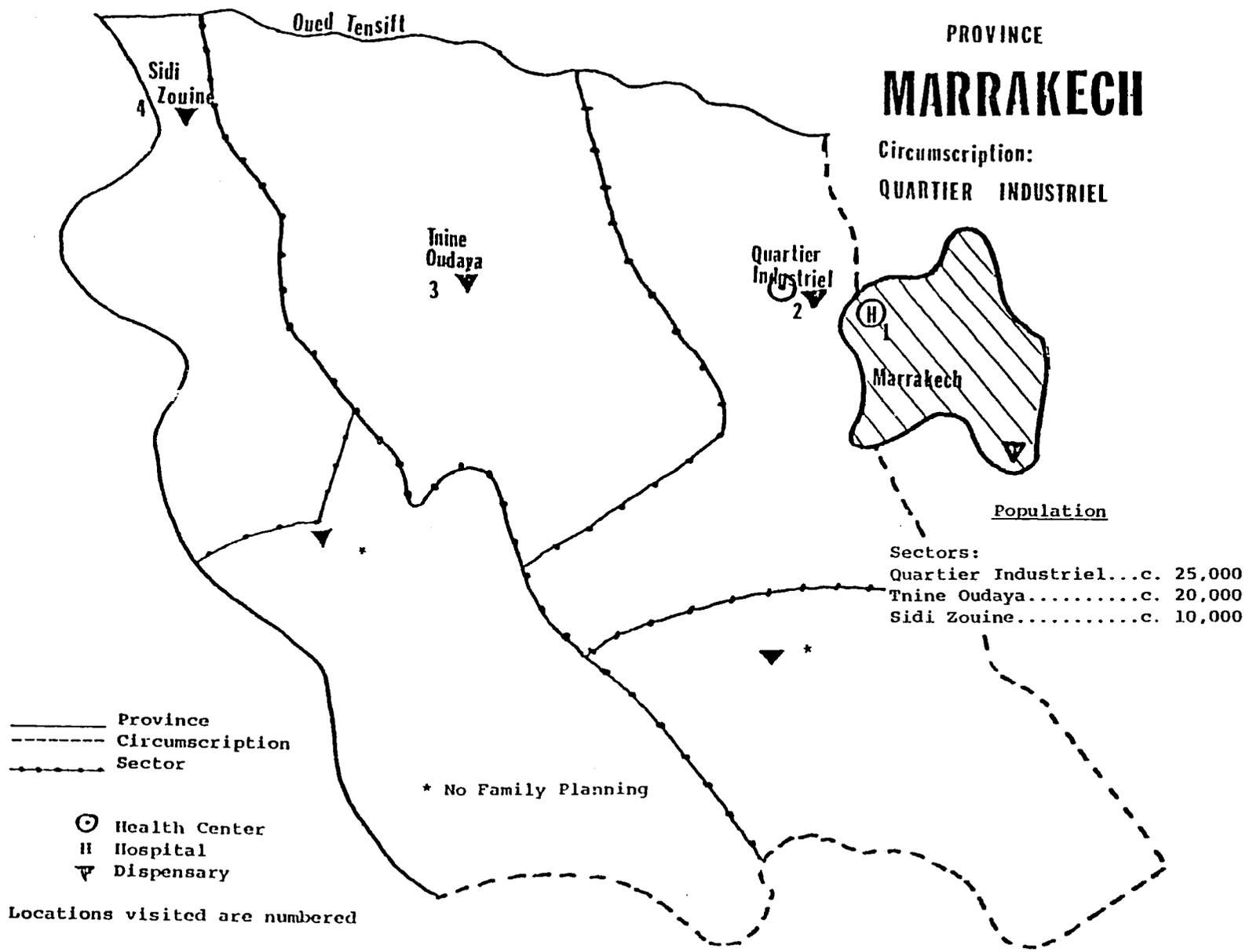
Status of Dispensary: In good condition.

Family Planning Activities: Quite good, improving, potential for serving as a model. The number of "first visits", and resupplying of pills, for 1975 by month and for January, 1976, is as follows:

<u>Month</u>	<u>First Visits</u>		<u>Resupply of Pills</u>
	<u>IUD</u>	<u>Pill</u>	
1	2	5	9
2	3	5	11
3	4	4	14
4	8	3	18
5	6	7	25
6	2	4	20
7	1	3	33
8 v a c a t i o n		
9	2	10	19
10	3	13	22
11	2	6	36
<u>12</u>	<u>3</u>	<u>6</u>	<u>31</u>
Total, 1975	<u>36</u>	<u>66</u>	238
	102		
1, 1976	0	6	45

Notes:

1. Mrs. Soukmani, a very devoted health worker, mother of three children and wanting to have a sterilization, stated that IUD's are on the way out. She inserted more IUD's in one month in mid-1974 than she did in the entire year 1975. The reason: side-effects (bleeding), and husbands prefer the women being "empty for the act".
2. The incidence of new acceptors is 4.6 per 100 women between the ages 15 to 49.
3. There is a steady increase of revisits for supply, from nine in January, 1975, to 45 in January, 1976. Hence incidence may approach prevalence.
4. Roger Bernard discussed with Mrs. Soukmani the implications of her trying to recruit 10 new acceptors rather than only five. After five minutes the husband joined her in the affirmation that she could easily and without forcing recruit 15 to 20 per month. For $15 \times 11 = 165$, which would amount to $165/2,270 = 7.3$ percent 1976 incidence. The 24-month activities would then lead to an important threshold of 9 to 11 percent prevalence.
5. Some points for early care: A considerable amount of AID-supplied equipment just sits in a back room. Some have the wrong plugs. Some have instructions only in English which the couple can't read. Mrs. Soukmani has slides, but there is no projector; they could use one immediately. There are no posters or other visual aids. Mrs. Soukmani thinks a sterilization program should be undertaken.
6. Mrs. Soukmani said that this was the only time she and her husband have ever received any encouragement on the work they do in family planning. She promises to increase her efforts and achieve new goals.



DART-SELECTED VILLAGE NO. 2: ARBAA GAZET

Field Visit: February 23, 1976

Place: Arbaa Gazet, Province of El Kelaa Des Sraghnas.

Population: 14,600, in 2,639 dwellings.

Public Health Facility: Dispensary.

Personnel: a) Mr. Khadija Ferrag, Infirmier du Secteur, b) itinerants, and c) supplemented for purposes of family planning by Mlle. Khotija Lakhrissi, Itinerante de Planning Familiale, from the provincial health headquarters, the only specialist in family planning we ran into throughout the health system outside the small staff at the National Center in Rabat. Mlle. Lakhrissi visits the Arbaa Gazet dispensary every Thursday morning and holds a clinic.

