

PD-AAR-727

UNCLASSIFIED

INTERNATIONAL DEVELOPMENT COOPERATION AGENCY

AGENCY FOR INTERNATIONAL DEVELOPMENT

WASHINGTON, D.C. 20523

PROJECT PAPER

MOROCCO: Population and Family Planning  
Support III (608-0171)

July 16, 1984

UNCLASSIFIED

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PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add  
 C = Change  
 D = Delete

Amendment Number

DOCUMENT CODE

3

2. COUNTRY/ENTITY

MOROCCO

4. BUREAU/OFFICE

USAID/MOROCCO

3. PROJECT NUMBER

608-0171

5. PROJECT TITLE (maximum 40 characters)

POPULATION/FAMILY PLANNING SUPPORT III

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY  
09 30 81

7. ESTIMATED DATE OF OBLIGATION

(Under "B." below, enter 1, 2, 3, or 4)

A. Initial FY 84

B. Quarter 3

C. Final FY 88

8. COSTS (\$000 OR EQUIVALENT \$1 = )

A. FUNDING SOURCE	FIRST FY 84			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	2,395*	2,865	5,260*	10,030**	7,860	17,890**
(Grant)	(2,395)	(2,865)	(5,260)	(10,030)	(7,860)	(17,890)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S.						
Host Country		5,450	5,450		34,288	
Other Donor(s)	300	700	1,000	2,000	4,000	
<b>TOTALS</b>	<b>2,695</b>	<b>9,015</b>	<b>11,710</b>	<b>12,030</b>	<b>46,148</b>	<b>58,178</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PHS	401	444		-0-	-	5,260	-	17,890	-
(2)									
(3)									
(4)									
<b>TOTALS</b>						<b>5,260*</b>			

10. SECONDARY TECHNICAL CODES (maximum 5 codes of 3 positions each)

420 450

11. SECONDARY PURPOSE CODE

412

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code BWB

B. Amount 3000

13. PROJECT PURPOSE (maximum 480 characters)

1. Establish availability of FF information and services for 70% of the Moroccan population.
2. Attain contraceptive prevalence of 35% of Married Women of Reproductive Age (MWRA) by 1988.
3. Introduce population planning, analysis, modeling and forecasting methods into the GOM development process.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY MM YY  
03 08 6 03 8 8 Final 03 8 8

15. SOURCE/ORIGIN OF GOODS AND SERVICES

700  941  Local  Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP Amendment)

\* Includes \$1,655,000 for AID/W-procured contraceptives (FY1984).

\*\* Includes \$5,955,000 for AID/W-procured contraceptives (LOP).

USAID/MOROCCO Controller approval of proposed method of implementation and financing.

Mark S. Matthews: *Mark S. Matthews* Controller

17. APPROVED BY

Signature

*W. C. Chase*

Title

Director, USAID Morocco

Date Signed

MM DD YY  
01 17 84

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

MM DD YY

## PROJECT AUTHORIZATION

Name of Country: Morocco

Name of Project: Population/Family  
Planning Support III

Number of Project: 608-0171

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Population/Family Planning Support III Project for Morocco (the "Cooperating Country") involving planned obligations of not to exceed \$5,260,000 in grant funds to be obligated in FY84 in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. The planned project activities cover a period of five years.
2. The project consists of the provision of technical assistance, training and commodities to assist the Cooperating Country to expand the availability of basic family planning and health services, to reduce the population growth rate, and to improve the health status of Moroccan mothers and children.
3. The Project Agreement(s) which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions, as A.I.D. may deem appropriate:

a. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the project shall have their source and origin in the Cooperating Country or in the United States except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the Cooperating Country or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing.

Ocean shipping financed by A.I.D. under the project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

b. Conditions Precedent

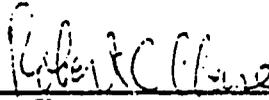
The Project Agreement shall contain a condition precedent in substance as follows:

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, A.I.D. shall assess the adequacy of the accounting and management system(s) of the implementing agencies of the Cooperating Country and shall determine that this system(s) is able to effectively account for the disposition of A.I.D. funds made available under this project to the implementing agency.

c. Covenants

The Project Agreement shall contain covenants in substance as follows:

The Cooperating Country agrees that further to A.I.D. Policy Determination No. 3 dated September, 1982, informed consent shall be obtained and documented for all requestors of sterilization services; that other temporary family planning methods shall be available at sterilization service facilities; and that neither abortion nor abortion-related activities will be conducted at facilities receiving A.I.D. assistance.

  
\_\_\_\_\_  
Robert C. Chase  
Director, USAID/Morocco

Date: 7/16/84

Clearances:PROG:WSRhodes: (draft)  
RLA:AWilliams: (draft)  
CONT:MSMathews:(draft)  
A/DIR:HPetrequin: \_\_\_\_\_

ACTION MEMORANDUM FOR THE MISSION DIRECTOR, USAID/RABAT

FROM : William S. Rhodes, USAID/PROG' *DR*

SUBJECT : Authorization of Morocco's Population and Family Planning Support III Project (608-0171)

PROBLEM

Your signature is required on the Project Paper facesheet and the Project Authorization of Morocco's Population and Family Planning Support III Project.

DISCUSSION

On March 28, 1984, the Mission Review Committee, under the USAID Director's chairmanship, reviewed and recommended approval of the Population and Family Planning Support III Project. As you will note in the Project Paper, the planned project activities cover a period of five years at a total estimated to A.I.D. cost of \$17,890,000. State 132642, re delegated authority to you to authorize this project for up to \$20.00 million. However, State 184720 has authorized only a one year FY84 obligation of \$5,260,000. As you know, that cable explained to the Mission that Administrator McPherson, after extensive consultation with "The Hill", and in view of the Government-wide policy discussion on family planning, had decided to "approve authorization of the 5,260 million dollars for life-of-project funding in FY'84 in lieu of 17.9 million over the five year life." As this decision was the result of high level discussions in Washington, we were instructed to change the authorization and grant agreements previously drafted to reflect it. This we have done. We have also been informed informally that the Agency will do everything in its power to assure that the authorization of additional funding for this (and other) population projects is obtained in FY1985 and beyond. This situation will be discussed with GOM Ministry of Health officials prior to the signing of the Project Agreement.

The goal of the project is to reduce Morocco's rapid rate of population growth and thereby diminish a key constraint to achievement of the country's economic and social development objectives. Previous activities in family planning have shown that a strong correlation exists between the availability of family planning services and lower fertility rates. The purpose of this project, therefore, is to extend the availability of family planning information and services so as to reach seventy percent of the Moroccan population and thereby to attain contraceptive prevalence of thirty-five percent of married women of reproductive age (MwRA) by 1988. Further, the project will introduce population planning, analysis, modeling and forecasting methods into the GOM development planning process.

The project consists of eleven sub-project activities which are described in detail in the Project Paper. The project will provide one long-term resident contractor to work with the Moroccan Family Planning Association (AMPF) to develop a contraceptive sales program, and several short-term consultants to be distributed across the eleven activities. There will be long- and

short-term training in support of the sub-project activities and a substantial component of in-country, in-service training in family planning for Ministry of Public Health (MOPH) personnel. Commodities include contraceptives, medical/surgical equipment, data processing equipment and software, fieldworker supplies, information/education materials, dietary supplements, and other miscellaneous items. Major project outputs include: 1) household service-delivery programs for family planning/health/nutrition services operational in Morocco's most populous provinces and major cities; 2) reproductive health/voluntary sterilization services available in provincial hospitals; 3) contraceptive and health products marketed by the private sector in selected villages and urban areas, and through rural markets (souks); 4) family planning/health information regularly presented via radio, T.V., print materials, and by household visitors; and 5) population analyses incorporated into the GOM development planning process.

The project design reflects the findings of a recent (December 1983) end-of-project evaluation for the Family Planning Support II Project (608-0155), including a long-term training component as a means of building a cadre of professionals with skills relevant to population and family planning programs. One concern raised by AID/W and discussed at length during the MRC review is that the project should address adequately the assistance to and the role of the private sector in project implementation. The project speaks to this concern at considerable length, as summarized in Rabat 3484. Initiatives vis-a-vis the private sector include: 1) support for Morocco's Family Planning Association (AMPF) to launch a contraceptive sales activity in villages, rural souks, and urban areas, and to develop family planning information/motivation materials and training programs; 2) funding for an Operation Program Grant (OPG) to support the development of a natural family planning (NFP) project with l'Heure Joyeuse, a Moroccan Private Volunteer Organization (PVO); and 3) family planning training to be provided by MOPH to private physicians and pharmacists to improve their effectiveness as family planning agents.

Of the \$5,260,000 to be obligated by this agreement, \$3,605,000 will be obligated through the ProAg and an OPG with l'Heure Joyeuse; the remaining \$1,655,000 will be committed to the procurement of family planning commodities through a centrally funded contract.

A Congressional Advice of Program Change was submitted to Congress--and per State 194957 expired without objection on June 30, 1984. This Congressional Notification showed A.I.D. FY84 and Life-of-Project funding authorized at \$5,260.00 million. It also noted that the overall project is "a five-year activity." There are no current human rights issues under Section 116 of the Foreign Assistance Act that would preclude provision of this assistance to Morocco.

Pursuant to Redlegation of Authority No. 113.3A, you have authority to authorize projects not in excess of \$10 million. Pursuant to State 184720 you have been authorized to approve this project for \$5,260,000.

RECOMMENDATION

That you approve the project by signing the Project Paper facesheet and the project funding by signing the attached Project Authorization.

APPROVED: (Signature)  
DISAPPROVED: \_\_\_\_\_  
DATE: 7/12/54

Clearances: PROG: SWRhodes: (draft)  
RLA: AWilliams: (draft)  
CONT: MMatthews: (Signature) - (Signature)  
A/DIR: HPetrequin: \_\_\_\_\_

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ACRONYMS AND ABBREVIATIONS

<u>AMPF</u>	:	Association Marocaine de la Planification Familiale "Moroccan Association for Voluntary Sterilization"
<u>AVS</u>	:	Association for Voluntary Sterilization
<u>CBD</u>	:	Community Based Distribution
<u>CBR</u>	:	Crude Birth Rate
<u>CEFPA</u>	:	Center For Population Activities
<u>CPS</u>	:	Contraceptive Prevalence Survey
<u>FP</u>	:	Family Planning
<u>GOM</u>	:	Government Of Morocco
<u>IE/C</u>	:	Information, Education and Communication
<u>IFFLP</u>	:	International Federation for Family Life Promotion
<u>INTRAH</u>	:	International Training for Health
<u>IPAVS</u>	:	International Project Association for Voluntary Sterilization
<u>IPDP</u>	:	Integrated Population Development Planning
<u>IPPF</u>	:	International Planned Parenthood Federation
<u>IUD</u>	:	Intra-Uterine Device
<u>IUSSP</u>	:	International Union for the Scientific Study for Population
<u>JHPIEGO</u>	:	Johns Hopkins Program in International Education for Gynecology and Obstetrics
<u>LOP</u>	:	Life Of Project
<u>MCH</u>	:	Maternal/Child Health
<u>MOPE</u>	:	Ministry Of Public Health
<u>MWRA</u>	:	Married Women of Reproductive Age
<u>NFP</u>	:	Natural Family Planning
<u>NFS</u>	:	National Fertility Survey
<u>NTCRH</u>	:	National Training Center for Reproductive Health

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OR : Operations Research

ORS : Oral Rehydration Salts

ORT : Oral Rehydration Therapy

PHSS : Population, Health and Social Services

PID : Project Implementation Document

PIP : Population Information Program

PRICOR : Primary Health Care Operations Research

RAM : Repair And Maintenance

RAPID : Resources for the Awareness of Population Impact

UNFPA : United Nations Fund for Population Activities

VDMS : Visite a Domicile pour Motivation Systematique  
"Household Visits for Systematic Motivation

VS : Voluntary Sterilization

WFS : World Fertility Survey

WHO : World Health Organization

+

I. PROJECT SUMMARY

The Morocco population program, after a long and indifferent start, is showing considerable promise. A recent evaluation (December, 1983) of the predecessor project 608-0155 reported that Moroccan contraceptive prevalence had increased from about 12% of married women of reproductive age (MWRA) in 1978 to approximately 27% of MWRA in 1983. Moreover, in areas served by the project's village outreach VDMS\* program, prevalence was found to be between 40% and 50% of MWRA.

These results represent the beginning of a potentially very strong program — judged even by service and prevalence standards more commonly applied to East Asian, rather than Near/Mid-Eastern population programs. However, the strength and long-term sustainability of the program are still limited in a number of key respects. These include:

1. Incomplete Coverage: The existing MOPH service delivery system of fixed clinics and VDMS field workers is effectively reaching only about 40% of the Moroccan population.

\* Visite à Domicile de Motivation Systematique. Ministry of Public Health (MOPH) health workers deliver integrated health/nutrition/family planning services at the household level in 13 of Morocco's 45 provinces and prefectures.

2. Exclusivity: Related to the coverage constraint, family planning (FP) service delivery is still a preserve confined largely to the GOM/Ministry of Public Health (MOPH). The private sector has yet to demonstrate its potential as a major source of low-cost FP services.
  
3. A weak "population" perspective: The GOM's liberalization of contraceptive availability -- through the MOPH system -- does not necessarily reflect a clear or pervasive understanding among GOM planners of the long-term implications of rapid population growth in Morocco. While these issues are being discussed with considerable frequency in public, population considerations have not yet been adequately factored into the GOM planning or policy-making process.
  
4. Fragility: The MOPH has moved fairly quickly to make up for several years of prior passivity on family planning. Recent progress has been due in good part, however, to the personal commitment of a relatively small number of senior personnel within the MOPH. The consolidation of the gains of the past few years is partly contingent upon the stability of this leadership -- at least until the FP program has been in place long enough, and built a permanent clientele large enough -- to ensure its institutionalization within in the GOM infrastructure.

As the recent population project evaluation (December, 1983) pointed out, Morocco has made substantial recent gains in its efforts to address its problem of rapid and excessive population growth. The country's annual rate of population increase remains very high, however, at approximately 2.8% per year; and until the limiting factors indicated above are effectively addressed, further progress in reducing this rate of growth will be blunted. The overall Goal of project 608-0171 therefore remains essentially the same as the goal of the predecessor project 608-0155, namely to reduce Morocco's rapid rate of population growth, and thereby diminish a key constraint to achievement of the country's economic and social development objectives.

This PP proposes to support a set of mutually-reinforcing activities which will address the program weaknesses noted above, and thereby contribute meaningfully toward attainment of the project goal. These activities fall into four broad categories including:

1. An increase in program coverage by expanding and adding GOM FP/health service networks to additional areas of the country;
2. The establishment of new service networks, particularly in the private sector;
3. The elevation of population concerns in the GOM development planning process, particularly in association with the Ministry of Plan; and

- 4 The continuation/consolidation of major elements of the program "base" developed under project 0155 to ensure the effective institutionalization of these elements in the GOM family planning program.

Expressed as a specific Project Purpose for achievement by 1988, these activities are intended to:

1. Establish regular availability of a full range of FP information and services for at least 70% of eligible couples in Morocco;
2. Produce national contraceptive prevalence of 35% of married women of reproductive age (MWRA); and
3. Introduce population planning, analysis, modeling and forecasting methods into the GOM development planning process.

The four general categories of project activities which will produce this project purpose can be further divided into 12 specific Outputs, which will be treated in this PP as separate subprojects. They are:

- \* 1. VDMS Expansion to 18 Provinces.
  2. Establishment of family planning/health outreach services in major urban areas.
  - \* 3. Improved training and services at the National Training Center for Reproductive Health.
  4. Establishment of voluntary sterilization/reproductive health services in 30 provincial hospitals.
- 4

- 5-
- \* 5. Improved Information, Education and Communications (IE+C) programs in the GOM and private sector.
  - \* 6. Improved family planning service availability through all clinics and outreach activities (commodities).
  - 7. Establishment of a contraceptive sales program in the private sector.
  - 8. Establishment of a natural family planning program in the private sector.
  - \* 9. Establishment of family planning information and service activities in other GOM ministries and agencies.
  - \* 10. Improved operations research, data collection and analyses.
  - \* 11. Improved population analysis and planning in the Ministry of Plan.
  - \* 12. Improved technical and management skills (training)

Activities marked with an asterisk (\*) include components which were begun under project 0155, and which are being continued under this follow-on project. All other activities are being initiated under this project.

Inputs: The estimated total U.S. cost of the project FY 1984-88 will be \$17.9 million. Major cost components are:

Technical Assistance	:	\$2.4 million
Commodities	:	\$7.9 million
		(including \$6 million for contraceptives).

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Training (U.S., 3rd country, and  
in-country) : \$1.3 million

Local Cost Support : \$4.8 million

Evaluation, Audit, Contingencies/

Inflation : \$1.4 million

GOM and private sector costs are expected to be the equivalent of \$34 million over the five-year project period. (Most of these costs will be in-kind). Thus, the U.S. contribution to the program represents about 34% of overall program costs.

II. BACKGROUND, RATIONALE AND DESCRIPTION

A. Background

The Government of Morocco (GOM) has maintained an official family planning program since 1966, although organizational problems and political sensitivity inhibited its implementation for almost 15 years. The 1968-72 Development Plan set a target of 500,000 new acceptors during the five-year period; less than 20% of this goal was achieved. The 1973-77 Plan revised the target downward to 391,400, acceptors, and about 75% of this goal was achieved. Following an interim Plan (1978-80) without a specific FP objective, the 1981-85 Plan called for the attainment of a contraceptive prevalence rate of 24% of married women of reproductive age (MWRA) by the end of the Plan period. It was during this latest Plan period that the Ministry of Public Health (MOPH) began to seriously pursue its own family planning (FP) objectives. The Plan's prevalence target for 1985 was surpassed in 1983, and will probably reach 30% of MWRA by the end of 1985.

USAID support for GOM population activities during these periods reflected the vigor (or lack thereof) with which the GOM pursued its family planning program. Thus, Project 608-0112, which covered the period 1971-77, was modest in its objectives and in its results. A follow-up project, 608-0155, both reflected and facilitated the GOM's intention to expand its FP activities. A brief history of these earlier projects, and their relationship to the

FY 1971-77: Family Planning Support (608-0112)

USAID assistance during this period was modest, amounting to approximately \$3 million over seven years. USAID financed the construction of 13 provincial family planning reference centers, a family planning headquarters building in Rabat, and the purchase of contraceptives, supplies and equipment for the national FP program. Very little participant training was offered, due in part to the non-availability of training programs conducted in the French language. Progress under the project was slow and uneven. A 1976 evaluation report was very critical of the program, suggesting that AID should suspend further assistance if several important changes were not forthcoming. Partly as a result of that report, USAID and the GOM Ministry of Public Health (MOPH) undertook the design of several new activities, represented essentially by project 608-0155. The FP service delivery system in place at the end of project 0112 (1977) was weak: contraceptives were available through approximately 300 larger health facilities of the MOPH, but only by physician prescription, following a physical examination of the client. In 1978, USAID/Rabat estimated that the MOPH served approximately 150,000 contraceptive clients, or 5% of MWRA. The private sector served approximately 200,000 persons (7% of MWRA) for a combined prevalence rate of 12% MWRA.

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FY 1978-83: Population/Family Planning Support II (608-0155)

This follow-on project was far more ambitious than its predecessor project. It provided \$11 million (including \$6 million centrally-funded support) to attain three broad objectives: 1) to increase contraceptive prevalence by 143%; 2) to increase the population awareness and commitment of key GOM officials and opinion leaders; and 3) to generate new demand for FP services. The project was designed to produce 8 outputs -- categorized in the Project Paper as subprojects -- to attain these purposes:

1. Completion of the Marrakech pilot household delivery (VDMS) program.
2. Expansion of household delivery (VDMS) services to 10 provinces. (Later increased to 13 provinces, as three of the original 10 split into smaller provinces).
3. Construction and equipping of 10 additional Family Planning Reference Centers.
4. Develop Professional Skills/of key GOM and private sector personnel (Participant Training).
5. Improved FP service availability in MOPH health facilities (provision of contraceptive supplies).
6. Establishment of a commercial distribution program.
7. Establishment of a National Information, Education and Communication (IE+C) program rooted in the private sector.
8. Completion of a national fertility and family planning survey.

Four additional outputs/subprojects were subsequently added to the project, using a combination of AID/W and bilateral funds. These were:

9. RAPID (Futures Group) computer simulations of the development impact of demographic trends.
- 10 Establishment of a National Training Center for Reproductive Health in Rabat. (USAID, AVS, JHPIEGO).
- 11 Completion of a Contraceptive Prevalence Survey, (USAID, Westinghouse), and
- 12 Establishment of communications/FP training in Nursing and Midwifery Schools. (USAID, INTRAH).

The late 1983 project evaluation found that 11 of the foregoing 12 subprojects were completed or under way. The exception was the commercial distribution program, i.e., the subsidized sale of contraceptive products through commercial outlets. Some of the key results of this program were:

- 1 Attainment of contraceptive prevalence estimated to be approximately 27% MWRA, or more than double the 1978 level;
- 2 Heightened official/popular attention to population concerns, represented by the inclusion of FP targets in the 1981-85 GOM Five Year Plan; public discussion of population/development issues at numerous colloquia, including the Moroccan Royal Academy sessions of 1982 and 1983; the issuance of a family planning postage

stamp; a RAPID presentation to Prime Minister and Cabinet in 1983; prominent coverage of population issues in the quasi-official press; and regular radio/T.V. broadcasts of FP promotional messages; and

3. Clear evidence that FP practice in Morocco has increased as the availability of FP information and services expanded. As of 1984, FP services were routinely available in all 1200 MOPH health facilities (compared to 300 facilities in 1978). Moreover, these services were provided by paramedics, rather than physicians. IUD-insertions are now offered by trained nurses in 600 of these health facilities. Paramedic-delivery of integrated FP/Health/nutrition services at the household level (VDMS) was well under way in thirteen of the country's 45 provinces.

In consequence of this expanded service network, the MOPH was serving approximately 600,000 FP clients at the end of 1983, or 17% of MWRA. Thus, while overall prevalence more than doubled during 1978-83, from 12% to 27%, contraceptive prevalence attributable to the GOM program (65% of FP users) increased more than three-fold, from 5% in 1978 to 17% in 1983.

Project 0155 did include some disappointments: The MOPH, which carefully guards its government-sanctioned responsibility for oversight of pharmaceutical distribution, has continued to oppose an expanded commercial sector role in

the sale of low-cost contraceptive products; construction of the 10 FP Reference Centers moved ahead more slowly than anticipated; and a second-stage expansion of VDMS in ten provinces was delayed until fall, 1983, pending the late arrival of UNFPA-provided mopeds for VDMS fieldworkers. However the overall objectives of Project 0155 were met or exceeded, even if the respective contributions of the individual subprojects to these objectives were not always as originally anticipated. The lack of a commercial distribution network, for example, was partially compensated by an unexpectedly vigorous GOM/MOPH effort to augment and "paramedicalize" its own FP delivery system. An added benefit arising from Project 0155 was its effect on the development of GOM policy and action in the areas of health and nutrition. The VDMS household-delivery concept was tested in Marrakech province in 1978-80 as a uni-purpose FP activity. The pilot project clearly demonstrated, however, that modest increments in resources could enable the existing health infrastructure to reach considerably larger numbers of people with other basic health services as well as FP. USAID and the MOPH subsequently proceeded to develop a "package" of integrated services\* which would be provided at the

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\* Contraceptives (pills, condoms, referrals for IUD's and sterilizations); oral rehydration salts (ORS) training and therapy; diet supplements for pregnant/nursing women; promotion of breastfeeding and good weaning practices; immunization, verification and referral.

household level in 10 (later increased to 13) provinces. The additional design, training and operational requirements of this revised VDMS project delayed its launching in the first group of three provinces until May, 1982. In USAID's view, however, the broader scope -- and impact -- of the expanded project warranted this delay, as did the MOPH's associated decision to move the first level of its FP/health system away from fixed clinics and onto the doorsteps of its clients.

Another unforeseen development under this project was the MOPH's decision to move ahead with sterilization training and services -- a contraceptive modality previously discounted by the MOPH as overly-sensitive in Morocco. The National Training Center for Reproductive Health in Rabat is currently training Moroccan physicians from around the country in sterilization techniques, and is a regional training facility for JHPIEGO-sponsored trainees from other francophone and arabic-speaking countries.

3. RATIONALE AND SUMMARY DESCRIPTION

1. General

Recent demographic trends in Morocco have been similar to those in other developing countries, namely, an accelerated rate of population growth resulting from a marked decline in mortality and the persistence of high fertility. As of mid-year, 1984, the population was estimated to be approximately 22 million persons, making

Morocco the most populous of the Maghrebian countries. The average annual growth rate during the 1971-82 period was approximately 2.8%. This rapid rate of growth has resulted in a population in which 45% of the population is under 15 years of age, and has very likely been a significant factor in promoting a sustained movement from rural to urban areas.

For the remainder of the century Morocco will face the consequences of past rapid growth. Considerable investment will be necessary to meet basic needs, to expand and upgrade education opportunities, and to create jobs at a rate adequate to reduce unemployment and to absorb the large number of youthful entrants into the labor market.

Morocco, like many other countries beset by population growth rates far in excess for their current ability to generate development resources, must embark on an integrated development program which includes measures to reduce population growth concurrent with efforts to stimulate growth in other development sectors.

This long-term effort clearly suggests an overall Project Goal for the population project presented in this PP, namely, to reduce Morocco's rapid rate of population growth and thereby diminish a key constraint to achievement of the country's economic and social development objectives.

The necessity to undertake measures to achieve this goal is cited in AID Policy Paper Population Assistance, dated September, 1982, which notes that "continued high rates of population growth significantly increase the cost and difficulty of achieving basic development objectives by imposing burdens on economies presently unable to provide sufficient goods and services for the growing population."

The introduction, within the past few years, of GOM-sponsored family planning activities appears to have contributed to a reduction in the rate of population growth -- a reduction most likely reinforced by other socio-economic changes also occurring during this period. Current fertility nonetheless remains very high, due in considerable measure to a continuing lack of effective family planning information and services for a large proportion of the Moroccan population.

Current contraceptive prevalence, as mentioned previously, is estimated to be 27% MWRA. The results of the Marrakech pilot VDMS project, the VDMS/Expansion project, and the 1982 Westinghouse Contraceptive Prevalence Survey (CPS) indicate, however, that between 50%-65% of Moroccan couples would accept a modern contraceptive method if such methods were made available to them.

