

# **CMS/Morocco Reproductive Health Baseline**

*Mobilizing Data and Indicators for Effective  
Private-Sector Program Interventions*

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**COMMERCIAL MARKET STRATEGIES**  
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

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Commercial Market Strategies (CMS) is the flagship private sector project of USAID's Office of Population and Reproductive Health. The CMS project, in partnership with the private sector, works to improve health by increasing the use of quality family planning and other health products and services.



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**ABOUT THIS REPORT**

CMS and LMS Marketing initially prepared this report under the title *Indicateurs de Base sur l'Utilisation des Méthodes de Longue Durée du Projet CMS au Maroc*. CMS presented the report to the Moroccan Ministry of Health. The report has broad implications, including building a stronger private sector and reinforcing past accomplishments in the Moroccan family planning program. As such, CMS believes that the report is valuable to a global audience as an example of how data is mobilized for program development in a family planning program that is nearing maturity.

**THE COUNTRY RESEARCH SERIES**

The papers in CMS's Country Research Series were developed to inform specific CMS country program operations, but they also contain results that may be of interest to a wider audience. All papers in the series were reviewed by CMS research staff in the field and in Washington, DC, as well as by relevant CMS program management staff.

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# 1 Introduction

## 1.1 CMS in Morocco

Morocco, a country of 30 million inhabitants, has witnessed major improvements in reproductive and child health in the last 30 years. The population growth rate decreased from 2.8 percent in the 1970s to 1.7 percent in 1996 to 1997. The fertility rate recently decreased from 4.2 children per woman in 1992 to 3.1 in 1997. The child mortality rate decreased from 122 per 1,000 children in 1970 to 37 per 1,000 in 1997 (PAPCHILD 1999).

National programs have played a major role in these improvements. Social marketing has contributed widely to the expansion of family planning (FP) and relieved some of the burden on the public sector. Challenges remain, however, as an increasing number of women desire to limit family size. Long-term methods of FP, such as injectables and intrauterine devices (IUDs), are becoming a larger focus of the FP program. The sustainability of FP programs is also of greater concern as donors consider withdrawing or reducing their assistance to these programs. Increasing the role of the private sector in the supply and delivery of reproductive and child health services and products is an important mechanism for increasing the sustainability of national programs.

To this end, the Commercial Market Strategies (CMS) project in Morocco is working toward three objectives:

- Increasing the sustainability of social marketing of reproductive and child health products and services, especially long-term contraceptive methods
- Establishing a network of private-sector reproductive and family health providers
- Promoting reproductive and child health-related corporate social responsibility

Currently, the social marketing program promotes three brands of FP products: the *Kinat Al Hilal* brand of oral contraceptive, the *Lawlab Al Hilal* IUD, and the *Hoqnat Al Hilal* injectable contraceptive. The social marketing program also promotes oral rehydration salts (ORS) called Biosel for children suffering from diarrhea.

This report is a partial account of a survey on awareness and use of reproductive and child health products and services among married women 15 to 49 years of age. CMS, in agreement with the Moroccan Ministry of Health (MOH), also carried out a survey and interviews with public and private health care providers and pharmacists in the community to assess their attitudes relative to FP and FP social marketing brands provided in Morocco.

This report is not exhaustive. A report entitled *Enquête sur les Connaissances, Attitudes et Pratiques (CAP) des Ménages en Matière de Planification Familiale*<sup>1</sup> contains a more complete tabulation of survey results. This report contains selectively reported and interpreted information that is directly relevant to the program.

## **1.2 Baseline and Follow-Up Indicators**

Given the past success of the Moroccan FP program, it is important to monitor progress and identify key areas for improvement. As the coordinator of all FP efforts, the MOH is most concerned with indicators that measure the impact of these efforts, such as contraceptive prevalence and the rate of usage of specific family planning methods. Some of the results presented here are part of regular efforts by the MOH to evaluate these indicators.

## **1.3 Main Research Questions**

Although CMS has already begun implementation of its activities, the program will need mid-term corrections. This report presents research intended to guide efforts through the second half of the project cycle. Questions that this paper addresses are:

- Does the Morocco FP program continue to build on the successes of the past?
- What are the characteristics of target groups of Moroccan women that make them suitable populations for the promotion of long-term FP methods?
- What factors influence the choice of supply provider/source among groups targeted by the social marketing program?
- How can social marketing efforts be consolidated to increase the contribution of the private sector?

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<sup>1</sup> The English translation is *Survey on Knowledge, Attitudes and Practices (KAP) of Households Relative to Family Planning*.

## **1.4 Document Overview**

There are four sections of results in this report that present complementary aspects of the Moroccan family planning program and the CMS project. As such, the sections can be read as a whole or individually. The first section is a presentation of indicators relative to the FP program and a baseline of important CMS indicators. The second section presents research relevant to designing programs for increasing the use of long-term FP methods, such as injectables and IUDs. The third section provides information on the social marketing program. The fourth section focuses on private-sector users and increasing the private sector's market share. Finally, a conclusion summarizes the results of each section and synthesizes common themes.

## 2 Methodology

### 2.1 Context

CMS contracted with LMS Marketing to conduct three linked surveys. The first was a household survey that collected information on the socioeconomic status (SES) of randomly selected households and identified people eligible for the other two surveys. The second survey, on which this report is based, interviewed married women of reproductive age on their knowledge and use of FP and maternal health care services. The third survey, which is not analyzed here, interviewed men and women who had recently been ill or injured about their health care-seeking behavior.

The CMS and LMS Marketing team employed a quantitative approach through structured questionnaires applied to a sample target population. This section summarizes the questionnaires, survey plan, data make-up and gathering, and data processing. The document *Knowledge, attitudes and practices of households relative to family planning: Deliverable 2* contains the complete details of the survey plan.<sup>2</sup>

Two questionnaires were prepared and used to gather data for this study:

- An “eligibility/household” questionnaire
- A “women’s” questionnaire

The questionnaires were based on model questionnaires in the *Demographic and Health Survey*.<sup>3</sup>

### 2.2 Eligibility/Household Questionnaire

The eligibility/household questionnaire allowed the team to record information on all members of the selected households, including name, family ties with the head of household, sex, age, residence situation, educational level and diseases or wounds during the last 30 days. The questionnaire was applied to the head of household or to the person recognized as such. Its aim was to select the people to whom the women’s questionnaire would be applied. The last part of the household questionnaire collected information on the characteristics of the household, belongings and daily household expenditures.

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<sup>2</sup> LMS Marketing. 2001. *Knowledge, Attitudes and Practices of Households Relative to Family Planning: Deliverable 2*. CMS Project: Washington, D.C.

<sup>3</sup> E.g., Azelmat, Mustapha, Mohamed Ayad et El Arbi Housni. 1996. *Enquête de Panel sur la Population et la Santé (EPPS) 1995*. Calverton, Maryland (U.S.) : Ministère de la Santé Publique, Direction de la Planification et des Ressources Financières, Service des Etude et de l’Information Sanitaire et Macro Internationale Inc.



## 2.3 Women's Questionnaire

The women's questionnaire covered all eligible women of the selected households (married women 15 to 49 years of age having spent the night before the interview in the selected household). In addition to the cover page, which was similar to the household questionnaire, it included the following subjects: socio-demographic characteristics, births, FP products and services, awareness of Al Hilal products, FP current users, supply sources, non-users of FP, other products and health services, children born during the last five years, prenatal care/delivery expenses/postnatal care and attitudes relative to OCs, IUDs, and injectables.

## 2.4 Sampling Methodology

### Survey Base

The CMS 2000 survey selected a stratified and representative sample at the national level composed of 135 primary sampling units.<sup>4</sup> The survey team used a probability methodology to select households for this survey under which each household of the population of households has a known, discrete probability of being selected for the sample. The use of a probability methodology requires the availability of an appropriate master sample as a survey base. The base of this survey was the master sample<sup>5</sup> prepared and used by the Moroccan Statistics Directorate for all of its household surveys.

### Stratification of Primary Sampling Units

To improve the precision of the estimates and to ensure a good geographic representation, the sample was stratified as follows:

- *Residence status (urban/rural) stratification.* The first stratification was based on urban/rural status of the household.
- *Geographic stratification.* Two-thirds (67 percent) of the sample was allocated to urban centers.<sup>6</sup> The urban sample contains 90 primary sampling units, compared to 45 primary sampling units for the rural sample. This ratio was selected for greater reliability of results at the national and urban levels. Basic activities of the CMS program are developed in urban centers.

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<sup>4</sup> A primary sampling unit is defined as a geographic area characterized by clear limits. The definition of the primary sampling units is based on the concept of Census District (D.R.) A primary sampling unit covers 2 to 3 contiguous districts, or an average of 300 households.

<sup>5</sup> The master sample is defined as a group of geographic areas or primary sampling units based on those chosen from sub-samples to carry out the different household surveys.

<sup>6</sup> This sample is not self-weighted at the national level, therefore all analyses weight the observations in the database (i.e. we made corrections so that rural observations and urban observations influence the analyses proportional to the respective populations). The techniques used are explained in LMS (2000).

## **2.5 Surveyor Training and Data Collection**

### **Training**

The LMS/CMS team carried out two training sessions across four days. The first training session was for supervisors. In the second session, the supervisors helped with the training of the surveyors.

### **Data Gathering**

The survey team gathered data from November 2000 to January 2001. A team of 24 surveyors collected the data in the field supervised by six LMS marketing supervisors and two CMS representatives. Most interviews were conducted in dialectical Arabic.

### **Data Processing**

#### *Coding and Gathering of the Questionnaires*

The completed and checked questionnaires were sent to the office of LMS Marketing in Casablanca, where the questionnaires were read again and coded before data entry. LMS Marketing used the Quantum Quancept module of the SPSS suite of products. This module transforms the questionnaire into a data entry form called script using a proprietary programming language.

#### *Processing and Analysis*

Before data analysis, LMS Marketing cleaned the data file. During this process of checking and auditing data, all variables were reviewed. Weights were calculated and applied for each household and each woman, as the sample is not self-weighted.

## 2.6 Household Characteristics

Table 2.1 presents the distribution of household members as reported by the survey. In general, people in their most economically productive years are over-represented in urban areas, so the dependency ratio is larger in the rural areas than in urban ones. People of these ages are also in their reproductive years. For social marketing programs, over-representation of women of childbearing age in urban areas is important.

*Table 2.1: Household population by age and gender*

Proportion (in percent) of the population (de facto) of the households by five-year age groups, according to urban/rural status and gender, CMS data 2000.