Social and Economic Conditions: Arbaa Gazet lies some four miles off the main road through the fertile plain that makes up the prosperous agricultural province of El Kelaa. The land, much of it irrigated, is covered with healthy looking growths of wheat, sugar beets, and vegetables, and with olive groves. Landholdings appear to be small. The provincial health director reported that religion has lost influence in this region. The village has no electricity.

Health Problems: General. The Provincial Health Director reported that infant mortality has been dropping sharply in recent years as whooping cough, scarlet fever, and infant diarrhea have come under control. There is endemic typhoid, and maintaining supplies of pure water is a problem. He further reported that the people of Arbaa Gazet have no conception of preventive health, and come to the dispensary normally only when ill or injured.

Status of Dispensary: Rudimentary cement structure. Dark and dank inside. First room inside entry filled with cartons of DDT apparently left over from a successful malaria campaign of past few years.

Family Planning Activities: None except during visits of Mlle. Lakhrissi, but she gave the impression of understanding her metier far beyond the ordinary level of comprehension of family planning of most of the paraprofessionals we met.

Over-all Impression: Although the area is prosperous, this village is truly rural, and isolated from town life. It is 20 miles from El Kelaa, the provincial capital. There is nowhere in the province, for example, where oral contraceptives are sold commercially. John Robbins and Laurie Zabin interviewed the local personnel while Roger Bernard and David Muchler talked with the Provincial Health Director. At the conclusion of the visit, on the basis of what had been learned about Mlle. Lakhrissi's activities, Dr. Bernard showed her the significance of the work she is doing, leaving her excited about the possibilities of serving larger numbers of women.

Record of Delivery of Services: Record shows 150 users of contraception in the sector. Surprisingly, all have chosen the IUD, with the exception of 10 to 20 women who use the pill. Typical attendance at Thursday clinics was 2 to 20 women. Average new acceptance per month was 10 to 20 women.

Notes:

1. Mlle. Lakhrissi reported that the women of this village were interested only in the IUD, to the exclusion of the pill. She could not explain how this one village happened to differ so diametrically from the Moroccan pattern. Her own good care of the women who have received IUD's may be a major part of the answer. Furthermore, she may have a bias toward the IUD, although she freely hands out pills in other dispensaries throughout the province.
2. Mlle. Lakhrissi is extremely conscious of contraindications. She checks carefully for indications of vaginal infection. The previous Thursday, only two women had come in for contraception, and each had to be treated for infection and told to return. The week before, 15 women came, only one of whom was not infected and could receive the IUD.

3. The best estimate of the infirmier was that there are 200 to 300 births in the secteur in a year. Most are born at home with only traditional attendants, but in the case of difficult births, he can call the provincial capital and request an ambulance to get the women to the hospital. In January he sent six or seven such women. The provincial health director said most of the difficulties arise from first births.
4. Although he has no figures on infant deaths, the infirmier does not consider infant mortality a major problem. He estimated that of the 200 to 300 births per year, all but 15 babies would live to the first birthday.
5. Stimulated by Dr. Bernard, Mlle. Lakhriissi estimated that she could get 20 to 30 new acceptors per month "without forcing". That would constitute 9 percent of the estimated women at risk protected in a year.
6. There seems to be no problem of supplies.
7. It's hard to tell just what the itinerants do on their trips through the hamlets that make up Arbaa Gazet. Our conclusion is that they do little for family planning. They certainly distribute no pills, and they may distribute no information. They seem to speak mainly with men.
8. Nonetheless, in principle, a woman can get good family planning if she has the motivation to visit the clinic on a Thursday. The distances from the dispensary do not seem to be a hurdle. The reasons no more women come than the pitifully small figures seem to be a combination of lack of knowledge, lack of information, the general suppressed state and lack of education of women, and the firm control of men over their activities.

DART-SELECTED VILLAGE NO. 3: TAGZIRT

Field Visit: February 23, 1976

Place: Tagzirt, a secteur in the Province of Beni Mellal.

Population of Catchment Area: 14,100.

Women 15-49: 3,100.

Public Health Facility: Dispensary.

Personnel: a) Mr. Abdul Karim Dehiba, Infirmier, b) Mrs. Zahia Azihi, and c) one Itinerant (travelling para-professional) away for a year at school. (The table of organization calls for two additional Itinerants.)

Social and Economic Conditions: Tagzirt is located on a plateau at a lower level of the western slopes of the Central Atlas mountains. The catchment area of the dispensary extends up into the mountains themselves, where a relatively small number of nomads and herds-men live at distances of eight to ten hours on muleback from the dispensary. Land on the lower plateau itself is held by small proprietors who appear to engage in subsistence farming. This is, indeed, a poor region within a relatively rich province.

Health Problems: General problems of a poor, mountain village. Infirmier did not cite maternal health, infant mortality, or family planning as among the important problems.

Status of Dispensary: An adequate small building in open country outside the settled village of Tagzirt.

Family Planning Activities: Minimal, except for a burst of activity in June, 1975. (See table.) Beni Mellal is the province in which the provincial health director ascribed the growth in pill acceptance during 1975 to a massive promotion campaign which he had initiated on the IUD during the second quarter. Records do not go back before June. Neither the nurse nor the infirmier seemed particularly impressed by the importance of family planning, although the nurse, with only three children, aged 19, 16, and 7, must engage in the practice. (The infirmier, in rather embarrassed fashion, admitted to six children.)

Supplies: Adequate, with no problems of resupply of the pill.

Nature of Visit: The team descended on (or ascended to) Tagzirt at nightfall, to the surprise of the pair of attendants, with a full delegation from provincial headquarters, including the health director and the director of preventive services. The team as a group interviewed the pair.

