

6080155 (2)
PD-AAC-699-81

97.

PROJECT PAPER REVISION

608-0155
Project No. 096 - 0112

POPULATION AND FAMILY PLANNING SUPPORT

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

1. TRANSACTION CODE

C

A. ADD
C. CHANGE
D. DELETE

PP

2. DOCUMENT CODE

3

3. COUNTRY/ENTITY

MOROCCO

4. DOCUMENT REVISION NUMBER

1

5. PROJECT NUMBER (7 digits)

155
608-0112

6. BUREAU/OFFICE

A. SYMBOL
NE

B. CODE
 03

7. PROJECT TITLE (Maximum 40 characters)

Population & Family Planning Support

8. ESTIMATED FY OF PROJECT COMPLETION

FY 8 3

9. ESTIMATED DATE OF OBLIGATION

A. INITIAL FY 7 8
C. FINAL FY 8 2

B. QUARTER 3
(Enter 1, 2, 3, or 4)

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$) - 4.2DH

| A. FUNDING SOURCE | FIRST FY | | | LIFE OF PROJECT | | |
|------------------------|----------|--------|----------|-----------------|--------|----------|
| | B. FX | C. L/C | D. TOTAL | E. FX | F. L/C | G. TOTAL |
| AID APPROPRIATED TOTAL | 1,182 | | 1,182 | 13,017 | - | 13,017 |
| (GRANT) | (1,182) | () | (1,182) | (13,017) | (-) | (13,017) |
| (LOAN) | () | () | () | () | () | () |
| OTHER U.S. | 1. | | | | | |
| | 2. | | | | | |
| HOST COUNTRY | | 5,000 | 5,000 | | 32,671 | 32,671 |
| OTHER DONOR(S) UNFPA | 53 | | 53 | 3,000 | | 3,000 |
| TOTALS | 1,235 | 5,000 | 6,235 | 16,017 | 32,671 | 48,688 |

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)

| A. APPROPRIATION | B. PRIMARY PURPOSE CODE | PRIMARY TECH. CODE | | E. 1ST FY 78 | | H. 2ND FY 79 | | K. 3RD FY 80 | |
|------------------|-------------------------|--------------------|---------|--------------|---------|--------------|---------|--------------|---------|
| | | C. GRANT | D. LOAN | F. GRANT | G. LOAN | I. GRANT | J. LOAN | L. GRANT | M. LOAN |
| (1) PH | 440B | 440 | | 1,182 | | 2,394 | | 2,917 | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| TOTALS | | | | 1,182 | | 2,394 | | 2,917 | |

| A. APPROPRIATION | N. 4TH FY 81 | | Q. 5TH FY 82 | | LIFE OF PROJECT | | 12. IN-DEPTH EVALUATION SCHEDULED |
|------------------|--------------|---------|--------------|---------|-----------------|---------|--|
| | O. GRANT | P. LOAN | R. GRANT | S. LOAN | T. GRANT | U. LOAN | |
| (1) PH | 3,350 | | 3,174 | | 13,017 | | <input type="checkbox"/> MM <input type="checkbox"/> YY <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 7 <input type="checkbox"/> 8 |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| TOTALS | 3,350 | | 3,174 | | 13,017 | | |

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 1 = NO
2 = YES

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE

Albert P. Disdier

Albert P. Disdier

TITLE

Mission Director

DATE SIGNED

MM DD YY

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

I.B. Recommendations

| | |
|---------------------------------|----------------------|
| For FY 78-82 only: | <u>(\$000s)</u> |
| Grant, U.S. Dollars | 13,017 ^{1/} |
| Over Life of Project (FY 71-82) | |
| Grant, U.S. Dollars | 16,063 ^{2/} |

1/ Includes centrally-funded elements as follows: contraceptives \$5,370,000; National Fertility Survey \$275,000; Commercial Distribution Program \$350,000; Operations Research Project (Marrakech) \$320,000.

2/ Includes centrally-funded contraceptives for prior years, totaling \$1,523,000.

I.C. Introduction, Rationale, and Summary - Description of Project

. Introduction

This Revision is a continuation of Project 60896-0112, Family Planning Support, which began in 1971. While many items of assistance included under the old project are to be continued, the project has undergone a complete revision -- from project inputs to sector goal -- to reflect the state of affairs in 1978 and to incorporate major action elements identified in the Multi-Year Population Strategy exercise just completed.

Essentially, this project aims at establishing a solid base within the host government for future planning and implementation of population programs. In doing so, the project includes three subpurposes specifically aimed at: (1) increasing contraceptive prevalence by 143%; (2) increasing awareness and commitment among key GOM officials and opinion leaders; and (3) generating new demand for contraceptive services.

The revised project includes eight major outputs which can, in a sense, be conveniently thought of as separate projects. This structure has been chosen in order to facilitate the AID project management task, since each of the eight outputs requires a relatively independent set of management actions related to, but distinct from, the other seven outputs. In brief, the eight outputs are:

- (1) Completion of the Marrakech pilot household delivery program
- (2) Expansion of household delivery activities to 10 additional provinces
- (3) Construction and equipping of 10 additional FP referral centers
- (4) Population manpower development (in-country and participant training)
- (5) Improved FP service availability in all health facilities
- (6) Establishment of a low-cost commercial distribution program
- (7) Establishment of a national Information, Education and Communication program rooted in the private sector
- (8) Completion of a national fertility and family planning survey.

The estimated total cost of the project to the U.S. from its inception in 1971 is \$16 million. Obligations through FY 77 have totaled \$3 million. The AID cost during the period covered by this Revision (1978-1982) is \$13.017 million, representing 81% of the overall U.S. cost. Higher costs during the next five-year period are the result of greatly increased activity with respect to the development of public and private sector service capability, the recruitment of new acceptors, and the higher associated contraceptive costs in both the public and the private sectors. Costs to the Government of Morocco

are expected to be on the order of \$32.7 million equivalent over the 5-year project period. Thus the U.S. contribution, while substantial, represents a small percentage (28%) of the overall cost.

Other donor support for activities outlined in this Project Paper consists primarily of IPPF financing of activities of the local family planning association, and UNFPA support for training, seminars, IE&C, and transportation elements of the government family planning programs in the Ministry of Health, the Ministry of Youth & Sports, and the Ministry of Labor.

The project is ongoing, and first obligations under this Revision are anticipated in the third quarter of FY 1978.

This Revision is fully consistent with present priorities of the Agency, with Congressional mandates, and with all statutory provisions pertaining thereto (see Mission Director's Certification, Annex 4). Although there are three project issues (see Section I.E.), there are no outstanding host government or AID issues which would inhibit the immediate implementation of this project.

There are, however, three matters of particular concern. These are: (1) the low level of GOM commitment to population planning; (2) present limitations on AID bilateral assistance activities; and (3) the marginal role of multilateral donors in the population sphere in Morocco. Each of these is discussed in detail in the body of this paper. In summary, our concerns are that: (1) real GOM interest and commitment seems lacking; (2) there are clear limits to AID bilateral assistance at present, beyond which it is not politically acceptable to go; and (3) the role of international agencies has, thus far, been marginal in providing population assistance to Morocco.

The Country Team will initiate and maintain a high-level dialogue with the GOM on food/population problems and ways they can best be dealt with (consistent with the latest guidance from the Department). This dialogue could conceivably result in new attention being given to these problems and possibly in new requests for AID or other donor assistance. There is also the risk that the opposite reaction might result, though we will of course strive to avoid a negative outcome. At the same time, we will be working closely with UN agencies and other international donors such as IPPF to encourage their support for population assistance in Morocco.

Rationale

The purposes of this Revision are:

(1) to reflect changes in project inputs and outputs based upon actual experience during the seven-year period since the original PROP was approved;

(2) to incorporate, wherever possible, quantifiable targets and indicators of progress toward achievement of project purpose;

(3) to incorporate new inputs into the project which deal explicitly with improvement of service availability in both the public and the private sectors; and

(4) to incorporate elements of training, technical assistance, and other support aimed at establishing in-country capability and willingness to plan, manage, and evaluate cost-effective population programs.

The modifications and additions to this Project which are herein proposed are based upon changes in the country situation since the original grant was approved in 1971. Among the significant happenings are:

(1) the launching and successful completion of the first phase of the Marrakech household distribution project, aimed at making orals and condoms available directly in the homes of all couples in Marrakech province over a 30-month period;

(2) a significant growth in Ministry of Health interest in family planning manpower development, and willingness to make key officials available for in-country and U.S. technical and administrative training;

(3) a clear and uncontested demonstration in both the Marrakech project and the newly-opened family planning referral centers (both partially USAID-financed) of the existing demand for contraceptive services which extends far beyond present GOM capability to meet; and

(4) a limited but growing awareness of the population threat to Morocco's future well-being, accompanied by increased willingness on the part of some key GOM officials (most notably, officials in the Ministries of Health, Youth and Sports, Labor, and Social Affairs) to pursue activist population and family planning programs.

We wish to be very careful not to imply that the Government of Morocco is at this point in time solidly committed to population efforts. On the contrary, and despite considerable rhetoric in national development plans and elsewhere, it seems clear that the present watchword is CAUTION in proceeding with population and family planning programs. There is even, at the very highest levels of government, the strong belief that increased population will necessarily constitute an increased manpower resource for development (see discussion in Technical Analysis section, p. 46, and Project Issues section, p. 14). Because of GOM sensitivities in this area, the situation demands that the U.S. proceed actively, but with consummate tact in providing population assistance.

While Morocco can in no way be likened to the Indonesias, the Thailands, the Taiwans, the Koreas, or the Singapores of the family planning world -- all of which have made excellent progress in family planning -- it has in several ways made significant progress with little accompanying fanfare. Contraceptive sales in private sector pharmacies are remarkably high, estimated to account for more than half of total contraceptive protection in the country or about 7% of MWRA ^{1/}. The GOM continues a policy of official ignorance of the private sector sales of orals without prescription, thus leaving open an important avenue for contraceptive availability. Contraceptive acceptance in the government's own program continues to grow, and there are some indications that continuation rates may be improving as well. There are an estimated 150,000 users (about 5% of MWRA) of modern contraceptives (mostly orals) as a direct result of the Ministry of Health programs. VSC ^{2/} services are also quietly offered in government hospitals and the MOH has requested sizable quantities of equipment and technical training in modern VSC techniques. In Marrakech, the MOH has for the first time reversed its policy on orals prescription: assistant nurses who are visiting from door-to-door are permitted to prescribe and to supply oral contraceptives to new acceptors. Initial acceptance in that project has been running at a high level: 61% of married women 15-44 contacted. The MOH plans to expand the household distribution project to other provinces during the life of this project revision, with support contained in this Revision.

Other ministries such as Youth and Sports and Social Affairs have shown interest in building family planning information activities into their ongoing programs. These and other factors contribute to a climate where there is an increased chance of program success, as compared to conditions prevailing at the time the original grant was approved.

1/ married women of reproductive age (i.e., 15-49; N = 2.9 million in January 1978)

2/ voluntary surgical contraception

Summary Description

This Revision proposes continued comprehensive support for the host government's national family planning program, including commodities, participant training, technical assistance, and local costs support.

Commodity support, estimated to run at about \$1.1 million annually over the remaining life of the project, consists primarily of contraceptives and medical/surgical equipment.

Participant training will be greatly stepped up in the next four years, and will be aimed at generating increased in-country ability to train others, as well as at improving important skills needed to plan, manage, and evaluate cost-effective family planning and population programs. Funding included herein is \$453 thousand for a total of 279 person-months of U.S. and third-country training, and \$78 thousand for 218 person-months of in-country training 1/.

Technical assistance to be provided under this project will be provided almost exclusively by contract individuals and organizations. One resident specialist is programmed for a 36-month period to facilitate the successful completion of the Marrakech project and its expansion to 10 additional provinces by 1981. A resident technician is proposed for a 27-month period to assist the MOH in the planning and evaluation of a national fertility and family planning survey. Eighteen person-months of contract services are proposed for an IE&C specialist to assist the private family planning association to establish a dynamic IE&C program. Approximately 21pm of resident contract services are included for the establishment of a low-cost contraceptive distribution program in the private sector. Additional short-term technical assistance is to be provided through centrally-funded contracts with the International Fertility Research Program (IFRP) in North Carolina, the National Center for Health Statistics (NCHS), and other organizations as required and appropriate. The estimated total cost of technical assistance under this Revision is \$723,000 thru FY 1982, including that provided under several contracts.

1/ In addition, 61pm of in-country training is included in the National Fertility Survey (Output No. 8) and 410pm of in-country training is included under the household distribution activities (Outputs 1 and 2) for a grand total of 961pm of training.

Local costs support is to be provided for the Marrakech household distribution project and its expansion to other provinces, for in-country training programs, and for construction of 10 additional family planning provincial referral centers. Costs of such support over the 1978-82 period are expected to run as follows: \$5.1 million for household distribution programs; \$78,000 for in-country training; and \$500,000 for construction of the 10 referral centers.

Overall estimated dollar costs for the revised project represent an increase of \$10.6 million or about five times more than the 1975 PROP estimate which ran only through FY 78. The increased cost which is not explainable by the additional four years life of project 1/ is attributable to: (1) higher input levels of centrally-funded oral contraceptives; (2) stepped-up participant and in-country training activities; (3) new private sector commercial distribution activities; (4) the Marrakech household distribution program and its expansion; and (5) increased IE&C 2/ activities aimed at gaining greater support for population programs from Morocco's key officials and opinion leaders.

A summary of AID financial inputs to date (thru FY 1977) and proposed for the revised project period (FY 78-82) is given in the following tables, arranged by assistance category (Table 1) and by each of the eight major outputs (Table 2). Full backup data is given in the Financial Analysis Section (III.B. p. 59).

1. Annual costs beginning in FY 78 will run at substantially higher levels over previous performance, largely as a result of greatly increased absorptive capacity and a generally higher level of FP activity than earlier envisioned.
2. Information, Education and Communication

Table 1

Summary of Proposed Obligations by Category, FY 78-82
(\$000s)

| <u>Category</u> | <u>thru</u> <u>FY 77</u> | <u>FY 78</u> | <u>FY 79</u> | <u>FY 80</u> | <u>FY 81</u> | <u>FY 82</u> | <u>Total</u> <u>FY 78-82</u> | <u>Total</u> <u>All years</u> |
|------------------------------------|-----------------------------|--------------|--------------|--------------|--------------|--------------|---------------------------------|----------------------------------|
| Technical Assistance ^{1/} | 100 | 55 | 130 | 85 | 25 | 25 | 320 | 420 |
| Training ^{2/} | 73 | 71 | 142 | 117 | 95 | 107 | 532 | 605 |
| Commodities ^{3/} | 2288 | 656 | 984 | 1260 | 1570 | 1185 | 5655 | 7943 |
| Other Costs ^{4/} | 585 | 400 | 1138 | 1455 | 1660 | 1857 | 6510 | 7095 |
| Totals | 3046 | 1182 | 2394 | 2917 | 3350 | 3174 | 13017 | 16063 |

1/ Technical assistance: these figures do not include technical services provided under the National Fertility Survey (Output No. 8), IE&C assistance to the AMPF (Output No. 7), or the commercial Distribution Program (Output No. 6). Technical assistance costs for these activities are included under other costs category. Together, such technical assistance represents 64 person-months and \$403,000 for a grand total of \$723,000 in TA costs.

2/ 279 person-months of long- and short-term US or third country training plus 218 person-months of in-country training.

3/ \$5,370,000 in centrally-funded contraceptives plus \$285,000 in Mission-funded commodities.

4/ Marrakech VDMS pilot project; VDMS expansion, IE&C program; commercial distribution program; National Fertility and FP Survey; FP Referral Centers; misc. others.