Age group	Urban			Rural			Total		
	Men	Women	Total	Men	Women	Total	Men	Women	Total
0-4	6.1	6.6	6.4	8.6	9.4	9.0	7.4	7.9	7.7
5-9	8.9	9.8	9.4	12.1	11.5	11.8	10.5	10.6	10.6
10-14	10.7	10.4	10.5	12.6	12.3	12.4	11.6	11.3	11.5
15-19	12.4	11.9	12.2	12.3	12.0	12.1	12.3	11.9	12.1
20-24	10.0	10.3	10.1	11.4	9.7	10.6	10.7	10.0	10.4
25-29	9.4	9.0	9.2	7.7	8.4	8.1	8.6	8.7	8.7
30-34	7.9	8.7	8.3	6.2	5.5	5.9	7.1	7.2	7.1
35-39	6.8	7.5	7.2	4.4	5.3	4.8	5.6	6.5	6.0
40-44	6.7	5.8	6.2	4.6	5.4	5.0	5.6	5.6	5.6
45-49	4.7	3.8	4.2	3.0	3.0	3.0	3.8	3.4	3.6
50-54	3.2	5.5	4.4	3.6	5.8	4.7	3.4	5.7	4.5
55-59	2.9	2.6	2.7	2.4	2.4	2.4	2.7	2.5	2.6
60-64	3.0	3.6	3.3	3.2	3.8	3.5	3.1	3.7	3.4
65-69	2.1	1.1	1.6	1.5	1.3	1.4	1.8	1.2	1.5
70-74	2.3	1.4	1.8	2.7	2.2	2.4	2.5	1.8	2.1
75-79	0.8	0.5	0.7	1.0	0.4	0.7	0.9	0.5	0.7
80-95	1.2	0.8	1.0	1.8	1.3	1.5	1.5	1.0	1.2
Undetermined/ Not known	1.1	0.7	0.9	0.8	0.4	0.6	1.0	0.6	0.8
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Number of observations *</b>	<b>2,857</b>	<b>2,989</b>	<b>5,846</b>	<b>1,783</b>	<b>1,663</b>	<b>3,446</b>	<b>4,640</b>	<b>4,652</b>	<b>9,292</b>

\*The number of observations is not weighted. These are gross numbers of observations used in the calculations. However, the distributions are weighted.

## 2.7 Analysis Techniques and Strategy

### Creation of an Indicator of Socioeconomic Status

An important element of any contraceptive social marketing program is the identification and targeting of appropriate socioeconomic strata. The goals of this report require a categorization of households according to their SES. Unfortunately, single variable measures of SES are difficult, if not impossible, to gather. Therefore, we used a process that draws on a wide variety of information to create an SES index.

The household head supplied information on the approximate amounts that his/her household spent on various regular and semi-regular expenditures in the household survey. The total of these expenditures is indicative of the household's SES and the ability of household members to pay for health services. Unfortunately, many households did not supply complete information on their expenditures. Only 682 households out of 1,574 surveyed provided complete expense information. In addition, household heads are not able to perfectly recall expenditures on all household items. To overcome these obstacles, an equation that estimates household expenditures based on household belongings was created.

Nearly all of the households answered the questions concerning belongings. Unlike household expenses, household belongings are easy to enumerate since they are physically identifiable. In the survey, household heads were asked if their household had the following assets: television, telephone, refrigerator, bicycle, motorcycle, tractor, cart and personal car. Other measures of household well-being were also contained in the survey, including electrical service, number of rooms in the house used for sleeping, and location of the household (urban v. rural).

There is a strong correspondence between the number and types of household belongings and regular household expenses. Mark Montgomery recently showed that this correspondence can be used to establish the economic status of a household.<sup>7</sup> A simple linear regression was used to quantify a multivariate relationship between household expenses (estimated with error as mentioned above), household belongings and urban/rural status. Table A.1 of the Appendix shows the regression results.

Each household's regular expenses, including the households that did not answer the questions concerning expenses, were then estimated with a formula derived from the regression analysis. The households were then ranked from poorest to richest and subdivided into five numerically equal classes: very poor, poor, middle class, upper middle class and rich.

Table 2.2 present profiles of these groups according to various demographic and social indicators. It shows that the relatively well-off households are concentrated in urban areas, with fewer people per room and more belongings. More than half of the households in the poorest groups have no electricity. The rich households are the only ones to have cars in significant numbers and only the two richest quintiles have telephones in significant numbers (there is a large difference in phone ownership between the upper middle group and the richest quintile).

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<sup>7</sup> "Measuring Living Standards with Proxy Variables," (with Michele Gagnolati, Kathleen Burke, and Edmundo Paredes), *Demography*, 2000, 37(2): 155-174.

Table 2.2: SES profiles of households

Urban/rural status, region and household characteristics by SES, CMS data 2000.

Characteristic	Household SES					Number
	Very poor	Poor	Middle class	Upper middle class	Rich	
<b>Residence</b>						
Urban	6.1	22.4	60.0	90.6	93.9	1,042
Rural	93.9	77.7	40.0	9.4	6.1	532
<b>Region</b>						
Sahara Region	1.2	1.2	3.8	2.4	4.1	48
Souss, Massa, Dra	10.5	15.6	11.5	4.7	4.8	137
Gharb, Chrarda-Bni Hs	9.2	6.5	2.9	3.4	4.9	79
Chaouia-Ouadigha	8.4	7.8	7.3	5.3	3.9	80
Marrakech-Tensift	25.6	13.2	6.4	6.0	6.4	148
Oriental	4.8	7.0	8.3	9.9	4.3	104
Grand Casablanca	1.4	3.8	17.1	20.2	24.3	234
Rabat-salé Zemmour	1.1	2.0	7.0	10.4	13.1	140
Doukkala	16.1	9.3	4.1	4.9	4.4	96
Tadla-Azilal	1.4	6.9	5.9	5.1	2.5	72
Meknes-Tafilalet	4.4	5.1	6.6	5.4	13.6	119
Fes-Boulemane	2.3	3.4	8.4	7.5	4.5	92
Taza-Al Hociema	5.9	10.1	4.2	7.6	2.7	94
Tanger-Tetouan	9.1	8.1	6.4	7.4	6.6	131
<b>Number of persons per room used for sleeping</b>						
1-2	21.4	33.7	26.5	25.2	46.0	473
3-4	62.1	52.7	54.7	56.1	48.7	855
5-6	14.8	11.0	14.7	13.8	4.8	197
7 or more	1.8	2.6	4.1	5.0	0.5	49
<b>Durable goods</b>						
Electricity	12.7	44.7	79.6	97.8	98.8	1,555
Television	32.0	73.2	89.9	99.3	100.0	1,557
Telephone	0.0	1.0	4.4	30.7	89.2	1,557
Refrigerator	0.0	5.4	20.0	86.5	97.6	1,557
Bicycle	9.7	17.9	12.0	22.7	18.3	1,558
Motorcycle	4.2	12.1	13.3	15.2	14.0	1,558
Personal car	0.0	1.9	3.7	6.7	30.1	1,558
<b>Total</b>	<b>20.0</b>	<b>20.1</b>	<b>20.1</b>	<b>20.2</b>	<b>19.6</b>	<b>1,574*</b>

## **2.8 Analysis Strategy**

It is expected that the majority of readers of this report are aware of public health and reproductive health issues. However, it is not assumed that readers have knowledge of advanced statistics. In the interest of presenting relatively simple numerical presentations, analysis of the data is limited to the cross tabulation of significant indicators and variables with parameters judged significant for the continuing success of the FP program.

### 3 Indicators and Tendencies in Morocco

#### 3.1 Impact of the FP Program

The FP program has made remarkable progress over the last 10 years, as modern contraceptive use increased from 42 percent in 1992 to 60 percent in 2000.

Table 3.1 and Graph 3.1 show the evolution of FP use over the last five years. Currently, contraceptive prevalence is 60 percent, an increase of 10 points over the last five years. The increase is due entirely to the greater use of modern methods, which increased from 42 percent to 52 percent. More than 80 percent of married women have used a modern FP method.

Table 3.1 also indicates the mix of methods used among women currently using a contraceptive. Oral contraceptive (OC) use in terms of percentage of total use has remained constant. IUDs and injectables have increased in share over female sterilization and condoms, but the total number of condom and sterilization users has increased due to an increase in continuous contraception use and women of childbearing age. Traditional methods, such as periodic abstinence and withdrawal, have decreased in share.

Graph 3.1: Contraceptive use, 1995 to 2000

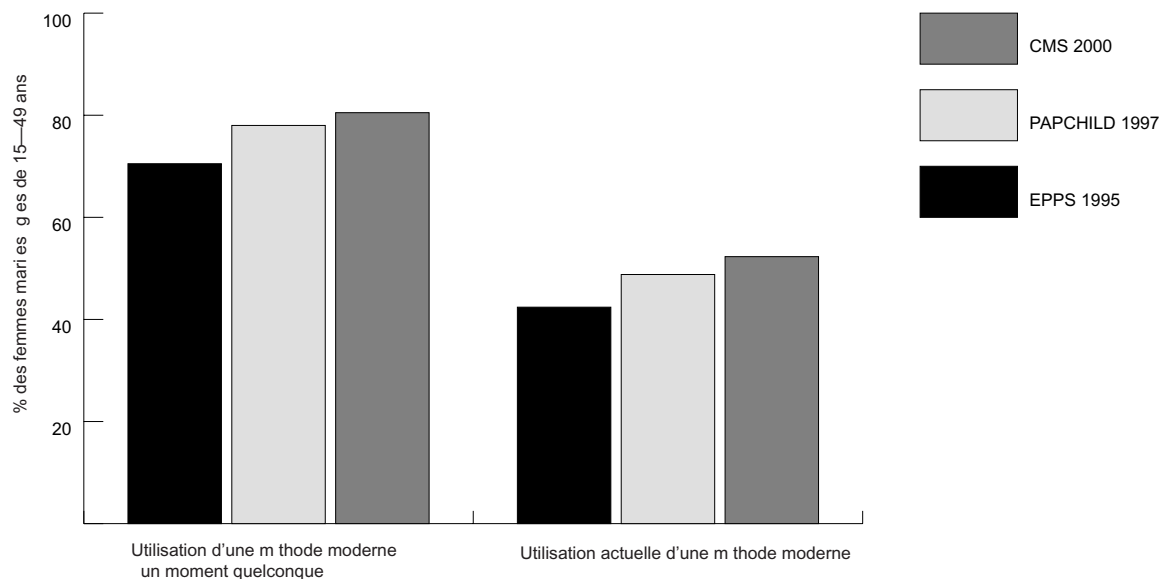


Table 3.1: Contraceptive use 1995 to 2000

Distribution (in percent) of married women aged 15 to 49 years by contraceptive method used, CMS data 2000, PAPCHILD 1997, and EPPS 1995.

Use	EPPS 1995 <sup>8</sup>	PAPCHILD 1997 <sup>9</sup>	CMS 2000
<b>Ever use of FP (now or in the past)</b>			
Any method	74.1	84.4	83.4
Any modern method	70.5	78.0	80.5
Any traditional method	23.5	38.5	11.9*
Never used	25.9	15.6	16.6
<b>Current contraceptive use</b>			
Any method	50.3	58.4	60.3
Any modern method	42.4	48.8	52.3
Any traditional method	7.9	11.6	8.0
Not currently using	49.7	41.6	39.7
Total	100	100	100
Number of observations	2,481	4,695	1,060
<b>Mix of methods currently used</b>			
<b>Modern methods</b>			
OC	64.2	65.6	63.7
IUD	8.5	9.1	12.8
Injectable	0.2	1.2	2.5
Vaginal methods	0.2	0.2	0.1
Condom	2.8	2.1	1.8
Female sterilization	8.5	5.1	5.9
Male sterilization	0.0	0.0	0.0
Implant/Norplant	0.0	0.2	0.0
<b>Traditional methods</b>			
Periodic abstinence	9.1	5.5	8.7
Withdrawal	5.6	5.1	4.4
Prolonged breastfeeding	0.0	5.5	0.1
Others	0.8	0.5	0.0
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Number of observations</b>	<b>1,248</b>	<b>2,742</b>	<b>661</b>

\* Because of imprecisions in the EPPS and CMS questionnaires, prolonged breastfeeding is underestimated for these surveys. Therefore, the use of prolonged breastfeeding, and consequently the sum of traditional methods and the total sum, are not comparable across the three surveys. However, the sums of modern methods are comparable.