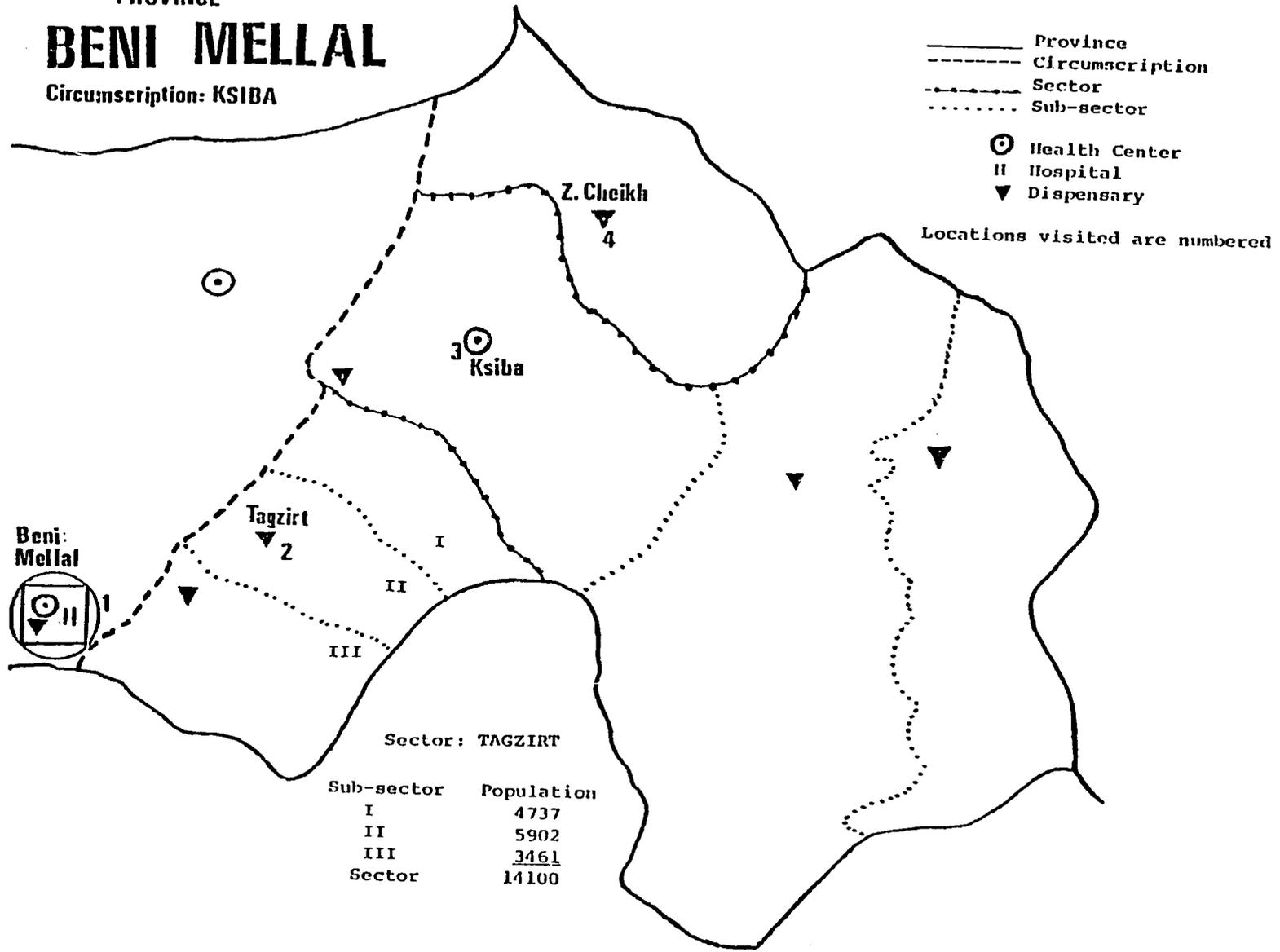
1975 Activities:

<u>Month</u>	<u>First Visits</u>		<u>Resupply of Pills</u>
	<u>IUD</u>	<u>Pill</u>	
June	21	26	6
July	3	1	14
August	0	1	17
September	0	4	16
October	0	1	14
November	0	3	36
December	<u>0</u>	<u>0</u>	<u>20</u>
Total 7 months	24	36	123

Percentage of women 15-49 as first acceptors during 1975: 2 percent.

PROVINCE
BENI MELLAL

Circumscription: KSIBA



DART-SELECTED VILLAGE NO. 4: ZAOUIA CHEIKH

Field Visit: February 24, 1976

Place: Zaouia Cheikh, a sector in the Province of Beni Mellal.

Population: 15,226.

Women 15-49: 3,300.

Public Health Facility: Dispensary.

Personnel: a) Mr. Charqui Assahri, Infirmier, b) Mr. Mohammed Iherch, Itinerant (traveling para-professional), c) supplemented on Thursday, which is "souk" day, or market day, by Dr. Philippe Magnet, a young French doctor who has been serving as medical director of the "circonscription" (district) of El Ksiba, of which Zaouia Cheikh is a part.

Social and Economic Conditions: Zaouia Cheikh is located in the foothills of the Central Atlas mountains, in what constitutes a poor region of the wealthy agricultural province of Beni Mellal.

Health Problems: The first notable aspect of the health situation in Zaouia Cheikh is that it is, as the Provincial Health Director had told us, "feebly organized". The two members of the staff of the dispensary are of a lower cut than most of the Infirmiers we met. Understaffed, they are almost overwhelmed by the enormity of the problems they face. The worst of these is venereal disease, which is not endemic but epidemic in the village, and, we gather from Dr. Magnet, throughout the Province. Mlle. Larraqui attributes the high rates of both syphilis and gonorrhoea to the tradition of prostitution in the Province. This, she thinks, springs from its prosperity, and from its being the source of a type of strolling acrobat and musician, the "cheikha", who travel in groups throughout the country, and whose women moonlight as prostitutes. Ironically enough, they are traditional entertainers at weddings.

Of the 150 men showing up at the dispensary on a typical morning, 10 will show new chancres. In Dr. Magnet's region, he believes that 80 percent of boys who have reached 15 have suffered at least one bout with gonorrhoea. Throughout the province, he says, men treat themselves with anti-biotics bought from the pharmacies at Beni

Mellal. The strains have become resistant, and he hasn't the ability to cope. The personnel of the dispensary don't even seem to be aware of the enormity of the problem.

Furthermore, there is a high rate of infant mortality, caused by under-nutrition, scarlet fever, whooping cough, and other infant plagues. Nearly all births are in homes, with traditional attendants.

Status of Dispensary: Typical basic cement building at edge of principal settlement within the township. Reasonably tidy, but they were probably expecting our visit, which had been decided on the night before.

Family Planning Activities: Minimal, except on Thursdays when Dr. Magnet comes for the day of the "souk," and then he's pretty busy with other health problems. The Infirmier gives pills to women requesting them, but one gets a sense that he does little or no family planning education. He gives only one cycle at a time because the women are so ignorant they can't remember the instructions for longer than a month, he says, or they give the extra pills to other women. There has been no IUD program at the dispensary, and he couldn't recall getting any interest in the IUD from women.

Nature of Visit: Laurie Zabin interviewed the Major and the Itinerant, while Roger Bernard and David Muchler concentrated on Dr. Magnet, and his appalling report on V.D. John Robbins had a particularly good interview with the Itinerant concerning what he does on his travels.

Activities, 1975 and January, 1976: Of all the dispensaries we visited throughout the country, the records of the one at Zaouia Cheikh were the poorest. This was in line with the situation at its sousconscription, El Ksiba, and at the provincial health headquarters in Beni Mellal. There were no figures at all for most of 1975. The Major, Mr. Nadir, and Mr. Mohammed Boukdir, Chief of Preventive Services for the Province, ascribed this lack to the inefficiency of a previous Infirmier. The Major has started a new notebook style of record on family planning acceptors for 1976, under the guidance of the circonscription staff, but the level of comprehension of the new infirmier casts some doubt on future records as well. There was no record of interest in the IUD.