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Moroccan experience to date serves to confirm this linkage between contraceptive service availability and level of contraceptive practice: since 1978, contraceptive prevalence has more than doubled, concurrent with a major expansion of FP service availability. This general relationship between FP service availability and FP practice is reflected in the A.I.D. Policy Paper Population Assistance, which notes that "a balanced program which provides modern contraceptive services and information, combined with strong community and family support for family planning, is the most effective way of helping couples achieve their fertility goals."

Given this powerful relationship between family planning service availability and lower fertility, USAID has identified the expansion of such service systems as the primary Purpose of this project. Of the project's three subpurposes, two relate directly to FP service extension and expansion. These are:

- The establishment of regular availability of a full range of family planning services for at least 70% of eligible couples in Morocco; and
- The attainment of contraceptive prevalence of 35% of married women of reproductive age (MWRA).

A third sub-purpose of the project reflects the need to forge a clearer perceptual linkage in the minds of GOM planners between the Goal statement and the FP service elements of the Purpose statement. That is, the GOM must begin now to consider the consequences of rapid population growth more realistically in its long-term development planning. Moreover when these relationships between population growth and development objectives are more closely observed, as for example in the RAPID models, a case for more vigorous family planning efforts becomes compelling. A third sub-purpose of this project, then, is

- to introduce population planning, analysis, modeling and forecasting methods into the GOM developmentplanning process.

As noted, effective family planning programs materially advance a country's social and economic development by diminishing the cost and difficulty of achieving that country's basic development objectives. At the family level, family planning also provides critically important health benefits for mothers and young children. In Morocco, the health benefits of the family planning program are amplified by the program's integration with other mutually-reinforcing health services.

The profound effects of rapid population growth on national and family well-being are acknowledged in the annual CDSS and ABS statements of USAID/Morocco. The USAID Mission has moreover identified Population/Family Planning as a primary concern of U.S. assistance policy in Morocco, along with efforts to increase food production and the development of domestic energy resources. The Mission is also examining the closely-related problems of rapid urbanization.

2. The MOPH: Its Primary Role under the Project

The Government of Morocco, represented largely by the Ministry of Public Health (MOPH), has demonstrated a substantial commitment to field an expansive FP program. It has taken major steps -- often involving difficult policy decisions, given the generally conservative milieu of the Moroccan health establishment -- to make this program work. These have included the "paramedicalization" of FP services (including insertion of IUD's by nurses); the initiation of sterilization training and services; the delivery of FP services to individual households; and the public promotion, via print and broadcast media, of family planning. It should be noted that these measures were taken in the continuing absence of an explicit GOM policy on population. The policy context which does envelop the FP program is the GOM/MOPH objective of promoting maternal and child health, including the 1981-1985

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Five-Year Plan affirmation that fertility management is an essential element of an MCH program. (The Plan also established a family planning target of 24% contraceptive prevalence by the end of the Plan period). The mixed-irony of the Morocco FP program is that it has exceeded in ambition and scope the programs of many countries having more forthright population policies, even while it has set theoretical limits on itself -- by defining and defending population actions in MCH terms. In the view of the GOM/MOPH, this MCH definition allows sufficient latitude to undertake a vigorous FP program which will address both demographic and health concerns, while simultaneously sheltering the program from the potentially-hostile reaction of elements which might feel compelled to react against a more explicit GOM population policy. USAID/Morocco is in general agreement with this GOM/MOPH strategy, particularly in light of the GOM's preparedness to pursue family planning-as-MCH to its fullest logical expression, i.e., the delivery of FP and related health services to the vast majority of fertile-age couples in the country. Under this project USAID will support major components of this MOPH service-extension effort, including the expansion of the VDMS project; establishment of FP/health outreach services in Morocco' larger cities; the introduction of voluntary sterilization/reproductive health services into provincial hospitals; and by providing training and commodity assistance, including contraceptives, for the growing national program.

3. Private Sector

The major share of USG support provided under the proposed project will be used to strengthen and expand the MOPH service delivery system. But even under the best of conditions, the MOPH could not be expected to reach all potential FP clients, suggesting the need for complementary service networks. In contributing to the creation and mobilization of these additional networks, USAID will attempt to influence the evolution of the Moroccan population program by strengthening the role of the private sector as a major partner in the program, i.e, to underwrite the private sector's demonstration that it can be an effective, efficient future alternative to the public sector as a source of inexpensive FP/health services.

The major private sector activity under the project will be a contraceptive sales program to be conducted by the IPPF-affiliated Moroccan Family Planning Association (AMPF). The AMPF will sell contraceptive and health products in villages, urban areas and rural souks in a potentially powerful test of the capacity of the Moroccan private sector to eventually assume this function. The AMPF will also be responsible for the development of national IE+C activities to promote family planning through print, cinema, TV and traditional/folk media.

Other project components involving the private sector include support for the natural family planning (NFP) training and service activities of a Moroccan PVO, L'Heure Joyeuse; and a series of training programs to expand the role of pharmacists and private physicians as FP motivation and service agents.

4. Other GOM

- a. Some specialized GOM ministries, agencies and parastatals provide FP information and services to their own constituencies (military, police, railroad workers, etc.). The MOPH, however, is the only GOM agency currently providing these services to the general public. As noted previously however, even the most comprehensive public and/or private service networks generally fail to achieve universal coverage of a population. Further to this project's aim to maximize such coverage, USAID will continue activities begun under Project 0155 to more fully engage other public service GOM ministries (Handicrafts and Social Affairs, Youth and Sports; Agriculture) in the FP program.
- b. As discussed previously, the GOM's response to population concerns to date has largely been limited to a family planning approach. In USAID's view, this approach can produce a powerful and cost-effective impact on Moroccan fertility, and is

within the near-term resource constraints of the GOM and AID. This approach should be broadened, however, to take cognizance of the GOM's responsibility to plan for the impact of population growth and change across other economic and social sectors. That is, a FP service program per se risks the possibility of ignoring the fine-tuning and targetting of resources which would flow from a deeper understanding of the broader determinants of individual and national fertility. This project will therefore include resources to reinforce the data collection, analysis and planning capability of the GOM to develop a more complete population planning approach to national development problems.

Together, the various activities to be undertaken with the GOM and the private sector include 12 Outputs which will collectively produce a broad-based population/family planning program.

These are:

- \*1. Expansion of the VDMS household-delivery program to 18 provinces. (Current coverage: 13 provinces).
2. Establishment of FP outreach services in the urban slums of Casablanca, Mohammedia, Rabat-Salé, and Tangier.
- \*3. Continuation of voluntary sterilization (VS) service and training activities the National Training Center for Reproductive Health.

4. Establishment of VS services in 30 provincial hospitals.
- \*5. Expanded IE+C activities (in the MOPH and AMPF).
- \*6. FP service availability in all (1200) MOPH health facilities (contraceptive supply).
7. A contraceptive sales program in the private sector (AMPF).
8. Establishment of a natural family planning (NFP) training and service program. (L'Heure Joyeuse).
- \*9. Expansion of FP information/service activities of other GOM ministries and agencies.
- \*10. Operations Research/Data Collection and Analysis (Ministries of Health and Plan).
- \*11. Population Policy Development (Ministry of Plan).
- \*12. Professional Skills Development/Participant training (various ministries).

Outputs marked with an asterisk (\*) were initiated under Project 0155, with varying degrees of achievement. They will receive continued support during this project; other outputs are new. Each of these outputs is described in detail in the following Section C, Detailed Description.

The relationship between the project's outputs and its purpose arises from a number of assumptions/propositions which can plausibly be regarded as having been affirmed to a large degree by experience in Morocco and most other developing countries currently supporting population/ family planning program, i.e. that:

- High fertility norms and societal props notwithstanding, a sizable demand exists for FP services (the so called "unmet need"). This proposition is buttressed by the results of the Morocco CPS, which noted a substantial unsatisfied demand for FP services in Morocco.
  
- A properly designed and managed FP program can satisfy much of this unmet contraceptive need. The dramatic increases in Moroccan contraceptive prevalence, concurrent with an expansion of the FP service network, support this proposition.
  
- A fairly well-managed FP program is a cost-effective means to attain a decline in fertility. Cost-benefit analysis of family planning and other development projects support this contention. (See Economic Analysis)

- The health benefits -- reduced maternal and child mortality and morbidity -- warrant the expenditure on FP program. FP has been shown to have a powerful role in improving these indices of health status (See Social Soundness Analysis).

Inputs: This Project Paper proposes comprehensive support for continuing and new elements, noted above, of Morocco's national population/family planning program. U.S. assistance will include participant training, technical assistance, commodity support and local cost support.

- 1). Training, The project includes funding for two broad categories of training and invitational travel: a) U.S./3rd country and in-country training generally supportive of the overall program, e.g, in data processing and analysis, program management/administration, research methodology, program evaluation, in-service health worker training, etc.; and b) U.S./3rd country and in-country training directly supportive of the individual project activities, e.g, fieldworker/manager training under the VDMS, Urban Services, Contraceptive sales, etc. sub-projects. Funding under the first category amounts to \$550,000, including \$300,000 for out-of-country training and \$250,000 for training in Morocco. Funding under the second, sub-project-specific, category amounts to

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\$780,000 for U.S./3rd country and in-country training. Total training and invitational travel support amounts to \$1,330,000.

2) Technical Assistance requirements for this project are expected to be provided in part by AID/W-funded grantees and contractors authorized to assist in specialized applications including project evaluation, survey and operations research, research design, market research. However, it is also expected that a substantial portion of the TA provided by AID/W intermediaries will be funded under the proposed project. These TA costs amounting to \$2.4 million are distributed throughout the various subprojects. Two significant components of TA costs include:

- a) a resident contractor to manage the AMPF private sector contraceptive sales activity for 24 person-months. The estimated cost of this contract (\$250,000) may be adjusted, depending on the contracting mechanism to be utilized, i.e., PSC or institutional contract. This latter decision will be made following a project feasibility assessment scheduled to take place in early FY 1985.
- b) A supplemental grant (\$1,320,000) to the Association for Voluntary Sterilization (AVS) to support the extension of VS/reproductive health services to provincial

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hospitals. USAID funds will be transferred from USAID to the existing AID/W-AVS cooperative agreement to enable AVS to carry out these activities in Morocco.

The project also includes \$75,000 to cover various consulting requirements expected to arise during the project.

- 3) Commodity Support estimated to be \$8 million over the life of the project, includes contraceptives (\$6 million), medical/surgical equipment (\$500,000); data-processing equipment and software (\$200,000); fieldworker supplies (\$200,000); IE+C supplies (\$300,000); weaning food (\$200,000) and miscellaneous materials (\$600,000) for the various sub-projects.
- 4) Local Cost Support totalling \$4.8 million over LOP will fund the start-up and operating costs in-country of the various sub-projects. Activities having a significant local cost component include VDMS (\$3.1 million); Urban Services (\$950,000); and Private Sector Sales (\$950,000).
- 5) Other Costs: The project includes contingency/inflation costs totalling \$1.2 million for miscellaneous and unforeseen costs/cost adjustments; \$80,000 to cover the costs of at least two intensive project evaluations and audits as considered necessary during the LOP; and \$75,000 -- mentioned previously -- for unspecified technical assistance.

The estimated total cost of the project to the U.S. for the period FY 1984--88 will be \$17.9 million, including \$11.9 million bilateral project costs and \$6 million for centrally-procured contraceptive supplies.

A summary of AID financial inputs for the project period (FY 1984-88) is presented in the following Table 1, arranged by each of the 12 major outputs. Additional detail is provided in the Cost Estimate and Financial Plan, pages 96-115.

TABLE 1

Summary of Proposed Costs by Activity

(\$000's)

<u>Output No.</u>	<u>Activity</u>	<u>FY84</u>	<u>LOP</u>
1	VDMS/Expansion	1500	3200
2	FP Services in Urban Areas	350	1000
3	National Training Center for Reproductive Health	100	250
4.	VS/Reproductive Health in Provincial Hospitals	500	1320
5	IE+C	200	750
6	Improved FP services (Commodities)	1780 <sup>1</sup>	6955 <sup>2</sup>
7	Private Sector Contraceptive Sales	-0-	1300
8	Natural Family Planning (NFP)	70	120
9	Non-MOPH FP Activities	-0-	300
10	Operations Research/Data Analysis	100	575
11	Population Policy Development	55	200
12	Training/Invitational Travel	120	550
13	Other Costs/Contingencies:		
	a) Technical Assistance	-0-	75
	b) Evaluation/Audit	20	80
	c) Contingencies/Inflation	175	1215
	T O T A L S. (incl. contraceptives)	<u>4970</u>	<u>17,890</u>
	(excl. contraceptives)	<u>3315</u>	<u>11,890</u>

1 Includes \$1.66 million for centrally procured contraceptives.

2. Includes \$6 million for centrally procured contraceptives.

C. DETAILED DESCRIPTION

This project can perhaps be most clearly understood by focusing on the project outputs, including a description of the inputs proposed to achieve each of these outputs.

It should be noted that each of the 12 outputs, while obviously related to the others, is a self-contained package, and can conveniently be thought of as the outcome of a separate sub-project. Moreover, each of the 12 outputs requires a relatively independent set of management actions which must be considered with, but is distinct from, the other 11 outputs. These subprojects/outputs are as follows:

Output Number 1.: Expansion of the VDMS Household Delivery Program to 18 Provinces.

Between 1978-1980 USAID assisted the GOM Ministry of Health in the conduct of a pilot program in Marrakech province to test the feasibility of household-level delivery of contraceptive services. Trained health workers made two home visits to virtually all women aged 15-44 in Marrakech province, the second visit after a three or four-month interval. The health worker asked families about their contraceptive practices and fertility; explained various contraceptive methods, and provided oral contraceptives or condoms sufficient for 4-5 months.

If condoms were declined and if oral contraceptives were contraindicated, women were referred to the nearest MOPH medical facility. At the second visit, healthworkers checked any problems related to the contraceptive method used, and offered a re-supply of contraceptives if so desired by the clients.

The Marrakech pilot program was probably one of AID's more successful operations research projects. It clearly demonstrated to the MOPH that household-level distribution of contraceptive supplies by trained paramedical personnel was logistically and politically feasible. Also, the very high client acceptor rates (approximately 60%) produced by the pilot project revealed the dimensions of the unmet demand for FP services in Morocco. In the wake of this successful trial effort, the MOPH decided to expand the home visiting program -- but with a major change: while the Marrakech pilot project had tested the feasibility of delivering one service, family planning, to individual households, the "Expansion" project was established as a family planning/primary health care program. USAID was in general agreement with the political and practical bases for this decision -- given the fact that the health workers' household visits might represent the only likely contact between the MOH health delivery system and much of Morocco's rural population.

The change nonetheless required a substantial re-design effort, including most notably the identification of an optimum "package" of health and family planning services to be offered by the MOPH household visitors. Following extensive review of various service combinations through 1980/81, the elements of this package were officially established in 1981 to include the following:

1. Family planning, including the distribution of oral contraceptives and condoms, and service referral for IUD-insertion and sterilizations.
2. Immunization verification and referral, upon examination of vaccination record cards for all family members.
3. Oral rehydration therapy (ORT), including household-level instruction in causes of/treatment for infant diarrhea, and provision of family supplies of oral rehydration salts (ORS).
4. MCH/nutrition, including promotion of breastfeeding and good weaning practices; growth-monitoring of children under two years of age; and provision of dietary supplements for nursing or lactating women.

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Training modules --for trainers and trainees -- were developed in 1981 for each of these interventions with assistance from USAID and Johns Hopkins University. UNICEF provided pre-packaged ORS, and funds to open a small (MOPH) factory for local production of ORS. UNFPA provided mopeds for household visitors. USAID provided support for incremental costs such as gasoline, fieldworker indemnité, contraceptives, weaning food, training of trainers' workshops, reporting forms, and posters and brochures promoting the program. Ten provinces were selected for participation in the VDMS project -- the primary selection criterium being high populationsize. These initial ten provinces consequently included about 40% of Morocco's population in the country's then - 34 provinces and prefectures.

Because of the greater amount of information and material to be transferred from healthworker to household, under the revised project the number of annual visits per household was increased from the original-design level of two, to a new level of 4-5 visits per household per year. Each VDMS worker was expected to make 12-15 household visits per day, for approximately 200 days per year. USAID also supported an expansive effort to train 600 nurses in IUD-insertion techniques, and provided IUD-insertion equipment for a like number of rural and urban dispensaries in order to make a reality of VDMS referral for IUD services.

Finally, in May, 1982, the revised and expanded VDMS project was launched in the three provinces of Meknes, El Jadida and Beni Mellal. The second seven provinces were scheduled to launch VDMS one year later (May 1983), but were delayed until November, 1983 by the late arrival of the second group of UNFPA funded mopeds. (By that time three of the latter group of provinces had been sub-divided into smaller provinces, such that VDMS is now in place in a total of 13 provinces).

As of April, 1984, the VDMS project had been under way in the three original "expansion" provinces for almost two years, and for six months in the second group of 10 provinces. Together, these 13 provinces still comprise about 40% of the Moroccan population, or 8.8 million people. VDMS services in these provinces are delivered by 2,200 MOPH nurses and practical nurses specifically-trained for this project.

Data from the current VDMS provinces, and particularly from the three "older" provinces, indicate that the project is performing to expectations. Contraceptive prevalence ranges from 40% to 50% of MWRA in VDMS project areas, for an average prevalence of about 45%.

Moreover, approximately 90% of all households in the three original project areas have been provided at least one of the array of VDMS services, suggesting that the project is well accepted by the community, and that it may be producing a similarly high impact on the health status of the client population.

The follow-on project for FY 1984-88 will continue and expand the VDMS activity on the premise that this sub-project has special potential to decrease fertility and to improve individual health status in Morocco. VDMS will produce these effects via the application of measures strongly endorsed in AID population and health policy statements, including the promotion of integrated health/FP services; reliance on existing health service infrastructure and non-physician personnel; and the promotion of health care at the community-level. The VDMS project has also demonstrated the accuracy of a proposition fundamental to the development of a family planning program: that FP acceptance and use is a direct function of contraceptive availability.

Under the new project 608-0171, USAID will continue support for the three "original" VDMS provinces of Meknes, El Jadida and Beni Mellal through FY 1985, and for the second group of 10 provinces through FY 1986. This schedule would be generally consistent with USAID's stated intention under the predecessor project 608-0155 to support VDMS in each participating province for three years -- a commitment foreshortened by the delayed launch of the VDMS program, and the termination of Project 608-0155 in FY 1984. USAID's three-year commitment would therefore be honored by extending VDMS support under the new project.



The added advantage to this extension is that external support for VDMS will continue into the next GOM Five-Year Plan period, 1986-90, thereby ensuring the uninterrupted conduct of the program pending MOPH efforts to target additional GOM resources for VDMS under the next Plan. As an inducement to this MOPH effort, USAID will propose to the GOM that AID will support the extension of VDMS to five additional provinces in 1986 if the GOM budgets the funds necessary to adequately continue VDMS in the original 13 provinces. USAID support for these five added provinces would however be limited to two years. In all, these 18 VDMS provinces plus the complementary urban and private sector activities described below, will make effective contraceptive services routinely available to about 70% of the Moroccan population.

Issue: The foregoing discussion assumes that the GOM will prepare its next Five-Year Plan (1986-90) on schedule. USAID points out the possibility, however, that the austerity measures currently being undertaken by the GOM may result in a one-year delay in preparation of the next Plan. That is, a belated Five-Year Plan would cover the period 1987-91, and an interim plan/austerity budget would be in force for 1986.

The MOPH has already taken steps under the current Five Year Plan to institutionalize VDMS in its regular budget. (USAID, for example, pays indemnités, or fieldworker incentives, for only two of the fieldworkers' 4-5 annual visits. The MOPH pays the balance). In the event of a strict austerity budget in 1986, and the possible inability of the MOPH to assume new

cost burdens for that interim period, USAID proposes to extend assistance across this period, to maintain the annual levels of VDMS funds reflected in the MOPH budget, i.e., as the baseline against which the GOM will calculate budgets post-1986.

A consequence of this one-year delay would be an extension of USAID support for all 13 VDMS provinces through FY 1986. USAID's proposal to sponsor an additional five provinces for two years, subject to the GOM's assumption of prior VDMS costs, would remain in effect -- but with a start-date one year later, in FY 1987. This Project Paper proposes therefore funding authorization sufficient to meet VDMS costs for the original 13 VDMS provinces thru FY 1986, i.e. in the event of such a delayed GOM Plan/budget commitment. USAID support (most of which are for local costs) for the VDMS project will be approximately \$1.1 million per year for the 13 provinces for two years (\$2.2 million), and \$500,000 per year (\$1,000,000 for FY 1987-88) for the five new provinces. The total funding authorization sought for the VDMS project is therefore \$3.2 million for the period FY 1984-88.

Output number 2: Family Planning Services in Urban Areas

Morocco is 43% urban (compared to 35% in 1971). As is the case in many developing countries, the urban population in Morocco is increasing at a much higher rate than the rural population -- the product of a high level of rural to urban

migration and continuing high birth rates in urban areas. (The 1982 census indicates that the inter-censal growth rate of the urban population was 4.4%/year, while rural growth averaged 1.4%/year).

Although the 1982 census revealed a higher growth rate for provincial urban centers than for Casablanca and Rabat-Salé, these two urban centers remain the end-points of a substantial share of the rural exodus. In the absence of an adequate supply of land and affordable housing in these cities, a substantial proportion of in-migrants establish dwellings in shanty-towns, or bidonvilles. The spontaneous settlements are growing even faster than their host cities -- probably at a rate of 7-10 per cent per year (Revised Shelter Sector Assessment USAID, 1982). Given their nominally "illegal" status, these urban squatter settlements are often afforded very low priority in the provision of a public services. The MOPH has indicated, however, its intention to extend integrated health/FP services to these urban communities.

The VDMS project does, of course, have an urban component: the provincial capital of each VDMS province is covered by the same household-visitation procedure used in rural areas. Urban VDMS workers work on foot, however -- mopeds are reserved for rural outreach workers; urban VDMS workers receive a lower daily indemnité than rural VDMS agents; and overall VDMS/urban costs are lower in consequence of this lower indemnité and non-use of mopeds, gasoline and oil.

Notwithstanding this existing "urban" program, VDMS has largely by-passed the population concentrations in Casablanca, Rabat/Salé and Tangier. For the most part, this disregard for the large cities reflects the MOPH's acknowledgement that basic health/FP services are generally available -- through both the public and private sectors -- in the metropolitan areas. Indeed, virtually all of Morocco's 450 pharmacies and 90% of the country's private doctors and dentists are found in Morocco's ten largest cities. Moreover, indices of health status, fertility and contraceptive practice reveal significant urban-rural differences in Morocco (as elsewhere).

These data mask, however, the dramatic differences, within the cities themselves, in public access to basic health/FP services. Residents of the rapidly-growing squatter settlements in and around the larger cities claim little physical or financial access to these services even though their living conditions make them especially vulnerable to health dangers

Under this project, the MOPH will organize and implement a household-visitation program specially-designed to meet the needs of urban slum-dwellers and residents of "temporary" settlements in and around the country's three largest cities. This activity is essentially an urban variant of the larger VDMS project; but it will benefit from design factors which will consider the different nature and characteristics of its

client population: lacking the traditionality, stability and tribal/ethnic cohesiveness of rural village life, but exposed to positive lures of "modernity" via TV, movies, advertizing, and possibly wage-employment, which make them perhaps more-inclined to adopt "modern" fertility practices. The project will include technical assistance to identify these special characteristics with more precision to aid the preparation of a directed information/motivation effort.

Delivery of services will be on the VDMS/urban model: a "package" of integrated FP/health services will be offered by a professional health worker, and persons requiring additional care and/or a clinical FP method will be referred to the nearest MOPH medical facility. Some complementary back-up to this system will be provided by the contraceptive sales program of the private Moroccan Family Planning Association (AMPF), as described under Output 7.

USAID plans to support this activity for three years, beginning with Casablanca in FY 1985, and adding Rabat/Salé and Tangier in FY 1986. USAID support will include start-up costs (training, materials, IE+C), and operating costs, essentially on the VDMS model.

Total AID costs for this activity are estimated to be \$1,000,000 during LOP, not including the cost of contraceptives.

# MAROC المغرب

خريطة ادارية: المقالات، الاقاليم

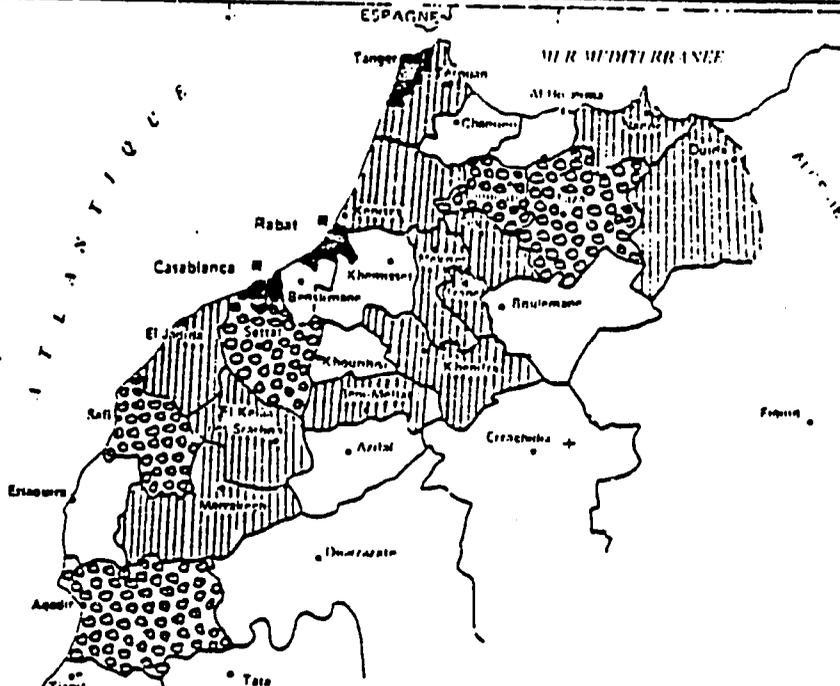
## CARTE ADMINISTRATIVE PROVINCES ET PREFECTURES

ECHELLE 1/5 000 000

LEGENDE

Siège de la Prefecture      مركز الولاية  
 Capitale de la Province      عاصمة المقاطعة

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### GOM/MOPH Services Outreach Programs:

#### Geographic & Population Coverage

- 
 13\* provinces launched under Project 608-0155; to be continued under Project 608-0171  
 Population: 3,300,000
- 
 5 provinces to be added under Project 608-0171  
 Population: 3,500,000
- 
 Metropolitan areas of Casablanca, Mohammediya, Rabat-Sale, and Tangier to be added under Project 608-0171  
 Population: 4,000,000

#### VMS Project

#### Urban Services Project

\* 12 shown. Kenitra province includes Sidi-Kacem province

Output Number 3: The National Training Center for  
Reproductive Health (NCRH)

The NCRH, established with USAID, JHPIEGO\* and IPAVS\*\* assistance under Project 0155, officially began activities in November, 1982. Its purpose is to serve as a national training and referral center for reproductive health, and to train medical and paramedical personnel in surgical techniques of family health/family planning.