<sup>8</sup> Enquête de Panel sur la Population et la Santé (Panel Survey of Population and Health).

<sup>9</sup> Pan-Arab Project for Child Development.



Table 3.2 and Graph 3.2 show that prevalence rates for modern contraceptive methods have increased in both urban and rural areas. Most of the increase in contraceptive prevalence in Morocco over the last 10 years has come from strong growth in the rural areas. Rural areas, however, still lag behind urban areas in total contraceptive prevalence by almost 15 percent.

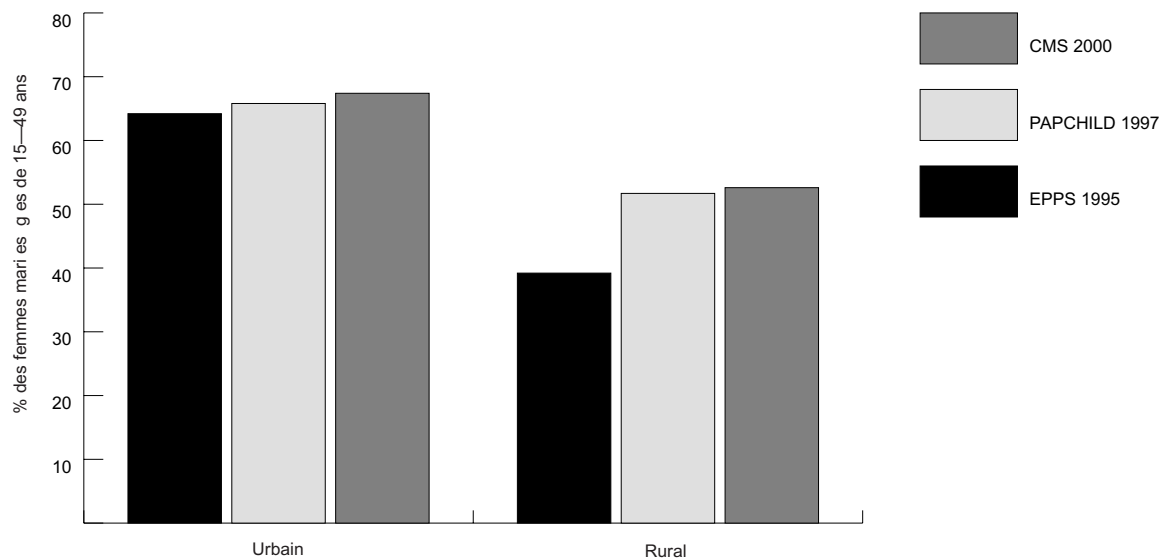
*Table 3.2: Current contraceptive use by urban/rural status, 1995 to 2000*

Distribution (in percent) of married women 15 to 49 years of age by currently used contraceptive method by residence, CMS data 2000, PAPCHILD 1997, and EPPS 1995.

Use	EPPS 1995	PAPCHILD 1997	CMS 2000
<b>Any method*</b>			
Urban	64.2	65.8	67.4
Rural	39.2	51.7	52.6
<b>Any modern method</b>			
Urban	51.0	54.3	56.5
Rural	35.6	43.8	47.9
<b>Any traditional method*</b>			
Urban	13.2	11.6	11.0
Rural	3.6	7.8	4.7
<b>Number of observations</b>	<b>1,248</b>	<b>2,742</b>	<b>661</b>

\* Because of the imprecisions in the EPPS and CMS questionnaires, prolonged breastfeeding is underestimated for these surveys. Therefore, the use of prolonged breastfeeding, and consequently the sum of traditional methods and the total sum, are not comparable across the three surveys. However, the sums of modern methods are comparable.

*Graph 3.2: Current contraceptive use by urban/rural status, 1995 to 2000*



Graph 3.3: Current use of IUD by urban/rural status, 1995 to 2000

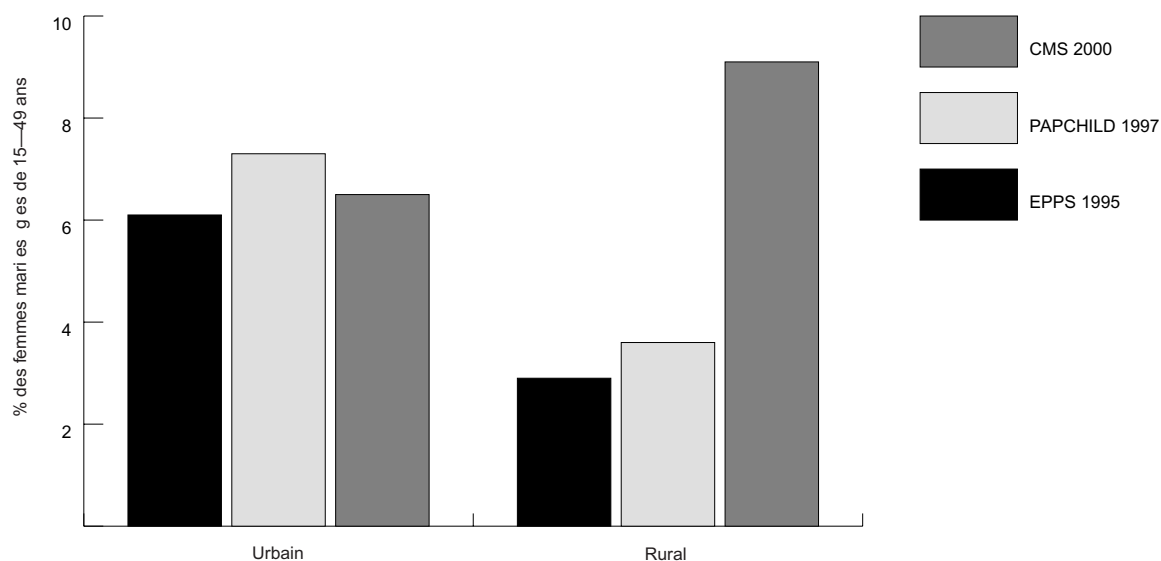


Table A.2 in the Annex presents contraceptive prevalence in rural and urban areas by method. The trends demonstrated in the table are similar to those mentioned above, with one distinct exception: the increase in IUD use is primarily a rural phenomenon. Graph 3.3 extracts some numbers from the appendix, demonstrating that while the prevalence of IUD use did not change over the last five years in urban areas, it tripled in rural areas during the same period.

Table 3.3 shows the supply sources of FP services for women. The first section of the table shows the sources for all methods, illustrating that the public sector still provides services and products for 60 percent of women currently using a modern FP method. However, in the last five years, the private sector, especially physicians, gained ground slightly. The second section shows OC sources. Since OCs are by far the most used method, the supply sources reflect the combination of sources in general.

The third section shows sources for IUDs, demonstrating that practically all the increase in the use of IUDs resulted from a significant increase in IUD insertions at public-sector providers, specifically public hospitals. Currently 90 percent of IUDs are obtained from public-sector providers.

Similarly, more than 95 percent of injectable users obtain their method from the public sector. The 1997 PAPCHILD survey showed that about 85 percent of injectable users obtained their services from the public sector. Thus, injectables remain a public-sector method and efforts made until 2000 to promote private-sector distribution were not successful.

Table 3.3: Modern contraceptive supply sources, by year

Distribution (in percent) of current modern contraceptive users by supply source or most recent information, according to specific methods, CMS data 2000, PAPCHILD 1997, and EPPS 1995.

Sources	EPPS 1995	PAPCHILD 1997	CMS 2000
<b>ALL MODERN METHODS</b>			
<b>Public sector</b>	<b>62.6</b>	<b>60.2</b>	<b>60.1</b>
Hospital	8.7	5.8	11.6
Maternity	1.9	0.4	0.6
Health center/dispensary	46.3	49.8	45.2
Home visit	5.1	0.3	1.1
Mobile team	0.6	2.0	1.6
<b>Private medical sector</b>	<b>37.1</b>	<b>39.8</b>	<b>37.7</b>
AMPF (Moroccan family planning association)	0.8	1.1	0.9
Pharmacy	33.4	35.3	31.7
Clinic/polyclinic	2.1	1.8	1.3
Physician <sup>10</sup>	0.8	0.8	3.8
<b>Other private sector</b>	<b>0.2</b>	<b>0.8</b>	<b>2.4</b>
Parent/friend	0.2	0.2	1.6
Not known/not declared	0.2	0.6	0.8
<b>Number of observations</b>	<b>1,063</b>	<b>2,289</b>	<b>562<sup>11</sup></b>
<b>Oral Contraceptives</b>			
<b>Public sector</b>	<b>58.2</b>	<b>54.8</b>	<b>51.8</b>
Hospital	0.0	0.4	6.1
Maternity	0.1	0.0	0.4
Health center/dispensary	50.8	49.4	41.9
Home visit	6.7	2.7	1.5
Mobile team	0.6	2.3	1.9
<b>Private medical sector</b>	<b>41.4</b>	<b>44.2</b>	<b>45.8</b>
AMPF	0.2	0.8	1.0
Pharmacy	41.0	43.0	41.0
Clinic/polyclinic	0.1	0.2	0.0
Physician	0.0	0.2	3.8
<b>Other private sector</b>	<b>0.1</b>	<b>1.1</b>	<b>2.3</b>
Parent/friend	0.1	0.3	1.7
Other/undeclared	0.2	0.8	0.6
<b>Number of observations</b>	<b>804</b>	<b>1,799</b>	<b>418</b>
<b>IUDs</b>			
<b>Public sector</b>	<b>83.2</b>	<b>88.0</b>	<b>90.2</b>
Hospital	9.3	8.4	17.1
Maternity	6.5	1.6	1.7
Health center/dispensary	66.4	76.8	71.4
Home visit	0.0	0.4	0.0
Mobile team	0.9	0.8	0.0
<b>Private medical sector</b>	<b>16.8</b>	<b>11.6</b>	<b>6.9</b>
AMPF	5.6	2.8	0.8
Pharmacy	0.0	0.0	0.0
Clinic/polyclinic	2.8	3.2	1.1
Physician	8.4	5.6	5.0
<b>Other private sector</b>	<b>0.0</b>	<b>0.4</b>	<b>3.0</b>
Parent/friend/other undeclared	0.0	0.0	3.0
<b>Number of observations</b>	<b>107</b>	<b>250</b>	<b>79</b>

<sup>10</sup> Final EPPS and PAPCHILD survey reports do not distinguish between physicians and midwives. This survey (CMS 2000) did not report any woman receiving FP services from a midwife.