Table 2
Summary of Proposed Obligations by Activity
(\$000s)

| <u>For</u> <u>Output No.</u> | <u>Activity</u> | <u>Thru FY 77</u> | <u>FY 78-82</u> |
|---------------------------------|--|-------------------|-----------------|
| 1 | Household Distribution Pilot Project | 147 | 375 |
| 2 | VDMS Expansion to 10 Provinces | 0 | 4,750 |
| 3 | Construction and Equipping of 10 Referral Centers | 505 | 650 |
| 4 | Manpower Development | 108 | 532 |
| 5 | Improved Services (commodities) | 2,175 | 5,655 |
| 6 | Commercial Distribution Program | 0 | 350 |
| 7 | IE&C Activities | - | 280 |
| 8 | National Fertility and FP Survey | 0 | 275 |
| Misc. | Consultants, evaluation, contingency | - | 150 |
| | Totals | 2,935 | 13,017 |

Project Administration

The revised project will continue to be coordinated by a USAID project manager (Population Officer) who will draw upon the resources of USAID/Morocco as appropriate. USAID will continue to arrange for the procurement and importation of commodities, and will administer the local costs elements of the project. A new resident specialist (contract) will have first-line responsibility for managing U.S. actions related to the Marrakech household distribution project and its expansion. Resident specialists are also proposed (1 each) for the National Fertility and Family Planning Survey (27 person-months), for IE&C assistance to the Moroccan family planning association (18pm), and for the establishment of a commercial distribution system (18-24pm). USAID will continue to plan and administer participant training elements of the project, drawing upon technical assistance from outside sources as appropriate.

Implementation will, of course, be the responsibility of Moroccan institutions receiving U.S. support. These institutions are: (1) the Ministry of Health; (2) the Association Marocaine de Planification Familiale (private family planning association); and, possibly (3) a semi-autonomous group established for the purpose of managing a commercial distribution program. Assistance in case No. 3 would be channeled through a U.S.-contractor responsible for the organization and management of private sector contraceptive distribution programs.

By the end of the Project period (September 1982) it is anticipated that all of the outputs listed in the Logical Framework (Part II, Section B) will have been achieved. The outputs are of such nature as to demonstrate real achievement in organizing an effective population/family planning program -- as measured by the OVIs ^{1/} listed in the Logframe -- and to demonstrate the existence of an indigenous capacity to plan, implement, manage, and evaluate successful population and family planning activities on a national level, which is the basic purpose of the Project.

^{1/} Objectively verifiable indicators

I.D. SUMMARY FINDINGS

1. Technical

Findings of the technical analysis suggest that the project as proposed is technically feasible, that the selected inputs are appropriate, and that the probability of attaining the overall project purpose is high. Specifically, the probability of attaining subpurpose No. 1 (raising contraceptive prevalence by 143% from 350,000 to 850,000) is estimated at better than 75%; the probability of achieving subpurpose No. 2 (increased population awareness and commitment) is estimated at 40-60%; and the probability of achieving subpurpose No. 3 (new demand) is estimated at better than 80%.

The difficulty in fully achieving subpurpose No. 2 arises from several deeply-rooted cultural convictions, chief among them the widespread Moroccan belief in the myth of greater power in numbers, i.e., that greater numbers of people necessarily constitute an increased economic development potential. Closely associated with this is a belief that Morocco's mineral riches and her thus far underdeveloped industrial and agricultural potential will somehow assure the future economic wellbeing of the nation. A third complicating factor is the current confrontation with neighboring Algeria, and the deeply-rooted belief that greater numbers of people necessarily equates with greater military strength. Despite these formidable barriers to dispassionate analysis of the economy and the critical factor of population growth, subpurpose No. 2 (gaining greater population awareness and commitment on the part of key Moroccan officials and opinion leaders) has been selected as an important subpurpose of the project, not so much in terms of achieving the numerical prevalence targets by 1982, but rather in terms of setting the stage for enlightened, efficient population programs over the long-term.

The technical analysis concludes that the achievement of the project purpose will have a significant positive impact upon Moroccan institutional capability to carry out cost-effective population programs and will have a significant demographic effect as well, perhaps reducing the crude birth rate from about 45 to 35 and the rate of natural increase from about 2.9% to about 2.1% per annum.

2. Financial

AID inputs proposed for this project seem consistent with AID policies and procedures and with present and probable future resource availabilities. Proposed AID inputs represent 28% of the estimated total cost of activities to be assisted.

GOM financial and other inputs are expected to total more than \$32 million during the remaining life-of-project.

3. Social and Economic

A full social and economic analysis was not possible for this Revision due to several constraints, including the lack of sufficient data. Nevertheless, it was concluded on the basis of existing evidence from Morocco and from other LDCs that the proposed activities will directly benefit poor and lower-middle income families, and will serve to reduce the need for GOM social sector investment over that which would otherwise be required. It was also concluded that there are no significant cultural or religious constraints to family planning in Morocco, and that a substantial demand for contraceptive services already exists. Data insufficiencies are being addressed thru ongoing and proposed social research, e.g., the Marrakech VDMS project, the National Fertility and Family Planning Surve-, and two proposed sociological studies linked to family planning acceptance and non-acceptance.

I.E. Project Issues

1. GOM Commitment - The level of commitment of the Moroccan Government to population planning is an issue which relates both to the attainment of the project purpose and to the sector goal. In past planning documents the GOM has recognized the threat of rapid population growth and has asserted its commitment to reduce birth rates, but vigorous and effective action toward this goal has been lacking. Recent statements by high government officials seem to indicate a decided indifference to the present rate of growth and even an endorsement of that growth in terms of Morocco's future manpower needs. For example, during a recent visit of a U.S. Congressional party, the Prime Minister remarked that population growth is not a problem in Morocco and that Morocco needs more people to realize its development potential. Other Moroccan officials at varying levels of importance have echoed similar views. Yet there are still others, at high as well as middle levels, who purport to be strong proponents of population planning activities in view of the country's accelerated growth rate and its deleterious effects on the pace of economic development. To some extent, it appears that the pros and cons of population programs are apportioned somewhat along political party lines, though there are numerous exceptions.

On balance, there does not appear as yet to be any strong GOM commitment to population activities, though it seems at least possible that some changes may occur as a result of the beginning high-level dialogue between U.S. and Moroccan officials on the food/population problem worldwide and in Morocco. It is possible that such efforts will develop a desire on the part of the GOM for population assistance which goes beyond that included in this Project Revision and, if so, such assistance will be requested separately.

The issue with respect to the present project would seem to be: "Does there now exist or will there be in the near future a sufficient level of GOM commitment to allow this project purpose to be attained?"

We believe the answer to be "yes", since the MOH, the Ministries of Youth and Sports, Labor, Social Affairs, and the private family planning association already have a sufficient mandate and maneuvering room to pursue population actions included in this project revision. In addition, the above-mentioned new dialogue and activities specifically included under subpurpose No.2 of this project can be expected to result in a somewhat greater GOM interest in, knowledge of and, hopefully, commitment to population programs.

2. Project Financing - USAID experience in financing construction and field activities of the MOH has not been very satisfactory, due to the extremely long and tortuous process of moving the necessary funds and documents through the GOM system. These procedures are largely beyond the control of the MOH, and are almost beyond belief in their complexity. The problem of financing MOH activities relates specifically to outputs 1, 2, 3 and 8 and possibly to output 7 as well.

In a recent meeting with the Secretary-General, MOH and his staff, the problem of financing was again discussed in detail, and several alternative solutions were examined. These necessarily involve Ministry of Finance concurrence. The MOH is confident that such agreement can be gotten and is proceeding to set up a tripartite meeting (MOF, MOH, USAID) to discuss the matter. There is precedent within the GOM system for the special fund-flow arrangement being suggested, and we are hopeful (cautiously optimistic) that the issue will be resolved in the very near future, possibly by the time this revision receives AID/W approval for implementation.

The successful resolution of this funding problem will be a condition precedent to any further obligation of AID funds for local costs financing.

3. Limits on AID Population Activities

As spelled out to some degree in Rabat 2955, there are limits beyond which the GOM will not allow a bilateral assistance agency to go in pursuing a more active population strategy. Some GOM officials have expressed their view that the U.S. should not provide bilateral population assistance, but that all assistance should be provided thru international agencies. Senior officials of the Ministry of Health, one of the primary supporters of population activities, have repeatedly stressed the government's desire to go slowly in developing population programs, and to keep a decidedly low profile insofar as publicity is concerned. While recognizing the urgency of effective action to deal with Morocco's population problems, U.S. mission leadership has reservations concerning expanded AID involvement in population activities in Morocco on political grounds.

Despite these constraints, AID intends to carry out a population assistance program as dynamic and effective as conditions will permit, and one which will actually achieve results in terms of reduced fertility. We believe that the package proposed in this PP revision is sound, implementable, politically acceptable to all parties, and about all the traffic will bear in terms of meaningful population actions. We also intend to shape other AID projects, existing and future, in such manner as to contribute indirectly to the attainment of population goals. This can, in our judgment, be best accomplished by a judicious selection of project activities which contribute to economic and social development in general but which also support strongly the development of the small family norm in Morocco. Such mission projects as Nonformal Women's Education, Job Training for Women, Nutrition, and Food-for-Peace can be tailored to contribute directly and indirectly to lowered fertility.

II. PROJECT BACKGROUND, LOGICAL FRAMEWORK AND DETAILED DESCRIPTION

A. Background

This Project is a continuation and redirection of Project 096-112 begun in 1971. It takes into account past progress, current trends, and future possibilities as detailed in Annex I, Multi-Year Population Strategy. Much background material on the cultural setting, the status of women, the economy, employment and food production, etc., is included in that annex and is not repeated here. Also included in that annex in part II of the strategy statement is a detailed account of Morocco's responses to the population problem thus far, covering both the public and private sectors. Finally, the MYPS includes an analysis of options available to the U.S. in furthering population programs in Morocco, and presents a strategy on which this Project builds. Included below is a brief summary of background factors leading to the present project.

AID assistance to the GOM family planning effort under this Project began in FY 71 and has until very recently been running at cost levels of about \$300 to 400 thousand per year. AID financed the construction of 13 provincial referral centers (and of a family planning headquarters building in Rabat, under another project). Contraceptives, supplies, and equipment for use in the national program have also been financed. Relatively little participant training has been done, due in part to difficulties of language. Progress of the government program has been slow and uneven. A 1976 evaluation report hit the program hard, suggesting that if several important changes were not soon forthcoming AID should suspend further assistance to the program. Partly as a result of that report a new climate for collaboration and positive action was established by the then Minister of Health. Important changes were made in program administration and in the dialogue with USAID. Several new activities were jointly developed, one of which was the Marrakech household distribution program which is now underway and in which the Moroccans have considerable pride. A national fertility and family planning survey is expected to get underway soon, with USAID financing and technical assistance from the U.S. National Center for Health Statistics, DHEW. Contraceptive acceptance is steadily increasing, 10 new referral centers have opened and are operating fairly well, a number of well-

attended regional seminars have been held, the MOH has requested and received technical and material assistance in several new areas (including the important area of VSC ^{1/}), five senior physician-administrators have received FP administration training in the U.S., four more have been nominated for similar training at PIEGO/Baltimore ^{2/}, and other positive actions have been taken. While the MOH cannot itself be expected to carry the entire FP burden for the country, it has demonstrated its willingness and capacity to undertake important new initiatives in family planning and to collaborate with other agencies of the government and in the private sector with respect to population programs. The MOH has some individuals who are perhaps most fully aware of the implications of continued population growth and who are, therefore, important spokesmen in spreading the word to other GOM officials. The new Minister of Health has repeatedly stated his commitment to population programs. Thus, despite the general GOM policy of considerable caution, the present climate remains favorable for further progress at least insofar as the Ministry of Health is concerned. Interest and some action exists in other ministries, but the Ministry of Health remains as the sole GOM purveyor of family planning services.

Considerable contraceptive activity takes place in the private sector, chiefly thru sales of oral contraceptives in the nation's 437 registered pharmacies. The private family planning association also provides direct services, somewhat to the displeasure of the Ministry of Health which would prefer to see the Association confine its activities to information and education. In all, we believe the private sector (including the pharmacies) serves slightly more contraceptors than does the government program about 200 thousand vs 150 thousand.

The MYPS identified several options available to USAID in moving forward with population programs in Morocco. These are, insofar as judged feasible, incorporated in this Project Revision. The basic project plan is included in the logical framework in the following section.

1/ voluntary surgical contraception

2/ program in International Education in Gynecology and Obstetrics

Logical Framework - Project 096-0112

OBJECTIVES

Sector Goal: To contribute to economic growth of the nation and to improve the well-being of Moroccan families by fostering a substantial and sustained reduction in completed family size.

Project Purpose: To establish and to demonstrate within both the public and the private sectors a capability to plan, implement, and evaluate cost-effective family planning programs

Subpurpose 1: By 1982, to increase contraceptive prevalence as follows:

- from 150,000 to 450,000 couples served by public sector programs; and
- from 200,000 to 400,000 couples served by private sector programs.

MEANS OF VERIFICATION

Among Project beneficiaries:

- reduced age-specific marital fertility rates, particularly in age groups 20-29
- reduced infant, child, and maternal mortality
- improved nutritional status of young children

Evaluation of achievement of overall purpose will be done taking into account the following sources and indicators

1. official MOH FP statistics survey data
private sector sources: pharmacies, drug houses, AMPF, private physicians

MAJOR ASSUMPTIONS

- Family planning, per se, contributes to economic development by reducing demands for social services investment, by increasing probability of full employment and individual productivity, and by improving political stability
- The Moroccan government will intensify its efforts to meet basic human needs.
- Family planning, per se, contributes to family well-being by improving the economic situation of the family, by improving nutritional and health status of family members, and by reducing infant, child, and maternal mortality.

1. - The GOM will continue to invest substantial resources in health and FP programs.
- Increased availability of contraceptive information and services will lead to higher prevalence
- Improved technical and managerial training of physicians, paramedicals, and administrators will lead to improved program performance.
- The GOM will use high-quality program and socio-demographic data to improve FP services.
- Private sector pharmacies, physicians, and organizations can be successfully recruited to support FP programs in Morocco
- By 1982, a greater demand for FP services will begin to result from other GOM and USAID projects, e.g., nonformal education for women, job training for women, nutrition programs, PL480, etc.
- Increased educational and job opportunities for women in Morocco will lead to increased FP practice and reduced family size.

Subpurpose 2: By 1982, to substantially raise levels of awareness of population problems and commitment to their resolution among key GOM officials and opinion leaders

Subpurpose 3: By 1982, to foster new demand for FP services through improved IE&C programs and increased availability of services.

Project Outputs

1. Marrakech VDMS household distribution project successfully completed
2. VDMS-type services extended to 10 populous provinces
3. 10 additional provincial referral centers opened

2. - Appearance at frequent intervals of supportive public statements by key GOM officials
 - Increased financial allocations for population programs
 - New legislation and/or programs aimed at curbing population growth
- survey data
 - clinic records
 - AMPF records
 - GOM and USAID estimates

1. MOH, USAID records and reports; VDMS data and reports; contractor reports
2. MOH, USAID records and reports; VDMS data and reports; contractor reports
3. On-site verification

- The GOM ministries of Health, Youth and Sports and Social Affairs will further strengthen their programs to promote FP practice, and other ministries such as Information, Interior, Labor, and Plan will initiate activities relating to population during the Project period.
2. - Increased availability of factual information on population dynamics will lead to increased awareness among opinion leaders and new legislation and/or programs by the GOM.
 - New commitment will be reflected in new legislation and/or programs directly or indirectly influencing population growth
 3. - Increased availability of information and services will create an additional demand for services.

1. No major medical, civil, or political incidents will result from VDMS project, interfering with its completion
2. Marrakech household distribution project will be judged successful and MOH will implement its expansion to at least 10 other populous provinces by 1981.
3. None

4. Special training programs completed for:
- . 400 physicians;
 - . 5000 paramedicals;
 - . 30 administrators;
 - . 10 statisticians/demographers;
 - . 5 IE&C specialists;
 - . 10 policy makers and opinion leaders.