The NCRH is located in the former Rabat Maternity Hospital, the Center houses a 30-bed maternity and ob/gyn service; a complete teaching facility including classrooms, a library and offices; technical facilities including two operating theatres, three recovery wards of 10 beds each, and all necessary ancillary services; and a endoscopic repair and maintenance (RAM) center to service all donated endoscopic equipment in Morocco.

Under Project 0155, the NCRH was renovated and equipped to commence its training and service activities. Medical staff of the Center were trained at Johns Hopkins and/or at Tunis under the JHPIEGO program; and the RAM technicians were trained in equipment maintenance in the U.S. and Tunis.

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\* Johns Hopkins Program for International Education in Gynecology and Obstetrics.

\*\* International Project, Association for Voluntary Sterilization.

Since the Center's opening in 1982, it has conducted four training courses in IUD-insertion techniques for 50 senior nurse-trainers from various provinces; and five courses in reproductive health/surgical techniques for 40 Moroccan and nine foreign physicians. The Center also provides training on a cost-reimbursable basis for private-sector physicians.

The Center performs approximately 100 surgical contraception procedures per month. Further to AID Policy Determination Number 3 of September, 1982, informed consent is obtained and documented for all requestors of surgical contraceptive services. Other, temporary family planning methods are available on-site at the NTCRH to ensure a free choice of contraceptive method. Neither abortion nor abortion-related activities are conducted at the Center. All FP services are provided free of charge to requesting patients, and no payments or other incentives are offered to potential requestors for any contraceptive method.

In 1983 the NTCRH was designated by JHPIEGO as an international training facility for JHPIEGO-sponsored trainees from other francophone and arabic countries in Africa and the Middle East. As noted above, nine foreign physicians had attended this training program as of March, 1984.

USAID's role as a donor to the NTCRH will be relatively modest under this new project, reflecting 1) the completion of "start-up" activities -- renovation and equipping of the center -- undertaken during the predecessor project; and 2) an expanded role of JHPIEGO and AVS as NTCRH sponsor. As the NTCRH is now a regional training center for francophone and arabic countries, a substantial portion of NTCRH training costs will be met by JHPIEGO in furtherance of that organization's global training program. AVS will also support a portion of the center's administrative costs via the AVS-MOPH sterilization services project described under Output Number 4. The MOPH itself will continue to be the primary contributor to the NTCRH, providing annual costs of approximately \$1.5 million for the center's operation, maintenance and personnel.

USAID's total contribution to the NTCRH over the five-year period FY 1984-88 will be \$250,000, to be used for special training, service and research costs not otherwise covered by the MOPH, JHPIEGO or AVS; local costs for NTCRH training and service programs in non-surgical forms of contraception (including injectable and/or implantable contraceptives after these methods obtain FDA approval for use in the U.S.); training for physicians and nurses responsible for the technical supervision of clinical FP activities; and operations research into other clinical FP methods considered for introduction into the national FP program.

The bulk of USAID costs (\$200,000) will be used to meet local costs of these service, training and research activities; and approximately \$50,000 will be used for the purchase, in the U.S. or Morocco, of medical supplies and equipment required by the Center.

By the end of the project, the NTCRH will have trained more than 150 Moroccans and international physicians in techniques of reproductive health and surgical contraception, performed approximately 5,000 surgical procedures, and will have established itself as a national center of excellence in training, service and research in family planning/reproductive health.

Finally, the NTCRH will play a central role in the initiation and continued technical oversight of the sterilization services activity described under Output Number 4, below. The Center will train hospital personnel responsible for activities under the sterilization program, provide refresher training, monitor the performance hospital staff, and repair/maintain laparoscopic equipment distributed to the participating hospitals.

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Output Number 4: Sterilization/Reproductive Health Services

The MOPH plans to widen the availability and accessibility of surgical reproductive health services including sterilization diagnosis and treatment of disorders of the reproductive system, and treatment for infertility. This will be achieved by the installation of comprehensive reproductive health service capabilities in 30 provincial hospitals throughout the country by the end of 1988.

The hospitals participating in this program will be staffed by surgeons and ob/gyns who have graduated from the NTCRH training program in surgical reproductive health procedures. The project will provide medical equipment and supplies for the 30 participating hospitals, the preparation of "dedicated space" if necessary, reimbursement to hospitals for incremental costs incurred by their provision of free VS services, and partial support for a project management cellule located at the NTCRH. This latter unit will be responsible for Moroccan logistics and technical oversight of the overall program, further to the NTCRH's role as training institution and national reference center for reproductive health techniques. The NTCRH will be responsible for ensuring that all surgical procedures, including pre-operative assessment and post-operative follow-up, will be conducted in accordance with the medical standards of the NTCRH and AVS guidelines -- both of which incorporate the requirements of AID Policy Determination Number 3 (Voluntary Sterilization) dated September, 1982.

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This will be a phased, five-year project. During the first year of activity, up to five hospitals will be selected in as many provinces. As noted above, these institutions will be staffed by physicians who have received certification on the surgical techniques of fertility management (laparoscopy, diagnostic endoscopy and minilaparatory) from the NTCRH. In addition, the NTCRH will ensure that the province-site for each hospital has the following characteristics:

- approval of the provincial medecin-chef to undertake surgical family health services;
- potential caseload or demand for VS services (preferably a province-site of the VDMS program);
- adequate facilities and staff to conduct services once additional resources are provided.

The specific resource requirements of each hospital participating in this program will be assessed separately (e.g., service subsidies to cover expendable supplies and other costs of surgical procedures, equipment, renovation to upgrade existing space or create new space for surgical procedures). No hospitals requiring renovation will be selected during the first year of the project, however. This decision reflects an effort to promote rapid expansion of services during the first year of the project, during which time much of the project's implementation features will be tested and refined.

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Subject to successful performance, and adjustments as necessary, during the first year of project activity, ten additional hospitals will be added during the second year, and fifteen hospitals during the third year. Each hospital will receive a maximum of three years of support, after which the added services are expected to become a routine part of the hospitals' health services.

The total estimated cost of this activity will be \$1.3 million over five years including \$213,000 for management, supervision and operational costs of the NTCRH; \$590,000 for equipment; \$450,000 for service subsidies and consumable supplies); \$30,000 for renovation; and \$25,000 for AVS technical assistance and monitoring. This support will be provided by AVS, using USAID/Morocco bilateral funds to be transferred to AVS' existing cooperative agreement with AID/Washington.\* This AVS Project Sub-agreement for this activity is attached as Annex V.

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\* Funds will be obligated under a USAID-GOM Project Agreement, and transferred by PIO/T and funds citation to AID/W the AVS Cooperative Agreement

Output Number 5: Improved Information, Education and  
Communication (IE+C)

Under the predecessor project 608-0155, USAID provided IE+C assistance to both the MOPH and to the IPPF-affiliated Moroccan Family Planning Association (AMPF). The generally observed distinction in our assistance for the two organizations held that USAID supported development of print materials (poster, brochures, VDMS-related hand-outs) with the MOPH, and broadcast materials (radio, T.V. spots) with AMPF. The latter activity included the purchase and installation of a video-studio at AMPF headquarters in Rabat. In the area of personnel training in IE+C, however, USAID broadly supported the activities of both organizations: with assistance from USAID and INTRAH, the MOPH developed nursing school curricula for FP/health communications (now in use in 30 nursing schools); and provided IE+C training for approximately 300 health education personnel from all of Morocco's then - 39 provinces. AMPF also used USAID assistance to conduct ten conferences and training workshops for journalists, women's groups and personnel from other GOM ministries, including Agriculture, Youth and Sports, and Handicrafts and Social Affairs. To date, AMPF has trained approximately 260 other-ministry personnel as FP motivation agents. Early in 1984, AMPF sponsored a "National Conference on Family Planning and Social/Economic Development", which was attended by leaders of government, all major political parties, unions and the private sector.

Under this project, USAID will continue relatively broad IE+C support for both the MOPH and the AMPF, at roughly the same funding-level as was established under project 608-0155 (approximately \$150,000 per year, or \$750,000 over the FY 1984-88 period).

Although USAID assistance for AMPF IE+C activities will remain within previously-established funding levels, some important innovations will be introduced: In addition to AMPF's, radio and TV advertising, conferences, workshops, etc., the Association will experiment with information media more consistent with Morocco's aural tradition, such as folk entertainers, storytellers, etc. In the electronic-media area, AMPF will allow other private, social welfare agencies and/or GOM agencies to use its video-production studio on a modest-fee basis to produce public service messages, on the condition that FP messages be woven into the content of these productions.

IE+C assistance for the MOPH will continue its emphasis on FF. Special, additional emphases will however include the development of materials to reinforce ORT efforts, particularly the "why-when-and how to" messages conveyed by MOPH outreach workers; the strengthening of breastfeeding/good weaning practices; and improved communications in support of infant/child vaccination and immunization. Assistance in these latter categories will be provided via the AID/W cooperative agreement with PRITECH.

In all aspects of IE+C assistance, particular attention will be given to improved targetting of print, film, broadcast and interpersonal communications; and on strengthened pre-testing of IE+C materials. Further to the recommendation of the December, 1983 evaluation of Project 155, GOM and AMPF proposals to produce IE+C materials will be accompanied by requestors' workplans for pretesting of proto-type materials, and for assessments of the results of these tests, as precedent to AID funding of production costs for these materials. These latter efforts will be conducted with technical assistance from Johns Hopkins/PIP and PRICOR.

Output Number 6: Improved Family Planning Services (FP  
Commodities)\*

Contraceptives represent the largest single project cost under project 608-0171, as they did under project 608-0155. The new project estimates a LOP requirement, FY 1984-88, of \$6 million for approximately 30 million monthly cycles of oral contraceptives, 3 million condoms, 300,000 IUD's, and 3,000,000 foaming tablets. In addition, USAID has estimated that \$500,000 will be required for medical supplies and equipment to extend the availability of clinical FP services through to the lowest (dispensary) level of the MOPH health system; \$200,000 for IE+C equipment; \$200,000 for data-processing equipment and software; and \$100,000 for VDMS fieldworker supplies (e.g., shoulder sacks, client record forms, etc.). (By comparison, project 608-0155 provided approximately \$4.5 million for oral contraceptives, condoms and IUD's, and \$800,000 for medical supplies and equipment over the period FY 1978-83).

Contraceptive use has almost tripled over the past six years, from approximately 350,000 users in 1978, to more than 900,000 in 1983. The bulk of this increase is attributable to the official

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\* . Includes commodity costs (\$7 million) broadly supportive of the overall project, but excludes commodity costs (\$1 million) directly linked to the individual subprojects.

GOM program, whose "market share" of contraceptive clients rose from 150,000, or 43% in 1978, to approximately 600,000 users, or 65% of total clients in 1983. Private sector sales of contraceptives also increased over the same period, albeit at a slower rate of gain than the MOPH program. On the basis of Westinghouse CPS data, USAID estimates that commercial sales of oral contraceptives increased 65% between 1978 and 1983 -- from 200,000 clients in 1978, to about, 330,000 in 1984.

Contraceptive practice in Morocco is expected to continue to increase gradually over the next five years, from the current contraceptive prevalence rate of 27% MWRA, to 35% - 40% of MWRA in by 1988. The contraceptive "mix", however, is also expected to change as more women take advantage of the IUD services installed over 1983-84, and the increasing availability of sterilization services as described under Output No. 4. Briefly, USAID estimates that the proportion of total users who rely on oral contraceptives will decline from 75% of all users in 1983, to about 65% in 1988 -- although total use of oral contraceptives will continue to increase. The projected condom requirement assumes increased use of this method as a result of VDMS distribution from 1% of users in 1983 to 2.5% in 1988 -- a possible ceiling (in Morocco) for this low-preference item.

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IUD use is expected, as noted, to increase overall, and relative to other, non-clinical methods. At present, about 10% of contraceptive users rely on the IUD. The projected LOP requirement for IUD's presumes that this proportion will rise to about 20% by 1988, in response to the recently-installed availability of these services, and their utilization by VDMS referral patients.

The commodity requirements for the sterilization and reproductive health sub-project are included under Output Number 4. USAID would note its projection, however, that VS will account for about 10% of all FP acceptors by 1988.

The \$500,000 projected for medical supplies and equipment. will provide IUD-insertion capacity in each of the 200 dispensaries which the MOPH intends to construct and/or renovate over the next five years, purchase occasional technical publications (usually in french) for Moroccan project personnel, and purchase trial quantities of new or promising contraceptive products appropriate to the Moroccan program. These might include, for example, modest quantities of injectable contraceptives (Depo-Provera) or implantable contraceptives (Norplant) if and when these products receive FDA approval for purchase and distribution by A.I.D.

The project will also provide \$200,000 for the purchase of the locally-produced weaning food Actamine 5 to be distributed at MOPH/MCH clinics and by health workers under the VDMS and Urban Services subprojects; and \$200,000 for the

purchase of data-processing equipment and supplies; and  
\$100,000 for the purchase of miscellaneous supplies such as  
reference materials, sample supplies of new contraceptive  
products, etc.

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Output Number 7: Private Sector Activities

Summary

Of the 12 outputs planned for the predecessor project 608-0155, only one -- establishment of a contraceptive retail sales program -- was not achieved. The Ministry of Health, which was a signatory to the Project Agreement concerning this activity, subsequently declined to sanction contraceptive distribution by non-health professionals. (Private sector sales are currently limited to licensed pharmacies). The subproject discussed in this section represents an attempt by USAID and the non-government (IPPF-affiliated) Moroccan Family Planning Association (AMPF) to demonstrate the feasibility of a liberalized, contraceptive-sales activity to a still-reluctant GOM, and to lay the groundwork for a far more expansive role for the private sector in furthering Morocco's population goals.

The AMPF program will include three components:

1. Contraceptive sales by resident agents in rural "localités" (towns/villages).
2. Family planning/health product sales thru kiosks in urban and semi-urban areas; and
3. FP expositions/sales at fairs, souks and public events.

Each of these activities is outlined below. A more detailed presentation of the overall subproject will be prepared upon the completion of a feasibility assessment in late 1984. The assessment will examine the technical merits of the AMPF program, as well as AMPF's administrative capacity to carry it out.

Current Private Sector Involvement in Family Planning

Relationship to MOPH Activities: The private sector already serves a substantial, and growing, number of FP clients in Morocco. In 1979, USAID estimated that approximately 200,000 persons obtained contraceptives from the private sector i.e. pharmacies.\* Based on findings of the 1982 Contraceptive Prevalence Survey (CPS), USAID estimates that about 330,000 persons currently purchase their contraceptives from the private sector -- a 65% increase since 1979.

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\* Contraceptive sales in Morocco are limited to approximately 450 pharmacies, most of which are in urban areas. The overall commercial distribution system in Morocco includes an estimated 50,000 retail outlets as follows:

- Pharmacies: 450
- Parfumeries: 70
- Drogueries-parfumeries: 260
- Libre-service: 50
- Large food stores: 3000
- Smaller stores/  
épiceries: 40,000-50,000

All of these stores are concentrated in urban areas, especially Casablanca (with nearly 20,000 in the greater metropolitan area.

There are about six pharmaceutical wholesalers and 300 general wholesalers, also concentrated in the cities. They provide physical distribution and many also provide storage facilities. Companies with relatively strong distribution systems, like Gillette, reach as many as 20,000 of these outlets.

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If private-sector prevalence had held constant at the 1979 level, less than 7000 of these 130,000 new clients would be attributable to population growth among the fertile population over that period. Clearly, private sales have grown considerably, in response to increased demand for contraceptives -- even while the domestic price of contraceptive products has more-or-less doubled since 1979, (from DH5 per cycle of oral contraceptives in 1979 to DH9-10 per cycle in 1984. Condoms have risen from a 1979 price of DH1 per piece to approximately 2DH per piece in 1984).

The reason(s) for these rising sales is not readily-apparent: The monthly cost of contraceptive protection remains relatively high -- indeed probably beyond the reach of Morocco's urban and rural poor. Pharmacies, and the private physicians who prescribe (but do not dispense) contraceptives are virtually all concentrated in urban areas. The total number of pharmacies -- 450 nationwide -- has remained relatively unchanged since 1979. (The GOM prohibits individual ownership of more than one pharmacy). And contraceptive advertising, while not explicitly prohibited by the GOM, is virtually non-existent -- reflecting MOPH opposition to the advertising of any pharmaceutical products.

Given these limits on the private sector, it is tempting to suggest one apparent explanation for the increase in contraceptive sales: the MOPH's concomitant efforts to popularize and de-sensitize contraceptive use through its own

clinics and outreach agents. This relationship may be over-stated. At the same time, its obverse is apparently not true, i.e., that a more vigorous public sector program has drawn clients away from the private sector. Both sectors have shown healthy growth.

This upward trend in pharmacy-based sales suggests that the pharmacies themselves might serve as a base, or a point of entry, for a program to market contraceptives and related health products on a subsidized basis. Indeed, informal inquiries among individual pharmacists do not reveal any vigorous opposition to this possibility. To date, however, the MOPH has dismissed the prospect of a pharmacy-based (or other-retail-based) sales program. Among the concerns cited by the MOPH are the following:

- A presumed objection from pharmaceutical companies currently providing contraceptives to the commercial market. A subsidy program would put downward pressure on commercial prices -- and profit margins -- which these companies require to maintain their investments in Morocco;
- Risk of a cultural backlash to the product promotion and advertising efforts needed to support a pharmacy-based subsidized sales program.
- Client confusion over brand-multiplicity; an increase in product-switching; and an attendant increase in side effects among pill-users;

- A decline in clients' perceived worth of the "free" MOPH product.

In addition to these concerns is the MOPH attempt to enhance its claim to additional GOM budgetary resources at a time of rigorous fiscal austerity. The MOPH has always been forthright in noting its "political" use of the family planning program to bolster MOPH internal arguments for increased GOM funding. In this context, the MOPH is not prepared to be perceived as shedding a major MOPH responsibility--and budget category--to the private sector. Reinforcing this MOPH position is the widespread Moroccan suspicion -- doubtless shared within the MOPH -- that pharmacies and pharmacists prey on sickness and injury by charging excessive prices for essential medicaments. (In fact, prices and margins are fixed, with wholesaler and retail margins established at 10% and 30% respectively).

Despite this mixture of genuine and otherwise-strongly-felt concerns, the MOPH is becoming modestly conscious of its need to remain flexible on the sales issue. This changing mood is due partly to the persistent encouragement of donors, but also to the Ministry's desire to remain abreast of the conventional international wisdom in the population field. Still unable or unwilling to concede a subsidized sales program through retail outlets/pharmacies, the MOPH is taking what it considers to be appropriate steps for Morocco. These include its intention to sponsor (an AID-supported) series of

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FP training programs for pharmacists to increase their skills as FP motivation/counselling agents; and a willingness to acquiesce in the implementation of the AMPF sales activities described below.

The AMPF Program: Some General Considerations:

The AMPF activities presented in this PP reflect tradeoffs implicit in the foregoing discussion of private sector capacity and MOPH reluctance. Compared to classical social marketing schemes, the three AMPF sales activities are relatively modest: They lack national coverage, at least in their initial phases; they add to, rather than co-opt, the existing retail system; and they will forego high-visibility promotion and advertising. On the other hand, they have the potential to demonstrate that another "tier" of demand exists for FP and related health products i.e., between high-priced products at pharmacies, and free products through the MOPH. In the longer run, the AMPF program conceivably anticipates the eventual replacement of the MOPH in village-level distribution of contraceptives. Such MOPH programs as VDMS and the Urban Services activity are re-sensitizing contraceptives among the general public while they are boosting prevalence. In the process, they are gradually undermining the "special" character of family planning and contraceptives as Health Ministry reserves, and are preparing the market conditions -- permanent, high demand for services -- which can be effectively satisfied by the AMPF and/or other elements of the private sector, such as the non-pharmaceutical elements of

the Moroccan retail system. In order for the private sector to play that eventual role, it must demonstrate now that it has the technical, logistic and administrative capacity to do so; and the public must be shown to be responsive to sales efforts which are not geared to an urban, middle-class clientele. In brief, the ultimate success of the AMPF project will depend on its ability to demonstrate that the private sector can function as effectively as, or better than the MOPH in providing FP services.

The AMPF Sales Program: Description

The three sub-activities of the AMPF Sales Subproject follows:

1. Contraceptive Sales through Village Agents

In 1977 AMPF initiated a mobile FP information and service program in the Rabat-Salé area. A year later, in 1978, AMPF expanded this program to (and in regions around) Casablanca, Tangier, Marrakech and Fas. The program utilized five mobile FP units provided to the Association by IPPF/London. Although AMPF referred to this activity as a community-based distribution (CBD) program, it did not reflect the key characteristics of a CBD activity, i.e., the permanent, in-village presence of FP agents. The program was in fact a mobile re-supply project, whereby AMPF vans visited towns and villages on a regular schedule to directly re-supply FP clients enlisted during previous visits of the mobile

unit. More recently, both USAID/Morocco and representatives of IPPF/London have urged AMPF to consider a more cost-effective approach to village-level provision of services, i.e., a program less dependent on costly and possibly-erratic mobile units, and more consistent with CBD fundamentals. The scheduled termination of IPPF support for the mobile project in 1984 added some urgency to these recommendations -- as did USAID's insistence that AID support for a follow-on activity would be contingent upon major changes in project design and costs factors.

The new activity discussed herein is a trial of such a revised approach. Specifically, AMPF will recruit and train 30 community FP agents from as many towns/villages in the four provinces of Kenitra, Khemisset, Temara-Skhirat and Salé (all of which fall within the jurisdiction of the Rabat/Headquarters branch of the AMPF). The population of the 30 localités is estimated to be approximately 660,000 persons, or about 108,000 families. Selection of individual agents will be made in consultation with local government, religious and social welfare authorities. Following the training of these agents, AMPF will conduct an information campaign in the participating provinces via radio spots and mobile unit visits, to introduce the new program to the local population. The 30 CBD agents will contact village leaders to introduce themselves and to describe the new service; and will act as resident re-supply

agents from their places of residence. These residences/re-supply depots will be clearly identified by prominently-displayed signs showing the AMPF logo.

These CBD agents will also establish 30 "users clubs" (club volontaires) of FP acceptors which will meet regularly for mutual reinforcement and information exchange.

A key feature of this program is that clients will be charged for contraceptive products. The AMPF has notionally established a price of DH2,00 (approximately \$0.26) for a one-month supply of contraceptives (one cycle of oral contraceptives or 10 condoms). This price is tentative, pending future assessment of popular demand for contraceptive products at that price. A final, optimum price will be determined on the basis of analysis of the trade-offs between cost and sales volume.

USAID's contribution to this activity will include operating costs for an AMPF vehicle for supervision and re-supply (visits will be far less frequent than under the current mobile unit project, as each CBD agent will maintain substantial stocks of contraceptive products): \$5,000/year; personnel costs (driver, project supervisor, honoraria for the 30 CBD agents): \$17,000/year; project materials (acceptor forms and files, AMPF signs): \$3,500/year; training for CBD

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agents: \$5,000; and costs of the 30 "users clubs": \$7,500/year. The total two-year cost to AID for this activity will be approximately \$71,000. AMPF has estimated that the project will recruit 22,000 new FP users during this two-year period.

Non-USAID support for the project will include the IPPF-provided project vehicle, and contraceptive products also supplied by IPPF. Revenues generated by the project will be retained by AMPF and the CBD agents on a 50-50 basis, or as established on the basis of price-and-margin tests to be conducted under the project. AMPF will apply its revenue toward overall operating costs of AMPF's national program, in an effort to commence practical steps toward financial independence from foreign donors (i.e., AID and IPPF).

Subject to the successful implementation (and revision as necessary) of this trial program in the four-province area noted above, USAID and AMPF will consider the extension of the project to the 15 additional provinces served by AMPF's other four regional branches in Casablanca, Tangier, Marrakech and Fes. These latter programs would commence in FY 1987 and continue thru FY 1988 at an additional cost of \$140,000, bringing total LOP cost of this activity to approximately \$210,000.

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2. Kiosk Sales:

Under this activity, AMPF will construct, furnish and operate, on a trial basis, 10 kiosks which will sell contraceptive and health products at less than market prices to the low-income residents of fringe communities (squatter settlements/bidonvilles) in Rabat and Casablanca. If the trial venture is successful, AMPF will construct and operate an additional 40 such units to serve additional settlements in and around the cities of Rabat, Casablanca, Tangier, Marrakech and Fes. Each kiosk will cost approximately \$4,000, and will be readily-transportable by pick-up truck to enable experimentation with various locations. The kiosks will sell contraceptive products (pills, condoms, spermicides); baby-health supplies (Actamine 5, oral rehydration salts, vaccination calendars); and some school supplies (paper, notebooks, pencils); and will be staffed by "social aides" trained by AMPF. Project costs to USAID for the 10-unit trial over the two year period FY 1985-86 would be \$139,000 including \$40,000 for construction of the 10 kiosks; \$8,000 for maintenance; \$2,000 for training; \$2,000 for transportation; \$62,000 personnel costs (including salary of \$2,500/year for 10 kiosk operators, and \$6,000/year for a project coordinator); and \$25,000 for sales articles (excluding contraceptives and ORS which would be donated by IPPF and the MOPH, respectively).

This activity will require careful advance preparation, and close coordination between USAID, AMPF, kiosk-fabricators, vendors of sales articles, and municipal authorities in Rabat and Casablanca. Indeed, for these reasons, and in view of AMPF's lack of prior experience in such an endeavor, USAID is approaching this activity far more conservatively than AMPF has proposed. (The AMPF proposal calls for the construction and operation of 20 kiosks per year for five years beginning in 1984, for a total number of 100 units by 1988).