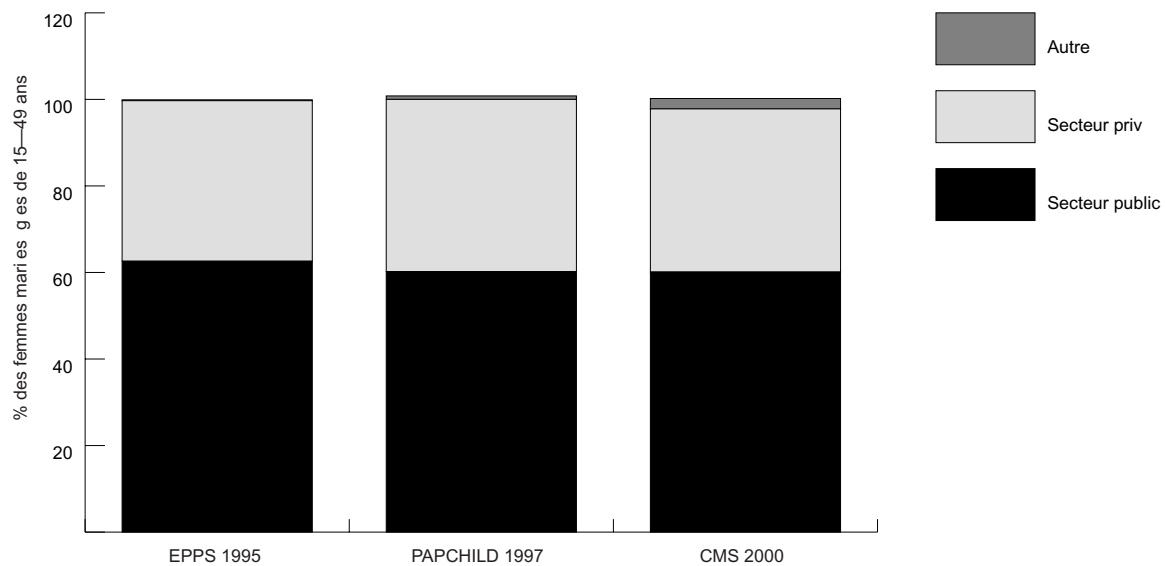
<sup>11</sup> Six of 40 sterilized women in the CMS sample did not specify where they were sterilized.

(Table 3.3)

Sources	EPPS 1995	PAPCHILD 1997	CMS 2000
<b>Injectables</b>			
<b>Public sector</b>	--	<b>(85.8)</b>	<b>(95.9)</b>
Hospital	--	(2.9)	(9.6)
Maternity	--	(2.9)	(0.0)
Health center/dispensary	--	(77.1)	(79.4)
Home visit	--	(0.0)	(0.0)
Mobile team	--	(2.9)	(6.9)
<b>Private medical sector</b>	--	<b>(14.4)</b>	<b>(4.1)</b>
AMPF	--	(2.9)	(0.0)
Pharmacy	--	(8.6)	(0.0)
Clinic/polyclinic	--	(2.9)	(4.1)
Physicians	--	(0.0)	(0.0)
<b>Other private sector</b>	--	<b>(0.0)</b>	<b>(0.0)</b>
<b>Number of observations</b>	<b>(2)</b>	<b>35</b>	<b>16</b>

Note: ( ) Based on less than 50 responses.

Graph 3.4: Modern contraceptive supply sources



### 3.2 Basic CMS Project Indicators

The CMS project tracks indicators measuring progress toward the achievement of defined results. This section establishes baselines against which future survey results may be compared. Principally, CMS is working to strengthen the role of the private sector in the supply and delivery of reproductive health products and services nationwide. To do this, CMS is working to help the MOH direct their services to disadvantaged populations, leaving relatively wealthier women to use the private sector.

CMS has developed 21 indicators that will be used to follow the progress of the CMS project in reaching its objectives; this report covers 16 of these 21 indicators. The indicators, as follow, are grouped under five headings: use of the private sector, social marketing brand awareness, knowledge of sources for social marketing products, perception of the quality-price ratio for social marketing products, and proximity of sources from which to purchase social marketing products:

- Percentage of modern method users who obtained their FP method from a private-sector source, by income level (Table 3.4).
- Percentage of women aged 15 to 49 who have ever heard of the CMS supported OC (Kinat Al Hilal), IUD (Lawlab Al Hilal), injectable (Hoqnat Al Hilal), and ORS (Biosel) (Table 3.5).
- Percentage of women aged 15 to 49 who know where to obtain the CMS supported OC, IUD, injectable, and ORS (Table 3.6).
- Percentage of women aged 15 to 49 who perceive the CMS supported OC, IUD, injectable, and ORS to be of good value as opposed to poor value (Table 3.7).
- Percentage of women aged 15 to 49 who have ever heard of the CMS supported OC, IUD, and injectable with access to at least one private or commercial source within 30 minutes travel time (Table 3.8).

Table 3.4 shows the source mix for obtaining FP services disaggregated by SES. Almost 75 percent of very poor and poor women use the public sector to obtain their FP services. In contrast, almost 70 percent of rich women obtain FP services in the commercial sector. Less than 50 percent of middle- and upper middle-class women use the commercial sector. As such, these women represent a definite target for the commercial sector and social marketing program.

Table 3.4: Modern contraceptive supply sources

Distribution (in percent) of current modern contraceptive users by supply source or most recent information, according to SES, CMS data 2000.

Supply source	Socioeconomic status					Total <sup>12</sup>
	Very poor	Poor	Middle class	Upper middle class	Rich	
<b>Public sector</b>	<b>72.8</b>	<b>75.6</b>	<b>65.3</b>	<b>53.8</b>	<b>33.9</b>	<b>60.2</b>
Hospital	9.1	9.7	15.0	12.5	9.5	11.3
Maternity	0.0	1.3	0.3	0.7	0.8	0.6
Centre de santé	33.5	17.6	24.4	15.2	9.3	19.9
Dispensary	26.8	41.1	21.8	24.7	14.3	25.6
Home visit	3.4	1.2	1.4	0.0	0.0	1.2
Mobile team	0.0	4.7	2.4	0.7	0.0	1.6
<b>Private medical sector</b>	<b>26.0</b>	<b>22.9</b>	<b>31.1</b>	<b>44.5</b>	<b>64.6</b>	<b>37.8</b>
AMPF	0.0	0.0	0.7	2.7	0.9	0.9
Pharmacy	24.9	22.9	27.9	35.2	48.1	31.8
Clinic/polyclinic	0.0	0.0	0.0	2.9	3.7	1.3
Physicians	1.1	0.0	2.5	3.7	11.9	3.8
<b>Other private sector</b>	<b>1.2</b>	<b>1.5</b>	<b>3.6</b>	<b>1.7</b>	<b>1.6</b>	<b>2.0</b>
Parent/friend	1.2	1.5	2.9	1.0	0.0	1.4
Undeclared	0.0	0.0	0.7	0.7	1.6	0.6
<b>Number of observations</b>	<b>76</b>	<b>89</b>	<b>128</b>	<b>131</b>	<b>129</b>	<b>553<sup>13</sup></b>

Reduced stock outs of FP social marketing products are another significant indicator of the CMS project's success. The project tracks total sales of its products through distributor reports and also tracks various indicators related to product awareness and perception. The increase in sales of social marketing products is often slow because the population knows little about these products or believes that they are of bad quality.

Table 3.5 shows the percentage of women aware of the various project-supported social marketing products. Approximately 25 percent of all women are aware of Biosel ORS and Kinat Al Hilal OCs. Awareness of the other CMS products is weak, at about two percent of women. However, the three social marketing products are better known than other FP products on the market.<sup>14</sup>

Almost half of the rich women, more than double the percentage of upper middle-class women, know Biosel. The Kinat Al Hilal OC is better known among the middle class and upper middle class, with almost 40 percent awareness. This is significant because the middle class is the target of the social marketing program. The Lawlab Al Hilal IUD and Hoqnat Al Hilal injectable are

<sup>12</sup> The nine women for which SES was not assessed were excluded.

<sup>13</sup> Six of 40 women reporting sterilization under the CMS survey did not indicate the source of sterilization

<sup>14</sup> The Copper T 380A and Depo Provera are the names under which Lawlab Al Hilal and Hoqnat Al Hilal, respectively, are sold internationally and sometimes in Morocco apart from the social marketing program.

better known by the relatively well-off groups of women, with weak awareness among other groups.

*Table 3.5: Spontaneous awareness of Al Hilal products*

Percent of married women of 15 to 49 years of age who are aware of Al Hilal products, by product according to SES, CMS data 2000.

Products	Very poor	Poor	Middle class	Upper middle class	Rich	Total <sup>15</sup>
<b>OC</b>						
Kinat Al Hilal	16.9	24.2	38.5	39.5	29.0	29.7
Adepal	4.6	8.6	17.4	26.5	41.3	19.1
Microdial	1.1	3.6	6.1	11.0	16.7	7.5
Minidril	2.2	1.3	4.1	3.1	9.3	3.8
Microgynon	0.7	0.2	1.4	2.4	4.1	1.7
<b>IUD</b>						
Lawlab Al Hilal	0.0	1.3	1.2	4.5	5.4	2.4
Copper T 380A	0.0	0.0	0.9	0.4	0.0	0.3
<b>Injectable</b>						
Hoqnat Al Hilal	0.2	2.0	1.2	1.4	4.7	1.9
Depo Provera	0.9	0.0	0.0	0.8	0.4	0.4
<b>Oral rehydration salts</b>						
Biosel	6.0	10.6	20.4	29.8	46.8	22.1
<b>Number of observations<sup>16</sup></b>	<b>163</b>	<b>181</b>	<b>231</b>	<b>242</b>	<b>228</b>	<b>1,045</b>

<sup>15</sup> Actual spontaneous responses; awareness was established through an open-ended question asking the names of brands that the women knew.

<sup>16</sup> The 15 women in households for which SES was not assessed were excluded.

The first part of table 3.6 shows that practically all women who are aware of Al Hilal products say that they know a source where they can obtain these products. The second part of the table shows the sources mentioned. Ninety percent of women who are aware of the Kinat Al Hilal OC know that they can find Kinat Al Hilal in pharmacies.

*Table 3.6: Knowledge of Al Hilal product sources among women who know of the products*

Spontaneous responses about main sources for Al Hilal products, CMS 2000 weighted data.

Locations	ORS (Biosel) <sup>17</sup>	OC (Kinat Al Hilal)	IUD (Lawlab Al Hilal)	Injectable (Hoqnat Al Hilal)
<b>Percentage aware of supply sources</b>	<b>97.9</b>	<b>98.2</b>	<b>86.5</b>	<b>89.2</b>
<b>Supply source</b>				
<b>Public sector</b>				
Hospital	-	12.1	(21.7)	(20.2)
Maternity	-	0.2	(0.0)	(0.0)
Health center	-	8.0	(22.5)	(6.6)
Dispensary	-	7.7	(16.5)	(25.6)
Home visit	-	0.6	(0.0)	(0.0)
Mobile team	-	0.0	(0.0)	(0.0)
Other public	-	1.0	(0.0)	(0.0)
<b>Total public</b>	<b>-</b>	<b>25.9</b>	<b>49.0</b>	<b>46.0</b>
<b>Private medical sector</b>				
AMPF	-	1.4	(5.8)	(3.8)
Clinic/polyclinic	-	0.0	(8.9)	(0.0)
Pharmacy	-	88.3	(41.6)	(63.8)
Physician	-	1.2	(20.4)	(7.7)
Midwife	-	0.0	(2.0)	(0.0)
<b>Total private medical sector</b>	<b>-</b>	<b>90.0</b>	<b>66.9</b>	<b>75.3</b>
<b>Other private sector</b>				
Parent/friend	-	0.0	(0.0)	(0.0)
Kabla	-	0.0	(0.0)	(0.0)
Other private	-	0.0	(0.0)	(0.0)
<b>Number of observations<sup>18</sup></b>	<b>-</b>	<b>333</b>	<b>36</b>	<b>25</b>

Note: Multiple responses possible; totals can be greater than 100%  
( ) Based on less than 50 responses.

<sup>17</sup> The survey did not include sources for Biosel.

<sup>18</sup> Women in households for which the SES was not established were included in this table but excluded from table 3.5.