5. Improved FP service availability in 1600 dispensaries, health centers, and hospitals

6. A private sector distribution program established, providing low-cost contraceptives across the country.

7. A national-level IE&C program established, run by AMPF in collaboration with the MOH, USAID, and IPPF

8. A National Fertility and Family Planning Survey, completed and analyzed

Project Inputs, FY 78-82

| | (\$000s) |
|----------------------|-------------|
| Technical assistance | 320 |
| Training (497pm) | 532 |
| Commodities | 5655 |
| Other costs | <u>6510</u> |
| Total | \$13017 |

Note: For detailed analysis of project inputs, see tables 6 and 8 thru 15 in Financial Analysis section

4. GOM, USAID, other donors records and reports

5. MOH statistical reports; improved client utilization and continuation rates; USAID estimates.

6. Existence of system; contractor reports; USAID and GOM reports

7. Radio/TV broadcasts; printed materials, AMPF reports; IPPF and contractor reports, USAID estimates, etc.

8. USAID, MOH, NCHS reports

4. Successful in-country training programs can be established, drawing on U.S. technical resources

5. With successful completion of VDMS project, MOH will change present policy on prescription of oral contraceptives to permit paramedicals in dispensaries to prescribe pills for new acceptors.

6. It will be possible to establish a workable subsidized contraceptive distribution program in the commercial sector in Morocco.

7. A major IE&C effort will be mutually agreed upon by the MOH, USAID, IPPF, and the AMPF, and will be successfully launched by the AMPF in 1978-79.

8. USAID, NCHS, and GOM will conclude formal agreement for study in FY 1978.

11.C. Detailed Project Description

Project Purpose: To establish and to demonstrate an indigenous capacity to plan, implement, and evaluate cost-effective population programs.

This project aims at correcting five key deficiencies which affect population programs in both the public and the private sector in Morocco. The basic assumption here is that....

Despite relatively healthy resource availabilities,

present weaknesses in:

- Population policy
- Program planning
- Management and administration
- Technical skills
- Program evaluation

result in constraints on: FP service availability, including FP information

and therefore in:

LOW FP ACCEPTANCE AND PREVALENCE LEVELS

Objective evidence supporting this assumption comes from a variety of sources, including data from the ongoing Marrakech project; analysis of MOH family planning program statistics; project documents; evaluation reports; and personal observation by AID, GOM, UN, and other interested observers.

Inputs in this project aim at strengthening all five of the above-listed weaknesses leading to higher program performance (increased prevalence level) and improved capacity to conduct effective population programs.

Three subpurposes are included to highlight three interrelated but distinct objectives, namely:

1. raising contraceptive prevalence;
2. raising population awareness and commitment; and
3. raising demand for contraception.

The appropriateness of the selected inputs and the probability of achieving each of the three subpurposes -- as well as the overall project purpose -- is discussed in Part III, section A, Technical Analysis, and will not be repeated here. This section will focus on a description of the planned inputs and outputs and the relationships between inputs, outputs, and purpose, including a discussion of critical assumptions at each level.

The project is arranged into an overall project purpose, three subpurposes, eight major outputs, and eight sets of inputs, each geared to a specific output. The project is so structured as to maintain, to the extent possible, the following logical pattern:

inputs + assumptions = outputs

outputs + assumptions = purpose

purpose + assumptions = sector goal

The project can perhaps be most clearly understood by focusing on the project outputs, i.e., specific things which are to result from this project. In doing this, we will describe the inputs and key assumptions which underpin each of the eight planned project outputs.

It should be noted that each of the eight outputs, while obviously related to other outputs, is a self-contained package, thus constituting a convenient project management grouping. Further, each output can be thought of as a separate project and, indeed, two outputs (Marrakech VDMS and National Fertility Survey) are in fact already so described. The advantage in grouping these separate projects under the one PP Revision is that all population-specific project activities funded by AID in Morocco can be related in a logically consistent and administratively convenient grouping.

Output #1 - Successful Completion of the Marrakech Household Distribution Project.

The Marrakech project is considered by USAID to be the most important of its population activities because of the solid support for this project within the Ministry of Health, the relative ease with which it could be incorporated within the public health structure throughout the country, and its tremendous potential for increasing contraceptive prevalence.

Briefly, the project aims at making orals and condoms, available directly in the homes of the 1.2 million inhabitants of the province of Marrakech within a 30-month period. The project design includes significant operational research elements which are already beginning to yield interesting and use data.

A complete description of the Marrakech project, as originally conceived, is contained in Annex 5, including a detailed budget.

At this writing (March 1973), the second round of visits in Phase Ia has just been completed. Approximately one-half of the homes in Marrakech city have now been visited twice within a 4-month period, more or less according to plan but with a somewhat delayed schedule due to administrative (financial) difficulties. Computer analysis of the first 26,000 visits has been finished; summary results are presented in the Technical Analysis section (III).

In summary, the results of the first visits were highly satisfactory to both the Ministry of Health and to AID. Acceptance levels were higher than anticipated, and there were no significant organizational, socio-political

or implementation problems, apart from the continuing bureaucratic problem of moving funds through the Ministry of Finance. (This problem was addressed in the Issues Section, p 14).

The results of the second visits are not yet available, though an eyeballing of the completed questionnaires seems to indicate that orals continuation at 3-4 months is satisfactory.

The Moroccan project manager, Dr. Md. Zarouf, believes strongly that the implementation schedule can be moved up so that phases Ib, and II and possibly III can be done simultaneously instead of sequentially as originally planned. USAID and DS/POP staff are planning to revise the project description to accommodate a change in scheduling, as well as other changes which seem indicated as a result of experience during the first phase. AID input levels should remain essentially at already approved levels or, possibly, may decrease slightly.

Implementation of the remaining phases of the Marrakech project is, of course, highly dependent on reaching a suitable agreement with the Ministry of Health and the Ministry of Finance on the channeling of AID funds for the project, since experience has shown the procedures outlined in the present Project Agreement to be less than satisfactory. USAID is giving this problem priority attention especially since it also relates to other AID projects both in population and elsewhere.

Financial inputs for achievement of this output are summarized in the input sheets in the preceding section, and are detailed in the Marrakech project description (Annex 5).

Experience thus far with the Marrakech project has demonstrated a clear requirement for continuing on-the-spot technical monitoring in order to ensure that the technical design is followed closely, that the effect of the many administrative bottlenecks is minimized, and that the research value of the project is maximized. Finally, and most importantly, there is the need to prepare for the expansion of this project to 10 other provinces (Output # 2) -- a mammoth undertaking. To meet this need, one contract technician is planned for a period of 36 months beginning in

September 1978. This is felt to be the bare minimum of technical assistance required to assure the attainment of outputs 1 and 2. Additional backup technical assistance will be provided by AID/W (DS/POP R, IFRP, and from other sources as appropriate).

Output # 2 - VDMS Extension to 10 Provinces

The Marrakech VDMS pilot project was, at the insistence of the Ministry of Health, designed in such a way as to be readily replicable on a broad scale. Inputs were trimmed to what was considered the minimum essential, and maximum use was made of the existing, extensive MOH health services network. Thus the foundation has been laid for the rapid expansion of household distribution services throughout much of the country.

Output # 2 consists of the establishment of VDMS-type services in 10 additional populous provinces by the end of the revised project period. The successful pilot experience in Marrakech and the basic VDMS design which lends itself well to expansion within the existing health structure are two positive factors which will assist in the replication process. A third important factor is the positive support for the activity within the Ministry of Health. Still, the expansion to 10 additional provinces will be a substantial undertaking.

As previously noted, USAID plans to provide the services of one contract technician for a 36-month period, approximately 27 months of which will be devoted exclusively to the attainment of Output # 2 (the first 9 months being concerned primarily with Output # 1). This individual may be made available by any of several possible contract mechanisms (psc, institutional contract, existing centrally-funded contract) according to AID/W preferences, but it is suggested that it would be highly desirable, if possible, to provide such a person under the auspices of the International Fertility Research Program (IFRP) for the following reasons: (1) IFRP is the organization now responsible under a centrally-funded contract for the data processing and analysis of VDMS data; (2) IFRP is fully familiar with the project design parameters and local conditions; (3) part of the pilot project objective is to transfer the data processing and analysis function from North Carolina to Morocco, and this will require continuing close

relationships over a substantial period of time between USAID, the Ministry of Health, and IFRP. AID inputs, other than technical assistance, for the attainment of output No. 2 consist of essentially the same categories and percentages of assistance as were provided for the Marrakech pilot experience (detailed in Annex 5). These inputs are, at this stage, tentative and are subject to negotiation with the Ministry of Health and to modification as deemed appropriate. The principle applied here has been USAID support for additional or incremental costs associated with household distribution activities, with heavy emphasis on non-recurring costs wherever possible. In fact, the MOH bears the great majority of costs for these activities, some 60% in the case of the Marrakech VDMS project.

It can be anticipated that three major hurdles must be overcome in order to achieve output No. 2. These are:

- (1) an assured availability of financial and material resources at the provincial level;
- (2) sufficiently motivated key personnel in the 10 selected provinces; and
- (3) organizational problems related to the availability of personnel and their targeting with respect to geographic sectors.

The first problem is explored in some detail in the Project Issues section (p 14), at least as regards financial flows. Availability of material support, particularly transport, is expected to be a knotty problem which will likely have to be addressed on a province-by-province basis. UNFPA support for the procurement of transport equipment would be a major help, but remains to be worked out and included in a formal agreement with the GOM.

Problem No. 2, motivated personnel, is a chronic difficulty encountered whenever an attempt is made to replicate a successful pilot experience. In part, the problem can be addressed by the selection of provinces, but this is not sufficient solution in the aggregate.

We have noted with some astonishment the positive effect of U.S. and foreign travel and training as a motivating influence among MOH personnel, being somewhat more influential in the Moroccan context than elsewhere. Without speculating too far on the reason for this phenomenon, it seems that the exposure to U.S. experiences and ideas is: (1) highly valued by many Moroccans; and (2) something quite outside their normal frame of reference, being more intimately linked with the Francophone world.

USAID thus plans to provide a substantially increased number of foreign travel and study experiences to key MOH and GOM officials, some of which will be geared specifically to personnel who will have major responsibility for the implementation of household distribution programs in their provinces.

The third above-mentioned problem (organization) can, we believe, most effectively be solved by finding effective ways to transfer the knowledge gained in the Marrakech experience to other provinces. A documentary film is presently underway (partially funded by AID) which tells the story of VDMS planning, organization, and implementation. This film will be used by the MOH as a training device. Additionally, it is tentatively planned to use Marrakech as a training center for personnel from other provinces so that they may gain on the job experience under the guidance of already experienced field agents, supervisors, and data controllers.

Senior personnel from the provinces would receive training in overall project management, and in effective means of gaining local government and other support for the program and in avoiding potential social or political problems. The timetable for expansion has not yet been established, and will to some extent be dependent on early success in solving the financial flow problem as well as on results from the rural experience (phases II and III) of the Marrakech project. It may be possible to consider an expansion to other urban areas of the country (which now contain about 40% of the total population) in the near future, since it now seems clear from the results of Marrakech phase Ia that the program is highly feasible and cost-effective in urban areas.

Output No. 2 - 10 Additional Provincial FP Referral Centers by 1982

AID has obligated funds totaling \$600,000 for the construction and equipping of 10 family planning referral centers (Centres de Reference). In previous documents these have generally been referred to as "Reference Centers", but a better translation from the French, and one which more accurately describes the FP service function of these centers, is the one we have chosen for this and future documents, i.e., "referral centers". As of January 1978, a total of 10 such centers have been opened. Their main purpose is to provide technical backup for all FP services offered in each province, accepting particularly difficult cases on referral from health centers, hospitals and private physicians. They are intended also to serve as centers of program research and experimentation, much as the Marrakech referral center is being used in support of the pilot household distribution project now underway in that province. In practice, the referral centers also accept "walk-in", i.e., persons who have not been referred from another facility. The referral centers are generally staffed by one full-time OB-GYN assisted by 3 to 6 specially-trained paramedicals. During 1977, eight of these centers served a total of 50,000 clients for all purposes (referrals for FP problems, new acceptors, checkup visits, etc..) Caseloads are increasing in most centers.

Inputs included in this revised project are intended to partially finance the construction and equipping of an additional 10 provincial referral centers. Estimated AID costs are \$50,000 for construction and \$10,000 for equipment for each center, representing about 29.6% of the total investment and operating cost of these centers over the remaining life of this project. The GOM will provide personnel, all operating costs, maintenance, etc. As a sidenote, facilities of the MOH are typically constructed and maintained to a high standard. To minimize the USAID administrative burden in financing the construction element of these centers, USAID plans to employ a fixed cost-reimbursable mechanism, i.e., upon notification that a center has been completed and is functioning, and USAID representative will make an on-site inspection followed by a payment to the Ministry of Finance on a fixed-cost basis (\$50,000 per center). This mechanism will be sufficient to

ensure that AID interests are met while avoiding lengthy and costly delays in rounding up the required documentation, interpreting that material, and making payments based on actual cost. USAID/Morocco has experienced considerable difficulty in this regard in the past, and wishes to avoid such problems in the future.

Like other outputs is mutually supportive of, and mutually supported by, other elements of this project. The referral centers have potential for initiating innovative programs to test new contraceptive methods (e.g., neo-sampon foam tablets, Depo-provera or the other injectables, etc.) as well as new outreach systems. There is some interest in developing mobile service units which can provide orals, IUDs, condoms, and possibly other contraceptive methods to rural populations located far from existing service facilities. There would seem to be an excellent opportunity for linking such mobile services to the household distribution program as it moves into rural areas, thus providing some clinical services in rural settings for clients identified during the household visits. Initiation of such services will be largely dependent on interest and motivation of the provincial medecine-chefs, and on the availability of necessary resources. Three medecine-chefs are already planning or implementing small-scale outreach services, and it is planned to discuss possibilities for mobile services on a broader scale in the near future. Thus we have included in this revision a modest sum (\$50,000) to be used to equip 15 mobile units and to partially defray the cost of such services. The budgetary provision is speculative and dependent on further specification of possible mobile services and agreement with the GOM on details.

Output # 4 - Special Training Programs

Development of Manpower Plan.

A prerequisite to the development of specialized training programs is the development of a comprehensive manpower development plan, covering in-country, U.S., and third-country training needs over the next four to five years. The objective here is the development, in close collaboration with the Ministry of Health and other concerned organizations

(including the Secretariat of State for Plan and Regional Development, the Ministry of Youth and Sports, the Ministry of Interior, and the Family Planning Association), of a manpower development plan for financing under this project revision.

Relatively little participant training was financed prior to FY 77. As there is now substantially increased interest on the part of the GOM and a somewhat expanded range of training opportunities (particularly in the French language) it is planned to focus increased attention and AID resources on the development of manpower needed for effective population planning. In order to develop the manpower plan, it is necessary to arrange for a three-member team to visit Morocco in early summer 1978 to explore needs and training possibilities in detail with concerned Moroccan institutions, USAID, and the UNFPA. Team composition should include a representative from the Program in International Education in Gynecology and Obstetrics (PIEGO) at Johns Hopkins University, a representative of the AID/W Office of Population, and a third member drawn from a university or consulting organization as appropriate. This team will work closely with a member of the USAID Population and Health Division and the MOH Population Division to identify needs and opportunities. The plan is intended to cover three categories of training: (1) US training (short-term, long-term, academic); (2) in-country training (short-term, training of trainers); and (3) third-country training (short-term technical and administrative managerial).

Provisional AID-financed training inputs are included in this project revision, totaling \$72,000 for 217 person-months of in-country training and \$452,000 for 279 person-months of third-country training. These figures do not include in-country training for VDMS project or its expansion, or for the National Fertility and FP Survey. These estimates are, of course, subject to substantial revision in accordance with findings and recommendations of the detailed manpower study.

It is intended that the consultative team will produce a draft manpower plan before departing from Morocco, with the final report plan to be delivered within 45 days following team departure. This timing will permit detailed study of the plan by the GOM, USAID, and other donors, and the scheduling of training to begin in FY 1979.

Development of Training Programs

The figures and training categories shown in this revision are tentative, and subject to revision following the production of the manpower plan.

Notionally, it is planned to assist the MOH in the development of in-country training programs which will eventually reach some 5,000 paramedicals in several categories, 400 physicians employed in MOH public health programs, and 70 nurse-trainers who are involved in ongoing in-service training programs of the MOH.

Additionally, foreign training (U.S. or third country) is tentatively planned for 30 FP administrators (primarily provincial *medecin-chefs*), 10 statisticians and demographers (from MOH, AMPF, and PLAN), 5 IECC specialists (from the MOH, the Ministry of Information, and the AMPF), and 10 policy-makers/opinion leaders drawn from various GOM entities and the private sector.