For January, 1976, and the first 23 days of February, the records were clearer. During January there were 39 acceptors, presumably, judging by the records, new acceptors. Of these, 12 have failed to show up for replenishment by the 24th of February. The infirmier thinks that some may have gone to Khanifra, a town 25 kilometers up the road, to buy pills from a pharmacy.

There have been 32 new pill users in February through the 23rd. The Infirmier believes that many women have an interest in the pill. He certainly isn't doing any job of pushing it.

The Itinerant, Mohammed Lherch, seems to have no conception of the possibilities of his role in promoting family planning. He travels to the outlying hamlets on donkey back. In principle, he is on the road four days a week -- staying in the dispensary on "souk" day, but in the first 24 days of February he had been on the road only five times. The other days his record showed him to have been prevented by bad weather, or by other requirements of the dispensary which I didn't understand. His farthest hamlet is 12 km. from the village, and it takes him an hour and a half to reach. Most of his hamlets are only 7 to 9 kms. away.

His daily records show a record of rejection by many householders, and of finding many houses empty. The number of houses he records as observing is far greater than the number of houses in which he holds an interview. His interviews are almost exclusively with men; only rarely does he appear to have talked with a woman. He does not try to talk family planning. No line on his form requires him to report on the family planning status of a household, or even on the maternal or child health situation as such.

During the five days of February on which he made visits, he observed 348 houses in four hamlets. (He visited one hamlet twice.) He actually saw 175 people.

The Major and the Itinerant emphasized to Mrs. Zabin the problem of male nurses. Women will not open the subject of family planning with them, and they are reluctant to do so themselves. The suggestion that they recruit satisfied acceptors as "intermediaries" was so immediately seized upon that it was clear that they have no hope of promoting family planning with males alone. A female nurse will, in the future, visit once a week for MCH and family planning, and the

possibility of using village women to help her seemed promising. It is hard to determine, however, the extent to which such "initiatives" may be local in origin.

DART-SELECTED SECTOR NO. 5: BAB BOUJAT/FESGDITE SECTOR OF THE CITY OF FES

Field Visit: February 25, 1976

Place: Bab Boujat/Fesgdite, a poor, urban sector of the city of Fes. (Because the dart had landed very near to the city of Fes, and because the Team had by February 25 visited four "dart-selected" rural sites, we decided to make the fifth selection an urban sector where we could see what happens in the poor, crowded areas of a city.)

Population of Catchment Area: 110,000 residents of the Bab Boujat region (circonscription), 35,000 residents of the Fesgdite sector.

Women 15-49: 25,000 in Bab Boujat region and 8,000 in Fesgdite sector.

Personnel: At Bab Boujat Health Center: One doctor, Dr. Michand, and rather extensive staff dealing with all health problems. Particularly concerned with family planning were a) Mr. Fahri Fassi Fihri, "major" of preventive services, and b) Miss Zhor Chdid, "animatrice" of family planning.

At Fesgdite Dispensary: a) Mr. Abdeslam Guennouni, "Infirmier" in charge, b) 2 women paraprofessionals on MCH, c) 2 men on "triage" of adults, d) 2 persons on "triage" of children, e) 1 person giving injections to men, f) 2 persons giving injections to women, g) 2 persons on adult care, h) 1 person on child care, and i) 2 cleaning persons. (15 total staff)

Social and Economic Conditions: The Bab Boujat Health Center and the Fesgdite Dispensary are located on opposite sides of a large courtyard, near the Bab Boujat (Boujat Gate) in the wall of the old city of Fes. The sector, therefore, draws both from the old city and the newer city, although on both sides of the wall the residents are relatively poor people: artisans, laborers, small shopkeepers, etc. From the crowded conditions, the lack of proper sewage and water facilities, and the apparent poverty of the residents, it would be appropriate to label the district a slum.

Health Problems: According to the Provincial Health Director, Dr. Haran Alaoui Fdili, the principal problems in Fes are connected with its problems of sewage disposal and lack of supplies of pure water. However, the Center and the Dispensary clearly deal with a broad range of problems.

Status of Center and Dispensary: The urban system, as represented at Bab Boujat and Fesgdite, was far more sophisticated than what we had seen in the countryside. The staffs were much larger, and the methods of dealing with patients more complex. There was, for example, a subtle distinction between the class of patients admitted to the Center--mainly those who were likely to end up needing to see a doctor--and those who were admitted to the Dispensary across the courtyard for routine examinations, shots, and other preventive care. The buildings were larger and more substantial than what we had seen in rural villages.

Family Planning Activities: Because the Center and the Dispensary are so close, and because patients have a theoretically easy access to the Fes maternity hospital, the system used in the city was quite different from that in the countryside. All new patients requesting contraception at the Dispensary are referred to the Center, where Mlle. Chdid handles their needs, assisted by other members of the Center's para-professional staff as appropriate. She served, for example, 78 new pill acceptors in January. Women wishing an IUD are referred to the maternity hospital. The number of such referrals ran up to six per month until last June, when Dr. Michand arrived at the Center. He discourages use of the IUD, and the rate has dropped off. Women can get resupplied with the pill--one cycle at a time--at the Dispensary.

Supplies: Adequate, with no problems of resupply of the pill.

Nature of Visit: A giant delegation, including the Evaluation Team, Mlle. Laraqui, Dr. Poulsen, Dr. Alaoui, members of his staff, and Mme. Najet Mrabet, the wife of the Governor of Fes, descended on the Bab Boujat complex. We conducted interviews pretty much en masse.

Notes: While the amount of family planning work done at Bab Boujat was not of great significance, the Team was immensely impressed by the nature of the system used for dealing with pregnant women. Starting at the dispensary level, para-professionals are trained in a system of "triage" which separates the pregnant women with problems and sends them upward through the system so that they are the ones who end up giving birth in the maternity hospital. Pregnant women are expected to visit the dispensary in the second, fifth, and eighth months for examination and, where appropriate, education in infant care. Women who appear to be having normal pregnancies are left to have their births at home under the care of traditional birth attendants. The system, however, includes "recyclage", or continuing training, of these women to give them instruction in midwifery. The system seems well adapted to a community of limited resources and with a restricted number of doctors, trained midwives, and hospital beds. Any community that can work out a sophisticated system such as this can certainly deliver family planning services if it chooses to assign family planning a high priority.

LIST OF PERSONS INTERVIEWED

RABAT

Ministry of Public Health

Dr. Abd-el-Kader Laraoui, Secretary General, Ministry of Public Health.

Dr. _____ Seffar, Chief of Technical Services, Ministry of Public Health

Miss Rachida Laraoui, Chief, National Family Planning Service.