One of the key objectives of a social marketing campaign is to convince the target population that the products have a good quality-price ratio.<sup>19</sup> Table 3.7 shows the perception of the quality-price ratio for CMS social marketing products among women who know at least one private source where the products can be obtained. Very few women were eligible to answer the questions regarding IUDs and injectables (the number of observations were only 26 and 25, respectively). Among the women who were eligible, two-thirds answered "don't know," which suggests that knowledge of these products is low. The perception of the quality-price ratio of the Lawlab Al Hilal IUD is better than that of the Hoqnat Al Hilal injectable.

Conversely, many women were eligible to answer questions regarding the Kinat Al Hilal OC and Biosel ORS, and relatively few answered "don't know." Their main perception was that the two products have a good quality-price ratio.

*Table 3.7: Perception of the quality-price ratio for social marketing projects*

By women aware of at least one private supply source for social marketing products, CMS 2000 data.

<b>Perception of the quality-price ratio</b>	<b>Good</b>	<b>Average</b>	<b>Bad</b>	<b>Don't know</b>	<b>Number of observations</b>
Kinat Al Hilal (OC)	47.3	11.5	10.3	31.0	333
Lawlab Al Hilal (IUD)	(15.4)	(15.4)	(3.9)	(65.4)	26
Hoqnat Al Hilal (Injectable)	(8.1)	(3.7)	(13.9)	(74.3)	25
Biosel (ORS)	69.0	9.9	0.4	20.7	251

Note: ( ) Based on less than 50 responses.

<sup>19</sup> Conceptually, this comparison of the quality-price ratio is done on two levels. First, the consumer must be convinced that family planning and the costs that it entails are worthwhile vis-à-vis the positive qualities of the product. Secondly, they must be convinced that the product in question has a good quality-price ratio compared to the other products on the market (public sector brands).

Another important aspect of increasing the use of FP social marketing products is to assess the accessibility of products for the target populations. Table 3.8 shows the proximity of access to Al Hilal products for women who are aware of these products and who know of a private supply source. About two-thirds of these women are within 15 minutes of an OC and IUD source and 80 to 90 percent live within 30 minutes. However, it is important to point out that these women already know of the products and it is probable that women with less knowledge of these products live further from these sources.

*Table 3.8: Proximity of access to Al Hilal products*

Time (in minutes) to walk to the closest source to obtain OCs, IUDs, and injectables, CMS 2000 data.<sup>20</sup>

<b>Time to walk to source</b>	<b>OC (Kinat Al Hilal)</b>	<b>IUD (Lawlab Al Hilal)</b>	<b>Injectable (Hoqnat Al Hilal)</b>
0-15 minutes	62.4	(57.6)	(60.3)
16-30 minutes	18.5	(27.8)	(35.5)
31-45 minutes	1.7	(0.0)	(0.0)
46-60 minutes	9.2	(4.5)	(0.0)
>60 minutes	5.1	(0.0)	(0.0)
Don't Know	3.6	(10.1)	(4.2)
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Number of observations</b>	<b>308</b>	<b>26</b>	<b>21</b>

Note: ( ) Based on less than 50 cases.

<sup>20</sup> Women who are aware of Al Hilal products and know at least one private supply source.

## 4 Potential Use of Long-Term Methods

The MOH seeks to increase the range of choices of contraceptive methods, including long-term methods. In Morocco, these long-term methods are injectables, IUDs, Norplant, and female sterilization. Currently, priority is given to injectables and IUDs, which are the two methods whose use is increasing fastest (Norplant has not been a program method since 1997). The main reasons for the increase in long-term methods are their practicality and ease of use for women. Moreover, a number of studies show that long-term FP methods are more cost effective than short-term methods.

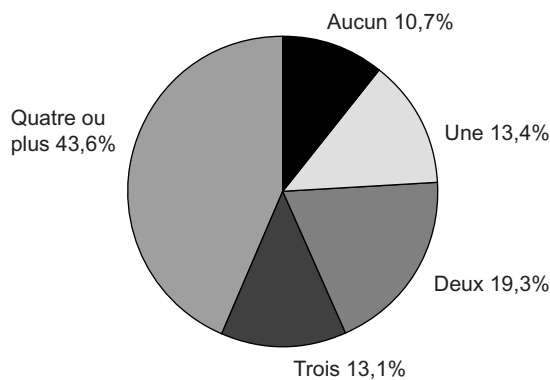
Table 4.1 shows the contraceptive prevalence of long-term methods according to the number of children a woman has. Women with three or more children are twice as likely to use an IUD as women with two children. Women with four or more children are five times more likely to choose sterilization than women with two children. Given that more than 50 percent of women have three children or more, as illustrated by Graph 4.1, they are ideal targets for long-term methods.

*Table 4.1: Current use of long-term methods*

Distribution (in percent) of married women 15 to 49 years of age using a long-term method at time of survey, CMS 2000 data.

Method	Number of living children					Total
	None	1	2	3	4 or more	
IUD	1.0	5.1	4.7	12.6	9.0	7.7
Injectable	0.0	1.3	2.3	1.7	1.6	1.5
Female sterilization	0.0	0.6	1.3	2.2	6.7	3.5
<b>Number of observations</b>	<b>113</b>	<b>149</b>	<b>202</b>	<b>142</b>	<b>454</b>	<b>1,060</b>

*Graph 4.1: Number of living children by family*



Nombre moyen d'enfants: 3,3%  
Source: CMS 2000

Table 4.2 presents profiles of various groups of women who can be targeted for long-term contraceptive use. On the left are women who already use FP methods according to whether they use a short-term method (OCs and condoms), a long-term method (injectables, IUDs, or sterilization), or less effective traditional methods. Women who use short-term methods and women who use traditional methods live mostly in urban areas. This corroborates the observation that most of the increase in IUD use over the last five years occurred in rural areas. As expected, users of short-term methods are younger than users of long-term methods. Users of traditional methods are older than users of long-term methods. Given that they already have several children on average, users of traditional methods could be a principal target for the use of long-term methods. Users of traditional methods and users of short-term methods are better educated than users of long-term methods.

Women who are not currently using a FP method were divided according to whether they intend to use a FP method in the future or not. Women who intend to use FP are younger, better informed, and have fewer children, which makes them poor targets for long-term methods. Ironically, women who do not intend to use FP have the best profile for long-term methods. They are older and nearly 40 percent have more than three children.

*Table 4.2: Profiles of current FP users and non-users by method currently used, intention to use among non-users, and past use of methods by non-users*

Distribution (in percentage) of married women 15 to 49 years of age by contraceptive use, residence, age, income, and educational level, CMS 2000 data.

Characteristics	Current users			Current non-users <sup>21</sup>	
	Short-term method	Long-term method	Traditional method	Intention to use in the future	No intention to use <sup>22</sup>
<b>Residence</b>					
Urban	58.4	49.6	70.9	43.9	41.4
Rural	41.7	50.4	29.1	56.2	58.6
<b>Age group</b>					
15-19	1.8	0.5	1.0	11.3	4.6
20-24	11.6	5.4	2.2	18.0	7.2
25-29	20.3	13.2	11.4	28.8	9.0
30-34	21.0	14.0	17.3	17.5	11.0
35-39	18.7	34.9	23.4	17.8	18.6
40-44	15.5	22.5	35.4	6.3	24.7
45-49	11.0	9.4	9.3	0.3	25.0
<b>Income</b>					
Very poor	22.1	29.6	9.5	31.0	30.1
Poor	23.8	17.8	20.2	22.9	34.0
Middle class	22.4	18.1	24.7	16.7	17.5
Upper middle class	16.3	14.6	14.6	16.8	10.6
Rich	15.4	20.0	30.9	12.6	7.9
<b>Educational level</b>					
None	67.0	75.8	56.5	59.4	78.1
Primary	14.4	15.2	19.5	19.2	15.2
Secondary or above	18.6	9.0	24.0	21.5	6.8
<b>Number of living children</b>					
None	4.4	0.9	1.0	24.3	20.3
1	11.8	7.3	9.2	18.5	17.0
2	23.9	12.4	13.5	24.3	12.4
3	15.0	17.3	11.0	9.8	10.6
4 or more	45.0	62.2	65.4	23.0	39.7
All women (n=1060)	39.6	12.6	8.1	19.2	20.3
<b>Number of observations</b>	<b>433</b>	<b>135</b>	<b>93</b>	<b>197</b>	<b>199</b>

<sup>21</sup> All women not using contraception at the time of the survey, including pregnant women.

<sup>22</sup> Includes women who do not intend to use a contraceptive method in the future or who do not know if they will use a method in the future.

Table 4.3 details awareness of short-term and long-term contraceptive methods by current users and non-users. Awareness of IUDs and injectables is weaker than knowledge of OCs, even for women who currently use a long-term method.

Women who intend to use FP know all methods well, including long-term methods. Women who do not intend to use a method know less about FP methods. Contrary to all expectations, women who do not intend to use FP had a higher probability of knowing the specific brand of a method.

*Table 4.3: Awareness of OC, IUD, and injectable methods and brands, CMS 2000 data<sup>23</sup>*

Awareness of methods and brands	Current users			Current non-users <sup>24</sup>		All Women
	Short-term method	Long-term method	Traditional method	Intention to use in the future	No intention to use <sup>25</sup>	
<b>Method</b>						
OC	99.4	92.6	98.7	95.9	84.6	95.4
IUD	61.0	77.6	72.2	66.6	45.3	62.8
Injectable	33.3	37.6	44.1	47.0	28.4	37.3
<b>Percent knowing at least one brand</b>						
OC	52.1	60.4	70.2	52.3	65.4	57.0
IUD	8.1	2.5	1.0	9.3	15.1	7.4
Injectable	8.2	8.7	3.5	10.5	22.6	10.4
<b>Number of observations</b>	<b>433</b>	<b>135</b>	<b>93</b>	<b>197</b>	<b>199</b>	<b>1,060</b>

<sup>23</sup> Awareness of FP methods is measured from unprovoked survey questions about methods and brands known by users who already intended to speak about the FP method.

<sup>24</sup> All women not using contraceptive methods at the time of the survey, including pregnant women.

<sup>25</sup> Includes women who do not intend to use a contraceptive method in the future or who do not know if they will use a method in the future.

Table 4.4 details the perceptions of current users and nonusers of FP about injectables, including side effects and health problems, availability and practicality. The first five columns of the table include only women who had an opinion regarding injectables; as detailed in the last column, many women did not have an opinion. Depending on the question, the percentage of women answering “don’t know” varied from 50 to 70 percent.

The side effects of injectables are a major concern of all groups of women. However, women who use long-term modern methods are less concerned with side effects than non-users, users of traditional methods, and users of short-term methods.

The accessibility and practicality of injectables raise less concern. A full 98 percent of users of traditional methods who have an opinion think injectables are easy to obtain. A large majority of women with opinions in all categories agree that injectables are not expensive and that they are effective.

*Table 4.4: Attitudes relative to injectables*

Distribution (in percent) of married women 15 to 49 years of age who agree fully with the following observations, among women with an opinion, CMS 2000 data.