A key problem in planning training programs for Moroccan officials in the past has been that of language; most Moroccans have fluency in Moroccan Arabic and French, but not in English. However, many educated Moroccans have a basis in the English language, typically having studied English for five to seven years. USAID is presently seeking financial means to support a language training program for interested Moroccan officials at middle and upper levels, many of whom could achieve a respectable English language capacity in a relatively short time and who would be excellent candidates for both short and long-term training.

Language training would be available to officials from ministries having direct relationship to AID priority sectors, e.g., agriculture, health, population, etc. Thus it may soon be possible to partially solve the language problem for some participants who would be sent for training under this project. Other solutions are also in view. Recently, a French-language training program for FP administrators has been established at PIEGO Baltimore. One provincial *medecin-chef* attended the first such course and four more have been formally nominated for the next course. PIEGO is also establishing French-language regional

technical training courses in Tunis and is interested in the possibility of establishing a regional facility in Morocco.

The development of high-quality in-country training programs drawing on U.S. technical assistance for program planning training techniques, and program evaluation will further enhance the training opportunities available to FP program personnel and will, of course, avoid the language problem.

Table 2 summarizes AID inputs for training.

T A B L E 3

Inputs for Output # 4 - Participant and In-country Training

Summary of Planned Obligations (\$000s)

| | Thru 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 78-82 | Total All Yr. |
|---|--------------|-------------|--------------|--------------|-------------|--------------|--------------|------------------|
| <u>Technical Assistance</u> | | | | | | | | |
| .Contract consultants 5 ¹ pm @ \$4000/m. | - | 18 | | 4 | - | - | 22 | 22 |
| <u>Participant Training</u> | | | | | | | | |
| . Long-term, \$ cost | 35 | 15.5 | 38.5 | 31.0 | 53.7 | 38.5 | 177.2 | 212.2 |
| . Long-term, # person-months | 35 | 12 | 30 | 24 | 42 | 30 | 133 | 173 |
| . Short-term, \$ cost | 38 | 46.0 | 66.0 | 66.0 | 30.0 | 43.0 | 276.0 | 314 |
| . # person-months | 24 | 24 | 45 | 34 | 13 | 25 | 141 | 165 |
| Total cost (\$) | 73 | 61.5 | 104.5 | 97.0 | 83.7 | 86.5 | 453.2 | 586.2 |
| Total Person-months | 59 | 36 | 75 | 58 | 55 | 55 | 279 | 338 |
| Total Trust Fund Travel Costs 1/ | 2 | (3.7) | - | - | - | - | (53.5) | (60.0) |
| <u>Other Costs</u> | | | | | | | | |
| .In-country Seminars \$ Cost equivalent | 35 | 9.0 | 18.0 | 19.8 | 10.8 | 20.7 | 73.3 | 113.3 |
| . # person-months equivalent | U | 25 | 50 | 55 | 30 | 57.5 | 217.5 | 217.5 |
| . # Persons trained | U | 30 | 120 | 75 | 75 | 90 | 440 | 440.0 |
| TOTAL \$ INPUTS..... | 108 | 70.5 | 142.5 | 116.8 | 94.5 | 107.2 | 531.5 | 639.5 |

1/ Local currency cost.

Output No. 5 - Improved Services in MOH Facilities

Most of the 13 project outputs contribute directly or indirectly to the improvement of FP services in MOH facilities. Such key factors as construction and equipping of facilities, manpower development, service extension, research, etc., are included under other outputs. The discussion below will therefore concentrate on AID commodity inputs, chiefly contraceptives, on improved IE&C materials for health practitioners, and on an important policy change which would have the immediate effect of improving service availability on a wide scale.

Commodities

The largest single commodity item is that of oral contraceptives, estimated at a \$4.5 million value for 23 million monthly cycles to be provided in FY 78-82.

Oral contraceptive acceptance has been growing rapidly, from 27,000 new acceptors in 1973 to 60,000 in 1975 and an estimated 83,000 new acceptors in 1977. Some 61% of urban women 15-44 contacted in the first phase of the Marrakech project accepted five cycles of orals during the first visit. Orals sales in private sector pharmacies have increased as well (from about 600,000 in 1970 to an estimated 2 million in 1977). The AID supply objective is to provide a minimum of one year's stock in country and one year's supply on order for 12% of Morocco's 3 million married women of reproductive age (MWRA). Orals inputs are geared to this objective, anticipating a further increased demand as MOH services are extended beyond the limits of fixed service facilities and as increasing numbers of couples wishing to avoid the next pregnancy (as a result of better information, increasing economic pressures, social change, etc.) avail themselves of free MOH services.

The popularity of IUDs is also growing in the GOM program, with an estimated 8,700 new insertions in 1977 (up from 7,500 in 1975 and 5,200 in 1973). USAID plans to provide 15,000 lippes loops, 17,000 Safe-T-Coils, and 15,000 copper 7s in the next five years, with a total value of \$100,000.

Condoms have not been popular in the government program. Neither have they found much acceptance in the private sector, for reasons not entirely clear. Undoubtedly there exists a cultural dislike for the method, but there have been virtually no serious attempts to popularize condoms. It is therefore difficult to estimate how much acceptance of the method could be obtained with a structured promotion and distribution program. The private sector distribution activity (Output 7) will be able to test this question with some validity. Notionally, USAID plans to provide 174,000 gross of condoms valued at \$870,000 for the government program and the private sector program in FY 1978-82. A total of 1,000 medical kits have been ordered through FY 77 (55 for IUD insertion and 500 for minilap). An additional procurement of 400 kits valued at \$40,000 is planned in the next five years.

The sum of \$100,000 is programmed for the procurement of Neo-sampooon loop tablets (vaginal foaming tablets) for use in the government program, based on the assumption that the Ministry of Health will find them in experimental tests to be effective and culturally acceptable in the Moroccan context. These tablets could also be widely used in the private sector distribution program. \$85,000 is provided for miscellaneous other costs, now unforeseen, related to contraceptive procurement or the procurement of medical/surgical equipment and supplies.

IE&C Materials for Health Professionals

The MOH has a substantial material capacity for the production of IE&C materials, including a well-outfitted printing plant located in the central family planning building in Rabat. However, it too--like AMPF--suffers from a scarcity of trained manpower. U.S. training, such as that offered at the University of Chicago, is desired and appropriate for several staff members of this unit, but not immediately possible due to language problems. It is planned to begin a series of structured English classes at the family planning building in the fall of 1978, drawing upon Peace Corps volunteers to provide the language training. Interest in learning and practicing English is high among MOH staff, and many already have a substantial base in the language through their

schooling. It is planned to send at least two members of the IE&C staff for U.S. training in FP/IE&C as soon as their level of English language proficiency permits. Further, nine person-months of consultant services are included herein to assist in the development of annual IE&C plans and/or in the evaluation of MOH IE&C efforts in family planning.

The periodic publication, Population Reports, produced by George Washington University in both French and English is considered by USAID and the MOH to be an extremely valuable source of information on population topics, ranging from macro assessments of population and ecology to specific, highly valuable summaries of the current state of the art in respect to selected contraceptive methods. Two thousand copies of each issue are now regularly distributed to MOH professional staff throughout the country. It is planned in the near future to begin distribution of these reports to Morocco's 600 private sector physicians and 400 private sector pharmacists, thus assuring that current, authoritative information is readily available to both public and private sector health practitioners on a continuing basis.

MOH Policy on Orals Prescription

It is hoped that as a result of the successful completion of the Marrakech project the MOH will change its present policy on the prescription of oral contraceptives. Orals are now generally available to new acceptors only in health centers, hospitals, and the provincial referral centers. In Marrakech, assistant nurses are permitted to determine, after posing a series of structured, qualifying questions, the acceptability of prescribing oral contraceptives for new clients, and those nurses are actually distributing five cycles of orals to each new acceptor. Providing that no serious difficulties are encountered in this system, the MOH may change its policy, thereby permitting orals prescription to new acceptors in its 800-odd dispensaries throughout the country. At present, dispensaries can only provide re-supply of orals to clients who have a prescription from a higher level facility. A policy change of this

type would be an extremely important action in making orals more easily accessible to new acceptors throughout the country. USAID will continue to urge the adoption of this policy, based on proven success in Marrakech and elsewhere. AID/W should, however, have no illusions concerning the difficulty of effecting such a seemingly simple and logical policy change in the Moroccan public health system. Change will come only when convincing evidence is at hand that the new policy would be politically, as well as medically, acceptable.

Output No. 6 - Establishment of a Low Cost Contraceptive Distribution Program in the Private Sector

Sales of contraceptives, particularly oral contraceptives, in the private sector are estimated to account for some 200,000 couple-years of protection at present. In 1977, USAID conducted a mini-survey to attempt to estimate the current volume of sales of orals and condoms. That survey is included as an annex to the Multi-Year Population Strategy paper which itself is an annex to this PP revision (Annex I). The results of the survey, based on interviews with pharmacists and clerks, indicated that sales of orals may account for as much as 387,000 couple-years of protection. This figure has subsequently been revised downward following discussions with a representative of a large pharmaceutical manufacturer in Casablanca (Schering). The revised figure of 200,000 couple-years is consistent with production and distribution figures cited by the Schering representative, both for his company and for others engaged in contraceptive marketing in Morocco.

Whatever the volume of sales may really be, the price of contraceptives on the retail market is well known--about \$1.25 to \$1.75 equivalent per cycle of orals and \$2.50 equivalent per dozen condoms. These prices are well above the level which could be easily afforded by most potential clients.

The margin of profit for the retailer (pharmacists) seems to lie between 20 and 50 percent, depending on brand name (there are 10 brands of orals commonly found on the local market). Thus, the pharmacist's profit per sale of orals is somewhere between 25 and 88 cents, say 45 cents on the average. The profit margin of 45

cents per cycle of orals (about 1 Dirham 90 Centimes) may still be more than the total price many Moroccan couples could afford to pay each month for contraceptives. Thus even if the GOM were to provide orals gratis to pharmacists, they would, in turn, have to reduce their profit per sale in order to make orals available at a price most Moroccans could afford (say 50 to 75 centimes or about 15 U.S. cents per cycle).

If greater sales volume could be assured, it's possible that the pharmacists might go along with a lower profit margin.

One problem, then, in working out an effective private sector contraceptive distribution scheme in Morocco will be the economics of supply, demand, and pricing. Another problem will be finding a way to ensure that low-cost, subsidized contraceptives do not directly compete with sales of contraceptives at prevailing commercial rates. It may be possible to find a way to make low-cost contraceptives available only to persons who cannot afford the commercial price, perhaps by requiring purchasers to show a "carte d'indigence" such as now used in the PL 480 food distribution program, or a special card issued by some Ministry of Health entity. It is highly probable that orals distribution in the private sector would be limited--at the insistence of the MOH and of pharmacists who represent a strong lobby in Morocco--to the nation's 437 registered pharmacies. Condoms and possibly neo-sampoon loop tablets could probably be made widely available in a variety of shops.

A consultant team is scheduled to visit Morocco in May 1978 to explore the possibility of establishing a contraceptive marketing system in the private sector. The parameters of the system have, obviously, not been worked out, but there is substantial interest in such a venture in the Ministry of Health. In addition, the President of the Moroccan Family Planning Association is herself a highly respected and influential pharmacist, who could be expected to provide valuable counsel to the exploratory team. We have included in this PP revision a provision of \$250,000 as a very rough estimate of what it might cost AID to support a commercial distribution program in Morocco during the period 1978-82. This illustrative figure includes technical services only: about 18-24 person-months of contractor services. Contraceptive costs are included under inputs for Output No. 5.

Output No. 7 - IE&C Program Run by AMPF

It was previously noted that the GOM has chosen to maintain a low profile in respect to IE&C activities, fearing the possibility that an opposition political party might again attempt to politicize the family planning movement and the government's role in it. Recently, the GOM has been somewhat more active in promoting family planning through audio-visual means, but it is probable that the basic low-profile policy will be maintained for the foreseeable future.

The private FP association (Association Marocaine de Planification Familiale or AMPF) has not been shy in pursuing IE&C activities. They have supported radio and TV programs, distributed posters, participated in public meetings, set up family planning displays at commercial fairs, and have in other ways been modestly successful in getting certain family planning messages across.

There are several weaknesses in the AMPF effort, however, which it is hoped to correct with assistance under this project. A fundamental constraint is the paucity of well-trained professional IE&C staff. It is planned to augment available professional capability by: (1) providing technical consultants to assist in the development of a comprehensive IE&C plan; (2) financing two additional slots within the AMPF for communications professionals; and (3) providing training opportunities in the U.S. for IE&C staff of the AMPF.

A second important constraint is the lack of coordination with the Government program. Both the MOH and the AMPF have stated their interest in working together, but there is no coordinated plan at present.

A third constraint is the absence of a comprehensive, professionally prepared, adequately funded plan for IE&C activities in Morocco. USAID intends to encourage the development by the AMPF of such a plan, with the close collaboration of the Ministry of Health, IPPF, UNFPA, and the Ministry of Information, thus simultaneously addressing constraints No. 2 and 3 noted above. Following the development of the plan and its approval by all concerned, AID

together with the IPPF and UNFPA will provide necessary technical, material and financial support to the AMPF to ensure its implementation.

It is tentatively planned to provide a resident IE&C specialist for a period of 18 months to assist in the development and evaluation of IE&C programs of the AMPF; \$90,000 is programmed for this purpose, though it may be possible to obtain the necessary support for such an individual from IPPF or UNFPA. This possibility will be fully explored before AID funds are committed for this purpose.

While it is expected that much of the IE&C plan will be targeted for potential new acceptors, an important target group to be included is the elite corps of GOM officials, industrialists, politicians, and business leaders who need to be convinced of the immediacy and reality of the population threat, and of the efficacy of doing something about it now.

A total of \$280,000 is provided herein for support to the AMPF, including \$90,000 for a technical specialist (18 pm), \$45,000 for consultants (9 pm), \$57,000 for commodities, \$70,000 for 96 pm local hire personnel, and \$18,000 for other costs. In addition, it is planned to provide short and long-term training opportunities for professional staff of the AMPF under Output No. 4. A key assumption associated with this output (No. 7) is that it will be possible for the AMPF and the MOH to agree on a coordinated IE&C program. We believe, at this time, that such agreement is possible.

Output No. 8 - National Fertility and Family Planning Survey

The Ministry of Health plans to conduct a major national survey of fertility and family planning, beginning in the fall of 1978. USAID support for the survey was solicited in the spring of 1976 and, after considerable jockeying due primarily to the highly critical FP evaluation report issued at about the same time, it was finally agreed in December of 1976 that AID would support a national survey through a centrally-funded agreement with the U.S. National Center for Health Statistics. A team from NCHS

visited Rabat in January 1977 and initial plans were made for the survey, tentatively shooting for a pretest in the spring of 1978. Preparations for the survey have progressed somewhat slower than hoped, and because of NCHS insistence that additional work is needed before the pretest can get underway, the pretest is now scheduled for the fall of 1978, with the main survey to take place in the spring of 1979.

NCHS has completed work on the survey protocol, working together with the MOH's chief statistician. The protocol is, in effect, a detailed description of the survey including a detailed budget covering three survey alternatives. Acceptance of the protocol by AID/W, USAID and the MOH will lead to the formal obligation of AID funds in the latter half of the current fiscal year (FY 78). It is planned to allot central funds under a worldwide project to USAID/Rabat for obligation under a formal agreement (ProAg) between USAID and the GOM, much as funds for the Marrakech VDMS project were put in place. This mechanism is believed to be the most efficient, leaving USAID/Rabat with control over funds release according to real progress on the survey and the counsel of NCHS.

The survey is expected to produce a reliable estimate--the first ever--of current fertility in Morocco as a whole, with reliable estimates also for aggregate rural and urban areas. Additionally, the survey will yield an important indicator of fertility in Marrakech province, the site of the household distribution program. Finally, very useful information on contraceptive knowledge and practice will be gathered, together with attitudinal items of interest to the Ministry of Health.

The technical sophistication of the sampling design should be applicable to other national surveys as well, thus improving the current state of survey research in Morocco.