Mrs. Ragouba Midas, Head of Nursing and Midwifery, National Family Planning Service.

Dr. Fathi Zaki Botros, WHO Communications Specialist.

Dr. Paul Cochet, WHO Audio-visual Specialist.

Dr. M'hamed Ouakrim, Acting Chief, Health Statistics Service.

_____ Lofti, in charge of family planning statistics, Health Statistics Service.

Mrs. Zhor Laazeri, Chief, Health Education Service.

Dr. Kodrat-Allah Osstowar, Senior Professor, Rabat University Faculty of Medicine and Medical Director, Rabat Maternity Hospital.

M. Marouzé Francis - WHO Technical Advisor.

Ministry of Youth and Sport

Mr. Jaadida, General Administrator.

Mme. Shissah, Director, "Foyers Feminins".

Ministry of Cooperation

Mr. El Amrani, Director of Cooperation

United Nations Office of Coordination

Peter Lowes, Coordinator

Mlle. Fatima-Zohra Bennani-Baiti, Program Assistant for Family Planning

Others

Dr. Fatima Mernissi, Professor of Sociology, University of Rabat

Abdul Llatif, Administrator, Moroccan Family Planning Assn.

M. Marouzé Francis - WHO Technical Advisor.

CASABLANCA

Dr. Mustapha Akhmiss, Provincial Health Director

Dr. Amal Salah, Medical Director, Maternity Hospital

Mme. Aicha Terrab, President, Casablanca Chapter, Moroccan Family Planning Assn.

Mme. Latifia Benchkroun, Director, Casablanca "Foyers Feminins"

Mme. Touria Mekouar, Director, Center of Specialized Technical Training for Girls, Casablanca

SEITAT

Dr. Tamim, Provincial Health Director

Dr. Zali

MARRAKECH

Dr. Mohamed Zarouf, Provincial Health Director

Dr. Rimbart - Chief of Preventive Services

Dr. Mohamed Benchaou, Ob/Gyn (Selected for training on family planning in Yugoslavia)

Dr. Diego Cazorla

Mme. Lahlou Amahl

Ibrahim Malik }
Zineb Soukmani } → Infirmier in Dispensary, Sidi Zouine

Dr. A. M. Laborde-Lauilé, Member of French Technical Cooperation Team working at the Industrial Quarter Dispensary.

EL KELAA DES SRAGHNAS

Dr. Idriss Tahiri, Provincial Health Director.

Dr. Allai, Gadiri, Administrator.

Mlle. Khoéifo Lakhrissi, Special "Itinerant" for Family Planning.

Khadija Ferraq, Infirmier, Dispensary in Arbaa Ghazet

Dr. Jebbar, Provincial Health Director.

Mohammed Boukdir, Chief of Preventive Services.

Mme. Afifa Shtatu, Nurse, (Trained in Brussels and London in family planning techniques; now working in surgery rather than family planning)

Mme. Zahia Azibi, Infirmier, Dispensary at Taghzirt

Abdul Karim Dehiba, Infirmier, Dispensary at Taghzirt

Dr. Philippe Magnet, Member, French Technical Cooperation Team; Director of Health Center at El Ksiba

Charqui Assahri, Infirmier, Dispensary at Zaouia ech Chèikh

Mohammed Lherch, "Itinerant", Sector of Zaouia ech Cheikh

FES

Dr. Hassan Alaoui Fdili, Provincial Health Director

Dr. Tayeb Merzouki - Chief of Preventive Services

Mme. Majeb Mrabet, Volunteer Leader of "Foyers Feminins" in five provinces. (wife of Provincial Governor)

Mlle. Zhor Chdid, Health Educator on Family Planning, Health Center at Bab Boujat

Fehri Farih Fassi, Senior Medical Technician, Health Center at Bab Boujat

Dr. Michand, Member, French Technical Cooperation Team; Director of Health Center at Bab Boujat

Abdeslam Guennouni, Infirmier, Dispensary at Fesgdite

MEKNES

_____ Provincial Health Director

_____ Chief of School of Nursing

_____ Director of Hospital, Maternite

KENITRA

_____ Provincial Health Director

M. Mohamed Kartout - Health Educator in Family Planning

UNITED STATES

Joel Montague, Regional Director, Middle East and South Asia, Population Council

Ms. Mary Hekmati, Coordinator, North African programs, UNFPA

Additional Women at Risk and New Acceptors (IUD, Pill, Condom), 1969-1975
Government of Morocco National Family Planning Program, Rabat

Calendar Year	Population Mid-Year	WOMEN AGED 15-49 YEARS				NEW ACCEPTORS		
		Percent	Number	Annual Increase		Number	Percent ♀ 15-49 + G	Annual Index of National Coverage
				Percent	Number			
column: A	B	C	D	E				
1968	13'851'545	22.65	3'137'375					
1969	14'308'097	22.60	3'233'630	3.066	96'255	21'304	0.66	21.5
1970	14'779'769	22.55	3'332'838	3.068	99'208	25'067	0.75	24.4
1971	15'267'350	22.50	3'435'154	3.070	102'316	28'953	0.84	27.4
1972	15'771'436	22.45	3'540'687	3.072	105'533	27'478	0.78	25.4
1973	16'292'613	22.40	3'649'545	3.074	108'858	37'030	1.02	33.2
1974	16'831'474	22.35	3'761'834	3.077	112'289	55'396	1.47	47.7
1975	17'388'633	22.30	3'877'665	3.079	115'831	72'179	1.86	60.4
1976	17'964'724	22.24	3'995'355	3.035	117'690	(121'459	3.04	100.0) ¹⁾