Attitude	Current users			Current non-users		Percent of all women who respond “don’t know”
	Short term method	Long term method	Traditional method	Intention to use in the future	No intention to use	
Have negative effects on health.	78.8	70.4	86.3	82.6	83.1	52.4
Cause sterility.	55.0	48.8	67.2	61.9	63.8	67.5
Cause weight gain.	58.6	51.4	76.0	63.0	72.8	68.7
Are difficult to use because of spotting.	63.9	48.7	74.0	70.7	65.5	68.5
Are bad because they interfere with menstruation.	79.0	79.0	85.4	81.9	83.3	58.2
Are easy to obtain.	83.3	87.8	97.9	83.6	79.3	49.9
Offer protection for months.	76.0	84.5	83.4	76.7	93.6	53.8
Are not expensive to use.	79.7	84.1	83.1	86.9	76.7	67.7
Are practical because the injections are only every 3 months.	75.0	70.5	76.3	72.1	81.5	55.1
<b>Number of observations</b>	<b>433</b>	<b>135</b>	<b>93</b>	<b>197</b>	<b>199</b>	<b>1,060</b>

Table 4.5 shows the attitudes of current users and nonusers of FP relative to the IUD. As with the previous table, only women who had an opinion regarding IUDs are included. Because IUDs are better known than injectables, women are more likely to have an opinion. The percentage of women who answered "don't know," as detailed in the last column, decreased considerably.

*Table 4.5: Attitudes relative to the IUD*

Distribution (in percent) of married women 15 to 49 years of age who agree fully with the following observations, among women with an opinion, CMS 2000 data.

Attitude	Current users			Current non-users		Percent of all women who respond "don't know"
	Short term method	Long term method	Traditional method	Intention to use in the future	No intention to use	
The IUD is bad for your health.	72.0	47.1	70.9	62.8	56.9	39.9
The IUD rises into the womb by itself.	67.3	35.0	68.2	67.2	60.8	51.4
It is difficult to become pregnant after having used the IUD.	35.7	26.2	26.7	19.6	37.3	50.7
The IUD is easy to insert.	77.7	87.8	92.3	80.7	82.5	37.3
The IUD is not expensive to use.	86.1	93.2	93.2	86.4	75.4	44.3
The IUD is easy to obtain.	86.9	96.7	95.4	88.5	81.0	36.4
The IUD offers long-term protection against pregnancy.	81.9	86.9	77.8	81.9	70.5	39.6
The IUD can interfere with sex.	66.8	34.3	63.0	64.5	46.7	54.5
<b>Number of observations</b>	<b>433</b>	<b>135</b>	<b>93</b>	<b>197</b>	<b>199</b>	<b>1,060</b>

A great number of women, particularly users of short term and traditional FP methods, believe that IUDs can cause health problems. Twenty-five percent of women with opinions believe that IUDs cause sterility. This percentage, however, is lower for women who intend to use FP.

Current users of long-term methods and users of traditional methods have a more favorable view of the use and accessibility of IUDs than the remainder of the population. Current users of short-term methods believe that IUDs are less practical and accessible than do long-term method users. In general, women who already use long-term methods are more favorable to the method. If these women could communicate the benefit of their experiences to other women and dispel common misconceptions, the sales of IUDs may increase. A more in-depth study is needed to determine if these perceptions are based on experience or misconceptions.



Table 4.6 shows the discontinuation rates for OCs, IUDs, and injectables. The percentages in the table represent the proportions of women who used a method in the past but who stopped use by the time of the survey. Many women stop using a method either to become pregnant or to change methods. Usually, the discontinuation rate is higher for short-term methods than long-term methods. The opposite trend is seen here: 70 percent of women who used injectables gave up the method, compared to less than 50 percent of OC users. Although the discontinuation rate for IUDs is lower than for injectables, it is still higher than the discontinuation rate for OCs. Given that the IUD is a long-term method and rather difficult to cease use of, the discontinuation rate should be lower than that for OCs.

*Table 4.6: Contraceptive discontinuation rate by method*

Distribution (in percent) of women who have stopped a method among women who used it at least once, CMS 2000 data.

<b>Method</b>	<b>Discontinuation rate</b>	<b>Number of observations</b>
OC	47.6	799
IUD	56.9	175
Injectable	(70.2)	48

Note: ( ) Based on less than 50 responses.

Table 4.7 shows the reasons why women stop using various FP methods. Slightly more than half of former OC users stopped using this method because of side effects. About 20 percent of former OC users stopped taking it to become pregnant and 10 percent stopped because they were breastfeeding. Practically all former users of injectables and IUDs stopped for reasons related to the method itself, including side effects, gynecological diseases or bleeding.

*Table 4.7: Reasons for discontinuing OCs, IUDs and injectables*

Distribution (in percent) of women who stopped OCs, IUDs, and injectables over the last five years, by reason for stopping, CMS 2000 data.

<b>Reason for Stopping</b>	<b>OC</b>	<b>IUD</b>	<b>Injectable</b>
Side effects	55.3	59.1	(100.0)
Forgot to take	0.7	0.0	(0.0)
Desire to become pregnant	21.4	8.5	(0.0)
Bleeding	0.0	5.6	(0.0)
No longer valid or expired	0.0	5.7	(0.0)
It disturbs her	0.0	8.1	(0.0)
Gynecological disease	1.8	7.9	(0.0)
No sexual intercourse/or infrequent sex	3.5	1.0	(0.0)
Breastfeeding	8.6	0.0	(0.0)
Sterility	3.8	0.0	(0.0)
Change of method	5.9	0.0	(0.0)
Menopause	5.3	0.0	(0.0)
Refusal by husband	2.5	0.0	(0.0)
For psychological reasons	0.0	1.4	(0.0)
Rumors	0.0	1.5	(0.0)
Other	3.0	1.4	(0.0)
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Number of observations</b>	<b>155</b>	<b>60</b>	<b>18</b>

Note: ( ) Based on less than 50 responses.

Table 4.8 shows the preferred future contraceptive method for women who are currently non-users but who intend to practice FP in the future. Almost three-quarters of all women who intend to use FP prefer OCs; about 10 percent prefer injectables and two percent favor IUDs.

*Table 4.8: Preferred contraceptive method for future use*

Distribution (in percent) of married women not currently using a contraceptive method but intending to use one in the future, CMS 2000 data.

<b>Preferred contraceptive method</b>	<b>Percentage</b>
OC	68.0
IUD	2.1
Injectable	10.7
Implant/Norplant	0.7
Diaphragm/foam/gel	0.0
Condom	0.4
Female Sterilization	4.4
Male Sterilization	1.5
Rhythm/periodic Abstinence	2.1
Withdrawal	0.7
Other	1.5
Don't know	8.1
<b>Total</b>	<b>100</b>
<b>Number of observations</b>	<b>197</b>

## 5 Private Sector

Most CMS efforts relate to the social marketing of FP products. This is done within the framework of building the sustainability of reproductive health services and, more specifically, increasing the role of the private sector. To the extent that the private sector takes charge of customers, the public sector will have additional resources to target disadvantaged population groups. This chapter provides information that may help guide efforts to create a broader role for the private sector.

Table 5.1 shows of the profiles of FP clients, disaggregated by the sector where they receive FP services. The number of clients at hospitals, other public sector, and clinic/polyclinic/AMPF is small, and therefore only large differences will be interpreted. Large sample sizes in the health center/dispensary/maternity and pharmacy columns may show significant differences.

Almost two-thirds of pharmacy customers live in urban areas. More than 80 percent of women who obtain services from professionals live in urban areas. Pharmacy customers are also younger than those of other providers, while a high percentage of hospital customers are between 35 to 39 years of age.

As expected, the majority of public-sector customers are poor and the majority of private-sector clients are rich or in the middle classes. More than 50 percent of public-sector customers (for all medical facilities) are classified as middle class or above. Given that social marketing products are affordable and close to half of customers are from urban areas, a greater number of public-sector customers could seek supplies at pharmacies.

Table 5.1: Profiles of current modern contraceptive users by supply source

Distribution (in percent) of current modern contraceptive users by supply source, CMS 2000 data.<sup>26</sup>

User profiles	Public sector			Private sector		Total
	Hospital	Health center/ dispensary/ maternity	Other public sector <sup>27</sup>	Pharmacy	Clinic/ polyclinic/ AMPF	
<b>Residence</b>						
Urban	49.7	49.3	(5.0)	65.5	(81.8)	55.8
Rural	50.3	50.7	(95.0)	34.5	(18.2)	44.2
<b>Age group</b>						
15-19	0.0	1.4	(0.0)	2.2	(0.0)	1.5
20-24	3.9	7.3	(11.3)	16.8	(10.9)	10.2
25-29	16.2	20.8	(0.0)	21.0	(7.5)	18.8
30-34	11.0	22.3	(28.0)	17.8	(19.5)	19.3
35-39	38.1	21.9	(26.0)	17.3	(13.5)	22.4
40-44	21.4	17.7	(19.9)	13.0	(22.8)	17.0
45-49	9.4	8.7	(14.9)	11.9	(25.7)	10.8
<b>Income<sup>28</sup></b>						
Very poor	14.4	23.4	(22.1)	13.9	(3.3)	17.8
Poor	6.8	25.7	(42.3)	14.2	(0.0)	19.7
Middle class	29.6	22.2	(30.6)	19.6	(12.0)	22.3
Upper middle class	23.0	18.4	(5.0)	23.1	(32.1)	20.9
Rich	16.2	10.3	(0.0)	29.3	(52.5)	19.3
<b>Educational level</b>						
None	71.5	77.0	(95.0)	56.8	(48.5)	69.0
Primary	17.0	14.5	(5.0)	14.0	(22.1)	14.7
Secondary or above	11.5	8.5	(0.0)	29.2	(29.4)	16.3
<b>Number of observations</b>	<b>64</b>	<b>251</b>	<b>11</b>	<b>182</b>	<b>38</b>	<b>562<sup>29</sup></b>

Note: ( ) Based on less than 50 responses.

<sup>26</sup> Six of the 40 sterilized women in the sample did not answer the question about the sterilization source.

<sup>27</sup> Includes mobile team and home visits.

<sup>28</sup> Women in households for which SES could not be determined were excluded.

<sup>29</sup> Current users who did not know the source to obtain their method are included in the total column.

Distribution across sectors for various FP methods is likely to differ, as the nature of services required for various methods is different. IUDs require the intervention of a trained professional. A professional with some training can provide services for injectables. OCs can be obtained from a pharmacist, although consultations are highly recommended.

Table 5.2 shows customer profiles by supply source and method. The first part of the table shows profiles for OC users. Since the majority of FP customers in Morocco are OC users, profiles for these customers are roughly the same as for all FP clients.

The second part of the table shows profiles for IUD users. As only five women in the survey obtain FP services from the private sector, this number is too low to generalize interpretations. It is notable, however, that all of the five interviewed women who use the private sector are classified as rich. Also, more than 50 percent of public-sector clients are classified as middle class or higher.

Table 5.2: Profiles of current modern contraceptive users by supply source and method

Distribution (in percent) of characteristics of current modern contraceptive users by supply source and method, CMS 2000 data.<sup>30</sup>

User characteristics	Public sector			Private sector		Total
	Hospital	Health center/ dispensary/ maternity	Other public sector <sup>31</sup>	Pharmacy	Clinic/ polyclinic/ AMPF	
<b>OC</b>						
<b>Residence</b>						
Urban	(56.5)	50.7	(5.4)	64.1	(92.3)	57.4
Rural	(43.5)	49.3	(94.6)	35.9	(7.7)	42.6
<b>Age group</b>						
15-19	(0.0)	1.6	(0.0)	2.3	(0.0)	1.9
20-24	(10.0)	6.3	(12.2)	17.5	(17.7)	12.0
25-29	(33.3)	21.6	(0.0)	21.9	(10.1)	21.0
30-34	(15.8)	23.2	(30.2)	17.6	(14.1)	20.6
35-39	(28.6)	17.4	(28.1)	17.6	(19.9)	18.7
40-44	(9.3)	19.2	(21.5)	12.9	(10.1)	15.5
45-49	(2.9)	10.8	(8.0)	10.2	(28.1)	10.5
<b>Income</b>						
Very poor	(6.2)	24.3	(23.9)	14.5	(0.0)	13.6
Poor	(16.6)	23.7	(37.6)	14.8	(0.0)	15.8
Middle class	(47.2)	24.9	(33.1)	20.4	(19.7)	25.1
Upper middle class	(26.8)	18.6	(5.4)	23.6	(26.8)	23.8
Rich	(3.3)	8.6	(0.0)	26.7	(53.5)	21.7
<b>Educational level</b>						
None	(64.9)	76.4	(94.6)	57.2	(52.0)	63.4
Primary	(21.2)	15.0	(5.4)	13.6	(15.7)	15.3
Secondary or above	(13.9)	8.7	(0.0)	29.3	(32.3)	21.3
<b>Number of observations</b>	<b>25</b>	<b>175</b>	<b>10</b>	<b>173</b>	<b>19</b>	<b>418</b>

Note: ( ) Based on less than 50 responses.