In USAID's judgement, a 10-unit trial, spread over two years, will be within the management capacity of the AMPF branches in Rabat and Casablanca, and will provide a practical test of the program's capacity for expansion. Such an expansion, e.g., up to a total of 50 units, would nonetheless be preceded by a careful evaluation of the trial activity's performance, and an assessment of the management capacity of the other AMPF branches to successfully undertake the project.

Additional AID costs of a 40-unit expansion in FY 1987-88 would be approximately \$550,000, for a total activity cost of \$683,000 during LOP.

Sales revenues earned by the kiosks will be retained by AMPF and re-invested in the project, primarily to cover the purchase-cost of non-donated commodities sold by the kiosks. The economic viability of this project — i.e.,

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its ability to cover most of its own running costs excepting donated contraceptives and health supplies -- will be key factor in USAID's consideration of a project expansion in FY 1987.

USAID notes that the population groups served by this activity could be alternatively reached via the VDMS/urban or CBD approaches described previously.

USAID's interest in the (more-or-less) "fixed unit" approach of the kiosks project is based, however, on the larger principle which it would demonstrate to the GOM and the commercial community: that the retail sale of contraceptive products is politically and financially feasible, and that non-pharmaceutical outlets can be effectively utilized as sources of such products. Unambiguous demonstration of this potential could clear the way for a far more active role for the "regular" commercial retail system as a source for FP information and services.

3. Mobile FP Sales at fairs, souks and public events:

The rural market, or souk, is one of Morocco's major social and economic institutions -- and is still the primary locus for most commercial transactions for the majority of rural Moroccans. Frequent fairs, religious festivals (moussems) and local or regional folk celebrations also attract large crowds throughout the year. This sub-activity exploits the market potential

(and the often commercial character) of these large popular assemblies, by making contraceptive products available for sale at these public gatherings. The "outlets" for these sales will be similar to those normally-utilized at souks and fairs. i.e., collapsable truck-transportable tents. The AMPF version, however, would include fittings and amenities which would allow it to be used for sales-plus-public motivation activities, such as showing movies/filmstrips/slides public discussions, and folk-entertainment with family planning themes (See p. 54 Output Number 5)

AMPF has had previous experience with this approach. The Association's IPPF-supported "exposition tent" is frequently used in urban settings as an educative and promotional device. The essential difference between the on-going and new activities is the decision to utilize the exposition tents as sources of contraceptive services, as well as FP information. This project will add four (4) new exposition units to the one (1) unit currently utilized by AMPF/Rabat (Headquarters) branch. i.e., to equip all five branches with this FP outreach capability. Each regional branch will be responsible for the day-to-day operation of its unit including the preparation and execution of an annual visitation schedule to regional souks, fairs and festivals. AMPF/Rabat will have overall responsibility for the project, and will coordinate the activities of the other four regional branches.

The AID contribution in support of this activity, FY 1985-88 will be \$148,000, including a one-time (FY 1985) cost of \$60,000 for procurement and outfitting of four (4) exposition tents (including tents, display panels and cases, movie/slide screens); and annual costs (FY 1985-88) of \$10,000 for transportation and maintenance, and \$12,000/year for AMPF field personnel.

Other support for this activity, including contraceptives, salary support for AMPF headquarters staff, project vehicles and movie and slide projectors, will be provided by AMPF/IPPF. As in the case of the two sales programs discussed previously, AMPF will retain sales revenues generated by this project and apply them toward meeting operational costs of the AMPF program.

Together, the three activities described above represent a major expansion of AMPF involvement in delivery (i.e. sales) of contraceptive and health products. If successful, the three ventures could have a profound impact on popular and GOM perception of contraceptives as routine consumer items, and hasten the involvement of Morocco's expansive small-retailer system in the provision of these services. The VDMS and Urban Services projects will concurrently be demystifying and de-sensitizing contraceptives by making them a standard fixture in many urban and rural households, thus

building a strong and continuing demand which can eventually be met by the private sector.

The cost to AID for AMPF's combined, three-part program will be approximately \$1,050,000 over the FY 1984-88 period, exclusive of technical assistance -- a relatively modest investment in terms of these activities' potential to effect the evolution of the Moroccan FP program.

#### Implementation Issues/Technical Assistance

USAID's primary concern in supporting these initiatives will be the management capacity of AMPF to make them work. AMPF is in the process now of upgrading and expanding its management structure, with assistance from IPPF/London. The actual amount and pace of USAID investments in support of these three activities will be a function of AMPF's ability to install the administrative measures necessary to effectively carry out its expanded role.

Technical assistance for the combined activity will be provided in two stages: First, USAID will draw upon the services of the AID/W-funded contractor (currently the Futures Group) retained to conduct pre-project feasibility studies of commercial and social marketing projects to conduct a pre-launch assessment of the AMPF project package. This study will include an assessment of the project's

technical feasibility and proposed structure, and of AMPF's management capacity to carry it out.

Upon completion of a successful feasibility study, and AMPF-USAID agreement to undertake such changes as might be suggested by that study, USAID will recruit a resident contractor via either a PSC or institutional contract to work with AMPF in the execution of the project. This contractor, tentatively funded at a cost of \$250,000 for 24 person-months, will work directly with AMPF during the initial critical period of project planning, organization, training, and testing on a pilot basis. A detailed scope of work for the contractor will be prepared upon completion of the project feasibility assessment. It is expected, however, that the major tasks which he/she will undertake with the AMPF will include:

- The establishment of an overall workplan for the project, including implementation plans for the separate elements (CBD sales, souk/moussem sales, kiosk sales) of the larger activity;
- Preparation of a program promotion strategy, i.e., for design of appropriate logos, product names and packaging, point-of-sale and/or consumer instructional materials;
- Establish methods and criteria for selection of sales agents; prepare a training plan for sales agents;
- Establish optimum prices and margins for sales products;

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- Establish procedures for receipt, stocking, distribution and accountability of project commodities;
- Establish procedures for accounting and control of project receipts and disbursements;
- Establish procedures for measurement of program results against objectives;
- Conduct test(s) of project activities in limited, pre-launch geographic areas;
- Establish collaborative relationships with the MOPH and the medical, pharmaceutical and business community;
- Train AMPF counterpart staff to continue management of the program.

The total USG cost for this private sector sales program, including \$1,050,000 for the three sub-activities and \$250,000 for contract technical assistance, will be \$1,300,000 over LOP.

Output Number 6: Natural Family Planning

The AID policy statement on Population Assistance (September, 1982) expresses the Agency's intention — further to Section 104(b) of the Foreign Assistance Act as amended in 1981 — to ensure that information and services relating to natural family planning (NFP) are included as appropriate among population activities supported by AID.

Under this subproject USAID/Morocco will execute a grant with a Moroccan PVO to offer NFP information, training and services for indigent couples in Casablanca. The training component of the project will also enable professional staff of the PVO to introduce NFP into the health and social service programs of other private and government agencies in Morocco.

Specifically, USAID will support the NFP program of 1'Heure Joyeuse (Happy Hour), a Moroccan PVO affiliated with the International Federation for Family Life Promotion (IFFLP). The sub-project will include three major activities over the three-year period 1984-1986:

1) the training of lay-educators in the delivery of NFP services, 2) the diffusion of information and education in the use of the NFP self-observation method of regulating fertility and 3) the training of trainers who will be capable of training the personnel of other Moroccan PVO's to offer NFP as a service to their clientele. These are described in more detail below.

1. Training of Lay-Educators: Eight educators will be trained in NFP over the life of the project. Their training will include/six months didactic training in anatomy and physiology, psychology, and communication, and instruction in teaching self-observation of the signs of fertility as a method of regulating fertility. This six month training will be followed by closely supervised field work in which the trainees will work with couples who desire to practice family planning using this method of self-observation. This will involve the counseling and education of the couple in NFP as well as the follow-up care necessary to assure that the couple understands and can read the physiological signs of fertility.
  
2. Diffusion of Information: This activity will institutionalize within the organization a system for diffusing information about NFP. The educators will organize group discussions for the women who visit the center's existing MCH clinic and introduce NFP to them as a method of fertility regulation. As successful

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utilization of this method requires the cooperation of the couple, women will be asked to return to the center with their husbands for further instruction. Further, L'Heure Joyeuse educators will visit the homes of the women who utilize the PVO's other services to inform and educate them about the NFP method. Once a couple has chosen to use NFP as their family planning method, the educators will provide individual and a small group counseling and education sessions for individual woman and for couples. Group counseling sessions will be offered either at L'Heure Joyeuse, or if several users of the method live near each other, in private homes. L'Heure Joyeuse's experience with a pilot NFP activity indicated that new users of the self-observation method will require supplemental instruction and encouragement on a weekly basis for about 2-3 months to ensure acceptance and continuation of the method. L'Heure Joyeuse has estimated that approximately 340 couples will adopt NFP over the three-year period of the project. L'Heure Joyeuse will develop an illustrated brochure and audio-visual aids concerning NFP methods to reinforce the education and counseling sessions. This IIC material will be developed for two audiences -- for the couple and for the training of personnel.

3. The Training of Trainers: The project will train eight NFP educators. Four of these trainees, i.e., those who demonstrate exceptional ability, will be selected to be trained as trainers and will receive supplemental training.

These four women will train the personnel of other organizations interested in integrating NFP into their regular services. One of these four women would be selected to supervise the activities.

At the end of the second year of the project l'Heure Joyeuse will organize a one week seminar on NFP for organizations in Morocco currently involved in family planning. These include, but are not limited, to the MOPH, Association Marocaine de Planification Familiale (AMPF) and the National Social Security Organization (CNSS). The purpose of this seminar would be for l'Heure Joyeuse to share their experience and to explore the desire of these organizations to become more actively involved in the provision of NFP services.

USAID support for this project will total approximately \$120,000 for the three-year period 1984-86, including \$75,000 for salaries; \$18,000 for training and the in-country seminar; \$12,000 for commodities, and \$15,000 for operating and miscellaneous costs.

USAID notes that L'Heure Joyeuse does not intend to offer FP services other than NFP to potential clients. The organization has indicated its willingness, however, to refer patients who will not or cannot utilize NFP to other sources, e.g., to MOPH or AMPF clinics and/or fieldworkers. This understanding will be incorporated into the USAID-L'Heure Joyeuse grant agreement.

Output Number 9: Other-Ministry FP Activities

Both USAID and external evaluators of project 608-0155 have commented on the predominant role of the MOPH as the primary provide of FP services in Morocco. This central role has been sanctioned by the GOM Cabinet, and is closely-guarded by the MOPH itself.

Under project 0155, USAID has tried, with modest success, to broaden Moroccan institutional involvement in the FP program. Over 200 fieldworkers of the Ministry of Youth and Sports, the Ministry of Agriculture, and the Ministry of Handicrafts and Social Affairs have been trained in FP under the USAID assistance program with AMPF, USAID has arranged third-party support for FP activities of the Moroccan military, and has provided clinical FP training in the U.S. for medical personnel of the Caisse Nationale (national social security system). The fuller potential of the extensive outreach systems represented by these other ministries remains, however, largely unrealized -- due to the Health Ministry's continuing reluctance to permit substantial other-ministry involvement in the provision of FP and/or health services.

As mentioned previously, the GOM has been displaying an increasing willingness to consider the problems of rapid population growth in a broader perspective, and to submit the issue for wider public and official discussion. This heightened public dialogue could conceivably lead to a GOM conclusion that population growth demands

a more urgent, expansive response. In that instance, the various service systems of other GCM and quasi-governmental ministries and agencies could be activated to fill their own niches in a broader FP outreach program.

Under this subproject, USAID will anticipate -- and seek to encourage -- the development of FP activities in ministries/agencies other than the MOPH. USAID funds will be used for training and invitational travel grants for key personnel from various ministries/agencies; medical supplies and equipment to support the clinical FP activities of non-MOPH organizations such as the Caisse Nationale, the Office Cherifien des Phosphates, and the Office National des Chemins de Fer, and seed-money for various non-MOPH agencies to launch FP service activities. This subproject will be linked closely with AMPF IE+C/training activities (Output No. 5), i.e., to both direct and to follow-up on AMPF's continuing program of FP training for personnel from non-MOPH agencies.

USAID estimates that LCP costs for this activity will be \$300,000, including \$100,000 for training and travel grants; \$100,000 for commodities; and \$100,000 for start-up operational costs for non-MOPH FP programs.

Output Number 10: Operations Research/Data Collection and Analysis

Operations Research: Operations research (OR) is an essential element in FP program planning, supervision and evaluation -- whether it is used to diagnose problem situations, or to test new, more cost-effective, approaches to service delivery. The consequences of a well-designed and executed OR project can be far-reaching -- as illustrated by the role of the Marrakech pilot VDMS project as antecedant to the current VDMS/Expansion project.

The MOPH has indicated its strong interest in pursuing a vigorous OR program which will provide management feedback on selected aspects of the FP program, and which would test adaptations/additions to the current program. Specific research topics of joint interest to both USAID and the MOPH include:

- an examination of the potential role of traditional birth attendants (TBA's) as village-level FP agents;
- Investigation and trial of FP/MCH service delivery mechanisms in urban and squatter settlements.
- studies of the delivery, acceptance and continuation of new contraceptive techniques. This will include an examination of the local feasibility of injectable and/or implantable contraceptives if and when these

methods are approved for procurement by AID (and after clinical trials of the method at the National Training Center for Reproductive Health -- see Output Number 3);

- a continuing series of mini-impact assessments of the differential effects of various program elements, e.g., IE+C media (print, broadcast, inter-personal); client satisfaction/continuation rates by type of service-provider; field-testing of revised record keeping and reporting procedures; and
- a test of fee-for-service approaches to health care and FP at MOPH hospitals and clinics.

The capacity of the MOPH to perform OR -- including selection and training of data-collectors, receipt and manipulation of data, and publication of results -- has been demonstrated by previous MOPH execution of the Marrakech project, the Morocco portion of the World Fertility Survey, and two Contraceptive Prevalence Surveys.

Moreover, the ongoing Health Management Improvement Project (608-0151) is contributing to the development of a much-improved MOPH management information system (MIS), including data processing equipment, software and training, which will facilitate the conduct of a more active OR program. The USAID contribution in support of OR activities will total approximately \$300,000 for technical assistance, local costs of training, preparation and printing of

questionnaires, fieldwork, and report publication. USAID expects that additional technical assistance requirements for these activities will be available under the AID/W-funded Operation Research Project (936-3030).

Data Collection and Analysis: Related data collection/analysis activities to be conducted under this project fall under three categories: execution of two contraceptive prevalence surveys (CPS) during the LOP; the analysis/publication of data produced by the Morocco National Fertility Survey -- the Morocco portion of the World Fertility Survey (WFS); and - continuing analysis and refinement of MOPH services statistics.

The two CPS's will be necessary to measure longitudinal changes in contraceptive practice in Morocco -- including changes attributable to the various project activities described in this document, and those produced by other non-program variables. With its use of a consistent master sampling frame and methodology and comprehensive questionnaire, contraceptive prevalence surveys offer a perspective on evolving program impact not otherwise available from FP program service statistics. The two CPS's planned for this project would be conducted by the MOPH with technical assistance from the AID/W-funded organization which successfully competes for the successor-contract to the current, Westinghouse CPS contract, utilizing supplemental USAID funds for local purchase of materials for training,

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questionnaires and report publication. The cost to USAID is estimated to be approximately \$150,000 for these surveys.

The Morocco National Fertility Survey (NFS/WFS) was completed in 1980 and the country report produced in 1983. Its five volumes contain a wealth of data on Moroccan fertility, mortality, morbidity, marriage patterns, occupation, education, income, and the inter-relationships between these and other socio-economic factors. USAID and the MOPH are in agreement that the utility of these data will be a function of the extent to which they are made generally-available for analysis and interpretation -- by the GOM, the academic community and the private sector.

Under this project, USAID will support NFS data user-workshops (two likely), and occasional seminars by the MOPH and other GOM organizations to present the results of these workshops and related analyses to other potential users. The total cost to USAID for these activities will be approximately \$25,000.

MOPH service statistics are very complete and detailed -- but lack the synthesis/analytic treatment necessary to make them of practical use to GOM program managers. A primary reason for the CPS's is to fill the information gaps left by an inadequate service statistics system. The project will build on data-management innovations introduced under the Health Management Improvement Project to further strengthen the collection, processing and analysis/presentation of MOPH

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data, with particular reference to FP, ORT, child health status and immunizations. The primary AID contribution to this effort will be technical assistance via USAID supplementation of existing AID/W agreements with CDC/Atlanta and/or PRICOR. The estimated cost of this TA will be \$50,000 over LOP.

Total USG costs for the foregoing OR and data management activities is expected to be approximately \$575,000.

Output Number 11: Population Policy Development

Morocco's population problem is gaining increasing attention as a legitimate, and urgent, concern of the GOM. The Morocco Royal Academy meetings of April and December, 1982 and the GOM Cabinet discussion of February, 1983\* all emphasized the challenge posed by rapid population growth to Morocco's future economic and social development. In practice, however, "population" concerns in Morocco are generally subsumed under a "family planning" rubric, while little is being done to inculcate a broader "population" perspective in the plans and budgets of other ministries, e.g., education, labor, public work and agriculture. Under this project, USAID will seek out opportunities to enlist senior-level GOM planners from other ministries to participate in appropriate seminars, workshops and short-term training on the development implications of population growth, and to offer such technical assistance as might be required to help institutionalize a broader framework for dealing with population as a development issue. Technical assistance may

\* A RAPID presentation was made at this meeting to the Prime Minister and the Cabinet. The presentation was made by the Minister of Health, with the assistance of an MOPH statistician trained by the Futures Group under the Morocco/RAPID subproject.

include provision of short-term instructors to the National Institute for the Analysis of Economic Statistics (INSEA) -- the economics/statistics training school of the GOM Ministry of Plan and Professional Training; short-term assistance to the Ministry of Plan in the preparation of the Five-Year Plan for 1986-1990; and participation in special conferences and/or colloquia on aspects of planning for population growth, e.g., future sessions of the Royal Academy and/or the Maghrebian Population Association.

USAID activities under this subproject will be coordinated closely with Project 608-0162, "Statistical Services". This latter activity includes a new component, added in FY 1983, to assist the GOM Ministry of Plan improve its analysis and planning applications of data derived from the 1982 census, and from a series of post-census surveys to be conducted through FY 1985. It also includes a population modeling and forecasting activity which might serve as the point of access for subsequent USAID assistance in selected aspects of the Five-Year Plan.

USAID support for this activity will include a mix of USAID and AID/W-funded technical assistance, of which the USAID cost is estimated to be \$150,000. The cost of training and invitational travel funds will total an additional \$50,000 for Moroccan participation in US/international conferences and training programs on population and development. Total LOP cost for this activity will be \$200,000.

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Beyond the foregoing "project" aspects of population policy development, USAID will continue its practice of engaging senior GOM and private sector leaders on the issue of population growth, and its implications for development in Morocco. Moreover, USAID negotiations with the GOM on other elements of the USG assistance portfolio (PL-480 resources, food production, housing, energy) will be used as occasions to underscore the intimate relationship between population growth and the likelihood of success in these other efforts. The recently updated Morocco RAPID model will be employed as appropriate in these discussions, along with materials which may be developed under the (AID/W-funded) RAPID II Project.

Output Number 12: Professional Skills Development (Training)

USAID will continue to pursue a similar training approach under the new project as was employed during project 608-0155: an emphasis on short-term, task-oriented training in the U.S. and third countries; and in-country (institutional and OJT) training in FP for current and potential providers of FP information and services. The project also includes funding for 48 person-months of long-term academic training in the U.S. for GOM middle-management personnel who display special promise or ability to effect program development.

The international and in-country training opportunities funded under this subproject will support the attainment of the broader objectives of the overall program. Other training costs directly supportive of individual subprojects are included in the AID contributions for those separate activities. Short-term international training/invitational travel under this subproject will include the participation of women managers (or potential managers) in CEFFPA\* courses, or other programs oriented toward reinforcing the role of female leaders; training in new contraceptive technologies; participation in international conferences and workshops (e.g. annual IUSSP\*\* meetings, University of Chicago summer workshops; participation in the 1984 World Population Conference; FP management and training programs at University of Pittsburgh, University of Connecticut, San Diego University, etc.); and special training/travel for key opinion leaders and decision-makers in the GOM and Moroccan private sector. USAID anticipates funding approximately 10 person-months of such short-term training per year over the LOP, and approximately 4 person-months per year of invitational travel for technical and/or policy level personnel to undertake visits abroad for purposes other than training per se. The total LOP cost for 75 person months of short-term international training will be \$200,000.

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\* Center for Population Activities

\*\* International Union for the Scientific Study of Population

Long-term training will be offered in the fields of health management, operations research and evaluation, and/or communications, depending on the availability of qualified candidates. Long-term training costs for 48 person-months of training will be approximately \$100,000. In-country training to be supported by this subproject will concentrate on the development and institutionalization of population, FP health-related skills in both the public and private sectors. Examples of such training will include in-service training for 1200-1800 physician-graduates serving their "obligated service" (two years) to various GOM ministries and agencies; the development and installation (in collaboration with WHO/European Region) of a FP module in the Moroccan medical school curriculum; support for a MOPH-sponsored FP training program for (private) pharmacists; and provision of refresher training in FP and related health activities for MOPH clinical and field personnel. USAID estimates that the cost of these in-country training program will be approximately \$250,000 over the LOP.

The total USG costs of U.S. and in-country training/invitational travel under this subproject will be \$550,000.

To repeat, the \$550,000 cited above does not include training costs directly associated with other subprojects such as training VDMS and "urban project" fieldworkers; AMPF "contraceptive sales" personnel; and VS/reproductive health training at the VTCZ. These costs are covered by the

sub-project budgets of these individual activities. Training funds provided under this subproject will support training activities in areas not covered by other subprojects, and particularly in skills areas which cut across all or most of the individual sub-projects.

#### MISCELLANEOUS

Technical Assistance: A portion of the technical assistance requirements of this project will be available under AID/W-funded grants, contracts and IQC's. Given recent trends toward bilateral funding (i.e., on a supplemental basis) of the TA services provided by AID/W grantees and contractors, the project includes approximately \$1.6 million for TA. These costs are distributed across the various subprojects as shown in Section II, "Cost Estimate and Financial Plan" . USAID expects, however, that additional needs will arise for specialized TA in areas not covered by existing AID/W-funded agreements, and for applications not foreseen in the subproject/output descriptions set forth above. USAID estimates that this supplemental TA will require approximately \$75,000 over LOP.

Evaluation: The evaluation plan for the project is described in Section V.III. of this Project Paper. USAID estimates that approximately \$60,000 in USAID funds will be required during LOP for the execution of this evaluation plan, i.e., for consultants, travel, per diem, report publication, etc.

Audit: The project includes \$20,000 to cover the cost of in-country audits should such audits be considered necessary by AID.

Contingencies/Inflation: Major departures/additions to this Project Paper will be re-negotiated with the GOM and reflected in revision(s) to the PP. The scope of this project paper is clearly ambitious, however, such that the need, if any, for additional funding for unforeseen activities should be modest. ("Other Costs" under project 608-0155 totalled \$100,000). For project 608-0171, USAID has proposed that funding authority for "Contingencies/Inflation" totalling \$1,214,000, consistent with contingency/cost escalation guidance transmitted to USAID per State 101216 dated April 6, 1984.

Total funding for Evaluation, Audit, short term technical assistance not associated with specific outputs, contingencies and inflation amounts to \$1,369,000.

II. COST ESTIMATE AND FINANCIAL PLAN

AID's contribution to this project is projected to be \$17,890,000 for fiscal years 1984-88. During this same period the GOM is expected to provide resources valued at roughly \$34 million, for a total program cost of about \$52 million. The AID proportionate share of the program will be approximately 34%.

The respective inputs of AID and the GOM to the project are presented in the following Tables 2-17. AID costs reflect estimated increases over LOP due to inflation and changes in currency exchange rates.

Table 2

Project Inputs for Output 1 (VDMS)  
(in \$000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
<u>Technical Assistance</u>		
- Short-term consultants (program assessment, training, data analysis) 8 p/m	-0-	80
<u>Commodities</u>		
- Contraceptives	(1,200)	(5,000) <sup>1/</sup>
- Fieldworker supplies	90	175
<u>Other Costs</u>		
- Personnel	970	2000
- Transport/travel	285	600
- Administration	40	95
- Training	105	220
- Motivation	10	30
<hr/>		
AID Total Excluding Contraceptives	1500	3200
Including Contraceptives	(2,700)	(8200)
<u>GOM</u>		
- Personnel	2,100 <sup>2/</sup>	12,125 <sup>3/</sup>
- Transport/travel	80 <sup>4/</sup>	460 <sup>5/</sup>
- Administration	56 <sup>6/</sup>	433 <sup>7/</sup>
<hr/>		
GOM total	2236	13,018
<u>AID + GOM Total</u>	<u>3736</u>	<u>16,213</u>

1/ Non-additive. Costs reflected under inputs for Output No. 6.

2/ Personnel costs of approximately \$162,500 per province per year for 13 VDMS provinces (13 provinces x 100 VDMS workers each x \$1625 salary per year per worker).

3/ Personnel costs of approximately \$162,500 per year per province per 13 provinces through FY 1988, plus costs of \$162,500 per province per year for 5 additional VDMS provinces for the period FY 1987-88.

- 4/ Transport/travel costs of approximately \$6125 per province per year for 13 provinces.
- 5/ Transport/travel costs of approximately \$6125 per province per year for 13 provinces through FY 1988, plus costs of \$6125 per province per year for 5 additional VDMS provinces for the period FY 1987-88.
- 6/ Administration costs of approximately \$4300 per province per year for 13 provinces.
- 7/ Administration costs of approximately \$4300 per province per year for 13 provinces through FY 1988, plus costs of \$4300 per province per year for 5 additional VDMS provinces for the period FY 1987-88.

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Table 3

Project Inputs for Output 2  
(FP/MCH Services in Urban Areas)  
(\$000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
<u>Technical Assistance</u>		
- Short-term consultants (program design, training, evaluation) 4 p/m	10	40
<u>Commodities</u>		
- Contraceptives	(400)	(1,500) 1/
- Fieldwork supplies	40	100
<u>Other Costs</u>		
- Personnel	150	500
- Transport/travel	40	100
- Administration	30	85
- Training	70	150
- Motivation	10	25
AID Total Excluding contraceptives	350	1000
Including contraceptives	(750)	(2,500)
 <u>GOM</u> 2/		
- Personnel	5	4000
- Transport/travel	2	70
- Administration	10	350
GOM Total	17	4420
<u>AID + GOM Total</u>	<u>167</u>	<u>5420</u>

1/ Non-additive. Costs reflected under inputs for Output No. 5.