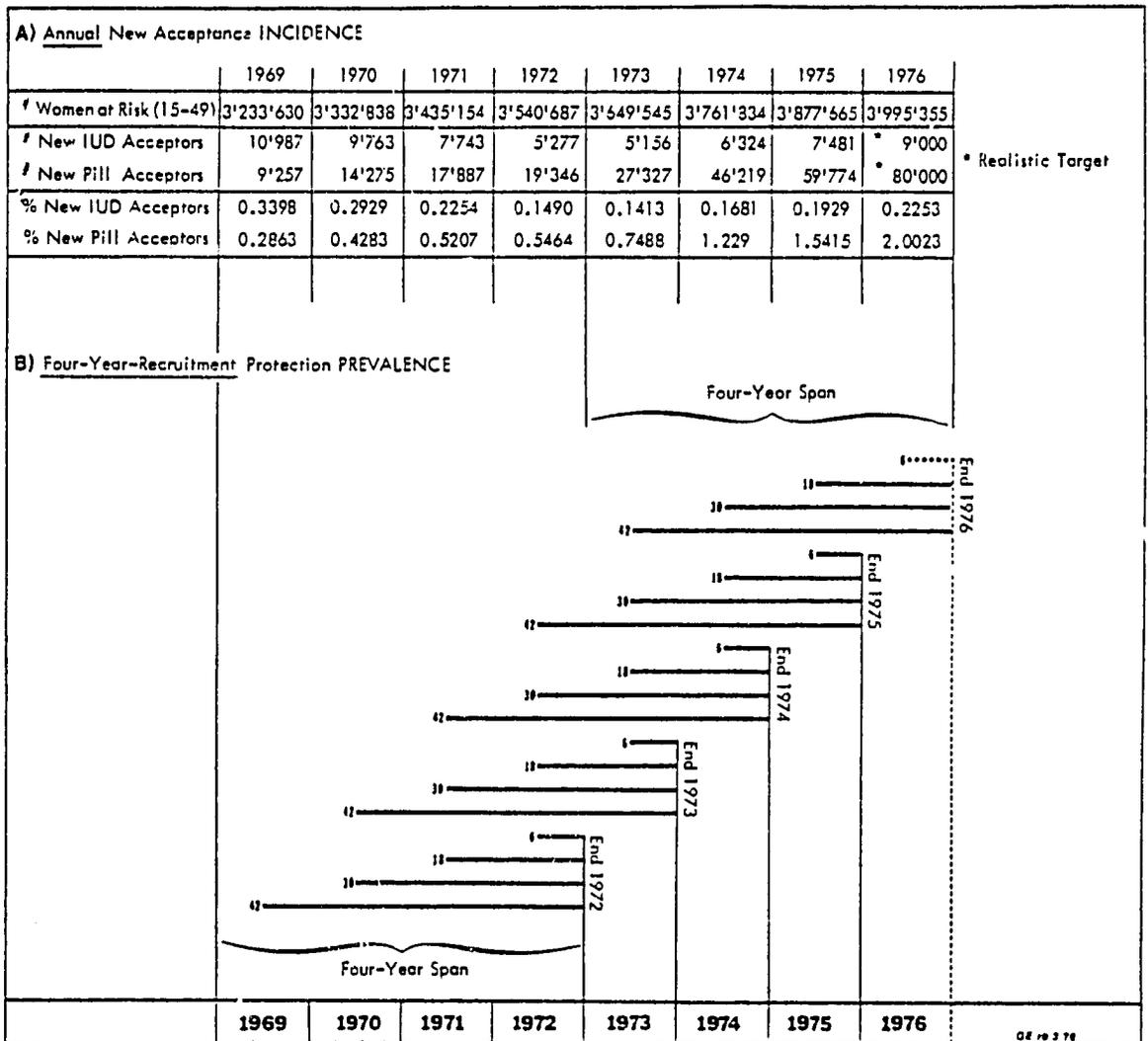
- A) GOM Population Projections, CERED, Publication No.14, Sept. 1975, Page 8, 1971-1976. Backprojections 1970-1968, rb.
- B+C) GOM Population Projections, CERED, Publication No.15, Oct. 1975, Page 7, 1971 & 1976. Backprojections 1970-1968, rb.
- D+E) Percent and Number Increase of Women aged 15-49 Years. Backprojections, rb.
- F) Number New Acceptors. 1969-1973: Lecomte, J. and Abd-El-Kadar-Laraqui. Morocco in Family Planning Programs: World Review 1974. Studies in Family Planning, 6:8, August, 1975. 1974-1975: Dr. Ockrim, personal communication to rb.
- G) $G = F/C$. New Acceptors per 100 Women aged 15-49 Years in that calendar year. New Acceptors of either Pill, IUD, or Condom.
- H) $H = G/D$. Ratio of (New Acceptors per 100 Women aged 15-49) to (New Women aged 15-49 per 100 Women aged 15-49).
This Ratio may serve as an INDEX of PERFORMANCE of the National Family Planning Program. Index 100 = Ratio 1.
- I) Number and Percent New Acceptors required in 1976 to reach Index 100. New recruitment would then equal the Additional Women at Risk.

ANNUAL NEW INCIDENCE OF ACCEPTANCE OF PILL AND IUD AND CORRESPONDING
ADDITIONAL PROTECTION PREVALENCE AT END OF YEAR, BY PRIMARY METHOD, 1969-1975
Government of Morocco National Family Planning Program, Rabat

Number Women Aged 15-49 Years	Annual Prevalence Gain in IUD Protection			Annual Prevalence Gain in Pill Protection			Combined Gain	
	Number New IUD Acceptors	Number New IUD Acceptors Not Yet Pregnant At End of that Year	Additional Percent Women Aged 15-49 Years 'IUD-protected' At End of Year	Number New Pill Acceptors	Number New Pill Acceptors Not Yet Pregnant At End of that Year	Additional Percent Women Aged 15-49 Years 'Pill-protected' At End of Year	Additional Percent Women Aged 15-49 Years 'Pill or IUD-protected' At End of that Year	
Formula:		$C = B \cdot 0.95$	$D = C/A$		$F = E \cdot 0.857$	$G = F/A$	$H = D - G$	
Coverage:	Acceptance Incidence	Protection Prevalence		Acceptance Incidence	Protection Prevalence		Protection Prevalence	
Column: A	B	C	D	E	F	G	H	
1969	3'233'630	10'987	10'437.65	0.32278	9'257	7'933.25	0.24534	0.56812
1970	3'332'838	9'763	9'274.85	0.27829	14'275	12'233.67	0.36706	0.64535
1971	3'435'154	7'743	7'355.85	0.21413	17'887	15'329.16	0.44624	0.66037
1972	3'540'687	5'277	5'013.15	0.14159	19'346	16'579.52	0.46826	0.60985
1973	3'649'545	5'156	4'898.20	0.13421	27'327	23'419.24	0.64170	0.77591
1974	3'761'834	6'324	6'007.80	0.15970	46'219	39'609.68	1.05294	1.21264
1975	3'877'665	7'481	7'106.95	0.18328	59'774	51'226.32	1.32106	1.50434
(1976	3'995'355	9'000	8'550.00	0.21400	80'000	68'560.00	1.71599	1.92999) ¹⁾