<sup>30</sup> Given the low number of current users of injectables (16), these women were not included in the table. However, 79.5 percent of injectable users obtain their method from health centers and dispensaries; in total, 96 percent of injectable users obtain their method from the public sector.

<sup>31</sup> Current users who do not know the source to obtain their method are included in the total column.

(Table 5.2)

User characteristics	Public sector			Private sector		Total
	Hospital	Health center/ dispensary/ maternity	Other public sector <sup>32</sup>	Pharmacy	Clinic/ polyclinic/ AMPF	
<b>IUD</b>						
<b>Residence</b>						
Urban	(34.6)	40.8	--	--	(63.3)	43.4
Rural	(65.5)	59.2	--	--	(36.7)	56.6
<b>Age group</b>						
15-19	(0.0)	1.2	--	--	(0.0)	0.9
20-24	(0.0)	11.1	--	--	(0.0)	8.1
25-29	(8.4)	20.8	--	--	(17.7)	17.7
30-34	(0.0)	18.0	--	--	(32.5)	15.2
35-39	(60.9)	30.3	--	--	(13.0)	36.4
40-44	(23.8)	15.8	--	--	(36.7)	18.6
45-49	(6.9)	2.8	--	--	(0.0)	3.2
<b>Income</b>						
Very poor	(29.9)	17.4	--	--	(0.0)	14.1
Poor	(18.0)	32.7	--	--	(0.0)	20.5
Middle class	(21.7)	17.3	--	--	(0.0)	19.2
Upper middle class	(15.3)	17.0	--	--	(0.0)	21.8
Rich	(15.0)	15.7	--	--	100.0	24.4
<b>Educational level</b>						
None	(72.8)	83.9	--	--	(54.4)	70.9
Primary	(5.8)	9.9	--	--	(0.0)	12.7
Secondary or higher	(21.5)	6.2	--	--	(45.6)	16.5
<b>Number of observations</b>	<b>13</b>	<b>57</b>	<b>--</b>	<b>--</b>	<b>5</b>	<b>79</b>

Note: ( ) Based on less than 50 responses.

<sup>32</sup> Current users who do not know the source to obtain their method are included in the total column.



Table 5.3 presents reasons why women choose a particular supply source. The columns for analysis are the same as the two preceding tables. The survey covers all the reasons that led a woman to choose her source, thus the sum of percentages in the columns exceeds 100 percent.

Health centers (public sector) and pharmacies (private sector) are the most frequent supply sources. Distance to the supply source is the reason most frequently mentioned to justify the choice of the source, followed by availability of the product, and the reception at the source.

For medical sources, such as hospitals (public) and clinics (private), distance is much less significant as a factor. For hospitals, product availability and the reception remain significant, but waiting time, cleanliness, and personnel are also significant factors. In clinics, the reception is by far the most significant factor in choosing a supply source.

It is difficult to draw conclusions from a survey such as this, but the findings suggest that to attract new customers, the private medical sector should concentrate on the middle class, and create an accessible, friendly, and pleasant environment.

*Table 5.3: Reasons for the choice of a FP service source by supply source*

Distribution (in percent) of current modern contraceptive users by reasons for the choice of a provider or a location, according to supply source, CMS 2000 data.<sup>33</sup>

Reasons	Public sector			Private sector		Total
	Hospital	Health center/ dispensary/ maternity	Other public sector <sup>34</sup>	Pharmacy	Clinic/ polyclinic/ AMPF	
Distance	(22.9)	56.0	(0.0)	59.3	(28.0)	51.0
Opening time	(6.5)	1.7	(0.0)	3.0	(3.8)	2.5
Acceptable waiting time	(28.6)	2.4	(5.0)	2.5	(7.1)	4.9
Reception	(34.6)	32.4	(18.7)	36.4	(66.2)	34.4
Presence of a trained person	(27.7)	11.0	(27.4)	10.8	(10.8)	12.8
Product availability	(41.4)	51.2	(42.8)	46.8	(10.6)	46.6
Intimacy/confidentiality	(9.2)	4.4	(5.0)	7.1	(10.2)	6.1
Cleanliness	(25.4)	12.0	(0.0)	14.1	(34.9)	14.7
Information available	(5.1)	5.4	(7.4)	7.5	(8.7)	6.8
Other	(0.0)	10.3	(14.7)	2.2	(12.8)	7.0
Don't Know	(7.2)	5.0	(18.7)	3.5	(5.6)	5.4
<b>Number of observations</b>	<b>40</b>	<b>249</b>	<b>11</b>	<b>182</b>	<b>25</b>	<b>528</b>

Note: ( ) Based on less than 50 responses.

<sup>33</sup> Multiple-response question; total can be greater than 100 percent.

<sup>34</sup> Current users who do not know the source to obtain their method are included in the total column.

In addition to attempting to increase the share of the private sector in providing FP services and supplies, the social marketing program in Morocco seeks to target the segments of the population with the ability to pay for FP services. Kinat Al Hilal (OC), Hoqnat Al Hilal (injectable), and Lawlab Al Hilal (IUD) are products of high quality and moderate price targeted to middle-class women.

As previously demonstrated, wealthier women are more likely to use the private sector. Table 5.4 shows the distribution of various brands of OCs among women using this method according to their SES ("SM subtotal" is the total of OCs sold within the social marketing framework).<sup>35</sup>

More than one-third of women in the three lower SES groups use the Kinat Al Hilal product. It is by far the most popular brand and women easily prefer it to the Adepal brand.

*Table 5.4: Current users of oral contraceptives*

Distribution (in percent) of current OC users by supply source and brand purchased, according to SES, CMS 2000 data.

Supply source	SSE					Total <sup>36</sup>
	Very poor	Poor	Middle class	Upper middle class	Rich	
Public sector	72.8	75.6	65.3	53.8	33.9	60.2
Private medical sector	26.0	22.9	31.1	44.5	64.6	37.8
Other	1.2	1.5	3.6	1.7	1.6	2.0
Total women	76	89	128	131	129	553
<b>OC brand</b>						
Kinat Al Hilal	(35.7)	(35.2)	(35.9)	17.9	11.3	24.5
Minidril	(5.7)	(0.0)	(6.0)	6.1	6.5	5.3
Microgynon	(16.0)	(0.0)	(9.4)	7.1	3.5	6.8
<b>SM Subtotal</b>	<b>(57.4)</b>	<b>(35.2)</b>	<b>(51.3)</b>	<b>31.1</b>	<b>21.3</b>	<b>36.6</b>
Adepal	(12.9)	(17.1)	(9.0)	24.0	30.3	20.3
Microdiol	(0.0)	(3.9)	(0.0)	10.6	12.5	6.6
Stederil	(11.3)	(2.3)	(4.0)	9.1	8.1	7.1
Microval	(5.2)	(10.6)	(7.2)	0.0	5.1	5.1
Milligynon	(0.0)	(0.0)	(0.0)	7.8	4.8	3.3
All others	(5.4)	(9.7)	(3.8)	15.3	15.0	10.6
Don't know	(7.8)	(21.2)	(24.7)	2.1	2.9	10.4
<b>Total</b>	<b>(100)</b>	<b>(100)</b>	<b>(100)</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Number of observations</b>	<b>17</b>	<b>22</b>	<b>42</b>	<b>54</b>	<b>66</b>	<b>201</b>

<sup>35</sup> Once the packaging is removed, Kinat Al Hilal cannot be differentiated from Minidril or Microgynon.

<sup>36</sup> The nine women whose SES could not be determined are excluded.

It is useful to know the characteristics that FP clients seek in providers to help direct FP users to the private sector. Table 5.5 shows the qualities that FP clients seek in providers according to the clients' SES. The availability of the product and the proximity of the provider are the most significant factors for women in lower SES groups. For wealthier women, proximity is the most significant factor, but other factors, such as a pleasant reception by personnel and the cleanliness of the establishment, are also important.

*Table 5.5: Reasons for the choice of a FP service source*

Distribution (in percent) of current modern contraceptive users by reason to choose a provider or location, according to SES, CMS 2000 data.<sup>37</sup>

Reasons	SES					Total <sup>38</sup>
	Very poor	Poor	Middle class	Upper middle class	Rich	
Distance	41.5	48.2	56.2	55.9	52.1	51.1
Opening time	3.0	4.6	1.5	1.4	1.7	2.4
Acceptable waiting time	0.0	2.6	8.3	7.0	4.3	4.6
Reception	25.4	24.8	35.2	37.6	48.7	34.5
Presence of trained personnel	8.5	13.7	15.9	6.9	17.9	12.7
Product availability	45.0	62.0	47.1	41.4	36.3	46.5
Intimacy/confidentiality	2.4	2.2	11.5	7.2	6.4	6.2
Cleanliness	11.8	1.8	11.6	14.0	20.6	14.6
Information access	13.5	1.0	4.8	6.3	7.9	6.5
Medication in credit	0.0	0.8	0.0	1.5	1.7	0.8
Free	4.2	3.2	1.6	2.9	0.0	2.4
Only one available	9.0	2.1	0.5	1.0	0.0	2.4
Nurse visits you	2.4	0.0	0.0	0.0	0.0	0.2
Other	0.0	0.7	0.0	1.6	3.6	1.1
Don't know	7.3	8.7	5.7	4.0	1.6	5.5
<b>Number of observations</b>	<b>73</b>	<b>86</b>	<b>122</b>	<b>120</b>	<b>119</b>	<b>520</b>

<sup>37</sup> Multiple-response question; total can be greater than 100%

<sup>38</sup> Women in households where SES was not been determined and sterilized women are excluded.

Women depend on many people and factors to make decisions relative to FP. Table 5.6 shows how people in various SES groups make decisions about the FP method they use. In all SES groups, most women make their FP decision without the assistance of a family member, a friend, or a health care provider. Almost three-quarters of women in the poorer quintiles make FP decisions without asking for someone's opinion. This tendency is less prevalent in the quintile of rich women, where only 51 percent make their decision without input.

Among women indicating that they had received assistance from others to make choices, most women in the very poor, poor, and middle classes consulted family members or friends, while 48 percent of rich women consulted a physician. On the other hand, only six percent of very poor women and about 20 percent of women in the poor and middle classes received counseling from a physician.