Table 4 below summarizes selected fertility, knowledge, and practice items to be measured.

Table 3aNFFPS: Summary of Selected Primary Survey Objectives

| <u>Index</u> | <u>Degree of Measurement Precision</u> |
|---|--|
| A. <u>General Fertility Rate (GFR) for Ever Married Females</u> | |
| 1. in Morocco | ±2% |
| 2. in Marrakech province | ±4% |
| 3. in urban areas | ±4% |
| 4. in rural areas | ±4% |
| 5. by literacy status (2 categories) | ±8% |
| B. <u>Knowledge of Contraceptive Methods, by Method</u> | |
| 1. all Morocco | ±2% |
| 2. urban areas | ±4% |
| 3. rural areas | ±4% |
| 4. by literacy status (2 categories) | ±8% |
| C. <u>Practice of a Contraceptive Method</u> | |
| 1. all Morocco | ±2% |
| 2. urban areas | ±4% |
| 3. rural areas | ±4% |

Improved MOH Statistical Capability

An important byproduct of this Output and of Output Nos. 1, 2 and 4 will be the development of improved MOH statistical capability.

Family planning statistics collected in the national program are, at present, not very useful for program management purposes due to inadequacies in the type of information collected, to delays in the gathering and reporting of the data, and to the absence of timely, penetrating analyses and reports. Thus, knowledge which might otherwise be available to administrators concerned with improving program performance is not available.

The adage that "a good program poorly measured is better than a poor program well measured" is no doubt valid, but it is equally difficult to improve program performance in the absence of detailed knowledge of program progress, successes, and problems. A balance must somewhere be struck.

The MOH statistical division is deficient in trained manpower, particularly as concerns the measurement of family planning programs. The division chief, himself well qualified in biostatistics, is acutely aware of the need to improve statistical capability within the MOH and is desirous of finding effective ways to draw upon western experience in this regard.

One participant recently returned from long-term statistical training in the U.S., thus adding to the MOH capability. It is planned to provide short and long-term training opportunities for an additional 10 statisticians and demographers over the course of this project revision. Most of these will be MOH personnel. A total of \$102,000 is provided to finance 62 person-months of training for this purpose.

MOH statistical personnel will benefit also from their collaborative work with demographers, statisticians and other measurement scientists from the International Fertility Research Program and the U.S. National Center for Health Statistics, under Outputs 1, 2 and 8.

While at this time no specific plans are included for the development of a sophisticated management information system, such assistance could be incorporated at an appropriate future time if the MOH should be truly interested in such a system.

III. PROJECT ANALYSES

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A. TECHNICAL ANALYSIS

This project is somewhat complex, containing an overall purpose and three distinct but interrelated subpurposes, more than a dozen action agents, eight major outputs, and several thousand identifiable actions which must be successfully completed in order to achieve the desired results, which are:

1. raising contraceptive prevalence from 350,000 couples in 1978 to 850,000 couples in 1982;
2. raising awareness and commitment levels of key GOM officials (resulting in new policies, legislation, and programs); and
3. raising demand levels for family planning services among the three million married women of reproductive age (MWRA).

It is believed that the successful accomplishment of these three subpurposes will constitute achievement of the overall purpose, which is to establish and demonstrate an indigenous capacity to plan, manage, and evaluate cost-effective population programs.

As a complete analysis of individual project actions is beyond the scope of this paper, this analysis of technical feasibility will focus on probability of success in achieving each of the three project subpurposes. Probability will be estimated on the basis of historical performance, present situational factors, effectiveness of planned inputs as agents of change, and foreseeable future events impacting upon each project objective.

SUBPURPOSE No. 1 - raising contraceptive prevalence. Table 4 below is a synopsis of family planning performance of the GOM program during the 5-year plan period ending December 1977. The MOH set out to obtain 392,000 new acceptors and, it would appear, very nearly achieved that number. The target was modest, however, representing only 13% of MWRA. Most new acceptors (more than 8 out of 10) chose oral contraceptives. IUDs were next in preference, followed by a very weak demand for condoms. The number of acceptors of terminal methods, mainly tubectomy, is unknown as the GOM keeps no records of VSC services, but is reliably considered to be substantial and growing. Thus the methods in use in the GOM program are modern and effective.

TABLE 4

ANALYSIS OF GOM FAMILY PLANNING TARGETS AND PERFORMANCE, 1973 - 1977

| <u>Year</u> | <u>1973</u> | <u>1974</u> | <u>1975</u> | <u>1976</u> | <u>1977*</u> | <u>All Years</u> |
|--------------------------|---------------|----------------------|----------------------|---------------------|-----------------------|----------------------|
| New Acceptor | | | | | | |
| <u>TARGET</u> | 70,220 | 64,570 (-8.0) | 74,300(+15.1) | 84,770(+14.1) | 97,530(+15.1) | 391,390 |
| <u>ACTUAL</u> | <u>37,030</u> | <u>55,396(+49.6)</u> | <u>72,179(+30.3)</u> | <u>77,913(+7.9)</u> | <u>100,242(+28.7)</u> | <u>342,760</u> |
| Pills | 27,327 | 46,219 | 59,774 | 63,708 | 83,282 | 280,310 |
| IUDs | 5,156 | 6,324 | 7,481 | 6,158 | 8,688 | 33,807 |
| Condoms | 4,547 | 2,853 | 4,924 | 8,047 | 8,272 | 28,643 |
| Actual as % of Target | 52.7 | 85.8 | 97.1 | 91.9 | 102.8 | 87.6 |

* Estimated on basis of performance through June 1977.

Orals acceptance in the Marrakech household distribution program has been running at 61% of all married females aged between 15 and 44 (urban population of Marrakech city). Some 37% claimed to already be using orals, either from public sources (23%) or private sources (14%). Thus, the simple increment, unadjusted for dropouts, would seem to be on the order of 25% (from 37% to 61%) among urban females 15-44 in Marrakech, or an increase of about 65% over previous prevalence levels. Fifty percent of women contacted claimed use of some contraceptive method, including IUDs, orals, sterilization, condoms, and traditional methods ("medicament Arabe"). A total of 67% of women contacted said they do not want additional children, and 40% had, they said, not been pregnant in the last three years although they were still menstrual and thus presumed fecund. A profile of VDMS women, drawn from computer analysis of the first 25,673 cases, is presented in Table 4a.

While the government cannot be said to be vigorously pursuing family planning programs, the Ministry of Health at least is moving ahead with new and effective actions such as the pilot Marrakech program. It is their stated intent to make family planning services freely available in all health institutions and to extend services directly into the home through outreach programs such as VDMS. Progress in achieving this aim will be hampered by lack of a clear and strong political mandate, resource scarcities in the wake of Sahara, administrative bottlenecks endemic to the country's bureaucratic structure, and a limited research and evaluation capacity. Still, much can be achieved with goodwill and within present mandates. It should be possible to incorporate the household distribution effort into the ongoing health program in at least 10 additional populous provinces. This action alone has tremendous potential for increasing the prevalence level. A commercial distribution program would seem to present no special political risks and would make contraceptives more generally available through private sector outlets, particularly if a subsidized system could be worked out to make orals available at very low cost for those who can't afford to pay the going rate (about \$1.50 per cycle at present). The private family planning association could mount a more effective national IE&C effort to promote family planning practice without the government having to assume any associated political risk. Thus, there is considerable scope for action by the government and by the private sector even without a strengthening of overall policy. A strengthened policy would, of course, increase the chances of success by opening new avenues for action and by raising the commitment of concerned agencies to set and to accomplish more ambitious population targets.

Profile of VDMS Women

| <u>Question Number</u> | <u>Index</u> | <u>First Batch (N=5,078)</u> | <u>Second Batch (N=3,350)</u> | <u>Third Batch (N=17,245)</u> | <u>Weighted Average (N=25,673)</u> |
|------------------------|---|----------------------------------|-----------------------------------|-----------------------------------|--|
| 7 | menstrual (including those now pregnant) | 93.6 | 92.1 | 98.2 | 96.5 |
| 8 | pregnant | 9.9 | 10.8 | 10.9 | 10.7 |
| | not pregnant | 87.1 | 86.6 | 87.8 | 87.5 |
| | don't know | 2.4 | 1.2 | 1.2 | 1.4 |
| 9 | been pregnant in last 3 years | 57.8 | 54.9 | 61.0 | 59.6 |
| | not pregnant in last 3 years | 41.5 | 43.8 | 38.5 | 39.8 |
| 10 | breast feeding | 23.7 | 25.2 | 25.9 | 25.4 |
| | not breast feeding | 72.2 | 70.4 | 71.2 | 71.3 |
| 11 | number of previous live births | | | | |
| | 0 | 6.3 | 8.0 | 5.2 | 5.8 |
| | 1 | 12.3 | 12.2 | 12.5 | 12.4 |
| | 2 | 13.4 | 11.9 | 13.7 | 13.4 |
| | 3 | 11.6 | 11.2 | 12.8 | 12.4 |
| | 4 | 11.2 | 10.8 | 12.4 | 12.0 |
| | 5 | 10.7 | 9.6 | 11.0 | 10.8 |
| | 6 | 11.3 | 9.0 | 11.3 | 11.0 |
| | 7 | 8.7 | 8.8 | 7.8 | 8.1 |
| | 8 | 6.6 | 7.0 | 6.8 | 6.8 |
| | >8 | 6.6 | 9.8 | 6.0 | 6.6 |
| 13 | % wanting no more children | 65.9 | 64.4 | 68.2 | 67.2 |
| 15 | claim habitual use of some contraceptive method | 47.9 | 48.4 | 51.3 | 50.2 |
| | condoms | 0.9 | 0.8 | 0.7 | 0.8 |
| | pills, public source | 22.5 | 21.3 | 23.6 | 23.1 |
| | pills, private source | 10.7 | 12.6 | 14.7 | 13.6 |
| | pills, all together | 33.2 | 33.9 | 38.3 | 36.7 |
| | IUD | 3.7 | 3.1 | 3.1 | 3.2 |
| | Accepted pills from worker | 63.0 | 59.5 | 60.8 | 61.1 |

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Probability of Achieving Target

The goal of 850,000 contracepting couples by 1982 includes some 450,000 couples in the government program and 400,000 in the private sector. Can these levels be met? We presently estimate that 150,000 couples are served by the government program and 200,000 couples are served by the private sector. Thus, the 450,000 target represents a three-fold increase for the GOM and a two-fold increase for the private sector. In Marrakech, 23.1% of married women 15-44 claimed to be enrolled in the government program and to be habitually using orals. An additional 13.6% claimed use of orals from private sources, for a total of 36.7%. Since overall acceptance of orals was 61.1% of all women contacted, it would seem that the net increase with respect to oral contraceptives was 24.4% of all MWRA (61.1% minus 36.7%). The increase from 23.1% to 61.1% represents a 2.7 fold increase in the number of women served by the government program. This 170% increase occurred in a period of 10 weeks. Spinoffs from the house-to-house effort accounted for additional new acceptors of orals, condoms, IUDs, and other methods. The FP Referral Center reported substantially increased activity as a direct result of the VDMS program.

The Marrakech experience is, thus far, completely urban. Presumably, the gap between desire for services and availability thereof is much larger in the rural areas. If this is true, the government program can expect to attract proportionately greater numbers of rural couples (over those already practicing) as it moves out of the cities. The planned introduction of VSC services on a broad scale will further increase the popularity of government FP services.

Orals activity in the private sector has been steadily increasing. Though estimates are rough, it would seem that about 200,000 women-years of protection are provided through private sector sales of orals. The 850,000 prevalence target includes a doubling of private sector sales in a five-year period, or a growth rate of about 14% per year. Based on past growth, this seems well within the range of possibility, particularly if an effective IE&C effort gets underway soon. A total of 850,000 contraceptive users by 1982 would correspond to a prevalence level of about 25% of all married

women of reproductive age. This also seems well within the range of the possible, just by making services freely and widely available and by stepping up the information campaign. Based on experience from other countries (Indonesia, Thailand, Korea, Colombia, etc.) and on fragmentary information from Morocco (such as Marrakech where 67% of MWRA say they want no more children but only about 40% are practicing an effective modern method), it should be possible to achieve a 25% prevalence level without the need for major social, economic, or political intervention. An important assumption associated with the achievement of sub-purpose No. 1 is that other GOM programs, including some which are AID-assisted, will have the effect of creating new demand for contraceptive services. It may be useful to explore briefly the basis for this assumption.

The literature on factors related to decisions to limit family size is voluminous, but far from definitive. Where correlations are established, causality is called into question and even the best-bet correlations do not always hold cross-culturally. Still, a handful of factors seem rather consistently present whenever low-fertility and high-fertility populations are compared. Perhaps the most reliable factor is employment of females outside the home. Another, almost as consistent, is educational status of the female, followed by educational status of the male. Fertility is almost universally lower in urban areas than in rural areas, presumably due to the economics of child-raising in the cities as well as to a generally more liberal or modern environment to be found there. Low infant and child mortality seem also to be generally correlated with lowered fertility, though not necessarily with reduced family size (fewer children are born, but fewer die). Some authors hold that a relatively equitable distribution of goods and services seems to correlate well with lowered fertility. The general level of development is widely thought to be correlated with fertility, though the question of threshold levels and the probability of ever reaching them is generally left unexplored.

The list is long. Speculation, analysis based on secondary sources, and unsupported assertions contribute to the muddle. What can be said with confidence about how best to reduce family

size -- beyond the provision of family planning information and services and the effectiveness of incentives and disincentives -- is, in fact, very little, with the notable exceptions of female employment and female education, both of which seem to be predisposing factors for rapid fertility decline, particularly when backed up by the availability of modern means of contraception.

USAID/Morocco is currently developing a project aimed at providing non-formal education opportunities to young women. Already in existence is a program of nonformal education for young girls aged 9 to 20 in 262 centers throughout the country. This latter program is supported by Title II Food for Peace donations. (A similar program, operated by another ministry with assistance from the UNFPA, provides trade opportunities for young girls, and also provides them with information on family planning). It is our intent to build family planning information into these nonformal education programs and to compare, in future years, the relative fertility of beneficiaries of these programs with that of matched controls who did not receive such training.

USAID is presently supporting two nutrition projects, one aimed at developing a national nutrition strategy cutting across all ministries and sectors, and the second at training nutrition-assistants who serve in 250 social-educational centers attended by 150,000 women who receive a ration of Title II food, are given instruction in how to prepare nutritionally adequate meals from low-cost foods locally available, and whose young children are weighed and measured regularly to follow their physical development on a standardized chart. Introduction of family planning information into this program is intended in the near future.

These programs, and others of a similar nature, can be expected to result in a heightened demand for contraception among project beneficiaries, quite apart from other beneficial and planned results.

Planned inputs under this project aim at ensuring that both government and private sector facilities have modern, effective contraceptives on hand and readily available to the public at no cost in the case of the government program and at low cost in the case of the private sector. Existing demand for contraceptives, the

greatly expanded availability and improved quality of services, and the growing demand as a result of programs directly and indirectly contributing to desire for family spacing or family limitation, should be sufficient to ensure an increase in prevalence of the magnitude targeted herein.

We conclude that the probability of achieving Subpurpose No. 1 is high, i.e., greater than 75%.

Subpurpose No. 2 - raising awareness and commitment. As pointed out in the background section, the situation with respect to awareness of the population threat in Morocco is very mixed indeed. While some thoughtful planners and analysts approach what could be termed a professional understanding of the demographic dynamics and potential of their country, most Moroccan officials have only a cursory overview of the situation. Not being accustomed to quantitative analysis of social and demographic trends, even those having before them the statistical projections of population growth for the next 30 years or so sometimes come to rather curious conclusions. In two recent editorials in the government-controlled daily, Le Matin, the editor presented population growth projections to the year 2000. After exploring the enormity of the country's future growth, he concluded: (1) the country must drastically step up its investment in new housing construction; and (2) that to stem the tide of rural-urban migration the country should develop numerous urban centers located all over the kingdom, each of which must have better facilities, infrastructure services, and amenities than do the large cities in order to attract and hold their residents. Nowhere in the two editorials did the author-editor make mention of the necessity of controlling the rate of population growth. Rather, he began with the assertion that Morocco can support a population of perhaps 40 to 50 million, and that that figure will be reached near the turn of the century. The non-specialist reader could have no inkling that the momentum of population growth would assure still another doubling, i.e., if population growth were to continue at more or less the present pace until the 40 million level is reached, it would be virtually impossible to prevent another doubling from 40 to 80 million or so because of the skewed age structure. Far more serious, however, was the suggestion that the government has at its disposal the necessary resources to step up housing construction on the scale suggested, and to build several hundred new mini-cities. Even if the resources were to be available, the article did not address the question of whether these measures: (1) would be a good use of resources; and (2) would work anyway.