2/ Estimations based on costs of implementing urban elements of the VDMS project. Actual levels of GOM support for this activity will be established following evaluation of the Urban Services Project.

Table 4

Project Inputs for Output No. 3  
(National Training Center for Reproductive Health (NTRH))  
(\$000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
<u>Technical Assistance</u>		
- Short-term TA (Operations and clinical research, curriculum development) 4 p/m	5	35
<u>Commodities</u>		
- Medical supplies and equipment	20	40
- Contraceptives 1/	-0-	10
<u>Other Costs</u>		
- Training	50	100
- Research	-0-	25
- Administration	25	40
AID Total	100	250
<u>GOM</u> 2/		
- Land value 3/	500	500
- Rent and maintenance	100	500
- Furniture and equipment 3/	100	100
- Personnel	310	1550
- Vehicles 3/	50	50
- Operational Expenses and patient services	85	425
- Administration	20	100
GOM Total	(515)	(4545)
<u>AID + GOM Total</u>	100	250

1/ Trial quantities of new contraceptive products for operations/clinical research prior to introduction into the national program.

2/ Non-additive. Costs reflected under inputs for Output No. 4, Voluntary Sterilization/Reproductive Health Services).

3/ One-time expenses.

Table 5Project Inputs for Output No. 4(Voluntary Sterilization/Reproductive Health Services)(\$000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
- Supplement to AVS Cooperative Agreement		
- Technical Support	10	30
- Service Costs	125	560
- Equipment	335	600
- Renovation	-0-	30
- Administration	30	100
	<hr/>	<hr/>
AID Total	500	1320
 <u>GOM</u>		
- Land value*	500	500
- Rent and maintenance	100	500
- Furniture and equipment*	100	100
- Personnel	310	1550
- Vehicles*	50	50
- Operational expenses and services	85	425
- Administration	20	100
	<hr/>	<hr/>
GOM Total	515	3225
 <u>AID + GOM Total</u>	<u>1015</u>	<u>4545</u>

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\* One-time expenses.

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Table 6Project Inputs for Output No. 5(Information, Education and Communications - IE+C - Activities  
(\$000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
<u>Technical Assistance</u>		
- Short-term consultants (materials design and pre- testing; design of information/ motivation strategies) 6 p/m	20	60
<u>Commodities</u>		
- Paper, ink, printing supplies, film and videotape	20	80
- AV equipment and supplies	60	250
<u>Other Costs</u>		
- Personnel (AMPF IE+C staff) 60 p/m	8	40
- Population conferences, seminars, training sessions	20	55
- Field-testing IE+C approaches	2	10
- Production costs of IE+C materials (inc. sub-contracts with advertising agencies)	70	255
AID Total	200	750
<u>AMPF/IPPF</u>		
- IPPF Grant	400	2000
- GOM Grant to AMPF	8	40
- AMPF Service revenues	35	175
<u>AMPF/IPPF Total</u>	443	2215

Table 6 Continuation

<u>GOM</u>	<u>FY 1984</u>	<u>FY 84-88</u>
- Personnel 1/	140	700
- Transportation 2/	55	275
GOM Total	195	975
<u>AID, AMPF/IPPF, GOM Total</u>	<u>858</u>	<u>3940</u>

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1/ Reflects salary costs of 45 (full-time) provincial F.P. Motivation/Education Officers at \$3139 per year per officer.

2/ Estimation, based on annual operating costs of one (1) MOPH mobile FP exposition unit (\$5000/year), and 23 mobile health education/FP service units (\$50,000/year).

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Table 7

Project Inputs for Output No. 6  
(Improved Services - Commodities)  
(\$000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
- Oral Contraceptives	1355	4855*
- IUD's	100	450*
- Condoms	100	350*
- Foaming Tablets	100	300
- Medical supplies and equipment	75	500
- Weaning food	50	200
- Data processing equipment and software	-0-	200
- Miscellaneous	-0-	100
AID Total	1780	6955
<u>GOM</u>		
- Personnel	1950 <sup>1/</sup>	9750
- Transportation	45 <sup>2/</sup>	225
GOM Total	1995	9975
<u>AID + GOM Total</u>	<u>3775</u>	<u>16,930</u>

1/ One full-time FP worker per clinic in 1200 clinics at \$1625 salary per worker per year.

2/ Estimate-based on approximate cost of transporting supplies to and within 45 provinces and prefectures at ± \$1000 per year per province.

\* AID/W procurement

Table 8

Project Inputs for Output No. 7

(Private Sector Contraceptive Sales - AMPF)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
<u>Technical Assistance</u>		
- Resident contract specialist - 24 p/m	-0-	250
<u>Commodities</u>		
- Promotional materials	-0-	150
- A.V. equipment and supplies	-0-	20
- Contraceptives	(To be provided by IPPF)	
<u>Other Costs</u>		
- Personnel	-0-	380
- Transportation	-0-	80
- Training	-0-	35
- Local contracts (construction of kiosks, <u>souk</u> tents)	-0-	250
- Maintenance	-0-	45
- Miscellaneous	-0-	90
	-----	-----
Local AID Costs	-0-	1300
<u>MPF/IPPF 1/</u>		
- IPPF Grant	(400)	(2000)
- GOM Grant	(8)	(40)
- Service revenues 2/	(35)	(175)
	-----	-----
<u>MPF/IPPF Total</u>	(443)	(2215)
<u>Total AID + AMPF/IPPF</u>	-0-	<u>1300</u>

Non-additive: Costs are reflected under inputs for Output No. 5, IE+C.

To be revised when subproject becomes operational. Sales of contraceptive and related health products will produce AMPF revenues which will be reflected as an AMPF contribution to the project

Table 9

Project Inputs for Output No. 8(Natural Family Planning)  
(S000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
<u>Commodities</u>		
- A.V. equipment and supplies	6	6
- IE+C materials	2	2
- Reference materials	2	2
- Instructional aids	2	2
<u>Other Costs</u>		
- Salaries (240 p/m)	45	75
- Training	6	10
- NFP Seminar		8
- Operations and maintenance	3	7
- Outreach services	4	8
AID Total	70	120
<u>L'Heure Joyeuse</u>		
- Revenues (clinic, daycare center, canteen)	7	20
- Donations from sponsors	3	10
- GOM subsidy	2.5	7.5
L'Heure Joyeuse Total	12.5	37.5
<u>AID and l'Heure Joyeuse Total</u>	82.5	157.5

Table 10

Project Inputs for Output No. 9

(Non-MOPH Family Planning Activities)  
(\$000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
<u>Commodities</u>		
- Medical supplies	-0-	25
- Promotional, IE+C materials	-0-	75
<u>Training/travel grants</u>	-0-	100
<u>Other Costs</u>		
- Program Operations	-0-	100
	<hr/>	<hr/>
AID Cost	-0-	300
 <u>GOM</u>		
Personnel, facilities, transport	-0-	50*
	<hr/>	<hr/>
<u>Total AID + GOM</u>	-0-	<u>350</u>

\* Rough estimate, depending upon type and extent of programs to be developed.

Table 11

Project Inputs for Output No. 10  
(Operations Research/Data Analysis)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
<u>Technical Assistance</u>		
- Short-term consultants (OR design/analysis; CPS planning and analysis; TA in FP served statistics, etc.) 30 p/m	50	300
<u>Commodities</u>		
- Printing supplies (research reports, questionnaires, etc.)	10	25
- Data processing materials	5	25
<u>Other Costs</u>		
- Fieldwork (enumerators, gas + oil, supervisors)	20	150
- Seminars, workshops	5	15
- Training (enumerators)	5	30
- Travel grants (conferences; analysis/report preparation)	5	30
	<hr/>	<hr/>
AID Total	100	575

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GOM\*

- Administration	-0-	140
- Field operations	-0-	50
- Data processing	-0-	16
- Data analysis	-0-	6
- Logistical support	-0-	5
- Seminars	-0-	2

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FOM Total -0- 219

AID and GOM Total 100 794

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Minimum contribution. Based on GOM support provided for Contraceptive Prevalence Survey (CPS) of 1983-84. Estimate represents GOM costs of two additional CPS's; GOM costs for other elements of the OR/Data Analysis activity are not included.

Table 12

Project Inputs for Output No. 11  
(Population Policy Development)  
(\$000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-88</u>
<u>Technical Assistance</u>		
- Supplements to AID/W grants/ contracts for ST technical assistance (IPDP; RAPID II, etc.) 10 p/m	50	150
<u>Training and Travel Grants</u>		
- Training (population modelling, econometrics, development planning, micro-computer applications) 7 p/m	5	35
- Conferences, seminars	-0-	15
	<hr/>	<hr/>
<u>AID Total</u>	55	200
 <u>GOM</u>		
- Personnel	26	79*
<u>GOM Total</u>	26	79
<u>AID + GOM Total</u>	<u>81</u>	<u>279</u>

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\* Estimated on the expectation that GOM personnel time will match ST technical assistance time on an at least 1:1 ratio (150 p/m of technical assistance x \$500/month GOM salary for one counterpart) plus GOM personnel costs for 7 p/m of training (7 p/m x \$500/month salary).

Table 13Project Inputs for Output No. 12:(Professional Skills Development - Participant Training)  
(\$000)

<u>AID</u>	<u>FY 1984</u>	<u>FY 84-83</u>
- Training Grants Short-term, various fields) 50 p/m	50	150
- Invitational travel (conferences, seminars, professional meetings) 20 p/m	20	50
- Long term training, U.S. 48 p/m	-	100
- In-country training (in-service FP/health training; special programs for pharmacists, TBAs, private physicians, etc.	50	250
	<hr/>	<hr/>
Total AID Costs	120	550
 <u>GOM</u>		
- Personnel	8	59 <sup>1/</sup>
- Travel	3	15 <sup>2/</sup>
	<hr/>	<hr/>
Total GOM	11	74
<u>AID + GOM Total</u>	<u>131</u>	<u>624</u>

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1/ GOM salary costs during 118 p/m of training and travel at \$500/month.

2/ Estimated cost of 15 roundtrip air tickets to the U.S.

Table 14

Other Costs - Evaluation, Audit, ST  
Consultants, Contingencies/Inflation

<u>AID</u>	<u>FY 1984</u>	<u>FY84-88</u>
Evaluation	20	60
Audit	-	20
Consultants	-	75
Contingencies/Inflation*	175	1214
<u>TOTAL</u>	<u>195</u>	<u>1369</u>

\* Calculated per price escalation guidelines contained in State 101216 dated April 6, 1984. Estimated annual price increases are:  
1984 : 3.5%  
1985 : 8%  
1986-88 : 9%

Table 15

USAID Assistance by Output and Funding Category, FY 1984-88  
(U.S. Dollar and Local Currency)

<u>Output</u>	<u>Technical Assistance</u>	<u>Commodities</u>	<u>Training<sup>1/</sup></u>	<u>Other Costs</u>	<u>\$</u>	<u>Local Currency</u>	<u>Total</u>
1. VDHS	80	175	220	2725	100	3100	3200
2. Urban Services	40	100	150	710	50	950	1000
3. NTCRII	35	50	100	65	75	175	250
4. VS/Reproductive Health	1320	(600) <sup>2/</sup>	-	-	620	700	1320
5. IE+C	60	330	55	305	350	400	750
6. FP Services	-	6955 <sup>3/</sup>	-	-	6955 <sup>3/</sup>	-	6955 <sup>3/</sup>
7. Private Sector Sales	250	170	35	845	270	1030	1300
8. NFP	-	12	10	98	10	110	120
9. Other-Industry FP	-	100	100	100	25	275	300
10. Operations Research/ Data Analyses	300	50	60	165	325	250	575
11. Population Policy Development	150	-	50	-	150	50	200
12. Training	-	-	550	-	300	250	550
13. Evaluation, Audit Contingencies/ Inflation	200	-	-	1170	800	570	1370
<u>TOTAL</u>	<u>2435</u>	<u>7942</u>	<u>1330</u>	<u>6183</u>	<u>10,030</u>	<u>7860</u>	<u>17,890</u>

1/0

1. With the exception of the \$550,000 shown for output No. 12, these costs are for U.S./3rd country and in-country training directly supportive of the various subprojects. Training funds under Output No. 12 are for general, system-wide training costs in such areas as program management and evaluation, research methodology, data processing; in-service training, etc.
2. Not-additive. Commodity procurement for Output No. 4 will be effected by AVS under their (USAID-supplementary) cooperative agreement with AID/W.
3. Includes 5,955,000 for centrally-procured contraceptives.

Table 16

Summary Table:

GOM Contribution, FY 1984-88

(\$000)

<u>Activity</u>	<u>FY 1984</u>	<u>FY 84-88 (LOF)</u>
1. VDMS	2,236	13,018
2. Urban Services	17	4,420
3. NTCRH	1/	1/
4. VS/Reproductive Health	515	3,225
5. IE+C	638 2/	3,190 2/
6. FP Services	1,995	9,975
7. Private Sector Sales	3/	3/
8. Natural Family Planning	13 4/	38 4/
9. Other-Ministry FP Activities	-0-	50
10. Operations Research/Data Analysis	-0-	219
11. Population Policy Development	26	79
12. Training	11	74
<u>Total</u>	<u>5,451</u>	<u>34,288</u>

1/ NTCRH costs are included under item 4 (VS/Reproductive Health) as the NTCRH is the GOM agency responsible for implementation of the latter project.

2/ Includes contributions from AMPF, IPPF/London, and GOM

3/ AMPF and IPPF/London contribution. Shown under item 5.

4/ L'Heure Joyeuse contribution.

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Table 17

Summary Table: USAID Assistance by Category,  
FY 1984 thru FY 1988

<u>Funding Category</u>	<u>Total</u>
Technical Assistance	2,435 <sup>1/</sup>
Commodities	7,942 <sup>2/</sup>
Training/Invitational Travel (U.S. and in-country)	1,330
Other Costs	4,813 <sup>3/</sup>
Evaluation, Audit, Contingencies/Inflation	1,370
<hr/>	
<u>Total</u>	<u>17,890</u>

- 1/ Major items include a supplemental grant to AVS (\$1,320,000) for the VS/Reproductive Health subproject; a resident contractor for 24 person-months to assist in the contraceptive sales activity (\$250,000); short-term TA in population policy development (\$150,000); and ST/TA in operations research, CPS's and data collection/analyses (\$300,000).
- 2/ Includes \$6 million for contraceptives; \$500,000 for clinic equipment and supplies; \$500,000 for IE+C equipment and materials; \$200,000 for data processing equipment and supplies; and \$740,000 for miscellaneous requirements of the various subprojects.
- 3/ Includes in-country operating costs of the various sub-projects exclusive of in-country training costs of the various activities. These latter costs are included under "Training/Invitational Travel," along with the cost of training not linked to any specific subproject.

Table 18

Summary of Proposed AID Obligations, FY 1984-88  
(S000)

<u>Inputs for</u>	<u>Description</u>	<u>FY 1984</u>	<u>FY 85</u>	<u>FY 86</u>	<u>FY 87</u>	<u>FY88</u>	<u>Total</u>
Output - 1	VDMS	1500	700	500	400	100	3200
Output - 2	Urban Services	350	250	200	100	100	1000
Output - 3	NICRH	100	50	50	30	20	250
Output - 4	VS/Reproductive Health	500	400	300	100	20	1320
Output - 5	IE+C Activities	200	150	150	150	100	750
Output - 6	Improved Services						
	- Contraceptives*(1655)	(1000)	(1000)	(1100)	(1200)	(1200)	(5955)
	- Other Commodities	125	350	300	125	100	1000
Output - 7	Pvt-Sector Sales	-0-	600	420	200	80	1300
Output - 3	Natural Family Planning	70	30	20	-	-	120
Output - 9	Other-Ministry FP Programs	-0-	50	100	100	50	300
Output -10	Ops. Rsch/Data Collection and Analysis	100	150	200	100	25	575
Output -11	Pop Policy Development	55	50	50	30	15	200
Output -12	Training	120	200	150	50	30	550
Other Costs	Evaluation, Audit ST consultants, contingencies	195	350	350	250	225	1370
<u>Total (incl. contraceptives</u>		<u>(4970)</u>	<u>(4330)</u>	<u>(3790)</u>	<u>(2735)</u>	<u>(2065)</u>	<u>(17,390)</u>
<u>Actual obligations (excluding contraceptives)</u>		<u>3315</u>	<u>3330</u>	<u>2790</u>	<u>1635</u>	<u>865</u>	<u>11,935</u>

\* To be purchased by AID/W with funds transferred from USAID OYB to S+T Bureau. These costs are included in USAID obligations under bilateral Project Agreements.

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III. IMPLEMENTATION PLAN

As this is largely a continuing project, many of its major elements (Output nos. 1, 3, 5, 6, 10, 11, 12) will continue to be implemented in accordance with past experience. There are, however, elements (particularly Output No. 7 -- Private Sector Distribution/Sales) for which no implementation experience has thus far been accumulated. Other new project elements will closely follow the experience of existing project (e.g., Output No. 2, "Urban Services" is patterned after the VDMS project), or benefit from the experience of similar efforts in other countries (e.g., Output No. 4, "VS/Reproductive Health Services").

Implementation of the overall project will begin with the signing of an "umbrella" Project Agreement in June, 1984. The ProAg will describe the purpose of the project, its major inputs and planned outputs. An initial obligation of \$3,170,000 will be made at this time plus an in-kind contribution of contraceptives valued at \$1,800,000. Implementing documents (PIO's, in country grants) will be prepared shortly thereafter. The major implementation actions further to each of the 12 Outputs are shown in the following pages.

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Major Implementation Actions forOutput No. 1 - VDMS/Expansion

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	ProAG signed	June, 1984
2.	MOPH firmly identifies five (5) additional VDMS provinces	December, 1984
3.	MOPH establishes budget for continuation of VDMS in Beni Mellal, Meknes and El Jadida beginning January, 1986	March, 1985
4.	Project evaluation	March, 1985
5.	Pre-launch assessment in the 5 new VDMS provinces	June, 1985
6.	PIL/initial release of funds for project activities in 5 new provinces	September, 1985
7.	Supervisor/Trainer training for personnel from 5 new provinces	November, 1985
8.	Fieldworker training in 5 new provinces	January-February, 1986
9.	MOPH begins funding for VDMS in Beni Mellal, Meknes and El Jadida	January, 1986
10.	Initiation of fieldwork in 5 new provinces	March, 1986
11.	Evaluation	March, 1986
12.	MOPH establishes budget for continuation of VDMS activities in 10 provinces	July, 1986

13. PIL for continuing VDMS assistance to 5 provinces October, 1986
14. MOPH begins funding VDMS in 10 provinces January, 1987
15. Project evaluation March, 1987
16. MOPH establishes budget for VDMS in 5 provinces July, 1987
17. Release of funds for 5 provinces thru December, 1987 October, 1987
18. MOPH assumes funding responsibility for the 5 provinces January, 1988

Major Implementation Actions for  
Output No. 2 - FP/MCH Services in Urban Areas

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	Preliminary planning with MORH	February - May, 1984
2.	ProAG signed	June, 1984
3.	Project workplan finalized	November, 1984
4.	Feasibility assessments in project areas completed	February, 1985
5.	Evaluation	March, 1985
6.	Funds released for initial activities in Casablanca	June, 1985
7.	Supervisor/trainer training in Casablanca	September - October, 1985
8.	Fieldworker training	November, 1985
9.	Initiation of fieldwork in Casablanca	January, 1986
10.	Evaluation	March, 1986
11.	Supervisor/trainer training for additional Casablanca prefectures	June, 1986
12.	Fieldworker training	July, 1986
13.	Initiation of fieldwork in additional prefectures	September, 1986
14.	Pre-Project planning in Rabat-Salé and Tangier	October - November, 1986
15.	Supervisor/trainer training in Rabat-Salé and Tangier	December, 1986
16.	Fieldworker training in Rabat-Salé and Tangier	January, 1987
17.	Initiation of fieldwork in Rabat-Salé and Tangier	February, 1987

18. Evaluation March, 1987
19. Final-year assistance plan completed by USAID and MOPH June, 1987
20. MOPH identifies budget resources to support program activities beginning January, 1987 July, 1987
21. Evaluation March, 1988
22. Final disbursement for project activities September, 1988

Major Implementation Actions for  
Output No. 3 - National Training Center for  
Reproductive Health

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	JHPIEGO and AVS agreements executed with NTCRH	March - May, 1984
2.	ProAg signed	June, 1984
3.	NTCRH annual workplan prepared/USAID assistance requirements established	August, 1984 September, 1984
4.	Equipment ordered; consultants requested	November, 1984
5.	Evaluation	March, 1985
6.	JHPIEGO and AVS agreements renewed	June, 1985
7.	USAID assistance requirements established; consultants scheduled	June - August, 1985
8.	Evaluation	March, 1986
9.	JHPIEGO/AVS agreements signed	June, 1986
10.	USAID assistance requirements established	September, 1986
11.	Equipment ordered/consultants scheduled	November, 1986
12.	Evaluation	March, 1987
13.	JHPIEGO/AVS agreements renewed	June, 1987
14.	Final-year assistance plan prepared	August, 1987
15.	Consultants/equipment ordered	October, 1987
16.	Evaluation	March, 1988

Major Implementation Actions for  
Output No. 4 - Voluntary Sterilization/Reproductive  
Health Services

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	Pre-project planning with AVS, MOPH	January - May, 1984
2.	ProAg signed	June, 1984
3.	PIO/T executed for AVS services	July, 1984
4.	AVS grant agreement amended	August, 1984
5.	Site visits to first five provincial hospitals	September, 1984
6.	NTCRH establishes project management unit	September, 1984
7.	Equipment ordered	September, 1984
8.	Equipment arrives	December, 1984
9.	Services begin in 5 hospitals	January, 1985
10.	AVS site visit	January, 1985
11.	Evaluation	March, 1985
12.	PIO/T executed	June, 1985
13.	AVS grant amended	July, 1985
14.	Equipment ordered for 10 hospitals	July, 1985
15.	Equipment arrives	October, 1985
16.	Services begin in 10 hospitals	November, 1985
17.	AVS site visit	November, 1985
18.	Evaluation	March, 1986
19.	PIO/T for AVS services	April, 1986
20.	AVS grant amended	May, 1986

21. Equipment ordered for 15 hospitals May, 1986
22. Equipment arrives July, 1986
23. Services begin in 15 hospitals August, 1986
24. AVS site visit August, 1986
25. Evaluation March, 1987
26. AVS support for initial five hospitals ends December, 1987
27. Evaluation March, 1988
28. AVS support for 10 hospitals ends October, 1988
29. AVS support for 15 hospitals ends July, 1989

Major Implementation Actions for

Output No. 5 - IE+C Program

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	Development of annual IE+C workplans with AMPF and MOPH	May, 1984
2.	ProAg signed	June, 1984
3.	Short-term consultants scheduled	September, 1984
4.	Equipment ordered	November, 1984
5.	Evaluation	March, 1985
6.	Development of annual IE+C workplans with AMPF and MOPH	May, 1985
7.	Equipment arrives	June, 1985
8.	Short-term consultants scheduled	September, 1985
9.	Equipment ordered	November, 1985
10.	Evaluation	March, 1986
11.	Equipment arrives	April, 1986
12.	Development of annual IE+C workplan with AMPF and MOPH	June, 1986
13.	Short-term consultants scheduled	September, 1986
14.	Evaluation	March, 1987
15.	Development of annual workplan with AMPF and MOPH	June, 1987
16.	Short-term consultants scheduled	September, 1987
17.	Final Evaluation	March, 1988

Major Implementation Actions for Output

No. 6 - Improved Services (Commodities)

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	Annual needs assessed (ABS)	April, 1984
2.	ProAg signed	June, 1984
3.	PIO/C's prepared	July - August, 1984
4.	Evaluation	March, 1985
5.	ABS	April, 1985
6.	PIO/C's prepared	June - July, 1985
7.	Evaluation	March, 1986
8.	ABS	April, 1986
9.	PIO/C's prepared	May - June, 1986
10.	Evaluation	March, 1987
11.	ABS	April, 1987
12.	PIO/C's prepared	May - June, 1987
13.	Evaluation	March, 1988
14.	ABS	April, 1988
15.	PIO/C's prepared	June - July, 1988

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Major Implementation Actions for  
Output No. 7 - Private Sector Distribution/Sales Program (AMPF)

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	Initial AMPF proposal submitted	January, 1984
2.	Proposal revised	February - April, 1984
3.	AMPF study tour: other commercial/ sales programs	May, 1984
4.	Feasibility study	November - December, 1984
5.	Implementation decision	January, 1985
6.	USAID-AMPF Grant Agreement signed	March, 1985
7.	Contract technician recruited	March - April, 1985
8.	Technican arrives	August, 1985
9.	Project workplan completed	December, 1985
10.	USAID-AMPF grant agreement revised	January, 1986
11.	Pilot activities launched	March, 1986
12.	Special assessment of pilot activities	July, 1986
13.	Implementation desision	August, 1986
14.	USAID-AMPF agreement revised	September, 1986
15.	Project expansion, as feasible	October - December, 1986
16.	Evaluation	March, 1987
17.	Implementation decision: project expansion/contractor assistance	April, 1987
18.	Contractor services end	August, 1987
19.	USAID-AMPF agreement revised	September, 1987
20.	Evaluation	March, 1988

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Major Implementation Actions for OutputNo. 8 - Natural Family Planning

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	Execute USAID - L'Heure Joyeuse grant agreement	July, 1984
2.	Eight persons trained as NFP trainers	December, 1984
3.	Clinic training of acceptors and outreach visits begin	January, 1985
4.	Evaluation	March, 1985
5.	Supplemental training completed for four "master trainers"	May, 1985
6.	USAID - L'Heure Joyeuse grant agreement amended	December, 1985
7.	Evaluation	March, 1986
8.	Instructional materials revised on basis of clinic/outreach experience	April, 1986
9.	National Seminar on NFP	October, 1986
10.	Determination of other-agency interest in NFP	January, 1987
11.	L'Heure Joyeuse technical assistance to install NFP in other agencies' programs (possible follow-on activity)	March, 1987