Table 5.6: Persons helping to make decisions on FP methods, CMS 2000 data

Persons helping	Very poor	Poor	Middle class	Upper middle class	Rich	Total <sup>39</sup>
<b>How was the decision made to use the method?</b>						
Alone	72.9	67.8	63.0	66.2	51.7	64.3
Other persons	21.1	31.1	28.8	29.9	36.5	29.5
Both	5.9	1.1	7.5	3.9	11.8	6.0
Don't know	0.0	0.0	0.7	0.0	0.0	0.2
<b>Number</b>	<b>73</b>	<b>86</b>	<b>122</b>	<b>119</b>	<b>119</b>	<b>519</b>
<b>Person helping to make a choice (among those who did not decide by themselves)</b>						
Husband	(36.3)	(25.1)	(16.6)	(24.8)	28.1	25.3
Friend	(17.0)	(13.7)	(1.9)	(13.5)	1.9	8.3
Other family member	(19.4)	(11.1)	(36.5)	(10.0)	10.2	17.8
Physician	(6.4)	(20.0)	(17.1)	(32.9)	48.4	27.1
Pharmacy	(1.9)	(8.4)	(0.0)	(4.5)	3.9	3.6
Nurse	(19.0)	(21.8)	(25.0)	(14.4)	2.9	16.0
Midwife	(0.0)	(0.0)	(0.0)	(0.0)	4.7	1.2
Mobile team	(0.0)	(0.0)	(2.8)	(0.0)	0.0	0.7
<b>Number of observations</b>	<b>23</b>	<b>30</b>	<b>48</b>	<b>41</b>	<b>58</b>	<b>200</b>

Note: ( ) Based on less than 50 responses.

<sup>39</sup> Women in household for which SES could not be determined and sterilized women were excluded. Also, women responding “don’t know” were excluded.

Table 5.7 shows the persons who help women make decisions concerning OCs in the private sector. The first column is for users the social marketing brand, the second is for OCs for breastfeeding women, and the third is for other brands of OCs.

Women using progestin OCs, which are recommended for breastfeeding women, make their choice with assistance more often than other women. However, only 14 women of 1,060 interviewed (less than two percent) use OCs recommended for breastfeeding women. As 17 percent of women are potentially breastfeeding,<sup>40</sup> this disconnect shows a strong potential market for progestin OCs.

Eighty percent of women using the social marketing brand make their FP decisions without assistance. Almost half of the users of OCs for breastfeeding women received assistance from a pharmacist, while 20 percent of women using the social marketing brand consulted a pharmacist. The third part of the table shows a continuation of this pattern. One-third to one-half of women using the social marketing brand mentioned pharmacies as the source of information in helping them make a decision.

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<sup>40</sup> This number is based on a calculation using the results on page 85 of the EPPS.

Table 5.7: Persons helping in making OC decisions according to brand, CMS 2000 data

Persons helping	Kinat Al Hilal	OCs for breastfeeding women (Microval, Millygynon)	Other brands	Total
<b>How is the decision to use this method taken?</b>				
Alone	79.2	(59.7)	65.6	67.5
Other persons	18.2	(40.3)	29.0	27.9
Both	2.6	(0.0)	5.3	4.7
<b>Number of observations</b>	<b>62</b>	<b>14</b>	<b>342</b>	<b>418</b>
<b>Person helping in making the choice (among those who did not decide alone)</b>				
Husband	(12.5)	(11.6)	20.5	18.5
Friend	(6.1)	(0.0)	5.8	6.2
Other family member	(25.1)	(0.0)	23.2	22.1
Physician	(33.1)	(29.7)	34.2	33.8
Pharmacist	(18.2)	(49.6)	0.4	5.0
Nurse	(4.9)	(9.1)	12.9	11.9
Midwife	(0.0)	(0.0)	1.9	1.6
Mobile team	(0.0)	(0.0)	1.1	0.9
<b>Number of observations</b>	<b>18</b>	<b>7</b>	<b>124</b>	<b>149</b>
<b>Where does this person work (if a provider helped)?</b>				
Hospital	(0.0)	(0.0)	18.2	14.5
Maternity	(0.0)	(0.0)	1.3	1.0
Health center	(12.7)	(21.9)	14.1	14.7
Dispensary	(8.8)	(0.0)	15.0	12.9
Home visit	(0.0)	(0.0)	1.4	1.1
Mobile team	(0.0)	(0.0)	2.0	1.6
AMPF	(0.0)	(0.0)	1.5	1.2
Pharmacy	(32.4)	(56.1)	0.0	8.9
Clinic/polyclinic	(14.8)	(0.0)	1.8	3.0
Physicians	(31.3)	(22.0)	43.7	40.3
Parent/friend	(0.0)	(0.0)	1.1	0.9
<b>Number of observations</b>	<b>10</b>	<b>6</b>	<b>68</b>	<b>84</b>

Note: ( ) Based on less than 50 responses.

## 6 Discussion and Conclusion

Contraceptive use continues to increase in Morocco. Most of the increase has occurred in rural areas. The IUD has seen the greatest share increase among FP methods. The increase has mainly occurred in rural areas where most services are obtained through the public sector.

There are two population segments that appear to be the best targets to further promote the use of modern FP methods: current users of traditional methods and women who intend to use FP in the future. These two population groups are well informed relative to other population groups. Women who use traditional methods are older, live in urban areas, and are quite rich. Women who intend to use FP in the future are generally young and live in rural areas.

Based on these profiles, it appears that the users of traditional FP methods are a potential market for long-term methods. A large majority reside in urban areas, where the majority of physicians are, they are older, and have the means to pay for private services. The users of short-term methods are also a target for long-term method use, but these women vary and require a subtler marketing plan.

Ignorance of long-term methods continues. More than half of women did not give an opinion about these methods, and those who did cited side effects as a problem. They do believe, however, that injectables are easy to obtain, accessible, and effective. Other indicators show that injectables are not popular, as can be seen by high termination rates for injectable users. Only 11 percent of women who intend to practice FP express a preference for injectables.

Women are not unfavorable to IUDs. However, the majority of women who are not current long-term method users believe that side effects exist; contrary to current users, of whom less than half think there are side effects. In fact, for almost all the usage and access indicators for IUDs, women who are current users are more favorable to the method. A marketing plan will have to take into consideration that actual experiences with IUDs are better than what women's predispositions would lead them to believe.

Side effects and specific characteristics of various methods are the main reasons for stopping FP. While the number of IUD and injectable users is relatively low, practically all former users mentioned these reasons for giving up their method. On the other hand, former OC users cited reasons related to fertility, the wish to have another child, or breastfeeding. The lesson learned is that much more attention must be paid to managing side effects related to long-term methods.

Biosel ORS and Kinat Al Hilal OCs are well known. Biosel is better known among relatively well-off women. Kinat Al Hilal is best known by middle-class women. An interesting case study for CMS would be to analyze the reasons for the differential awareness of these two products from one social class to another. The Hoqnat Al Hilal injectable and Lawlab Al Hilal IUD are relatively new and unknown products.

Women of lower SES choose their supply and service sources according to relatively pragmatic criteria. They want the source to be close by and the method to be available. Women of higher SES mention other factors, such as facility cleanliness and proper reception by providers, in addition to pragmatic criteria.

Most women currently using a FP method make their own decision about their preferred method. Women who are better off are more likely to follow the advice of their physician. Women in poorer groups who receive help to decide mostly turn to family members or friends.





## 7 References

Azelmat, Mustapha, Ahmed Abdemoneim. 1999. *Enquête sur la Santé de la Mère et de l'Enfant (ENSME) 1997*. Ministère de la Santé, direction de la planification et des ressources financières, service des études et de l'information sanitaire et PAPCHILD.

Azelmat, Mustapha, Mohamed Ayad et El Arbi Housni. 1996. *Enquête de Panel sur la Population et la Santé (EPPS) 1995*. Calverton, Maryland (U.S.): Ministère de la Santé Publique, Direction de la Planification et des Ressources Financières, Service des Etude et de l'Information Sanitaire et Macro Internationale Inc.

CMS/Morocco. 2001. *Workplan: January-December 2001*. Rabat: CMS/Morocco.

Commercial Market Strategies/Morocco. 2001. *Enquête sur les connaissances, attitudes et pratiques (CAP) des ménages en matière de planification familiale*. Rabat: CMS/Morocco.

LMS Marketing. 2001. *Connaissance, attitudes et pratiques des ménages en matière de planification familiale : Deliverable 2*. CMS Project: Washington, D.C.

Montgomery, Mark, Michele Gragnolati, Kathleen Burke, and Edmundo Paredes. 2000. *Measuring Living Standards with Proxy Variables*, *Demography*, 37(2): 155-174.

## 8 Annex

Table A.1: Regression results used to estimate regular household expenses

Variable	Number (Percentage who have the facility or asset)	Coefficient	Std. Err.
<b>Water source</b> (1=tap, 0=other)	63.0	0.240**	0.096
<b>W.C.</b> (1=w.c., 0=other)	67.6	0.155+	0.088
<b>Floor plan</b> (1= finished, 0= natural/rudimentary)	77.4	0.109	0.086
<b>Durable goods in the household</b>			
Electricity (1=in the household)	66.6	0.004	0.115
Radio	82.8	0.288**	0.072
Television	78.8	0.169+	0.098
Telephone	24.9	0.201*	0.077
Refrigerator	41.7	0.211**	0.080
Washer	10.2	0.319**	0.100
Bicycle	16.1	-0.116	0.072
Motorcycle	11.6	-0.009	0.118
Car	9.9	0.159	0.117
Tractor	0.8	0.585**	0.157
Carriage/mule/horse	23.2	-0.772	0.088
No. of persons per bedroom	0.38 (Average)	0.324+	0.174
Constant		8.263	0.408
R-square:	0.362		
<b>Number of observations</b>	<b>682</b>		

\*\* p < .01 level; \* p < .05 level; + p < .01 level

Table A.2: Current contraceptive use by urban/rural status according to different sources

Distribution (in percent) of married women 15 to 49 years of age by currently used contraceptive method, according to urban/rural status.

Method	EPPS 1995	PAPCHILD 1997	CMS 2000
<b>URBAN</b>			
Any method	64.2	65.8	67.4
Any modern method	51.0	54.3	56.5
Any traditional method	13.2	11.6	11.0
Not using	35.8	34.2	32.6
<b>Method Mix</b>			
OC	56.4	61.2	62.8
IUD	9.5	11.1	9.6
Injectable	0.0	1.4	2.4
Vaginal methods	0.5	0.3	0.1
Condom	4.0	3.3	2.8
Female sterilization	8.7	5.2	5.9
Male sterilization	0.0	0.0	0.0
Implant/Norplant	0.3	0.0	0.0
Periodic abstinence	12.9	7.9	9.5
Withdrawal	6.9	6.4	6.5
Prolonged breastfeeding	0.0	2.7	0.3
Others	0.8	0.6	0.0
Total	100	100	100
<b>RURAL</b>			
Any method	39.2	51.7	52.6
Any modern method	35.6	43.8	47.9
Any traditional method	3.6	7.8	4.7
Not using	60.8	48.3	47.4
<b>Method Mix</b>			
OC	73.8	70.7	65.0
IUD	7.4	7.0	17.3
Injectable	0.3	1.2	2.7
Vaginal methods	0.0	0.2	0.0
Condom	1.0	0.6	0.4
Female sterilization	8.1	5.0	5.7
Male sterilization	0.0	0.0	0.0
Implant/Norplant	0.0	0.2	0.0
Periodic abstinence	4.3	2.5	7.6
Withdrawal	3.8	3.7	1.3
Prolonged breastfeeding	0.0	8.5	0.0
Others	1.3	0.4	0.0
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>