- A) GOM Population Projections, CERED, Publication No 15, Oct. 1975, Page 7, 1971 & 1976. Backprojections 1970-1969, rb.
- B,E) Number new IUD and Pill Acceptors. 1969-1973: Lecomte, J. and Abd-El-Kadar-Laraoui. Morocco in Family Planning Programs: World Review 1974. Studies in Family Planning, 6:8, August, 1975. 1974-1975: Dr. Oakrim, personal communication to rb.
- C) Number new IUD Acceptors not yet pregnant 6 months after 'mid-year insertion'. GOM National Follow-up Survey of 1972-1973 IUD and Pill Acceptors, Rabat, 1974.
 $C = B \cdot 0.95$ (= 'Any Method Protection Rate 6 months after primary IUD insertion', Table 3 in GOM publication).
- D) Annual National Prevalence Gain in IUD Protection (at end of that year).
 $D = C/A$. Percent Women at Risk (15-49 Years) additionally protected in 1975 was 0.18%.
- F) Number new Pill Acceptors not yet pregnant 6 months after 'mid-year acceptance'. GOM National Follow-up Survey of 1972-1973 IUD and Pill Acceptors, Rabat, 1974.
 $F = E \cdot 0.857$ (= 'Any Method Protection Rate 6 months after primary Pill acceptance', Table 3 in GOM publication).
- G) Annual National Prevalence Gain in Pill Protection (at end of that year).
 $G = F/A$. Percent Women at Risk (15-49 Years) additionally protected in 1975 was 1.32%.
- H) Annual National Prevalence Gain in Protection from Pregnancy at End of that Year by New Pill and IUD Acceptors during that Year.
 $H = D - G$. Percent Women at Risk (15-49 Years) additionally protected in 1975 was 1.50%.
- 1) Realistic Target of New IUD and Pill Acceptors for 1976 (-rb-), enabling the estimation of the 1976 Annual National Prevalence Gain in Protection from Pregnancy at End of that Year by New Pill and IUD Acceptors during that Year.
 $H = D + G$. Percent Women at Risk (15-49 Years) additionally protected in 1976 would then be 1.93%. However, during the same period the Women at Risk (15-49) will have increased by 3.04%.

FROM METHOD-SPECIFIC ANNUAL "NEW ACCEPTOR INCIDENCE"(A)
 TO METHOD-SPECIFIC FOUR - YEAR - RECRUITMENT "PROTECTION PREVALENCE at End of That Year"(B)
 Percent Women Aged 15-49 Years
 Government of Morocco National Family Planning Program, Rabat



PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: 1969 to 1977
From FY 1969 to FY 1977
Total U.S. Funding: \$2,237,000
Date Prepared: Sept. 7, 1974

Project Title & Number: Family Planning Support - 112

SUBMISSION: ORIGINAL REVISION: 1 DATE: 9/30/74 PAGE 41 of 41 PAGES

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To reduce the annual population growth rate from 3.21 in 1972 to 2.92 in 1977.</p>	<p>Measures of Goal Achievement:</p> <p>Reduction of birth rates from 49 per thousand population in 1972 to 43 in 1977.</p>	<p>Census and sample surveys.</p>	<p>Assumptions for achieving goal targets:</p> <p>1. That the birth rates will be reduced faster (from 49 to 43) than the crude death rates (from 17 to 16) during the 1972-77 period.</p> <p>2. That Moroccans will want to plan the size of their families and increasingly seek FP services as they become available.</p>
<p>Project Purpose:</p> <p>To establish an institutional capability to provide FP services to three million couples of reproductive age throughout the country, by 1977.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> 1. A capability to effectively operate approximately 875 MCH-FP centers with trained medical & para-medical staff. 2. IFSC, Medical, Nursing, Training, Statistical & Admin. units established in National FP center, headed by 8 qualified professional staff. 3. A total of 391,600 acceptors introduced to FP during the five year period 1972-77. 	<p>COM records, reports, FP service statistics and field observations.</p>	<p>Assumptions for achieving purpose:</p> <p>Religious and political opposition to FP in Morocco will not adversely affect the project.</p>
<p>Objectives:</p> <ol style="list-style-type: none"> 1. One FP Reference Center established in 11 of 75 provinces, staffed with three especially trained para-med. personnel under OB-GYN specialists or surgeon supervision. 2. Clinical FP Training Centers established in 10 provinces and Rabat. 3. National & 12 regional or provincial FP seminars conducted during 1972-77. 4. Analytical demographic evaluation unit established in Secretariat for Plan 	<p>Measures of Output:</p> <ol style="list-style-type: none"> 5. A total of 450 medical & 5,000 para-medical personnel trained in FP staffing all FP service points. 6. 600 monitors in women centers trained in FP IL&C. 7. Six mobile educational units staffed and equipped to provide FP IL&C services. 8. IICU material produced; See II.B.2a. 	<p>COM and USAID records and reports - field observations.</p>	<p>Assumptions for achieving outputs:</p> <p>That the Ministry of Health will give substantial priority to the program and receive the necessary cooperation from other ministries (Plan, Inter Information, Education, Youth & Sp. etc.)</p>
<p>U.S. Inputs:</p> <p>Technical Services: DE (FP physician); two "OIEA" Demographic Analysts; short term IDV consultants. Participatory Training: 2 long term; 3 short term. Contraceptive Medical & Audio-Visual Equipment; contraceptives. Other Costs: Support to FP seminar; construction and renovation of FP centers.</p>	<p>Implementation Target (1972-77) and Funding See Text and Exhibit Section IV</p> <p>Total U.S. Inputs FY 72-77: <u>2,358,000</u></p> <p>Total COM Inputs CY 77-77: (Estimated) <u>14,200,000</u></p> <p>Total Other Donors CY 77-77: (Estimated) <u>1,717,000</u></p> <p>(UNFPA-1977-Tord Foundation/ Population Council) (Estimated) <u>1,717,000</u></p> <p>Total Project Inputs <u>8,575,000</u></p>	<p>COM and USAID records and reports - (and information obtained through cooperation with other donors).</p>	<p>Assumptions for providing inputs:</p> <p>That the COM will provide for:</p> <ol style="list-style-type: none"> (1) Timely completion of construction to provide space for U.S. commodities (2) Timely assignment of qualified staff to National FP center and all FP Reference Centers. (3) Timely distribution of contraceptive supplies to all service points.

OUTPUT TABLE

(All data are cumulative)

Item	CY 1973 Actual	CY 1974	CY 1975 Projected	CY 1976	CY 1977
2. Establishment of a National FP Center in Rabat - to house, Central FP Administration, communication unit, professional services and Min. Health Training, Health Education and Statistical Division.		X			
3. Staffing of Central FP Services: (Medical-Nursing, IE&C, Training & Administration) Cumulative number of staff	3	3	4	6	8
3. Establishment of Clinical FP Training Center in Casablanca (advanced training). Number of personnel completed FP training in Casablanca:		X			
(cumulative)					
Medical	-	-	24	48	96
Paramedical	-	-	48	96	192
4. Number of personnel completed FP training in Rabat Centers: (cumulative)					
Medical Students	21	53	100	170	240
(Physicians)	12	30	50	80	110
Advanced Training (Para-medical)	18	36	56	86	126
5. Number of Health Centers - staffed with Medical and Paramedical personnel, providing ICH-FP services 6 days a week	180	200	210	220	230
6. Number of dispensaries equipped and staffed to provide part time FP services with para-medical personnel	-	-	100	300	570
7. Cumulative number of medical and para-medical personnel trained to provide part time FP services in above service points:					
(Medical)	350	375	400	425	450
(Basic Training) (Para-medical)	3,000	3,500	4,000	4,500	5,000
8. Establishment of FP Reference Centers staffed with especially trained personnel, providing full time FP services:					
Cumulative number of Centers	-	-	11	18	25
Cumulative Number of Full Time Staff	-	-	33	54	75
9. Inclusion of FP - IE&C in curricula of Ministry of Interior and Youth & Sports Women Centers ("Poyers Feminins")					
Cumulative Number of Centers	-	100	165	370	400
Cumulative No. of Non-tricees Trained (basic training)	-	200	300	400	600