Major Implementation Actions for  
Output No. 9 - Other Ministry FP Activities

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	Exploratory meetings with various ministries and AMPF	September, 1984 January, 1985
2.	Short-term consultant training and equipment needs identified for initial activities	February, 1985
3.	Determination of assistance mechanism (e.g., augmented AMPF grant or direct support to other ministries)	March, 1985
4.	Evaluation	March, 1985
5.	Equipment ordered	June, 1985
6.	Equipment arrives	October, 1985
7.	Consultant visits/ST training completed	February, 1986
8.	Initial activities reviewed/Evaluation	March, 1986
9.	Determination of assistance requirements for expanded activities	June, 1986
10.	Short term consultants scheduled; equipment ordered	July, 1986
11.	Expanded activities launched	November, 1986
12.	Evaluation	March, 1987
13.	Consultant, training and equipment requirements established	April, 1987
14.	Consultants, training scheduled/ equipment ordered	July, 1987
15.	Evaluation	March, 1988

Major Implementation Actions for  
Output No. 10 - Operations Research/Data Analysis

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	ProAG signed	June, 1984
2.	National Fertility Survey (WFS) seminar	July, 1984
3.	1984 Contraceptive Prevalence Survey (CPS) report issued	September, 1984
4.	OR workplan and schedule prepared	December, 1984
5.	Short-term consultant assistance scheduled	January, 1985
6.	Evaluation	March, 1985
7.	PIO/T executed for 1986 CPS	June, 1985
8.	Fieldwork for initial OR study completed	July, 1985
9.	OR Report issued	November, 1985
10.	1986 CPS Questionnaire/sample finalized	December, 1985
11.	CPS field interviewers trained	January, 1986
12.	CPS fieldwork completed	February, 1986
13.	Evaluation	March, 1986
14.	Short-term consultants scheduled	June, 1986
15.	OR fieldwork completed, 2nd study	December, 1986
16.	Evaluation	March, 1987
17.	OR Report issued, 2nd study	April, 1987
18.	PIO/T for 1988 CPS	July, 1987

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- 19 Changes introduced in FP/MCH service statistics system September, 1987
20. Questionnaire/sample completed for 1988 CPS November, 1987
21. CPS fieldworkers trained December, 1987
22. CPS fieldwork completed February, 1988
23. Evaluation March, 1988
24. Revisions completed in FP/MCH service statistics system April, 1988
25. OR workplan prepared/ST consultants scheduled May, 1988
26. OR fieldwork completed 3rd study July, 1988
27. OR report issued, 3rd study September, 1988

Major Implementation Actions for  
Output No. 11 - Population Policy Development

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	Preliminary planning with Ministry of Plan and Office of the Prime Minister	May - June, 1984
2.	Assistance plan prepared for initial activities	June, 1984
3.	ProAg signed	June, 1984
4.	PIO/T executed for consultant and ST training support	September, 1984
5.	Initial activities begin	November, 1984
6.	Evaluation	March, 1985
7.	PIO/T executed for consultant/training assistance	August, 1985
8.	Evaluation	March, 1986
9.	Assistance plan revised	June, 1986
10.	PIO/T executed	July, 1986
11.	Evaluation	March, 1987
12.	ProAg	April, 1987
13.	Assistance plan prepared	May - June, 1987
14.	PIO/T executed	July, 1987
15.	Evaluation	March, 1988
16.	Assistance plan prepared for end-of-project activities	April, 1988
16.	PIO/T revised for residual/terminal activities	May, 1988

Major Implementation Actions for

Output No. 12 - Training

<u>Action No.</u>	<u>Description</u>	<u>Target Date</u>
1.	General agreement with GOM	May, 1984
2.	ProAg signed	June, 1984
3.	Annual training plan prepared for in-country training	August, 1984
4.	Schedule prepared for short-term consultants for in-country training activities	March, 1985
5.	Evaluation	March, 1985
6.	Annual training plan prepared	August, 1985
7.	Schedule prepared for short-term consultants	October, 1985
8.	Evaluation	March, 1986
9.	Annual training plan prepared	August, 1986
10.	Short-term consultants scheduled	October, 1986
11.	Evaluation	March, 1987
12.	Annual training plan prepared	August, 1987
13.	Short-term consultants scheduled	October, 1987
14.	Evaluation	February, 1988

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IV. MONITORING PLAN

All project activities, including those funded by AID/W grantees-contractors, will be monitored by USDH staff of USAID/Morocco. Direct monitoring will be the responsibility of the Project Managers in the USAID Population, Health and Social Services (PHSS) Division. These individuals will be supported by the USAID Controller, Regional Contract Officer, Regional Legal Advisor, and Program Officer in matters pertinent to these latter officers' areas of responsibility.

USAID Project Managers will participate in all project evaluations, and will ensure that evaluation findings and recommendations are reflected in revisions, as appropriate, in project design or execution.

Initial releases of funds to each of the subprojects will be made only upon receipt of detailed budget estimates. Subsequent releases will be made upon receipt of adequate justification for additional funds and evidence of expenditure of prior releases.

Progress/performance reports will be required semi-annually from recipients by the Project Managers, and retained for reference during routine and intensive project evaluation.

V. SUMMARIES OF ANALYSES

A. Social/Beneficiary Analysis

Societal benefits of reduced fertility include higher per capita income, greater public access to educational, health food and recreational resources; reduced strain on public infrastructure such as transportation, water, sewerage and housing; and a lower likelihood of social/political unrest.

At the level of individual well-being, the advantages of decreased fertility include lower maternal morbidity and mortality; lower infant mortality; and a reduced incidence of illicit abortion.

Family planning also offers to women the means to take control of their own fertility and to thereby alter the traditional patterns of childbearing which have kept them from fuller participation in the social and economic development process.

Finally, family planning offers to individual couples the means to realize their basic human right to determine their own fertility.

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These societal and individual benefits are of particular significance in Morocco: a rapidly-growing population (doubling time: 27 years) is absorbing the bulk of the country's economic gains and investment in new social infrastructure; infant mortality is very high (110 per thousand), notwithstanding the country's "middle-income" status; women's participation in social and economic life is increasing, but still lags far behind their male counterparts; and the "unmet need" for FP services is substantial: according to the 1982 CPS, approximately 50% of current non-users of a contraceptive method would accept FP if a method were offered to them. (Potential number of immediate acceptors: 1,200,000 persons). This augmented practice of FP would translate into substantial reductions in infant mortality (WHO has estimated that the widespread adoption of FP could reduce infant mortality in most developing countries by 25%). These improvements in child survival and health status would be further reinforced by the Morocco program's practice of linking FP with other MCH services such as ORT, expanded immunization, and child growth monitoring/promotion of breastfeeding.

B. Administrative Analysis

1. AID: The Population, Health and Social Services (PHSS) Division of USAID Mission will continue to exercise primary responsibility for the management and oversight of the project. The three USDH staff in this division will be augmented by a resident contractor who will assist in the management of the private sector (AMPF) contraceptive sales activity.

A number of AID grantee/contractor organizations will also participate in the project. Major intermediaries will include the Association for Voluntary Sterilization (AVS), which will assist in the implementation of the Voluntary Sterilization/Reproductive Health sub-project; Johns Hopkins/PIEGO, which will continue to support the National Training Center for Reproductive Health; and Westinghouse (or its successor), which will assist in the execution of two Contraceptive Prevalence Surveys. Other supporting organizations or AID/W-funded programs will include Johns Hopkins-PIP; CDC/Atlanta; INTRAH, PRICOR, IPDP and RAPID-II, each of which will assist in pertinent aspects of IE+C development; program logistics and evaluation; training, operations research; and population policy development.

2. GOM: The Ministry of Public Health will continue to be the primary recipient of U.S. assistance under this project. The management and administrative capacity of the MOPH to conduct a nationwide FP/MCH program has been tested under the predecessor project 608-0155, and found to be adequate. The ongoing Health Management Improvement Project (608-0151) is further strengthening MOPH administrative sub-systems which support the FP program. Most USAID financial assistance for the MOPH will continue to be channeled through the Ministry of Finance; but occasional support will be provided directly (e.g., to the National Training Center for Reproductive Health), and via direct USAID payment for goods and services delivered by local vendors to the MOPH. At the province level primary responsibility for execution of the program will rest with the provincial medecin chef, and under his direction, the medecin chef of SIAAP -- the MOPH ambulatory and primary health care system.

Other GOM ministries participating in the project will include the Ministry of Plan and Professional Training -- USAID's primary institutional counterpart for expanded activities toward development of a broader population policy framework for Morocco -- and the Ministries of Handicrafts and Social Affairs, Agriculture, and Youth and Sports.

Personnel from the latter group of ministries were trained under project 608-0155 as FP motivation agents; this new project will encourage the assumption by these ministries of a more active, i.e., service-delivery role in a larger population program. If that transition is possible, USAID will execute a separate, "umbrella" Project Agreement with the Ministry of Finance on behalf of the different participating ministries. In the interim, USAID will continue support for FP training activities for other-ministry personnel via USAID assistance for AMPF.

3. Private Sector: AMPF will undertake two broad activities under the project: a) a continuation of its on-going IE+C and other-ministry FP training programs; and b) a contraceptive sales project in villages, urban areas and rural souks. USAID support for the IE+C activity will continue under the same arrangement established under project 608-0155: assistance resources will be channeled directly to AMPF, although the organization's IE+C/training program will be included under USAID's Project Agreement with the MOPH.

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AMPF's contraceptive sales project will be administered under a separate agreement (most likely: Field Support Grant or OPG) between USAID and AMPF. The specific terms of this agreement will be determined following a pre-project feasibility study of the sales project to be conducted in early FY 1985. That study will also examine in more detail the capacity of AMPF to assume the added technical and administrative burden of this subproject.

L'Heure Joyeuse, a Moroccan PVO affiliated with the International Federation for Family Life Promotion (IFFLP), will conduct a NFP program in Casablanca with assistance provided by a Field Support Grant agreement with USAID.

Both AMPF and L'Heure Joyeuse have satisfied all of the AID certification requirements establishing their eligibility to receive USG assistance.

4. Other Donors: The only other major donor to the Moroccan population program is the United Nations Fund for Population Activities (UNFPA).

UNFPA is currently administering a 1981-86 assistance program having a value of approximately \$5 million. USAID-UNFPA coordination is close and frequent.

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including joint programming of funds in complementary areas of activity, and routine sharing of project reports and evaluations, USAID staff worked closely with the UNFPA Needs Assessment Team (1980) which laid the groundwork for the existing UNFPA program; and expects to similarly cooperate with the next Team visit in late 1985 or early 1986.

C. Technical Feasibility Analysis

The key objective indicators that this project has attained its purpose will be: 1) the regular availability of FP/MCH information and services for 70% of the Moroccan population; 2) contraceptive prevalence of at least 35% of MWRA; and 3) the incorporation of population analyses, planning and forecasting into the GOM development planning process.

Population coverage of the project was estimated by the December, 1983 evaluation to include about 40% of the population (i.e., 8.8 million people in 13 VDMS provinces. Other, non-outreach, elements of the project was not factored in to this estimation). The new project will build upon this base by adding 1) five new VDMS provinces (population: 3,500,000); 2) FP/MCH services in Morocco's larger cities (population: 4,000,000); and a private sector contraceptive sales program which will initially reach about 700,000

persons. (Again, non-outreach elements of the program, such as VS and other clinical services, are not included). These new activities will add approximately 8,200,000 to the "reach" of the existing program, for an end-of-project coverage of over 17 million persons, or about 70% of the total population in 1988.

The national contraceptive prevalence which would be produced by the foregoing (70%) coverage projection can be estimated on the basis of current prevalence in project and non-project areas of the country. This analysis (See Annex VIII.) suggest that national contraceptive prevalence in 1988 would be as high as 39% of MWA. indicating that the 35% target established for the project is relatively conservative.

Incorporating population considerations into the GOM's development planning process will be a multi-track effort. At the project/institutional level, USAID will build upon current relationships with the Ministry of Plan (IPDP project, RAPID, the Statistical Services Project) to develop a broader "population" perspective in that Ministry's planning activities, with particular attention to preparation of the next Five Year Plan (1986-1990). The Ministry's

considerable technical depth and high-calibre leadership will facilitate the attainment of this objective to bring the "population factor" to the attention of Morocco's senior leadership, and to opinion-shapers in the private sector.

On a broader level, USAID negotiations with Moroccan counterparts on other bilateral matters--including PL-480 resources, food production, housing guarantees, and energy production--will underscore the intimate linkages between these development concerns and population growth. These linkages will be reviewed with GOM leadership at the highest levels to promote a heightened appreciation of the need for a comprehensive approach to population issues.

D. Economic Analysis:

The Economic Analysis attached as Annex IX demonstrates the high return to investments in family planning services which maintain and then increase the rate of contraceptive prevalence. First, a simulation produced using the RAPID model for Morocco shows that the benefits of reducing the birth rate are many orders of magnitude greater than the costs of providing the necessary services. Second, a benefit-cost analysis using Moroccan data on consumption and productivity, and making extremely conservative estimates about the effectiveness of the family planning services, shows that benefits exceed the costs in all cases, in spite of the very modest assumptions about benefits.

The Economic Analysis also discusses the question of program size. It concludes that program expansion represents a good use of resources, and suggests that the case for even greater coverage might eventually be analyzed drawing upon the post-census sample survey data soon to be released, and the National Contraceptive Prevalence Survey. Administrative and other constraints to expansion of the program should be examined following analysis of the data with the idea of providing coverage everywhere it is economically rational to do so.

E. Financial Analysis:

The GOM Five-Year Plan, 1981-85, included for the first time a specific budget for family planning activities. (Total: Approximately \$17.6 million at the 1981 exchange rate, or about 2% of the MOPH budget for 1981-85). USAID and the MOPH analysis of anticipated GOM support over the life of this project indicate that the GOM will provide the equivalent of approximately \$34 million in program support during 1984-88.

The major components of recurrent costs post-project will include contraceptive supplies (\$1.5 - 2 million/year); supplies, material, replacement of durable equipment and FP program operating costs (\$2 million/year); and personnel costs of the FP delivery system.

The recurrent cost of contraceptive supplies will be very modest or absent, however, given the likely continuing availability of these products from external donors. Other commodities, equipment and operating costs represent only 1.7% of the total MOPH budget; and in view of the GOM's strong commitment to the FP program, USAID does not anticipate significant GOM difficulties in meeting these costs. Under-utilized GOM personnel engaged in the FP program were largely in place before the program was organized, and are not likely to be reduced upon conclusion of project assistance.

The GOM Ministries of Finance and Public Health have demonstrated their competence under the predecessor project 155 to receive, disburse and adequately account for AID funds.

The USAID Controller will undertake an assessment of the current GOM accounting system and will certify the adequacy of that system prior to the initial disbursement of funds under the project. Methods of implementation and financing proposed for procurement of goods and services will allow USAID/Morocco to exercise adequate surveillance over the disposition of project-funded resources. These procurement methods are set forth on pages 9 and 10, Annex X (Financial Analysis). All methods of financing have primary been approved in the general "Mission Financing Policy and Procedures."

VI. CONDITIONS, COVENANTS AND NEGOTIATING STATUS

Conditions

No disbursements shall be made to the GOM under this project until AID has assessed the adequacy of the accounting and management system(s) of the GOM implementing agencies, and determined that this system(s) is able to effectively account for the disposition of AID funds made available under this project to the implementing agency and help prevent misuse, waste and fraud of U.S. Government provided funds..

Covenants

Further to AID Policy Determination No. 3 dated September, 1982, informed consent shall be obtained and documented for all requestors of sterilization services; other, temporary family planning methods shall be available at sterilization service facilities; and neither abortion nor abortion-related activities will be conducted at facilities receiving AID assistance.

Negotiating Status

The elements of this project have been discussed at senior-levels of the Ministry of Public Health, the Ministry of Plan, the Moroccan Family Planning Association, UNFPA and UNICEF. All parties have indicated approval in principle.

Following approval of this PP, USAID will proceed to conclude a formal agreement (ProAg) with the Government of Morocco -- represented by the Ministry of Finance -- outlining the project purpose, and describing the major activities of the project. It

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VII. EVALUATION ARRANGEMENTS

Several evaluative procedures have been built into this project. These procedures are both specific to the twelve separate outputs (subprojects) and general, to evaluate overall progress toward the project purpose.

The status of the individual subprojects will be formally assessed on an annual basis by the USAID project officer and the Mission Evaluation Officer, with the first such evaluation scheduled for March 1985. Two of the subsequent assessments — in March, 1986 and March, 1988 — will be special in-depth evaluations and will include participants from AID/W and possibly other organizations. This project includes up to \$80,000 in project funds to cover the costs of these intensive evaluations.

The annual evaluations will examine the implementation plans for each of the various activities to determine if they are on schedule, or if not, to identify special problems impeding execution of the sub-project and to determine if any implementation plan(s) needs to be modified.

The two intensive evaluations will undertake these same tasks, with additional emphasis on program and environmental 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-political-economic setting underlying the project will be examined to determine if they are still valid. Significant baseline statistics and other reliable data will be examined to determine the degree of progress toward attainment of the project purpose.

The primary sources for baseline statistics and indicators of change over LOP include the Morocco National Fertility Survey (NFS) of 1980; the 1982 and 1984 Contraceptive Prevalence Surveys; and two additional CPS's to be conducted in 1986 and 1988. The Ministry of Plan has tentatively scheduled a Demographic Survey for 1986 which may also provide a data-source for project evaluation.

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SUBJECT: POPULATION AND FAMILY PLANNING SUPPORT PHASE  
III (602-4171) NEAC REVIEW OF THE CONCEPT PAPER

1. THE NEAC MET ON SEPTEMBER 1, TO DISCUSS THE CONCEPT PAPER. USAID IS COMPLIMENTED FOR SUBMISSION OF A WELL-WRITTEN AND WELL-PREPARED DOCUMENT, MORE COMPREHENSIVE THAN EXPECTED FOR THIS STAGE OF PROJECT DEVELOPMENT. MAJOR RECOMMENDATIONS OF THE NEAC INCLUDE THE FOLLOWING:

(A) TIMING FOR PROJECT PAPER DEVELOPMENT IS NOT INCLUDED IN CONCEPT PAPER. THERE WAS GENERAL AGREEMENT THAT IMPLEMENTATION OF CONTINUING PROJECT ACTIVITIES SHOULD NOT BE IMPEDED BY TIME INVOLVED IN EVALUATION OF CURRENT PROJECT, NEAC REVIEW OF EVALUATION, AND INCORPORATION OF EVALUATION RECOMMENDATIONS INTO NEW PROJECT PAPER. AFTER REVIEWING TIME REQUIRED FOR ABOVE STEPS AND REVIEW OF TIMING FOR FY-84 FUNDS FOR CONTRACEPTIVES, VMMS AND PERHAPS SOME OTHER PROJECT ELEMENTS, USAID MAY WISH TO PREPARE BRIEF AMENDMENT TO CURRENT PROJECT COVERING THOSE FY-84 REQUIREMENTS. IF AMENDMENT TO CURRENT PROJECT IS THE BEST OPTION, SUGGEST USAID PREPARE AMENDMENT AS SOON AS PRACTICAL. SEE...

ASSUMES THAT IF USAID PLANS TO EXTEND BLS FOR ADDITIONAL YEAR, NO FY-84 OBLIGATIONS WOULD BE INCURRED AS BALANCE REMAINING PLUS EARLY FY-84 OBLIGATION, IF NEEDED, WOULD BE USED FOR EXTENSION. PLEASE CONFIRM. THE AIM OF THIS RECOMMENDATION IS NOT TO IMPLY THAT DEVELOPMENT AND APPROVAL OF NEW PROJECT WILL TAKE A YEAR, RATHER, IT SPRINGS FROM A CONCERN THAT IMPLEMENTATION NOT BE IMPAIRED.

(B) THE CONCEPT PAPER HAS ONLY GENERAL COMMENTS ON THE STATUS AND IMPACT OF THE CURRENT PROJECT. THE PROPOSED EVALUATION OF PROJECT BLS SHOULD PROVIDE SOLID INFORMATION ON STRENGTHS AND PROBLEMS AREAS WITH PARTICULAR ATTENTION TO EXPANSION OF VMMS ACTIVITY, EFFECTIVENESS OF FAMILY PLANNING, HEALTH AND NUTRITION INTERVENTIONS, AND POSITIVE OR NEGATIVE EFFECT OF INTERRELATED VMMS ACTIVITIES ON ACCEPTANCE OF FAMILY PLANNING SERVICES. THE NEAC ANTICIPATES THAT THE EVALUATION OF PROJECT BLS AND DISCUSSION OF...

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III (608-0171) NEAC REVIEW OF THE CONCEPT PAPER

1. THE NEAC MET ON SEPTEMBER 1, TO DISCUSS THE CONCEPT PAPER. USAID IS COMPLETING FOR SUBMISSION OF A WELL-WRITTEN AND WELL-PREPARED DOCUMENT, MORE COMPREHENSIVE THAN REQUIRED FOR THIS STAGE OF PROJECT DEVELOPMENT. MAJOR RECOMMENDATIONS OF THE NEAC INCLUDE THE FOLLOWING:

(A) TIMING FOR PROJECT PAPER DEVELOPMENT IS NOT INCLUDED IN CONCEPT PAPER. THERE WAS GENERAL AGREEMENT THAT IMPLEMENTATION OF CONTINUING PROJECT ACTIVITIES SHOULD NOT BE IMPACTED BY TIME INVOLVED IN EVALUATION OF CURRENT PROJECT, NEAC REVIEW OF EVALUATION, AND INCORPORATION OF EVALUATION RECOMMENDATIONS INTO NEW PROJECT PAPER. AFTER REVIEWING TIME REQUIRED FOR ASSESS STAFF AND REVIEW OF TIMING FOR FY-84 FUNDS FOR CONTRACEPTIVES, VMMS AND PERHAPS SOME OTHER PROJECT ELEMENTS, USAID MAY WISH TO PREPARE BRIEF AMENDMENT TO CURRENT PROJECT COVERING THOSE FY-84 REQUIREMENTS. IF AMENDMENT TO CURRENT PROJECT IS THE BEST OPTION, SUGGEST USAID PREPARE AMENDMENT AS SOON AS PRACTICAL.

ASSUMES THAT IF USAID PLANS TO EXTEND 0155 FOR ADDITIONAL YEAR, NO FY-84 OBLIGATIONS WOULD BE RECORDED AS BALANCE REMAINING PLUS EARLY FY-84 OBLIGATION, IF NEEDED, COULD BE USED FOR EXTENSION. PLEASE CONFIRM. THE AIM OF THIS RECOMMENDATION IS NOT TO IMPLY THAT DEVELOPMENT AND APPROVAL OF NEW PROJECT WILL TAKE A YEAR, RATHER, IT SPRINGS FROM A CONCERN THAT IMPLEMENTATION NOT BE IMPACTED.

(B) THE CONCEPT PAPER HAS ONLY GENERAL COMMENTS ON THE STATUS AND IMPACT OF THE CURRENT PROJECT. THE PROPOSED EVALUATION OF PROJECT 0155 SHOULD PROVIDE SOLID INFORMATION ON SUCCESSSES AND PROBLEM AREAS WITH PARTICULAR ATTENTION TO EXPANSION OF VMMS ACTIVITY, EFFECTIVENESS OF FAMILY PLANNING, HEALTH AND NUTRITION INTERVENTIONS, AND POSITIVE OR NEGATIVE EFFECT OF INTERRELATED VMMS ACTIVITIES ON ACCEPTANCE OF FAMILY PLANNING SERVICES. THE NEAC ANTICIPATES THAT THE EVALUATION OF PROJECT 0155 AND DISCUSSION OF...

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RECOMMENDATIONS WILL PROVIDE BASIS FOR GUIDANCE IN PREPARING NEW PROJECT PAPER. UNDERSTAND THAT EVALUATION IS SCHEDULED FOR FIRST QUARTER OF FY-84.

(C) LOGICAL FRAMEWORK FOR NEW PROJECT IS EXCELLENT. NEAC SUGGESTS THAT ASSUMPTIONS IN COLUMN FOUR BE REVALIDATED DURING EVALUATION OF PROJECT 2155.

(D) ECONOMIC AND FINANCIAL ANALYSES IN NEW PROJECT PAPER SHOULD EXPLICITLY DEAL WITH ISSUE OF RECURRING COSTS. CAN GCM PROVIDE AN INCREASING SHARE OF COSTS OF EXPANDING FAMILY PLANNING PROGRAM, PARTICULARLY IN LIGHT OF 20M AUSTERITY PROGRAM. THE NEAC NOTES THAT TITLE I GENERATIONS ARE NOT NOW BEING BARMARKED BY THE GCM. ECONOMIC AND FINANCIAL ANALYSES SHOULD DISCUSS POSSIBILITIES AND PROBLEMS OF ESTABLISHING A SPECIAL ACCOUNT TO EXPECT POSSIBLE USE OF TITLE I GENERATIONS TO COVER SOME OR ALL OPERATING COSTS OF FAMILY PLANNING PROGRAM.

(E) CONCEPT PAPER ONLY BRIEFLY DISCUSSES POTENTIAL FOR PROVISION OF FAMILY PLANNING SERVICES THROUGH THE PRIVATE SECTOR. PROJECT PAPER SHOULD PROVIDE THOROUGH DISCUSSION OF POTENTIAL FAMILY PLANNING ROLES OF PHARMACISTS, PRIVATE VOLUNTARY ORGANIZATIONS, AND PHYSICIANS IN PRIVATE PRACTICE. FUTURE EVALUATION CAN DEAL WITH WHY PRIVATE SECTOR HAS NOT BEEN INVOLVED TO DATE AND PROVIDE SUGGESTIONS FOR ALTERNATIVE APPROACHES/STRATEGIES IN THE FUTURE.

(F) A.I.D S FAMILY PLANNING ASSISTANCE HAS BEEN

CONCENTRATED IN MINISTRY OF HEALTH. THE NEAC, WITH SYMPATHIC SUPPORT OF DEPUTY AA, SUGGESTS THAT MISSION SHOULD RAISE LEVELS OF DISCUSSION, USING MISSION DIRECTOR AS APPROPRIATE, TO EXPLORE POSSIBILITIES OF INVOLVING OTHER MINISTRIES AND PRIVATE SECTOR ORGANIZATIONS IN ADDITION TO MINISTRY OF SOCIAL AFFAIRS AND AMPF. THE NEAC IS CONCERNED THAT APPROACHES OUTLINED IN CONCEPT PAPER, WHILE COVERING MANY ASPECTS OF COMPREHENSIVE FAMILY PLANNING PROGRAM, ARE INSUFFICIENT TO ACHIEVE BROAD COVERAGE ULTIMATELY REQUIRED FOR SUBSTANTIAL FERTILITY REDUCTION UNLESS OTHER MINISTRIES AND PRIVATE SECTOR ARE ACTIVELY INVOLVED.