A second common response to the fact of rapid population growth in Morocco is the rationalization of that growth in terms of increased human potential. This theme is currently popular as Morocco and Algeria rattle swords at one another. Increased numbers means to many Moroccans, increased human potential whether for armed conflict or for economic development purposes. In a recently published speech, Morocco's Monarch spoke of the future millions of new citizens to be added by the year 2000, the only-mentioned problem being the need to educate them. In a recent speech the country's highest planning official struck a similar chord: Morocco's growth problems can be solved by long-term planning to achieve self-sufficiency in the next 12-15 years. Period. A dispassionate analysis of current social and economic problems in Morocco, the quality of government planning to deal with these problems, the degree of adherence to past economic plans, and past performance in major economic sectors (such as agriculture) would not lend much support for this view of the future. Moreover, few persons seem to be taking a hard look at the present situation in which the great majority of Moroccans find themselves, their unmet needs, and the size of the investment required just to approach the provision of BHN for the existing population, not to mention the needs of a second Morocco of 18 million new citizens within 25 years. (The limitations on available resources, present and future, were covered in the economic background section of the Multi-Year Population Strategy, Annex 1).

What, then, are the chances that this project can affect:

(1) Basic understanding of the population problem which Morocco faces; and (2) real commitment on the part of the GOM to cut short its losses (since the present age structure is such as to pose an inexorable potential for a doubling and possibly a tripling of population)? The project inputs relating to this question are:

(1) An IE&C effort aimed at GOM decision-makers and other influential persons, run by the private family planning association with technical cooperation from IPPF, USAID, and the Ministry of Health;

(2) informal, low-key contacts by U.S. officials with GOM officials, aimed at exploring the range and depth of understanding of the problem, and at filling in any factual gaps;

(3) special presentations for key officials during their visits to the U.S. and, possibly, other countries, designed to heighten their understanding of the demographic threat their country faces; and

(4) demonstration by means of successful field programs such as VDMS that a demand for contraceptive services already exists among the population at large, that family planning programs can

be successful and a-political, and that, quite aside from the numbers game and the economic savings to the nation's treasury, the lives of many Moroccan families can be improved through child spacing and family limitation.

In the context of present-day Morocco where endemic problems go largely unexplored in the public media, where statistics are neither sufficient nor widely shared, where the training and experience of senior officials is often more theoretical than practical, and where there is a tendency to view the future in optimistic rather than pragmatic terms -- any attempt to bring realism to the understanding of the population threat will undoubtedly experience rather rough sledding. Yet without such realism, in thought and in practice, Morocco faces the continuation of a weak, poorly understood and articulated population policy which will predictably result in disastrous social and economic consequences.

We conclude that the possibility of achieving Subpurpose No. 2 by 1982 in any meaningful sense is only fair, perhaps 40 to 60 percent. The nascent high-level dialogue (cf p. 14) may improve the chances of success somewhat over this estimate. New estimates will be prepared at the time of the scheduled project evaluations and changes in strategy will be made as appropriate.

Subpurpose No. 3 - increasing demand. The following discussion focuses exclusively on actions included and funded in this project which are intended to intensify the demand for family planning services. Not included herein, but specifically treated in the detailed discussion of project assumptions (section III.B., page 52) are indirect influences on the creation of new demand, including those arising from other USAID and GCM programs. Primary actions leading to the achievement of Subpurpose No. 3 include: (1) the expanded availability of contraceptive services themselves; and (2) the expanded availability of information pertaining to family planning, including motivational materials linking family planning practice to improved personal and family well-being. Seven of the eight project outputs relate directly to these two categories, i.e., either to expanded service availability or to expanded IE&C activities.

The primary technical assumptions underlying the creation of new demand through the means selected herein are:

(1) the ready availability of family planning services, particularly if offered directly in the home, serves as a powerful stimulus to consciously consider the adoption of a modern FP method and, in many instances, to actually accept and practice a method; and

(2) the impact of family planning messages, properly conceived, timed, and sequenced, can strongly support a decision to adopt a method of child-spacing and can, in some instances, actually precipitate such a decision, leading the interested couple to actively seek family planning services.

Neither of these assumptions is a high-risk one. Both are well established as a result of many years' experience of family planning

programs in varied cultural settings. With results now flowing in from AID-financed household distribution projects in 14 countries, it can be confidently stated that the availability of modern contraceptive devices within the home does in fact lead to higher prevalence levels-- dramatically higher levels in most cases. In Morocco, the experience of the Marrakech household distribution project, Phase Ia, confirms the basic assumption: orals prevalence jumped from 37% to 61% of MWRA in a 10-week period. Overall prevalence (i.e., the percentage of couples claiming to use any contraceptive method, including traditional methods) increased by at least 20%. No doubt Marrakech is a special case in that prevalence levels are unusually high already. Nevertheless, the basic assumption remains valid, and there would seem to be no logical reason why the same basic approach should not be productive in creating new demand and higher prevalence levels elsewhere in the country. Time--and the experience gained as a result of the implementation of this project--will tell.

The evidence relating IE&C activities to creation of new demand is not quite so clearcut, at least not in the case of Morocco. The GOM has intentionally restricted its IE&C activities to a very low and seemingly ineffective level. At present, only the private family planning association (AMPF) carries on what could be regarded as a modestly effective IE&C program. The GOM has shown little indication of its willingness to change the basic low-profile policy; it has been and apparently will continue to be content to allow the AMPF to dominate the IE&C scene.

In our estimation, the MOH has, by design or inadvertence, overlooked a number of politically "safe" and potentially effective IE&C actions with respect to its own personnel and the health service-providing community in general. For example, the distribution on a regular basis of technical articles on family planning to MOH personnel and to private physicians and pharmacists could serve an important inservice training purpose. Recently, the MOH agreed to distribute 2,000 copies of each issue of Population Reports (GW University) to its medical and paramedical personnel. In addition, five regional family planning conferences were held in 1977 with the support of the UNFPA, aimed at increasing awareness and improving technical competency of participants in each conference. At present, a major documentary film is nearing completion (again with UNFPA support) and a film on the Marrakech project has just been started. These and similar actions-- hopefully in greater numbers, variety, and with increasing sophistication-- in the next five-year period should help improve what has been a woefully inadequate IE&C performance in the past.

Family planning information is also being built into the womens' training programs of the Ministry of Youth and Sports

with financial support from the UNFPA. Entraide Nationale, the country's social welfare arm, is considering the introduction of similar information activities in its centers for training of 60,000 women and its food demonstration/distribution centers which reach 125,000 women throughout the country. These are important innovations in that they reach directly about 185,000 young women of poor to lower-middle income classes who can now or in the near future benefit from the practice of family planning.

The AMPF has initiated a series of TV spots in recent months, promoting child spacing and family planning. The organization has several times declared its willingness to cooperate with the government-sponsored program and to develop a complimentary IE&C program which would bolster acceptance in the government program. Thus far, although the MOH has indicated its desire to collaborate, no plan has been established and mutually agreed on. This project proposes to simulate a series of meetings attended by key representatives of the AMPF, the Ministry of Health, the UNFPA, the IPPF, and USAID to work out a long-term plan for a major IE&C effort to be implemented by the AMPF (with financial support from USAID, IPPF, and possibly, the UNFPA). Details of the plan, including its periodic review and modification by an oversight committee, remain to be worked out. It would include, however, at least two target groups: key public officials and opinion leaders, as mentioned under subpurpose No. 2 above; and the pool of potential acceptors of family planning services. While the AMPF at present lacks the technical personnel to direct such an effort, it is planned under this project to finance the required technical personnel as well as other necessary inputs.

We estimate the probability of achieving subpurpose No. 3 to be high, on the order of 80% or more, contingent upon the critical assumption that it will be possible for all concerned parties (including, at minimum the AMPF, the MOH, USAID, and IPPF) to develop and agree upon a comprehensive IE&C plan which is feasible for implementation beginning in 1978-79.

Implications of Achieving Project Purpose

1. On Moroccan Institutions - The successful achievement of the three subpurposes of this project could be expected to result in a significant strengthening of indigenous capability in respect to the planning, management, and evaluation of population programs. While Moroccan institutions are often quite good in launching new programs and activities, careful forward planning and critical program analysis (particularly cost/benefit analysis) is typically not done. There is, however, an increasing willingness to learn modern planning, management, and evaluation techniques to increase program

efficiency, and this project contains a number of inputs and outputs which will directly and indirectly augment Moroccan experience in the application of modern techniques to population programming. Increased experience in this area should result in the application of increasingly sophisticated management methods to population programs in Morocco, further improving their effectiveness.

2. On Demographic Trends - A total of 850,000 contracepting couples by 1982 (Surpurpose No. 1) would represent a 2.4-fold increase in all contraceptors, and would correspond to a prevalence level of about 25% of all married women of reproductive age. While it is technically hazardous to estimate what effect this prevalence level might have on birth and growth rates, conceivably it could result in a 22% drop in the crude birth rate (from 45 to 35 per 1,000) and, coupled with the expected further decline in mortality, an overall growth rate of about 2% per annum. Although this would be impressive performance, it would still mean that Morocco would by 1982 be adding more than 400,000 new citizens to her population annually. In very rough terms, the associated changes in vital rates might look something like this:

| <u>Index</u> | <u>1978</u> | <u>1979</u> | <u>1980</u> | <u>1981</u> | <u>1982</u> |
|--------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Crude Birth Rate <u>1/</u> | 45 | 43 | 41 | 38 | 35 |
| Crude Death Rate <u>2/</u> | 16.5 | 16 | 15.5 | 15 | 14.5 |
| Rate of Natural Increase <u>3/</u> | 2.9 | 2.7 | 2.5 | 2.3 | 2.1 |
| Total Population (millions) | 18.5 | 19.1 | 19.6 | 20.1 | 20.6 |
| Number of Births Prevented <u>4/</u> | 37,500 | 47,500 | 55,000 | 60,000 | |

1/ Crude Birth Rate or CBR=total number of births during year divided by mid-year population

2/ Crude Death Rate or CDR=total number of deaths during year divided by mid-year population

3/ Rate of Natural Increase or RNI=total births minus total deaths

4/ Prevented Births=number deducted from both numerator and denominator which would otherwise prevail for any given year on basis of population size and CBR/CDR from previous year.

Figures assume a moderate decline in CDR as result of declines in contagious diseases and in fertility.

III. B. Financial Analysis

AID inputs for this revised project are estimated at \$1.2, \$2.4, \$2.9, \$3.4 and \$3.2 million, respectively, for the fiscal years FY 78 - 82, totaling \$13 million by the end of the revised project period. These inputs, together with AID inputs during the period FY 71 - 77, amount to a grand total of \$16 million. Tables 6 and 8 thru 15 detail proposed inputs. Table 1 summarizes AID inputs under this project since inception in FY 1971. Table 3 is a rough, conservative estimate of GOM costs for family planning to date and over the revised project period.

Table 5FP Project 0112: Total AID assistance FY 71 thru FY 77(\$ 000s)

| <u>Category</u> | <u>Mission-funded</u> | <u>Centrally-funded</u> | <u>Total</u> |
|-----------------|-----------------------|-------------------------|----------------------------|
| U.S. Personnel | 100 1/ | - | 100 |
| Participants | 73 | - | 73 |
| Commodities | 765 2/ | 1523 3/ | 2288 |
| Other Costs | <u>438 4/</u> | <u>147 5/</u> | <u>585</u> |
| Totals | 1376 | 1670 | GRAND TOTAL: 3046 ===== |

1/ US personnel were formerly charged to project funds, but now are charged to general support costs.

2/ includes \$113,000 equipment for FP Referral Centers

3/ Centrally-funded oral contraceptives (\$ 1,463,000) and condoms (\$60,000)

4/ includes \$392,000 for construction of 13 FP Referral Centers; \$25,000 printing and seminar support costs; and \$11,000 US personnel support costs

5/ Marrakech VDMS project.

Table 6
SUMMARY OF PROPOSED AID OBLIGATIONS FY 78-82

FY 78-82

| <u>Inputs for</u> | <u>Description</u> | <u>FY 78</u> | <u>FY 79</u> | <u>FY 80</u> | <u>FY 81</u> | <u>FY 82</u> | <u>TOTAL</u> |
|-------------------|--|--------------|--------------|--------------|--------------|--------------|---------------|
| Output # 1 | . VDMS, Phase II & III . VDMS Technician, 9pm | (175) 55 | (145) | - | - | - | (320) 55 |
| Output # 2 | . VDMS expansion . VDMS technician, 27pm | - | 300 100 | 850 70 | 1600 | 1830 | 4580 170 |
| Output # 3 | . Referral Centers | - | 330 | 320 | - | - | 650 |
| Output # 4 | . Training, 196pm | 71 | 142 | 117 | 95 | 107 | 532 |
| Output # 5 | . Improved Services - Centrally-funded contraceptives (656) - Mission-funded commodities | - | (914) 70 | (1200) 60 | (1500) 70 | (1100) 85 | (5370) 285 |
| Output # 6 | . Commercial Distribution Program 1/ | - | (200) | (150) | - | - | (350) |
| Output # 7 | . IEAC Program 2/ | - | 83 | 125 | 50 | 17 | 280 |
| Output # 8 | . National Fertility & FP Survey | (200) | (75) | - | - | - | (275) |
| Other Costs | . Periodic/project evaluations, short-term consultants, contin- gencies. | 25 | 30 | 25 | 35 | 35 | 150 |
| <hr/> | | | | | | | |
| TOTALS | . Mission-funded | 151 | 1060 | 1567 | 1850 | 2074 | 6702 |
| | . Centrally-funded | (1031) | (1324) | (1350) | (1500) | (1100) | (6315) |
| | . Combined mission and centrally- funded | 118 | 2394 | 2917 | 3350 | 3174 | 13017 |

1/ includes 18-24pm resident technical services (contract)

2/ includes: 18pm resident technical services (contract) plus 9pm short-term consultants.

Table 7GOM Costs for FPA Rough but Modest Estimate

(in \$000s)

| <u>Item</u> | <u>FY 71-77</u> | <u>FY 78-82</u> |
|------------------------------|-----------------|-----------------|
| VDMS Project | 114 | 666 |
| VDMS Expansion | | 8030 1/ |
| FP Referral Centers | 765 | 4475 2/ |
| Personnel | 7500 | 15000 3/ |
| Facilities, transport, misc. | <u>2250</u> | <u>1,500</u> 4/ |
| | 10,629 ===== | 32,671 ===== |

Thus GOM costs for 5-year period FY 78-82 are expected to total a minimum of \$6.5 million per year.

1/ See Outout #2

2/ See Outout #3

3/ 900 dispensaries x 1 paramedic x 1 hr per day x 1200 days = 1 million person-hours @ 1 dollar per hour = \$ 1 million; 350 health centers & hospitals x 1 physician and 1 paramedic x 1 hr per day x 1200 days = 2 million person-hours @ \$5 per hour (\$5 for physician, \$1 for paramedic) = \$ 12 million; plus HQ staff, medicin bheer's, misc. other personnel = roughly \$15 million total.

4/ @ 30% of personnel costs.