OUTPUT TABLE (Cont'd)

(All data are cumulative)

Item	CY 1973 Actual	CY 1974	CY 1975 Projected	CY 1976	CY 1977
10. Cumulative Number of Mobile Units staffed and equipped to provide FP - IE&C services - (MNPPA)	-	-	2	4	6
11. Establishment of Regional or Provincial FP Seminars or Workshops. Cumulative Number of Seminars		(1 Nat. Seminar)	4	8 (2 Nat. Seminars)	12
12. Establishment of an Analytical Demographic Research Unit in Division of Statistics, Secretariat of Planning (under a separate project)				X	

Tab. n° 14

- ETAT D'ACTIVITE DES CENTRES DE PLANIFICATION FAMILIALE -

PAR PROVINCES ET PREFECTURES -

- ETAT COMPLET DU 3^e TRIMESTRE 1974/1975 -

PROVINCES et PREFECTURES	Années	Agadir	Al- Mocina	Beni- Mellal	El- Jadida	El- Kala	Fes	Kénitra	Mehis- est	Morocco	Khroubga	Ka- Za-Souk	Marrakech	Meknes	Mador	Quar- zato	Cujda	Safi	Sottat	Tangor	Tara	Tétouan	Casa (Préf.)	Morocco Total	TOTAL
1) Nombre de visites initiales pour toutes raisons	1974	973	433	5305	2609	472	4316	3922	687	1229	3367	1644	1457	786	1142	155	1675	2283	2639	198	1848	706	6076	2055	45177
	1975	935	344	6406	3939	817	4929	4621	3920	1345	7047	1207	1040	1696	2345	555	2433	1944	2868	271	1281	395	11330	2705	64373
2) Appareils Intra- utérins	1974	16	0	58	37	56	60	60	6	1	4	0	72	171	28	0	20	8	0	13	16	26	485	75	1212
	1975	34	0	15	9	76	69	26	0	32	1	1	37	130	17	2	13	2	0	24	22	13	703	90	1316
a) Insertions	1974	1	0	0	0	11	1	0	0	0	0	0	12	8	0	0	0	2	0	0	0	0	32	9	76
	1975	3	0	0	1	7	1	0	0	0	0	0	5	1	0	0	0	1	0	1	0	0	24	7	51
b) Reinsertions	1974	0	0	0	13	15	15	9	0	6	3	0	17	14	2	0	15	3	0	5	8	6	79	25	235
	1975	8	0	2	4	4	19	9	0	3	0	0	9	20	3	0	1	2	0	3	5	2	118	28	240
d) Expulsions	1974	2	0	2	1	28	1	4	1	0	0	0	7	5	0	0	0	0	0	0	1	2	33	4	91
	1975	5	0	0	1	8	2	4	0	2	0	0	5	5	0	0	0	0	0	0	1	1	2	33	2
c) Grossesses	1974	0	0	8	0	0	2	0	0	14	0	0	0	0	0	0	0	0	0	0	0	2	24	10	70
	1975	2	0	0	0	1	0	0	0	0	0	0	0	2	0	0	0	0	0	1	0	1	3	2	33
2) Autres visites de contrôle	1974	4	0	700	476	259	604	332	0	53	142	0	451	1300	91	0	92	156	285	368	15	1145	3770	821	10064
	1975	103	0	0	463	273	120	150	0	91	0	2	435	900	724	0	160	274	145	76	370	212	3716	777	8991
3) Nombre de consult. ayant reçu pour la 1 ^{er} fois.	1974	439	163	471	290	149	608	599	107	114	285	103	609	411	337	108	401	318	695	139	274	277	2078	540	9595
	1975	628	131	662	209	242	788	449	111	108	285	137	768	710	271	188	583	597	945	150	256	355	3735	523	13131
a) Conduits	1974	0	0	0	5	4	134	67	0	0	0	0	82	24	1	0	0	87	0	0	1	3	143	6	557
	1975	44	3	3	0	0	183	36	0	0	23	0	42	47	3	0	0	404	48	0	89	1	141	89	1156
4) Nombre de consult. revenues pour :	1974	1407	85	1448	723	615	2452	686	200	85	1305	451	2966	1094	240	352	0	1158	0	610	536	819	3394	1198	21876
	1975	1459	71	1696	620	746	2623	1336	700	263	1566	458	2760	978	390	867	1039	1341	3080	502	761	461	8278	1898	34013
a) Pilules (1)	1974	0	0	0	18	36	8	0	0	0	135	41	4	15	0	37	0	88	0	0	0	71	28	31	512
	1975	0	0	0	0	36	117	4	0	0	177	62	279	5	78	11	5	60	3	0	65	9	24	123	1058

Tab. n° 14 Bis - ACTIVITE DES CENTRES DE PLANIFICATION FAMILIALE -

PAR MOIS

(Etat comparatif du : 3ème Trimestre 1974/1975)

ACTIVITES \ M O I S	JUILLET		AOÛT		SEPTEMBRE		TOTAL	
	1974	1975	1974	1975	1974	1975	1974	1975
I) Nbre de visites initiales pour toutes raisons	14755	25061	16876	17959	14146	21353	45777	64373
II) Appareils intra-utérins :								
a - Insertions	551	629	309	415	352	272	1212	1316
b - Réinsertions	29	27	25	11	22	13	76	51
c- Retraits	75	106	76	57	84	77	235	240
d- Expulsions	33	25	43	26	15	19	91	70
e- Grossesses	13	2	9	4	11	5	33	11
f - Autres visites de contrôle	4199	3714	2658	2689	3207	2588	10064	8991
III) Nbre. de consultant-tes ayant reçu pour la 1ère fois								
a - Pilules	3515	4604	3166	3816	2914	4711	9595	13131
b - Condoms	131	569	144	300	282	287	557	1156
IV) Nbre. de consultant-tes revenues pour:								
a - Pilules	25530	38337	24395	29082	21876	34013		
b - Condoms	1078	1061	994	748	512	1058		