(G) THE NATURAL FAMILY PLANNING PROGRAM SHOULD BE DESIGNED TO INCLUDE EVALUATION OF THE EFFECTIVENESS OF THE METHOD WITHIN THE CULTURAL CONTEXT OF MOROCCO.

(H) THE NEAC ENCOURAGES MISSION TO EXAMINE PLANS FOR URBAN EXPANSION DURING PROJECT PAPER DEVELOPMENT. 20335

ON BIDONVILLES (WHICH ALSO RELATES TO LARGELY PRIVATE-SECTOR ISSUES RAISED ABOVE) LEAVES LARGE URBAN POPULATIONS STILL WITH INSUFFICIENT ACCESS TO INFORMATION AND CONTRACEPTIVE SUPPLIES. DISCUSSION OF PROPOSED URBAN COVERAGE SHOULD ALSO BE INCLUDED IN BENEFICIARY ANALYSIS SECTION OF PROJECT PAPER. WE WILL EXPECT PP (AND EVALUATION TO THE EXTENT APPROPRIATE) TO PROVIDE HARD NOSED ANALYSIS OF WHAT IT WILL TAKE TO MOUNT AN EFFECTIVE FAMILY PLANNING EFFORT IN MOROCCO SO THAT USAID ROLF CAN BE VIEWED IN THAT CONTEXT.

(1) THE NEAC NOTED THAT THERE HAS BEEN NO OPERATIONS RESEARCH IN MOROCCO RE THE MIX/EFFECTIVENESS OF CONTRACEPTIVES NOW PROVIDED. THE EMPHASIS ON PILLS AND THE DIFFICULTY OF USING IUD'S EXTENSIVELY IN THE ABSENCE OF FEMALE NURSES, ESPECIALLY IN THE RURAL AREAS, IS ACKNOWLEDGED. THIS MAY BE AN APPROPRIATE AREA FOR INVESTIGATION AS PART OF THE NEW PP.

2. AID/W PREPARED TO PROVIDE TDY ASSISTANCE AS REQUIRED TO HELP WITH EVALUATION AND PREPARATION OF PROJECT PAPER. SEULTZ

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OF FEMALE NURSES, ESPECIALLY IN THE RURAL AREAS, IS  
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SUBJECT: POPULATION AND FAMILY PLANNING SUPPORT PHASE  
 II (608-0155) NEAC REVIEW OF FINAL EVALUATION

REF: STATE 264868 (SEPTEMBER 16, 1983)

1. THE NEAC MET ON MARCH 13, 1984 TO DISCUSS THE SUBJECT EVALUATION. THE NEAC COMMENDED USAID AND THE EVALUATION TEAM FOR A WELL-WRITTEN EVALUATION REPORT WHICH PRESENTS DATA, RECOMMENDATIONS AND LESSONS LEARNED IN A WELL-ORGANIZED FORMAT. A SEPARATE MESSAGE ON THE USE OF THIS EVALUATION AS A MODEL AND COPIES OF THE REPORT WILL BE SENT TO ALL NE BUREAU MISSIONS SOON.

2. THE NEAC RECOMMENDED THAT USAID PROCEED WITH THE DEVELOPMENT OF THE FULL PP FOR THE FOLLOW ON PROJECT, TAKING INTO CONSIDERATION THE RESULTS OF THE EVALUATION.

3. THE NEAC EXPRESSED A SPECIAL INTEREST IN THE NEW PP'S PLANS FOR PRIVATE SECTOR FAMILY PLANNING ACTIVITIES, AND URGED USAID TO RENEW ITS EFFORTS TO ATTAIN A HIGHER LEVEL OF PRIVATE SECTOR ACTIVITY IN THE FUTURE. THE USE OF SEPARATE AGREEMENTS WITH PRIVATE SECTOR ORGANIZATIONS (ASSUMING THAT THESE ORGANIZATIONS

QUALIFY FOR GRANTS AS PVO'S) WAS SUGGESTED, IN ADDITION TO THE PROJECT AGREEMENT WITH THE MOF.

4. THE VALUE OF LONG TERM TRAINING WAS DISCUSSED, AND QUESTIONS WERE RAISED RE MOROCCAN INTEREST AND LANGUAGE REQUIREMENTS. THE NEAC RECOMMENDED THE USE OF LONG TERM TRAINING WHENEVER POSSIBLE AS A MEANS OF BUILDING A CADRE OF PROFESSIONALS WITH SKILLS RELEVANT TO POPULATION AND FAMILY PLANNING PROGRAMS.

5. THE FUNDING LEVEL PROPOSED FOR THE NEW PP EXCEEDS MISSION DELEGATION OF AUTHORITY. THE NEAC WOULD BE WILLING TO CONSIDER A REDELEGATION OF AUTHORITY TO ALLOW MISSION APPROVAL OF THE PP. HOWEVER THE NEAC WOULD LIKE TO REVIEW THE PRIVATE SECTOR COMPONENTS OF THE NEW PP. IF IT IS FEASIBLE FOR USAID TO PROVIDE THE NEAC WITH DETAILS OF PRIVATE SECTOR PROJECT ELEMENTS FOR NEAC REVIEW. A

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PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project:  
From FY 86 to FY 88  
Total U.S. Funding \_\_\_\_\_  
Date Prepared: March, 1986

Project Title & Number: Population and Family Planning Support, Phase III (608-0171)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																
<p><u>Program Sector Goal:</u> The broader objective to which this project contributes:</p> <p>Reduce Morocco's rapid rate of population growth and thereby diminish a key constraint to achievement of the country's economic and social development objectives.</p>	<p><u>Measures of Goal Achievement:</u></p> <ol style="list-style-type: none"> <li>1) Population growth rate reduced.</li> <li>2) Reductions in age-specific fertility rates.</li> <li>3) Reductions in infant, child and maternal mortality.</li> </ol>	<p>Demographic survey to be conducted by GOM Ministry of Plan in 1985 (part of MOP's Inter-censal survey series).</p>	<p><u>Assumptions for achieving goal targets:</u></p> <p>Continuing high rates of population growth significantly increase the cost and difficulty of achieving basic development objectives by imposing burdens on economies presently unable to provide sufficient goods and services for the growing population.</p>																
<p><u>Project Purpose:</u></p> <ol style="list-style-type: none"> <li>1) Escalate regular availability of a full range of family planning (FP) information and services for at least 70% of eligible couples in Morocco.</li> <li>2) Attain contraceptive prevalence of 35% of Married Women of Reproductive Age (MWRAs).</li> <li>3) Develop a broader "population" awareness as part of GOM development planners.</li> </ol>	<p><u>Conditions that will indicate purpose has been achieved: End of project status.</u></p> <ol style="list-style-type: none"> <li>1) FP services available at 1,200 MOPH health facilities; through 3,000 VDMS outreach personnel; at rural markets (souks) in 15 provinces; and thru AMPP sales agents in towns, villages and urban areas.</li> <li>2) Number of couples practicing family planning to increase from 1983 total of 920,000 to 1988 total of 1,365,000.</li> <li>3) GOM Five-Year Plan includes population growth and impact analyses across various development sectors.</li> </ol>	<ol style="list-style-type: none"> <li>1) MOPH, USAID records and reports.</li> <li>2) FP program service statistics; analysis of contraceptive stock flow.</li> <li>3) AMPP sales statistics.</li> <li>4) Contraceptive prevalence surveys.</li> <li>5) On-site verification.</li> <li>6) Examination of GOM Five-Year Plan.</li> </ol>	<p><u>Assumptions for achieving purpose:</u></p> <ol style="list-style-type: none"> <li>1) The GOM will continue to invest substantial resources in health and FP programs.</li> <li>2) High fertility norms and societal prope notwithstanding, a sizable un-saturated market exists for FP services (the so-called unmet need).</li> <li>3) A properly designed and managed FP program will satisfy much of this unmet need and lead to higher contraceptive prevalence.</li> </ol>																
<p><u>Outputs:</u></p> <ol style="list-style-type: none"> <li>1) Household-level service delivery program for FP/Health/Nutrition services operational in 18 provinces and in Rabat/Salé, Casablanca and Tangier.</li> <li>2) Voluntary sterilization (VS) services available in 30 provincial hospitals.</li> <li>3) Contraceptive/health products marketed in 6 provinces and in urban/peri-urban areas.</li> <li>4) FP information regularly presented via radio, T.V., movie messages and by household visitors.</li> <li>5) Population Analyses incorporated into GOM central planning process.</li> </ol>	<p><u>Magnitude of Outputs:</u></p> <ol style="list-style-type: none"> <li>1) Approx. 3,000,000 couples visited at least twice per year by a VDMS or urban outreach worker.</li> <li>2) Free VS services available on demand at 30 hospitals staffed by at least 40 physicians and surgical nurses trained in VS procedures.</li> <li>3) Contraceptives available for sale thru ~ 100 AMPP agents/outlets.</li> <li>4) FP messages broadcast at least weekly on radio and T.V.</li> <li>5) GOM Five-Year Plan (1986-90) reflects analysis of 1982 census and other survey data.</li> </ol>	<ol style="list-style-type: none"> <li>1) On-site verification of project activity.</li> <li>2) Examination of household visitation records of VDMS fieldworkers.</li> <li>3) Monitoring of radio, T.V., movie presentations.</li> <li>4) Examination of planning documents for the 1991-95 Five-Year Plan.</li> </ol>	<p><u>Assumptions for achieving Outputs:</u></p> <ol style="list-style-type: none"> <li>1) The GOM will pursue its stated plan to expand the VDMS project into 3 additional provinces and into major urban areas.</li> <li>2) The GOM will assume the costs of the VDMS project in the 13 "original" VDMS provinces.</li> <li>3) The GOM will implement VS services in provincial hospitals without being deterred by considerations of political/religious counter-reaction to GOM involvement in VS.</li> <li>4) GOM will authorize "air-time" for broadcast FP messages.</li> <li>5) GOM will apply planning/modeling/forecasting technologies introduced under the project into the Five-Year Plan development process.</li> </ol>																
<p><u>Inputs:</u></p> <table border="0"> <tr> <td>FP 1984-88:</td> <td>(5000)</td> </tr> <tr> <td>Technical Assistance</td> <td>2435</td> </tr> <tr> <td>Training (U.S. - Morocco)</td> <td>1330</td> </tr> <tr> <td>Commodities</td> <td>7942</td> </tr> <tr> <td>Other Costs</td> <td>-813</td> </tr> <tr> <td>Evaluation, Audit,</td> <td></td> </tr> <tr> <td>Contingencies/Inflation</td> <td>1370</td> </tr> <tr> <td></td> <td>17890</td> </tr> </table>	FP 1984-88:	(5000)	Technical Assistance	2435	Training (U.S. - Morocco)	1330	Commodities	7942	Other Costs	-813	Evaluation, Audit,		Contingencies/Inflation	1370		17890	<p><u>Implementation Target (Type and Quantity)</u></p> <ol style="list-style-type: none"> <li>1) 110 P/M TA (project evaluation, special studies/surveys, local training/workshops, resident LT contractor; AVS project support).</li> <li>2) 100 P/M short-term training in 1st, 2nd and 3rd countries.</li> <li>3) 30,000,000 monthly cycles of oral contraceptives at \$4,350,000 3,300,000 condoms at \$150,000; Other: \$200,000.</li> <li>4) Local Costs: VDMS - Urban outreach programs: \$2,300; VS program: 500; IEC: 500; AMPP sales: 1000; Non-MOPH FP activities: 100; Miscellaneous: 130</li> </ol>	<ol style="list-style-type: none"> <li>1) USAID and AID grantees/contractor reports.</li> <li>2) Shipping documents &amp; reports on contraceptive and commodity deliveries.</li> <li>3) Consultant reports.</li> <li>4) PIO/Ts, PIO/Cs, PIO/Ps.</li> <li>5) USAID financial records.</li> <li>6) SFIO-J4s submitted by recipient agencies.</li> </ol>	<p><u>Assumptions for providing inputs:</u></p> <ol style="list-style-type: none"> <li>1) GOM can effectively absorb and utilize AID-provided resources.</li> <li>2) The GOM possesses the political will to undertake an expanded FP/health program, but lacks sufficient technical, training and physical resources needed to do so.</li> <li>3) Other donors are not able to provide the assistance described herein.</li> </ol>
FP 1984-88:	(5000)																		
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5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects under the FAA and project criteria applicable to individual funding sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? Yes

A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act Sec. 523; FAA Sec. 634A; Sec. 653(b). 1.

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;  
 (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

(b) ~~Yes~~

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,00, will there be 2  
 (a) engineering, (a) Yes  
 financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? (b) Yes

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

3. No further legislative action is requested.
4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973?

4. N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

5. N/A
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

6. N/A

7. FAA Sec. 601(a).  
Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
7. N/A
8. FAA Sec. 601(b).  
Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).
8. U.S. technical consultants will assist in implementation of the project. U.S. universities and business will provide training for host country nationals.
9. FAA Sec. 612(b), 636(h);  
FY 1982 Appropriation  
Act Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.
9. The Project Agreement will so provide

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? 10. N/A
11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? 11. Yes
12. FY 1982 Appropriation Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? 12. N/A
13. FAA 118(c) and (d). Does the project take into account the impact on the environment and natural resources? If the project or program will significantly affect the global commons or the U.S. environment, has an environmental impact statement been prepared? If the project or program will significantly affect the environment of a foreign country, has an environmental assessment been prepared? Does the 13. N/A

project or program take into consideration the problem of the destruction of tropical forests?

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

14. N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

1.

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward

a. (a) The project will expand the availability of family planning and health services and thereby increase the quality and quantity of health care for the country's poor.

(b) N/A

better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

a. (c) This project was proposed by the Moroccan Government, which has committed significant human and financial resources toward its implementation.

(d) Pregnant and lactating women are a high priority target population of the GOM health system.

(e) The GOM National Training Center for Reproductive Health will train physicians and nurses from other Arabic and francophone speaking countries in the region.

b. Yes

c. Yes

d. The GOM will provide in-kind and financial resources representing more than 50% of the cost of the entire program.

e. FAA Sec. 110(b).  
Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

e. No grant capital assistance will be provided under the project.

f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

f. Yes

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes

g. The program is focused on expanding the delivery of family planning and health services to improve the health status of the population. Project activities include the training of Moroccan health personnel in the medical and management techniques necessary to plan, implement and evaluate an integrated health and family planning program.

2. Development Assistance Project Criteria (Loans Only)

2.

a. FAA Sec. 122(b). Information and conclusion on capacity of

a. N/A

the country to repay the loan, at a reasonable rate of interest.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

b. N/A

c. ISDCA of 1981, Sec. 724 (c) and (d). If for Nicaragua, does the loan agreement require that the funds be used to the maximum extent possible for the private sector? Does the project provide for monitoring under FAA Sec. 624(g)?

Project Criteria Solely for Economic Support Fund

3.

a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the extent possible, does it reflect the policy directions of FAA Section 102?

a. N/A

b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities?

b. N/A.

c. FAA Sec. 534. Will ESF funds be used to finance the construction of the operation or maintenance

c. N/A

of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such use of funds is indispensable to nonproliferation objectives?

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

d. N/A

**INTERNATIONAL PROJECT**

**PROPOSAL**

AVS SUBAGREEMENT NO. MOR-03-SV-1-A, MOROCCO

Section A: Program Summary

**TITLE:** National Program for Reproductive Health

**GRANTEE:** National Training Center for Reproductive Health

**PROJECT DIRECTOR:** Professor Mohamed Tahar Alaoui  
Director  
National Training Center for Reproductive Health  
Zankat Soekarno  
Rabat, MOROCCO

**PROGRAM DURATION:** Five (5) Years (renewable on a yearly basis pending the availability of funds) April 1, 1984 to June 30, 1989.

**BUDGET DURATION:** Fifteen (15) months; April 1, 1984 to June 30, 1985

**BUDGET TOTAL:** \$350,480 (US) - Maximum

PROGRAM GOAL

The purpose of this subagreement to the Moroccan National Training Center for Reproductive Health is to widen the availability and accessibility of surgical reproductive health services. This will be achieved through the provision of operational support to the National Training Center in Rabat for its service activities and by a comprehensive follow-up effort of graduate NTCRH trainees to assist their institutions in the establishment and expansion of services. Over the course of the five year program duration, up to thirty facilities will have institutionalized surgical reproductive health services as part of their on-going service activities.

# INTERNATIONAL PROJECT

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## I. PROGRAM SUMMARY

The primary goal of this five year effort is to expand the availability and accessibility of high quality surgical family health services throughout Morocco. The essential building block of this expansion is the National Training Center for Reproductive Health (NTRH), the model family planning/reproductive health service and training facility in the country. The strategy of the program is to incorporate service delivery into the on-going reproductive health activities of provincial Ministry of Public Health (MOPH) facilities in a logical and low-key manner. This will be done through a comprehensive trainee follow-up effort whereby institutions of NTRH trainees are provided the necessary support and technical guidance to enable trainees to utilize their skills. Through this comprehensive approach, the foundation is being laid for a solid national service program, with the NTRH taking the lead role in training, supervision and quality assurance.

At the present time, there is no explicit policy on voluntary surgical contraception in Morocco. In fact, there is no stated population policy; however, family planning service delivery is a very important part of the Ministry of Public Health's efforts to improve infant and maternal health. Surgical family health services are now not part of the national family planning program, but they are provided on a limited basis in some urban and provincial hospitals on the grounds of medical justifications.

The NTRH's creation was a major step forward in the introduction of surgical family health services through the training of medical personnel. However, beyond training, a more aggressive approach is required in order to expand services. A preliminary needs assessment conducted by AVS at the request of the NTRH and USAID/Rabat indicated that a provincial hospital's capability for providing these services is limited, despite the availability of trained staff. This is due to the fact that although such services are often requested by women, their performance is often displaced by the performance of more pressing, emergency surgery. Thus, this project addresses the need for dedicated space and the expendable supplies which are required for the performance of this elective surgery.

Over the course of the next five years, up to thirty (30) institutions, which have had staff trained in surgical family health procedures at the NTRH, will be given the basic support to initiate and expand services. Each participating institution will be given a maximum of three years assistance, after which it is anticipated that the facility will have been given the necessary means to implement its service program with its own resources. Moreover, once demand for services builds, the facility

# INTERNATIONAL PROJECT

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will be in a better position to allocate resources to the provision of services.

The total cost of the program over the five years is approximately \$1.3 million. The major inputs to the provincial hospitals are for equipment, minor renovation and expendable supplies, and to the NTCRH for its service, and program supervision activities. The program is co-funded by the John Hopkins Program for the International Education of Gynecologists and Obstetricians (JHPIEGO) which provides support for the NTCRH's training activities at a funding level of approximately \$250,000 per year.

## SUMMARY OF PROGRAM OBJECTIVES

1. Continue the delivery of surgical family health services at the National Training Center for Reproductive Health in Rabat.
2. Provide assistance to institutions of graduate trainees of the National Training Center for Reproductive Health in the establishment of surgical family health services. During the first project year, five (5) institutions will be included in the program.
3. Provide on-going technical supervision to trainees to maintain quality control and continuity in instruction for surgical family health activities.
4. Strengthen the management capacity of the National Training Center for Reproductive Health to administer the national program.

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AVS SUBAGREEMENT NO MOR-03-SV-1-A, MOROCCO

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## II. PROGRAM JUSTIFICATION AND BACKGROUND

The Ministry of Public Health (MOPH) has the primary responsibility in Morocco for the implementation of family planning activities on the premise that family planning is directly related to family health and the individual's well-being. Thus, the MOPH has undertaken to integrate family health activities in all its service programs and has succeeded in introducing them into virtually all the Ministry's 1,200 facilities (provincial hospitals, health centers and dispensaries). The MOPH is the only governmental department involved in the delivery of family planning services and accounts for a large portion of the actual services delivered in this country of over 20 million.

Several innovative family planning programs have been undertaken by the MOPH, such as the VDMS program (Visites a Domicile de Motivation Systematique) which offers five health interventions, including family planning, at the household level by visiting health workers. This program is operating in three provinces with plans for expansion into another eight. In addition, there are thirteen (and another five under construction) "reference" centers at the provincial level; the purpose of this network is to service as technical back-up for all family planning activities offered in the province. Thus, the family planning infrastructure is very well-developed in Morocco and is well-suited to an effort designed to introduce surgical family health services on a wide scale.

Against this backdrop, the National Training Center for Reproductive Health (NCRH) was created in 1979 and officially began activities in November 1982. Its purpose is to serve as a center for excellence for reproductive health activities in Morocco and to train medical and paramedical personnel in the surgical techniques of family health. The rationale for the provision of surgical family health services is based upon the well-known risks of high parity among women over 30, especially those who have had previous high-risk pregnancies. Given an historical emphasis on curative rather than preventive service (although this is beginning to change in Morocco due, in large part, to the efforts of the MOPH), many women do not have access to pre-natal care and thus the problems associated with high-risk pregnancies continue, especially in the rural areas. The NCRH was created to address this problem through the provision of specialized training in surgical family health methods.

The NCRH is located in the former Maternity Hospital in Rabat and is supported through a joint effort by the MOPH, the United States Agency for International Development/Rabat, Johns Hopkins Program for the International Education of Gynecologists and Obstetricians (JHPIEGO) and the Association for Voluntary Sterilization's International Program. The NCRH houses a 30-bed maternity and obstetric/gynecology service; a complete teaching facility, including classrooms, a library and offices; technical facilities, including two operating rooms and three recovery wards with a total of thirty beds and all ancillary services; and

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a laparoscopic repair and maintenance center to service all publicly-donated equipment in Morocco.

Since the facility opened in November 1982, between 30 and 100 surgical procedures are performed per month. The first physician's training course was held in late April 1983 and two more followed in June and September. It is anticipated that 40 trainees will be instructed during a year's time (10 trainees per course, 4 courses per year) in surgical methods of family health and in 1984 trainees from Franco-phone African countries will be accepted into the program as well. Now that training activities have been inaugurated and are underway at the NTCRH, there is a need for the NTCRH to ready itself to serve in a technical capacity once these trainees return to their home institutions which are, in most cases, provincial hospitals.

As the foundation upon which a national surgical family health service program can be built, the NTCRH is committed to taking special care to ensure quality training and service delivery. The NTCRH is in an excellent position, as the model reproductive health facility in Morocco, to serve in the role of technical advisor to its trainees and can ensure quality control by providing assistance to and maintaining a formal link with them. This project will provide the means for the NTCRH to serve in this capacity and will result in a national, coordinated effort to establish surgical family health services in 30 institutions over a five year period.

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## III. PROGRAM OBJECTIVES AND DESCRIPTION

1. Continue to deliver surgical family health services at the National Training Center for Reproductive Health.

The National Training Center for Reproductive Health is the model center in Morocco for the delivery of surgical family health services. These services are conducted as a tripartate effort involving gynecology, obstetrics, and family planning. An active surgical service program will be undertaken and it is estimated that 800 procedures via laparoscopy and minilaparotomy will be financed by AVS under the first-year subagreement. The remaining surgical procedures conducted in conjunction with training will be supported by JHPIEGO; however, all procedures performed at the NTCRH regardless of financing will be reported to AVS.

All services, including preoperative assessments and post-operative follow-up, will be conducted in accordance with NTCRH and AVS medical guidelines under the supervision of the NTCRH's qualified technical personnel, the curricula vitae of whom are on file at AVS. Trainees in laparoscopy are specialists in obstetrics/gynecology or surgery, whereas general practitioners are eligible for training in minilaparotomy.

All requestors of surgical services will be provided with pre- and post-operative counseling, and informed consent will be obtained and documented according to AVS requirements for same. An informed consent form in compliance with AVS requirements is on file at AVS. To ensure a free choice of contraceptive method, a full range of temporary family planning methods is available to all potential requestors of surgical methods at the reference center on the grounds of the NTCRH. The obstetric/gynecology service and reference center are the main referral points for the NTCRH and are responsible for the initial counseling of requestors. Pre- and post-operative counseling is then provided by the physician. Neither abortion or abortion-related activities as prohibited by AVS are provided by the NTCRH. Post-operative follow-up visits take place eight days after surgery at the NTCRH.

2. Provide assistance to institutions of graduate trainees of the National Training Center for Reproductive Health in the establishment of surgical family health services. During the first project year, five (5) institutions will be included in the program.

### Selection

The National Training Center for Reproductive Health (NTCRH) is responsible for selecting the trainees and their institutions which will be

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assisted with regard to the establishment of surgical family health services. A list of participating institutions to be included in the project over the next five years is found in the Financial Plan (Section IV) of the subagreement document.

Institutions with graduate trainees who have received certification in the surgical techniques of fertility management (laparoscopy and mini-laparotomy) will be selected by the NTCRH Project Director for participation in the program. The trainee's skills, motivation and interest will be of primary importance; however, he/she must come from an institution with the following characteristics:

- o approval or support of the medecin-chef of the province to undertake surgical family health activities
- o potential caseload and demand for services (preferably a province in which there exists a NOPH reference center or VDMS program)
- o adequate facilities and staff to conduct service once project inputs are in place

Prior to the implementation of the program, the NTCRH will submit a definitive list of institutions selected for inclusion under the first year project. Also, the NTCRH will submit to AVS the names of the trainees who will be the operating surgeons under the program at the provincial hospitals.

## Provision of Resources

Following selection, the NTCRH will determine the level of resources required by each participating institution for service delivery. Three types of support will be given as noted below:

- o Expendable supplies -- The NTCRH will be responsible for procuring, packaging and distributing packages of expendable supplies to the participating institutions. The standard "kit" will include such things as catgut, needles, sutures, gloves, etc. for use in the program.

The NTCRH will make available an initial supply to each facility at the start of the program. Replenishment will depend upon the level of services performed and the submission of statistical reports.

- o Renovation -- No major renovation is foreseen for any of the participating institutions; rather, funds will be included under the five year project for 15 of the 30

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ance, painting, cleaning and electrical installations of dedicated space, if necessary.