Table 8

| <u>Project Inputs</u> | | | |
|---------------------------------------|------------------|-------------------|---------------------|
| <u>For Output I (VDMS)</u> | | | |
| <u>(in \$000s)</u> | | | |
| <u>AID</u> | | <u>Thru FY 77</u> | <u>FY 78 - 82</u> |
| <u>Technical Assistance</u> | | | |
| . Resident Specialist (contract) 9 pm | | 0 | 55 |
| <u>Commodities</u> | | | |
| . Contraceptives (centrally-funded) | | 0 | (235) ^{1/} |
| <u>Other Costs^{2/}</u> | | | |
| . Personnel | | (83.5) | (188.2) |
| . Transport/travel | | (35.0) | (42.0) |
| . Administration | | (13.7) | (31.5) |
| . Training | | (6.5) | (10.0) |
| . Motivation; souk demonstrations | | (8.5) | (28.7) |
| . Documentary training films | | 0 | (20.0) |
| <hr/> | | | |
| Totals | Mission-funded | 0 | 55.0 |
| | Centrally-funded | (147.2) | (320.4) |
| <u>GOM</u> | | | |
| . Personnel | | 107.4 | 527.8 |
| . Transport/travel | | 0 | 122.5 |
| . Administration | | 6.8 | 15.8 |
| <hr/> | | | |
| | GOM Total | 114.2 | 666.1 |
| <u>AID & GOM</u> | Grand Total | 261.4 | 1,041.5 |

^{1/} Non-additive; figure costs reflected under inputs for output #5.

^{2/} All centrally-funded under worldwide operations research project.

Project Inputs
For Output 2 (VDMS Expansion)
in US \$000s

| <u>AID</u> | <u>Thru FY 77</u> | <u>FY 78-82</u> |
|---|-------------------|-----------------|
| <u>Technical Assistance</u> | | |
| . Resident contract specialist (27 pm) | 0 | 170 |
| <u>Commodities</u> | | |
| . Contraceptives | 0 | (2,500) 1/ |
| <u>Training</u> | | |
| . Short-term participant training (20 pm) | 0 | 50 |
| . In-Country training (350 pm) | 0 | 170 |
| <u>Other Costs</u> | | |
| . Travel and transport | 0 | 770 |
| . Personnel | 0 | 2,720 |
| . Administration | 0 | 450 |
| . Motivation | 0 | 370 |
| . Obs. Travel | 0 | 50 |
| | ----- | ----- |
| TOTAL AID..... | 0 | 4,750 |
| <u>GOM</u> | | |
| Personnel | 0 | 6,400 |
| Transport | 0 | 1,250 |
| Administration | 0 | 230 |
| Data Processing - UNFPA | 0 | 150 |
| | ----- | ----- |
| TOTAL GOM..... | 0 | 8,030 |
| AID & GOM GRAND TOTAL: | 0 | 12,780 ===== |

1/ Centrally-funded; non-additive figure as cost reflected under Inputs for Output # 5.

Table 10Project InputsFor Output 3 (Referral Centers)(in US\$000s)

| <u>AID</u> | <u>Thru FY77</u> | <u>FY 78-82</u> |
|---|------------------|-----------------|
| <u>Commodities</u> | | |
| . Equipment for 10 new centers | 0 | 100 |
| . Equipment for existing centers | 113 | 20 |
| . Equipment for 15 mobile units | 0 | 30 |
| <u>Other Costs</u> | | |
| . Construction of 10 new centers | 0 | 500 |
| . Construction of first 13 centers | <u>392</u> | <u>0</u> |
| AID total | 505 | 650 |
| <u>GOM</u> | | |
| Land | 26 | 20 |
| Equipment and furnishing | 39 | 30 |
| Operational expenses 10 new centers (at \$4,000/mo.) | 0 | 1,200 |
| Operational expenses first 13 centers (at \$4,000/mo.) | 700 | 3,000 |
| Support of mobile units-vehicles, supplies, personnel | <u>0</u> | <u>225</u> |
| GOM total | 765 | 4,475 |
| <u>UNFPA</u> | | |
| Vehicles, equipment, supplies | <u>53</u> | <u>125</u> |
| GRAND TOTAL... | 1,323 | 5,250 |

Table 11

PROJECT INPUTS
FOR OUTPUT 4 (TRAINING)
(in \$000s)

| <u>AID</u> | <u>Thru FY 77</u> | <u>FY 78-82</u> |
|--|-------------------|-----------------|
| <u>Technical Assistance</u> | | |
| . Contract consultants, 5 ¹ / ₂ pm | | 22.0 |
| <u>Participant Training</u> | | |
| . Long-term (138 pm new + 35 pm old) | 35 | 177.2 |
| . Short-term (141 pm new + 24 pm old) | 38 | 276.0 |
| . Trust-fund Travel Costs | (8) 1/ | (62.2) 1/ |
| <u>Other Costs</u> | | |
| . In-Country training, seminars | <u>35</u> | <u>78.3</u> |
| Total AID costs | 108 | 531.5 |
| | (8) 1/ | (62.2) 1/ |
| <u>GOM</u> | | |
| . Personnel Costs | <u>43</u> | <u>299.7</u> |
| COMBINED AID & GOM COSTS..... | 151 | 831.2 |
| | (3) 1/ | (62.2) 1/ |

1/ Local-currency cost.

Table 12Project InputsFor Output 5 (Improved Services)

(in US\$000s)

| <u>AID</u> | <u>Thru FY77</u> | <u>FY 78-82</u> |
|----------------------------------|-----------------------|-----------------------|
| <u>Commodities</u> | | |
| . Orals | (1,463) ^{1/} | (4,500) ^{1/} |
| . IUDs | -- | 100 |
| . Condoms | (60) ^{1/} | (870) ^{1/} |
| . Medical kits | -- | 50 |
| . Misc. others | -- | 50 |
| | <hr/> | <hr/> |
| Total Mission funded | 652 | 200 |
| Total centrally-funded | (1,523) ^{1/} | (5,370) ^{1/} |
| <u>GOM</u> | | |
| Personnel | 7,500 | 15,000 |
| Facilities and misc. other costs | <u>2,250</u> | <u>4,500</u> |
| GOM total | 9,750 | 19,500 ^{2/} |
| GRAND TOTAL..... | 11,925 | 25,070 |

1/ centrally-funded contraceptives

2/ very rough estimate of total GOM costs for FP services offered in 1,400 dispensaries, health centers, and hospitals; does not include GOM costs for VDMS project, VDMS expansion, and FP Referral Centers which are shown elsewhere and which together total \$879 thousand for period FY 71-77 and \$13.2 million for period FY 78-82. See table____,p.____.

Table 13Project InputsFor Output 6 (Commercial Distribution Program)(in US \$000s)(All Costs Centrally-funded)

| <u>AID</u> | <u>Thru FY 77</u> | <u>FY 78-82</u> |
|---------------------------------------|-------------------|-----------------|
| <u>Technical Assistance</u> | | |
| . Contract Services (30pm) | 0 | (250) |
| <u>Commodities</u> | | |
| . Crals, condoms, neo-sampoon tablets | 0 | (2,100) 1/ |
| <u>Other Costs</u> | | |
| . Publicity efforts | | <u>(100)</u> |
| TOTAL AID Cost... | 0 | (350) |
| <u>GOM</u> | | |
| . Storage, handling, transport | 0 | <u>50</u> |
| TOTAL GOM Cost... | 0 | <u>50</u> |
| TOTAL: GOM & AID | <u>0</u> | <u>400</u> 2/ |

1/ Non-Additive figure; costs for these contraceptives included in Inputs for Output 5

2/ Not including cost of contraceptives

Table 14

Project Inputs
For Output 7 (IE & C)
(in US \$000s)

| <u>AID</u> | <u>Thru FY 77</u> | <u>FY 78-82</u> |
|--|-------------------|-----------------|
| <u>Technical Assistance</u> | | |
| . Resident contract IE&C specialist, 13 pm | - | 90 |
| . Short-term consultants, 9 pm | - | 45 |
| . Trust-fund travel costs | - | (6) 1/ |
| <u>Commodities</u> | | |
| . 2 mobile vans | - | 30 |
| . A-V equipment and supplies | - | 27 |
| <u>Other Costs</u> | | |
| . Personnel, local hire (96pm) | - | 70 |
| . IE&C seminars | - | 10 |
| . Studies, media testing | - | 8 |
| | ----- | |
| TOTAL AID COSTS:..... | 0 | 280 (6) 1/ |
| <u>AMPF/IPPF</u> | | |
| <u>Personnel</u> | | |
| | | 26 |
| <u>FACILITIES, Transport, misc.</u> | | |
| | | 78 |
| | | ----- |
| TOTAL AMPF COSTS:..... | | 104 |
| COMBINED AID & AMPF COSTS | | |
| | | 384 ===== |

1/ Local-currency cost.

Table 15Project InputsFor Output 8 (National Fertility & FP Survey)(in U.S. \$000's)

| | <u>Thru FY 77</u> | <u>FY 78 - 82</u> |
|--|-------------------|-------------------|
| <u>AID</u> | | |
| Technical Assistance (21 pm) ^{1/} | 0 | (91) |
| Training ^{2/} | 0 | (14.4) |
| Other Costs ^{3/} | 0 | <u>(169.8)</u> |
| Total AID (centrally-funded) | 0 | (275.2) |
| <u>GOM</u> | | |
| Personnel, facilities, transport, etc. | 0 | 192.5 |
| <u>WHO</u> | | |
| Resident Technician, 13.5 pm | 0 | <u>65</u> |
| Combined AID/GOM/WHO Total | <u>0</u> | <u>532.7</u> |

^{1/} One resident technician (contract) is programmed for 27 months; WHO will contribute \$65,000 toward cost of this technician; AID costs shown include 13.5 pm for this technician plus 7 pm for other short-term consultants (NCHS).

^{2/} Approximately 61.4 pm of in-country training.

^{3/} Local personnel, costs, materials, supplies, etc.

III. C. Social and Economic Analysis

Due to time and personnel constraints and to a paucity of relevant social and economic data in Morocco concerned with family life, it has not been possible to develop a full-blown social and economic analysis for submission at this time. There are, however, numerous bits and pieces from earlier work by social scientists in Morocco which, when coupled with what is known of the impact of population programs in other LDCs, constitutes in our judgment sufficient evidence to assume that the overall social and economic impact of the proposed activities will be highly beneficial at the family level as well as at the national level. Project beneficiaries are, in the main, poor and lower-middle income citizens who live in circumstances not unlike those of poor people everywhere. Morocco's middle income status is deceiving, since the great majority of her citizens are poor by any standards. Literacy levels are low (24% for males, 15% for females, and 2% for rural females), morbidity and mortality rates are high (IMR 130, CDR 16), agricultural yields for most small farmers are low, and the future holds little promise of change for many Moroccans. The ranks of the landless unemployed are growing, overall unemployment runs at an (unofficial) 25%, and GOM efforts to provide low-cost housing to stem the spread of urban slum areas are unable to keep up with even a small fraction of the need. In this context, the provision of free and low-cost modern contraceptive services on a strictly voluntary basis seems a humane, cost-effective means of reducing infant, child and maternal mortality rates and of improving the economic situation of the family, particularly the families of the urban poor but increasingly (as pressure on available cultivable land increases) for the rural poor as well. The investment on the part of the GOM is relatively small, when compared to direct and short-term benefits. For example, in 1977 the GOM spent the equivalent of \$100 for each child in school in Morocco. Looking only at the cost of public education, then, the value of a prevented birth would be a minimum of \$500 for the first five years of schooling and probably somewhat more. The GOM investment needed for each new citizen--just to maintain the BHN status quo--is enormous, particularly when viewed in global terms: housing, health services, employment, welfare, education, public utilities, etc.

A short but detailed description of the social, economic, and political setting of Morocco is contained in the Multi-Year Population Strategy (Annex 1). In the fourth annex to that Strategy statement, Dr. Robert Fernea, an anthropologist closely associated with Morocco, describes social and cultural factors of significance in regard to population policies and programs. He concludes that:

- (1) There are no significant cultural or religious constraints to family planning in Morocco;
- (2) The rapidly changing nature of particularly urban but also rural life in Morocco has created a growing demand for contraceptive services; and
- (3) This demand is not always clearly recognized by high Moroccan officials or by foreigners including some Americans.

He argues that the basic human needs of the poor (health care, shelter, clothing, food, employment, education) are much the same as those of the relatively well-off, thus the demand for contraception already exists. USAID plans to pursue opportunities to expand existing knowledge of the socio-economic correlates of population planning in Morocco. Data collected in the Marrakech household distribution project and in the forthcoming National Fertility and Family Planning Survey will be extremely valuable in this regard. A preliminary anthropological research proposal is under present consideration for possible AID financing. It concerns psycho-social correlates to acceptance and nonacceptance of contraceptives offered by visiting nurses in the Marrakech project. Other social inquiries will no doubt be proposed and will be considered on their own merits. By the end of the revised project period, much more will be known about the social and economic dimensions of population programs in Morocco, hopefully with sufficient scope and accuracy to permit statistically valid conclusions to be drawn.

IV. Implementation Arrangements

A. Administrative Arrangements. As in the past, USAID direct-hire personnel will have primary responsibility for the management of activities proposed in this project revision. There are, however, several important proposed changes in the administrative arrangements. These involve personnel who will be involved in the monitoring of the project, as well as new institutions to receive assistance under the revision.

Direct-Hire Personnel. Present staffing of the USAID Population and Health Division consists of one Population Officer (Division Chief), one Health Project Development Officer, and one FP Development Officer. The Health Officer serves as project manager for two nutrition projects, and will soon assume responsibility for the large (\$15 million) PL 480 Title II program. She also assists in the management of population projects, particularly in the area of participant and in-country training, and is currently discussing possible new health activities with MOH officials. The FP Development Officer, a recently converted IDI, assists in the management of population projects (primary responsibility for the National Fertility and FP Survey plus other responsibilities) and handles USAID activities in Science and Technology. The population officer has primary responsibility for management of USAID population activities and overall administrative responsibility for all Division programs. As pointed out by the MFPS consultant team, this arrangement does not leave sufficient time for forward planning and for the development of new programs, since management responsibilities of ongoing programs take most of the available time. The MFPS team suggested the addition of a full-time contract technician to monitor and assist in household distribution project activities (Marrakech and its expansion) and such an individual is included in this Revision.

The addition of a contract technician to monitor household distribution programs will undoubtedly be of great assistance. Other contract assistance is proposed in this revision, including manpower required to fully develop the private sector distribution program (13-24 pm), the IESC program of the AMFH (27 pm), and the National Fertility and Family Planning Survey (27 pm). Contract manpower is already available on a short-term basis for assistance in the Marrakech VDMS program and the National Fertility and Family Planning Survey.

In our considered judgment, the proposed increase in the number and extent of population activities as a result of this project revision will impose a greater administrative burden on the USAID Mission than can be comfortably and professionally accommodated within the present staffing arrangement.

A more suitable arrangement would be the establishment of one additional direct-hire position and the assignment of a fully qualified, experienced, and energetic population program manager to that position. This would permit the present population officer to devote additional time to the important functions of coordination, forward planning, and development of new population programs.

Contract Personnel. One contract specialist is to be provided for a period of 36 months to monitor household distribution programs (CF discussion on pp. _____ and _____). A second contract consultant is proposed for an 18-month period to work with the AMPF on the development of a national IEMO program, providing on-the-job training for some AMPF staff and filling in with some technical skills while other AMPF staff are in long and short-term training. A third contract technician is to be provided for a period of 27 months to assist in the planning and evaluation of the National Fertility and Family Planning Survey. This individual will be partially (50%) financed by the World Health Organization. A fourth contract technician will be needed to establish a private sector commercial distribution program (18-24 months). Short-term contract consultants are to be provided for the National Fertility and Family Planning Survey, the Manpower Development Plan, the Marrakech VDMS Project, and other technical assistance needs as yet not fully defined.

Institutions.

1. The Ministry of Health (MOH). The MOH is the primary recipient of assistance under this project; MOH organization is shown in the accompanying chart. Day-to-day contact between USAID and MOH normally involves entities of the MOH Population Division, primarily the Family Planning, Health Statistics, and Health Education Services. Regular contact is also made with the Ministry's Technical Committee, composed of the chiefs of FP,

Statistics, and MCH Services plus representatives from the Minister's office and others as necessary. A monthly meeting at the Secretary-General level has been initiated, at the suggestion of the Secretary-General, to review progress, problems and possible new programs.

Project Agreements under this project are all cleared by the Ministry of Health before going to the Foreign Affairs or Finance Ministries for final GOM approval.

Working arrangements with the MOH are at present cordial, warm, and highly satisfactory--we trust to both parties.

2. The Association Marocaine de Planification Familiale (AMPF). Under this Revision, USAID proposes for the first time to provide direct assistance to the AMPF. In the time since its establishment in 1966, the AMPF program has developed to include both information and service elements. Currently, there are 11 AMPF clinics in operation, providing services roughly equivalent to those provided by MOH facilities. The AMPF prides itself on having a greater number of contraceptive clients per unit of investment than does the MOH program, due to their unipurpose mandate and lower overhead. Recently the AMPF initiated a household visiting program somewhat similar to the Marrakech program, but lacking the research elements. Their experience with this activity has been entirely satisfactory, and they plan to expand it, somewhat to the displeasure of the MOH which would prefer to see the AMPF concentrate on IE&C activities and leave the provision of services to the government program.

IPPF provides annual financing at about the level of \$140,000. This constitutes the great bulk of financial resources available to the Association. The AMPF is headed by a President, Mme Doukkali, who is a pharmacist and an influential citizen. The technical services director and Vice President is Dr. Md. Alaoui, a well-qualified Professor of OB-GYN of endless energy, enthusiasm, and concern for the family planning movement in Morocco. The AMPF governing board consists of members drawn from both the public and the private sector. A headquarters staff of three*directs day-to-day operations. Proposals under

* Total full-time HQ staff = 7; total permanent staff of AMPF is 60, including drivers, clerks, etc.

this Revision call for the financing of two full-time professional IE&C staff for the AMPF, and a contract consultant for 18 pm to develop its IE&C program. Short and long-term training for AMPF staff is also provided for.

It is tentatively planned to provide financial support to the AMPF through the MOH, subject to the establishment of a special financial arrangement as discussed in the project issues section (p. 14). AID-financed IE&C activities of the AMPF would be examined periodically by a joint committee including the MOH, USAID, IPPF, and the UNFPA. The need for frequent USAID-AMPF contact during the first 18 months would be substantially reduced by the presence of the contract specialist.

3. Private Sector. Administrative arrangements for development of a private sector contraceptives distribution program are expected to involve a centrally-funded contract under which the contractor would provide personnel services in-country necessary to plan and establish a private sector organization to manage the program. This procedure follows essentially the pattern in Sri Lanka, Bangladesh, Nepal, and elsewhere. USAID responsibility would include some direct assistance to the contractor in getting established in Morocco, and in coordinating with the MOH and other GOM agencies. USAID would also be responsible for monitoring contractor activities, and for evaluating the results of those activities.

Role of International Agencies

It is a matter of Mission policy to encourage international agencies such as UNFPA, IPPF, UNICEF, and the World Bank to expand their population assistance in Morocco wherever possible.

At present, the UNFPA has a \$2 million, 3-year project with the Ministry of Health and the Ministries of Labor and Youth & Sports to undertake family planning IEC&C activities. The grant also finances in-country and third-country training, and includes limited commodity assistance. Disbursements under this project have been disappointingly slow. The UNFPA is presently planning to establish an office in Rabat, probably additional to rather than in lieu of the regional office in Tunis, to permit a closer supervision of activities under the current project and to develop new program components here and in other West African countries. Such a move will be welcomed as it will permit closer coordination between USAID and UNFPA.

The IPPF also maintains a regional office in Tunis. IPPF provides comprehensive financial, technical, and commodity support for the programs of the Association Marocaine de Planification Familiale. IPPF has not been fully pleased with the performance of the AMPF to date. We believe that, in part, this situation has developed due to the absence of close monitoring of the AMPF program by IPPF, a task which is difficult due to there being no IPPF office in Rabat. We believe, however, that the AMPF is capable of good performance in areas of mutual interest to AID and to IPPF, and that collaborative AID-IPPF assistance to the AMPF could benefit all concerned. For this reason, we have included as Output 7 in this FP a provision for direct AID assistance to the AMPF in the area of family planning information, education and communication. These proposals have been discussed with the IPPF regional representative who indicated his concurrence in the substance of the proposed assistance contained in this proposal. He was assured that any such assistance from IPPF would be welcomed by USAID. The matter will be further discussed with IPPF London.

UNICEF has provided commodity assistance in population under the UNFPA grant, and is planning to establish a sub-regional office in Rabat during the summer of 1973. This will afford the opportunity to collaborate more closely with UNICEF on activities relating directly and indirectly to population problems and, hopefully, to obtain greater population-related inputs from this well-respected international agency.

The World Bank is currently discussing with the GOM plans for a major regional development program (Grand Programme des Petits Projets) to include socially-oriented development activities. The Bank has indicated interest in assisting in the population area, but has thus far been unable to reach agreement with the GOM on specific activities. The Bank is financing the construction of a School of Public Health in Morocco. USAID plans, under Output No. 4, to provide training assistance to faculty members in the population area.

Thus while international assistance in the population area is now at a modest level, there would appear to be promising developments which may result in significantly stepped-up multi-lateral assistance. The Mission will be actively working to facilitate such change.

IV.B. Implementation Plan

Implementation of this Revision will begin with the signing of an "umbrella" ProAg in June 1978 (see draft project description Annex 6). The ProAg will describe the purpose of the project, its subpurposes, and its major inputs and outputs. Initial obligation of FY 78 funds (\$151 thousand) will be done at this time, and implementing documents (PIOs) will be prepared shortly thereafter.

An important element in the new ProAg will be the proposed new procedures for funds release by USAID and handling by the GOM. For Outputs 1, 2, 7 and 8 it is proposed to establish individual bank accounts for which the MOH will have direct access, though with appropriate controls by the GOM Ministry of Finance and by USAID/Rabat. Release of funds by USAID would be geared to rate of use of previously released funds, and to the appropriate expenditure of those funds as determined by the USAID Project Manager and the USAID Controller in consultation with budget and finance officials of the MOH and the MOF. Specific language of this section of the ProAg remains to be worked out jointly among the MOF, MOH, and USAID.

As this is largely a continuing project and not a wholly new one, major elements of the revised project will continue to be implemented in accordance with past experience and with existing implementation plans (e.g., Outputs 1, 5, and 8). There are, however, new elements for which no implementation experience has thus far been accumulated.

In this section, major implementation actions or checkpoints are identified for each of the eight principal outputs. The numbers on the following chart are geared to specific implementation actions for each output, listed on the eight pages following the chart.

Major Implementation Actions
for Output No.1 - Marrakech Pilot Project

| <u>Action No.</u> | <u>Description</u> | <u>Target Date</u> |
|-------------------|---|--------------------|
| 1. | Resolution of funding problems | June 1978 |
| 2. | Revision of detailed project description | May-June 1978 |
| 3. | ProAg Revision signed | June 1978 |
| 4. | Funds released for next phase of project | July 1978 |
| 5. | Training film completed | August 1978 |
| 6. | Contract technician arrives | September 1978 |
| 7. | Next phase begins | September 1978 |
| 8. | Phase completed and evaluated | Jan-Feb 1979 |
| 9. | Funds released for final phase of project | February 1979 |
| 10. | Final phase begins | February 1979 |
| 11. | Final phase ends | July 1979 |
| 12. | Final evaluation completed | November 1979 |

Major Implementation Actions
For Output No. 2 - VMS Expansion

| <u>Action No.</u> | <u>Description</u> | <u>Target Date</u> |
|-------------------|---|--------------------|
| 1. | Begin planning for expansion | January 1979 |
| 2. | Completion of preliminary plans | May 1979 |
| 3. | Prog signed | June 1979 |
| 4. | Funds released for first stage of expansion | July 1979 |
| 5. | Initiation of fieldwork | October 1979 |
| 6. | Completion of fieldwork | May-June 1980 |
| 7. | Evaluation of first stage of expansion | June-July 1980 |
| 8. | Obligation of additional funds | July-Aug 1980 |
| 9. | Begin fieldwork in additional provinces | October 1980 |
| 10. C | Completion of fieldwork | May-June 1981 |
| 11. | Evaluation of second stage expansion | June-July 1981 |
| 12. | Obligation of additional funds | July-Aug 1981 |
| 13. | Begin fieldwork in additional provinces | October 1981 |
| 14. | Completion of fieldwork | May-June 1982 |
| 15. | Evaluate expansion experience | Summer 1982 |

Major Implementation Actions
For Outout No. 2 - Referral Centers

| <u>Action No.</u> | <u>Description</u> | <u>Target Date</u> |
|-------------------|---|--------------------|
| 1. | Evaluation of existing centers performance completed by USAID/Morocco | September 1978 |
| 2. | Obligation of funds for five additional centers and equipment | October 1978 |
| 3. | Equipment ordered | Oct-Nov. 1978 |
| 4. | Plan for mobile operations approved | Oct-Nov. 1978 |
| 5. | Equipment for mobile operations ordered | November 1978 |
| 6. | Equipment arrives | Jun-Oct 1979 |
| 7. | First centers completed | October 1979 |
| 8. | Mobile operations underway | November 1979 |
| 9. | Obligation of funds for 5 additional centers and equipment | Nov.-Dec. 1979 |
| 10. | Equipment ordered | January 1980 |
| 11. | Equipment arrives | November 1980 |
| 12. | Evaluation of mobile operations completed | June 1981 |
| 13. | All 10 Referral Centers Completed, reimbursed | September 1982 |

Major Implementation Actions for
Output No. 4 - Training

| <u>Action No.</u> | <u>Description</u> | <u>Target Date</u> |
|-------------------|---|--------------------|
| 1 | General Agreement of GOM | May 1978 |
| 2 | Initial funds obligated | June 1978 |
| 3 | Scope of Work for Contractor | June 1978 |
| 4 | Arrival of consultants | July 1978 |
| 5 | Training plan finished | September 1978 |
| 6 | Long-term candidate identified | October 1978 |
| 7 | In-country training begins, per plan | November 1978 |
| 8 | Short- and long-term candidates nominated | January 1979 |
| 9 | Long-term candidates depart | June 1979 |
| 10 | Review of training results and next year plan | December 1979 |
| 11 | Long-term candidates nominated | December 1979 |
| 12 | Long-term candidates depart | June 1980 |
| 13 | Review | December 1980 |
| 14 | Long-term candidates nominated | December 1980 |
| 15 | Long-term departures | June 1981 |
| 16 | Review | September 1981 |
| 17 | Long-term candidates nominated | December 1981 |
| 18 | Long-term departures | June 1982 |
| 19 | Evaluation of training | September 1982 |

Note: Short-term training will be interspersed as appropriate to needs and opportunities for training. In-country training schedule and actions to be developed as part of Manpower Plan.

Major Implementation Actions for
Output No. 5 - Improved Services

| <u>Action No.</u> | <u>Description</u> | <u>Target Date</u> |
|-------------------|-----------------------------|--------------------|
| 1 | Annual needs assessed (ABS) | April 1978 |
| 2 | ProAg signed | June 1978 |
| 3 | PIO/Cs prepared | July-August 197 |
| 4 | Annual needs assessed (ABS) | April 1979 |
| 5 | ProAg signed | May 1979 |
| 6 | PIO/Cs prepared | June 1979 |
| 7 | Annual needs assessed (ABS) | April 1980 |
| 8 | ProAg signed | May 1980 |
| 9 | PIO/Cs prepared | June 1980 |
| 10 | Annual needs assessed (ABS) | April 1981 |
| 11 | ProAg signed | May 1981 |
| 12 | PIO/Cs prepared | June 1981 |
| 13 | Annual needs assessed (ABS) | April 1982 |
| 14 | ProAg signed | May 1982 |
| 15 | PIO/Cs prepared | June 1982 |

Major Implementation Actions for

Output No. 6 - Commercial Distribution Program

| <u>Action No.</u> | <u>Description</u> | <u>Target Date</u> |
|-------------------|-------------------------------------|--------------------|
| 1 | Consultant Feasibility Study begins | May-June 1978 |
| 2 | Proposal received and approved | September 1978 |
| 3 | ProAg signed | October 1978 |
| 4 | Resident technician arrives | January 1979 |
| 5 | Pilot activities underway | June 1979 |
| 6 | Evaluation of pilot program | May 1980 |
| 7 | Full-scale implementation decision | June 1980 |
| 8 | Obligation of funds | August 1980 |
| 9 | Launching of activities | September 1980 |
| 10 | Review of program | September 1981 |
| 11 | Evaluation of program | September 1982 |

Major Implementation Actions for
Output No. 7 - IE&C Program

| <u>Action No.</u> | <u>Description</u> | <u>Target Date</u> |
|-------------------|--|--------------------|
| 1 | Detailed discussions begin with AMPF, MOH | July 1978 |
| 2 | Preliminary proposal approved | September 1978 |
| 3 | Funds obligated for contract services | December 1978 |
| 4 | Contract consultants in place | April 1979 |
| 5 | Detailed plan for IE&C activities approved | August 1979 |
| 6 | Funds obligated for expanded activities | December 1979 |
| 7 | Equipment and supplies ordered | January 1980 |
| 8 | Equipment arrives | July-August 1980 |
| 9 | Funds obligated for continuing activities | December 1980 |
| 10 | Equipment ordered | January 1981 |
| 11 | Equipment arrives | July-August 1981 |
| 12 | Final obligation for continuing activities | December 1981 |
| 13 | Evaluation of IE&C program | Summer 1982 |

Major Implementation Actions for

Output No. 8 - National Fertility Survey

| <u>Action No.</u> | <u>Description</u> | <u>Target Date</u> |
|-------------------|----------------------------------|--------------------|
| 1 | Detailed study protocol prepared | April 1978 |
| 2 | Manuals prepared | June 1978 |
| 3 | ProAg signed | August 1978 |
| 4 | Pretest completed | January 1979 |
| 5 | Main survey begins | February 1979 |
| 6 | Fieldwork completed | May 1979 |
| 7 | Data cleaned and tabulated | August 1979 |
| 8 | Preliminary report issued | November 1979 |
| 9 | Final report on analysis | April 1980 |
| 10 | Final survey report published | September 1980 |

See attached bar chart for further implementation details

IV. C. Evaluation Plan

Evaluation will be carefully built into this project and will be a two-tiered process. Since the eight outputs are in a sense eight separate activities (or subprojects), each has its own implementation plan, and for each there is a point, different from the others, when it will be logical to evaluate progress. At the same time, in order to assess overall progress toward the project purpose, an annual evaluation will be scheduled for each November, just prior to drafting the Congressional Presentation. The first regular evaluation is scheduled for November 1978. A special in-depth evaluation, which will include participants from AID/W and possibly other organizations, is scheduled for October 1980.

The annual evaluations will focus on elements that affect all of the sub-activities. Important assumptions affecting achievement of the project purpose (e.g., timely GOM financial support) and the general socio-economic setting underlying the project will be examined to determine if they are still valid. Each of the implementation plans of the various activities will be discussed to determine if there are special problems, if additional reviews need to be scheduled for specific activities, and if any implementation plan needs to be modified. Significant baseline statistics and other relevant data will be examined to determine the degree of progress toward the three subpurposes in the logical framework.

In the month preceding the annual evaluation, discussions will be initiated by the project manager with appropriate Moroccan officials of the Ministry of Health to prepare an agenda for the evaluation. The logical framework itself should be reviewed to ensure not only that all points are covered and all relevant issues raised, but also to determine whether or not all parties are satisfied that sufficient progress is being made toward each of the three subpurposes.

IV.D. Conditions, Covenants, and Negotiating Status

Conditions

As noted in the Issues Section, the resolution of the funds flow problem will be a condition precedent to the further obligation of AID funds for local costs financing. We expect to resolve this problem by June 1978.

Covenants

AID funds used in support of VSC activities will not be used for payments to clients or doctors, and will not in any way be used to abridge the individual rights of citizens to freely and voluntarily avail themselves of VSC services.

Negotiating Status

Elements of this project have been discussed at staff-levels of the Ministry of Health, with the Moroccan Family Planning Association, and with representatives of the IPPF, UNFPA, and UNICEF. All parties have indicated approval in principle.

Following approval of this PP Revision, USAID will proceed to conclude a formal agreement (ProAg) with the Government of Morocco, outlining the project purpose and subpurposes, and describing the eight major activities. It is planned to conclude this agreement in June 1978.