Equipment -- With regard to the provision of equipment, the needs of the participating institutions may differ; therefore, the equipment to be provided under this program has been divided into two categories. Category A Equipment consists of small items of medical and surgical equipment, and will be given to all participating institutions in order to ensure that all the appropriate items exist to initiate services. Category B Equipment consists of capital operating room equipment and will be provided to those facilities which lack the necessary equipment to establish a surgical program. Under the year-one budget, it is anticipated that three of the five institutions will receive Category B Equipment. In the long run under the five years of the program, it is foreseen that 20 of the 30 institutions will require Category B Equipment.

AVS will provide and ship the equipment according to these pre-packaged categories to facilitate the warehousing and distribution of equipment to the hospitals in the outlying provinces.

## Service Delivery

The NTCRH will be responsible for ensuring that all surgical family health services, including pre-operative assessment and post-operative follow-up, will be conducted in accordance with the medical standards of the NTCRH and AVS guidelines. All requestors of surgical methods will be provided with pre- and post-operative counseling and informed consent will be obtained and documented according to AVS requirements for same. The informed consent form currently in use at the NTCRH will be made available to institutions participating in this program.

Temporary family planning methods are available on-site at each provincial hospital to ensure a free choice of family planning method to all requestors of surgical services. In addition, there are mobile family planning team reference centers and VDMS teams in select provinces which may serve to counsel and refer clients to the surgical service as well as to provide temporary methods. Neither abortion nor abortion related activities as prohibited by AVS are or will be conducted in these facilities using AVS funds.

For budgetary purposes, the estimated caseload at each service site is 250 procedures for an annual level under the year-one project of 1,250 procedures. However, the caseload may vary from site to site and some readjustment may be necessary during the course of the program.

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3. Provide on-going technical supervision to trainees to maintain quality control and continuity in instruction for surgical family health activities.
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To ensure that a strong link is maintained between the NTCRH and its graduate trainees which are participating in the program, medical supervision visits will be undertaken by NTCRH technical staff. Three visits are programmed under the first year budget for each of the five institutions; however, the frequency of visits will decrease in subsequent project years as the program matures. Of these three visits, two are considered routine, whereas the third will be in the event of an emergency (i.e., to investigate a complication).

The function of the routine visits will be to:

- observe the performance of surgical procedures by the trainee
- check compliance with basic medical standards and program policies such as informed consent
- provide additional assistance or instruction on site as necessary
- obtain feedback on the progress of the program

These medical supervision visits are to be distinguished from those included under the NTCRH's operational budget (JHPIEGO) for short-term trainee follow-up and the installation of the laproscopator. These visits, on the other hand, are intended to provide supplementary, in-depth medical supervision of the trainee's activities once the project inputs are in place for the purpose of program monitoring and evaluation.

Medical field visits will be the responsibility of the Medical Field Coordinators who are designated from the technical/training staff of the NTCRH on a rotating basis. This system will ensure the availability at all times of qualified medical staff to address the needs of the national program.

Strengthen the management capacity of the National Training Center for Reproductive Health to administer the national program.

A special administrative unit will be established within the NTCRH to attend to the administrative management of the program. It will consist of the Project Director, Program Manager, Administrator/Accountant, the Medical Field Coordinators, and a Secretary. The job responsibilities of these positions are on file at AVS.

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The major duty of the administrative unit is to manage all aspects of the program, including the development of all necessary systems, standards and procedures for program and supervisory activities; the preparation and submission of all reports; the procurement, packaging and distribution of expendable supplies; the warehousing and distribution of AVS-provided equipment; program assessment and evaluation; and the monitoring of all contractual and medical requirements, including informed consent.

Program supervision will be accomplished through the receipt, monitoring and follow-up of statistical and medical reports from all participating institutions; and from administrative visits to each facility at least once during the course of its first year in the program. (These visits will coincide with one of the medical supervision visits previously mentioned.)

Finally, to promote and ensure the participating institutions' cooperation with and understanding and commitment to the national program, a coordination meeting will be held at the NTCRH once a year which will include the medecin-chef and the administrative director of the provinces in which the program will take place. The purpose of this coordination meeting will be to:

- o review the objectives and plans for the program
- o review the logistics of the program, including supplies and equipment provision
- o review routine reporting and administrative requirements
- o discuss medical standards and informed consent procedures
- o obtain feedback on progress of the program.

# INTERNATIONAL PROJECT

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## IV. FINANCIAL PLAN

This is foreseen to be a five year project whereby NTCRH trainees from up to 30 provincial hospitals are provided with the necessary technical assistance and support to establish surgical family health services. Any one provincial hospital will receive a maximum of three years of support after which it is assumed that services will have become a routine part of the health services provided by the hospital.

At the end of the project's duration, the goal of widening the accessibility and availability of surgical family health services outside the capital city to the provinces will have been realized and that these services will have become institutionalized and entrenched in the public health system. The prospects for such institutionalization are good, as the types of project inputs are those which can eventually be absorbed by the Ministry of Public Health.

A proposed schedule for phasing in and out provinces under this program is set forth in the table below:

<u>Project Year</u>	<u>Coverage of Provinces</u>	<u>New Provinces/Equipment Needs</u>	
Year One	5 new provinces	Marrakesh	A/B
		Fez	A/B
		Agadir	A/B
		Oujda	A
		Meknes	A
Year Two	5 continuation provinces	Tetouan	A/B
		El Kalaa	A/B
	<u>10 new provinces</u>	Khenifa	A/B
	15 total	Tanger	A/B
		Kenitra	A/B
		El Djedida	A/B
		Beni Mellal	A/B
		Safi	A
		Taza	A
		Essnouira	A
Year Three	15 continuation provinces	Rabat Sale(2)	A/B
		Casablanca(4)	A/B
	<u>15 new provinces</u>	Teznit	A/B
	30 total	Sidi Kassem	A/B
		Nador	A/B
		El Alhussina	A/B
		Casablanca(1)	A
		El Hachidia	A
		Ourzazate	A
		Tharissa	A

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## Section B: Budget

### I. IN-COUNTRY PROGRAM COSTS

#### A. NATIONAL TRAINING CENTER FOR REPRODUCTIVE HEALTH

1. SERVICES (15 months) \$ 24,000 (US)

Institutional reimbursement for program activities (\$30/case x 800 cases not performed in conjunction with JHPIECO training program)

2. NATIONAL PROGRAM SUPERVISION/COORDINATION \$ 21,975 (US)

a. Personnel (15 months)

Program Director	honorary
Program Manager (\$6,500 x 60%)	\$4,875
Medical Field Coordinator (\$12,000 x 20%)	\$3,000
Accountant/Administrator (20%)	900
Secretary (20%)	600

b. Supervisory Field Visits

Administrative Supervision - 1 visit x 2 days x \$50/day x 5 centers	500
Medical Supervision - 3 visits (2 routine, 1 emergency) x 2 days x \$50/day x 5 centers	\$1,500

c. Coordination Meeting - Rabat

2 persons (medecin chef and administrative director) x 2 days x \$50/day x 5 centers	\$1,000
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d. Operational Expenses

Communications	\$2,500
Printing/Office supplies	1,750
Warehousing/distribution of equipment	2,250

e. Local Purchase equipment

Photocopier	3,000
calculator	100

# INTERNATIONAL PROJECT

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<u>Project Year</u>	<u>Coverage of Provinces</u>	<u>New Provinces/Equipment Needs</u>	
Year Four	25 continuation provinces	none	5 sets A for replacement
Year Five	15 continuation provinces	none	5 sets A for replacement

Details regarding the types and level of AVS support to the NTCRH over the next five years are contained in the section of the document entitled "Budget Notes." A reduction in the level of funding to the NTCRH is planned for the third project period so as to begin the phasing-down of project inputs by AVS. This phasing-down is then continued through the fifth year, after which time the MOPH will assume the financing of the NTCRH.

An overview of the contributions to the NTCRH are set forth below. These figures are annual estimates (except for AVS's figures which are based on the 15-month project duration).

## Ministry of Health Contribution

Land value (one-time expense)	\$500,000
Rent and maintenance	100,000
Furniture and equipment (one-time expense)	100,000
Salaries for medical and administrative personnel	310,000
Vehicles (one-time expense)	50,000
Operational expenses (drugs, x-rays, laboratory expenses)	50,000
Family planning services	35,000
Administration	<u>20,000</u>
Total (excluding one-time expenses)	\$515,000

## JHPIEGO

Contribution for all costs associated with training, including the provision of laproscopators and spare parts	\$250,000
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## AVS

Includes support for the NTCRH's service, and program supervision costs; plus support of five provincial hospitals	\$357,505
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# INTERNATIONAL PROJECT

Section B: Budget  
page 2

## B. PROVINCES PROGRAM

1. SERVICES (12 months) \$ 25,000 (US)

Expendable supplies (\$20/case  
x 250 cases/center x  
5 centers

25,000

SUB-TOTAL INCOUNTRY  
COSTS: \$ 70,975 (US)

## II. AVS COSTS

A. \* EQUIPMENT - AVS PURCHASE \$273,375 (US)

(See Sec. B: Equipment Category Breakdowns)

### 1. FOR 5 CENTERS IN PROJECT YEAR 1

3 sets B x \$15,000 .. 45,000  
5 sets A x \$ 3,500 17,500

### 2. FOR 10 CENTERS IN PROJECT YEAR 2

7 sets B x \$15,000 105,000  
10 sets A x \$ 3,500 35,000

### 3. SHIPPING, HANDLING, SURCHARGE

(35%) 70,875

# INTERNATIONAL PROJECT

Section B: Budget

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B. TECHNICAL SUPPORT

\$ 6,080 (US)

4 programmatic site visits  
travel (4 x \$500)  
per diem (4 visits x  
7 days x \$60/day)

2,000

1,680

1 medical site visit  
travel  
per diem (15 days x \$60/day)

1,500

900

C. BANK TRANSFER CHARGES

\$ 50 (US)

SUB-TOTAL

AVS COSTS: \$279,503 (US)

TOTAL BUDGET: \$350,480 (US)

# INTERNATIONAL PROJECT

## SECTION B: BUDGET

### EQUIPMENT CATEGORY BREAKDOWNS

#### A. Category A Equipment (\$3,500/set)

- 1 set pelvic exam instruments
- 3 sphygmomanometers (1 each for the exam, OR and recovery rooms)
- 3 stethoscopes (1 each for the exam, OR and recovery rooms)
- 3 thermometers (1 each for the exam, OR and recovery rooms)
- 2 minilap kits
- 1 vasectomy kit
- 1 pelvic emergency surgery kit
- 1 manual aspirator
- 1 manual resuscitator
- 1 emergency oxygen resuscitation unit (demand resuscitation)

#### Intubation equipment:

- 1 Laryngoscope
- 10 airways
- 5 endotracheal tubes

- 1 basic IV stand
- 10 bottles Sporocidin concentrate

#### B. Category B Equipment (\$15,000/set)

- 1 manual operating table (adjustable to trendelenburg position)
- 1 gynecological exam table
- 1 examination lamp
- 2 revolving stools for exam and OR
- 1 adult scale
- 1 OR lamp
- 1 basic instrument table
- 1 stretcher
- 1 autoclave
- 1 anesthesia machine

# INTERNATIONAL PROJECT

AVS SUBAGREEMENT NO. MOR-03-SV-1-A. MOROCCO

## BUDGET NOTES -- OVERVIEW

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
<u>NTCRH</u>						
SERVICES	\$ 24,000	\$ 24,000	\$ 25,000	\$ 20,000	\$ 20,000	\$113,000
SUPERVISION	21,975	21,000	23,000	20,000	14,500	100,475
 <u>PROVINCES</u>						
SERVICES	25,000	75,000	150,000	125,000	75,000	450,000
EQUIPMENT	273,375	273,375	23,625	23,625	0	594,000
RENOVATION	0	10,000	20,000	0	0	30,000
<u>TECHNICAL SUPPORT</u>	<u>6,080</u>	<u>6,080</u>	<u>6,080</u>	<u>4,240</u>	<u>4,240</u>	<u>26,720</u>
TOTAL:	\$350,430	\$403,375	\$274,705	\$192,865	\$113,740	\$1,369,125

Note: These figures do not include Bank Transfer Charges of \$50 per year.

# INTERNATIONAL PROJECT

AVS SUBAGREEMENT NO. MOR-03-SV-1 to 5-A

## BUDGET NOTES

### NATIONAL TRAINING CENTER FOR REPRODUCTIVE HEALTH

#### 1. SERVICE

Institutional reimbursement for program activities is calculated at 30/case. This includes \$20 for expendable supplies, \$6 for operational expenses and \$4 for food. These funds are to be used only for those cases not done in conjunction with the JHPIEGO training program as JHPIEGO has budgeted \$30/case under its cost per trainee reimbursement scheme.

This subsidy will be in effect for the two project years, after which time it will be reduced to \$25 for the third year and \$20 in the fourth year and fifth year in an effort to promote institutionalization.

#### 2. NATIONAL PROGRAM SUPERVISION

##### a. Personnel

Program Director -- No AVS funding is foreseen for this position as JHPIEGO is paying funds representing 42% of the NTCRH Director's FT salary under its program.

Program Manager -- AVS is assuming 60% of the FT salary of this position and JHPIEGO is assuming the remainder.

The Medical Field Coordinator position will be budgeted at 20% of a FT medical position at the NTCRH; however, the position will be carried out by several physicians who will rotate to do the field work.

The Accountant/Administrator and Secretary will receive an "indemnity" representing approximately 20% of their FT salaries for overtime worked on this project; however, it is assumed that they will spend more than 20% of their time on this project.

The same salary levels are foreseen for the five project years.

##### b. Supervisory field visits

Each visit is calculated on the basis of \$50/day for two days and this amount is intended to cover both travel and per diem. This is an average for budgeting purposes but will be disbursed on an actual cost basis.

Administrative visits will be performed by the Program Manager and Medical visits will be performed by the Medical Field Coordinator.

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Budget Notes  
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Under the first year program, five centers will receive 1 administrative visit and up to three medical supervision visits (2 for routine follow-up and one in the event of an emergency).

Under the second year program, it is foreseen that each of the centers will receive up to one administrative and two medical field visits on the average.

In the third year, the institutions included under the project will receive an average of one administrative and one medical visit during the year although it is anticipated that not all of the institutions will be covered since some of the "older" centers may not require supervision and some of the "newer" one may require more than one medical visit. In the fourth and fifth project year, the same formula will apply; one administrative and one medical visit is foreseen for each of the participating institutions (25 in year 4 and 15 in year 5).

## c. Coordination Meetings in Rabat

During the first and second program years, funds are provided for two persons from each of the centers to attend a coordination meeting in Rabat about the project's implementation. It is anticipated that the medecin-chef of the province and the hospital administrator will attend this coordination meeting as they will be overseeing the activities in each of the provinces.

During the third program year, two persons from each of the new centers included under the program will attend the coordination meeting; whereas one person will attend from the "older" centers.

Under the fourth and fifth year, each of the participating centers will send one person to the coordination meeting.

## d. Operation Expenses

These funds are included for communications, printing, and warehousing; and distribution of equipment.

Year	1	:	\$6,500
	2	:	7,000
	3	:	5,000
	4	:	5,000
	5	:	2,500

# INTERNATIONAL PROJECT

AVS Subagreement No. MOR-03-SV-1 to 5-A  
Budget Notes  
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Distribution of equipment will be implemented through the National Office of Transportation. Each trip is calculated on the average to be \$100 per trip. (Although more will be budgeted for multiple trips).

## PROVINCES PROGRAM

### 1. SERVICES

It is anticipated that each institution will perform on the average 250 cases per year. The NTCRH will purchase and distribute stocks of surgical and medical supplies to each of the participating centers. The per case cost of these expendable supplies is calculated to be \$20. Each institution is eligible to receive up to three years of support, after which time it is assumed that the center will absorb the cost of the service program.

### 2. EQUIPMENT

The equipment to be provided by AVS is divided into two categories. Set A includes all minor surgical instruments and emergency equipment and will be given to all participating institutions. Set B, on the other hand, includes major capital equipment items for the less-equipped centers. Set A is calculated to cost \$3,500 and Set B to cost \$15,000. Shipping and handling is estimated at 35 percent.

Year 1 :     5 Sets A  
              3 Sets B

Year 2 :     10 Sets A  
              7 Sets B

Year 3 :     15 Set A  
              10 Sets B

Year 4:       5 Sets A (for replacement)

Year 5 :       5 Set A (for replacement)

Provisions for Years 1 and 2 will be budgeted under the first project year; Year 3 will be provided under the second project; and replacement sets will be provided under the third and fourth years.

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### 3. MINOR RENOVATIONS

Minor renovations will include such things as painting, electrical installations, maintenance, etc. No renovations are foreseen for the first project year in an effort to facilitate the implementation of the program.

Under the second and third project years, it is anticipated that 5 and 10 centers will require minor renovation averaging \$2,000 per center.

### 4. TECHNICAL SUPPORT

Technical support from AVS staff will be conducted on site and funds are included for travel and per diem for four programmatic site visits by Africa/Middle East Regional Office staff and one medical site visit by AVS Medical Division staff. This frequency of visits will be maintained during the first three project years after which time the frequency will be reduced to two programmatic and one medical site visit per year for the fourth and fifth project years.

ANNEX VI

SOCIAL SOUNDNESS AND BENEFICIARY ANALYSIS

A. Introduction

The societal benefits of family planning have been discussed widely in recent years. Frequently-cited consequences of declining fertility have included such broad social and economic benefits as higher per capita income, greater public access to educational, health, food, and recreational resources; reduced strain on public infrastructure such as transportation, water, sewerage and housing; and a lower likelihood of political/social unrest. At the micro-level, some advantages of decreased fertility have been remarked to include lower maternal morbidity and mortality; lower infant mortality; improved nutrition; and reduced incidence of abortion. Family planning has also been cited as an economic "good" but with social/ethical overtones, i.e. as a means whereby women may alter their traditional patterns of childbearing and thereby seek broader participation in social and economic life. And, as affirmed at the Bucharest Population Conference of 1974, and echoed in AID policy statements, the ability of couples to voluntarily determine their own fertility is an inalienable human right -- the observance of which is facilitated by the availability of family planning information and services.

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This section will touch briefly on some of the foregoing social consequences of declining fertility -- particularly those which clearly affect individuals at the personal and family level. This discussion is not comprehensive, given the large volume of existing literature on the subject, and the generally-acknowledged perception that voluntary fertility management is a desirable goal for most individuals, societies and governments.

The following table offers a partial overview of the social context of the Morocco Population/Family Planning Project:

SOCIAL/ECONOMIC INDICES FOR MOROCCO, 1984

1.	Total Population (mid-1984 estimate)	22 million
2.	Crude Birth Rate	38 per 1000
3.	Crude Death Rate	12-13 per 1000
4.	Rate of Natural Increase	approx. 2.6% per annum
5.	Years to Double Population	27 years
6.	Percent of Total Population under Age 15	42.1%
7.	Population Distribution, Urban/Rural	42.7%/57.3%
8.	Rate of Growth of Urban Population	4.4%
9.	Years to Double Urban Population	16
10.	Total Females 15-49 Years of Age	4.9 million
11.	Married Females 15-49	3.4 million

12.	Number of Households				3.5 million
13.	Persons per household:				5.9
	Urban:				3.7
	Rural:				8.3
14.	Total fertility (for women 45-49 in 1982)				7 children
	Rural:				7.4 children
	Urban:				6.3
15.	Estimated Contraceptive Prevalence				930,000
16.	Contracepting Couples as % MWRA				27%
17.	Number of Persons per physician				11,000
18.	Infant Mortality Rate				110 per 1000 births
19.	Life Expectancy at Birth				56.5 years
20.	Major Courses of Death				Measles, respiratory and gastrointestinal diseases
21.	School Enrollment as % of school-age population in age group:				
		<u>Urban</u>	<u>Rural</u>	<u>Total</u>	
		<u>Urban</u>	<u>Rural</u>	<u>Total</u>	
	- Preschool/Koranic School:	4.6	11.6	7	
	- Primary:	56.9	73.6	62.6	
	- Secondary:	34.8	14.3	27.4	
	- Post Secondary:	3.7	10.7	2.3	
	- Secondary:	3.7	0.7	2.3	
22.	School population by sex:				
	- Male:				62%
	- Female:				38%
23.	Literacy Rate				35%
	- Male:				49%
	- Female:				22%
24.	Female Literacy Rate, Rural Areas				5%
25.	GNP per capita, in U.S.\$				760

Note: All figures are estimates and should be read with caution.

B. Social and Cultural Factors

The relationship of social and cultural factors to fertility practice in Morocco has not been well-examined in the literature. Two studies have, however, offered some Morocco-specific conclusions concerning the significance of the factors in regard to population policies and programs. Robert Fernes, in "Social and Cultural Factors Involved in Population Program Strategy in Morocco" (APHA, 1977), observed 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).

Basically, Fernea 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 of contraception already exists.

Fatima Mernissi, in a unpublished "reflections paper" prepared at USAID's request in 1983, generally shared, and elaborated upon, Fenea's key observations. Mernissi' noted that:

- 1) The Moroccan religious community is currently troubled by the possibly inconsistency of family planning with "correct" behavior. The religious leadership will quickly support FP, however, once the level of popular acceptance of contraceptive practice rises to a point which clearly expresses the will of the Ulema or Islamic community. Mernissi claims that FP practice in Morocco has already reached that level, and that the open endorsement of the religious and political leadership is imminent;
  
  - 2) Changing patterns of family structure -- including the diminished importance of the extended family as mediator and safety net for broken marriages -- are compelling Moroccan women to be more independent and assertive in establishing their fertility goals. Specifically, Moroccan women are choosing to have fewer children for what appear to be contradictory reasons: a) to leave themselves relatively unencumbered (marriageable, employable) in the event of a failed marriage; and b) to produce a more "modern" domestic environment for a husband whose self-and-family-image has been changed by urbanization and the influx of Western notions of "modern" family life.
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3) Related to No. 2, above, Mernissi claims that changes in popular attitudes toward "tradition" and "modernity" are pervasive -- and clearly in the direction of modernity. One aspect of this change -- which may be an acceptance of outer forms rather than internalized values -- is the identification of a smaller family with a "better" life.

Government leaders, meanwhile, retain a patronizing image of the country's citizenry as conservative, tradition-bound, and unprepared for an explicit, public discussion of population issues. Again, Mernissi believes that government pronouncements will very shortly fall in line behind popular practice.

Both writers' presumptions of the social and cultural acceptability of FP in Morocco have been supported by survey and actual program experience. Contraceptive practice in Morocco has invariably increased in response to increased availability of FP services -- in apparent reflection of a considerable latent and hitherto unmet need for these services. USAID and the GOM nonetheless agree that comprehensive knowledge of the socio-economic correlates of population planning in Morocco is still lacking. Analysis of the recently-published National Fertility Survey (the Morocco portion of the World Fertility Survey - WFS); the 1983-84 Contraceptive Prevalence Survey (fieldwork under way in December, 1983 - January, 1984); and the 1982 national census during the new project period will provide extensive new information about the social and economic dimensions of

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C. Beneficiary Analysis

An assessment of the impact of family planning on selected aspects of social and individual well-being follows:

1. Maternal and Child Health\*

Family planning impacts directly and importantly on health, and particularly on maternal and infant health. High fertility is associated with high infant mortality; and maternal mortality -- the risk of dying in childbirth -- is greatly affected by the total number of children that a woman bears in her lifetime. It is also affected by the age at which she bears these children and the spacing between pregnancies. These factors of number and timing also have a major impact on the chance each of her children will have for survival.

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\* The following discussion of maternal and child health benefits of family planning draws on several sources. See Annex for a list of resource documents consulted for this and other sections of the Project Paper.

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Women's Health: Pregnancy and childbirth are among the most important causes of death of women of child-bearing age in most developing countries. The effect of pregnancy and birth on a woman's health is, in part, determined by the number of pregnancies she has had and the spacing between each pregnancy. A birth interval of less than one year is commonly two to three times riskier than a birth interval of two to three years or greater. Moreover, international data show that the risk of maternal death for high-order pregnancies holds true regardless of the woman's social level. The major reason that maternal deaths increase with birth order is that complications of pregnancy and childbirth rise sharply among third and later births. Such complications include hemorrhage, pulmonary embolism, toxemia and anemia. While these complications kill many women, they weaken and injure many more. Women of high parity are also at an increased risk of developing diabetes, cancer of the cervix, rheumatoid arthritis, hypertension and malnutrition. (Fathers of large families, incidently, are more likely to develop hypertension and gastric ulcers).

A mother's age at pregnancy is also an important factor in determining maternal health. Childbearing in the teens and past mid-thirties is riskier for both the mother and her offspring than when the mother is in her twenties. As in the case of high-birth order risks, the age-related risks of pregnancy are not confined to poor women. These risks are exacerbated for the poor, however, because poorer women are far less likely to face problems in a hospital, or with access to good medical care.

Moreover, complications which might be manageable in a hospital become far more serious, or life-threatening, if they occur when a woman is delivering her baby at home, with the help of a relative or untrained midwife -- the situation in Morocco, where 85% of all deliveries are in the home.

Infant and Child Health: The same factors which increase risks to maternal health also affect the survival chances of children. A child's chances of being born healthy, and of surviving the first few years of life, are reduced by close birth intervals, high parity, and age of the mother.

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International data (WFS, WHO studies) show an increase in death among infants born after short intervals, with this risk to infant health continuing even after the first year of life. This higher rate of fetal and infant deaths may be due, in part, to the lack of time for the mother's body to fully recover after the last pregnancy, (the "maternal depletion syndrome") and by too-rapid weaning from the breast because of a subsequent pregnancy.

International studies also show a strong and consistent relationship between birth order and child health, whereby fetal death rates increase with birth order. While all of the reasons for this relationship are not clear, part of the explanation may lie in the birthweight of the infant. Beginning with the fourth child, the proportion of babies of low birthweight increases steadily.

Low birthweight infants have a much higher risk of dying during the first year; and they may also have more health problems than other children, if they survive. (A WHO Scientific Group has proposed that part of the effect of birth order on child health probably operates through nutritional factors:

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"The incidence of diarrheal disease, the principal cause of death in less developed countries during the first two years of life, is clearly associated with poor weaning practices, and early weaning often follows a short pregnancy interval. The ensuing malnutrition, which reaches its peak during the second year of life, is also related to the high incidence of other infectious diseases." - WHO Technical Report Series No. 842, Geneva, 1970).

The health of infants is also affected by their mother's age when they are born. WFS data from several countries indicate that infant mortality of women under the age of twenty is considerably higher than that of a mother in her twenties. Children born to older women are more likely to suffer debilitating, and possibly life-threatening, health problems.

In summary, the health status of women and children in developing countries is determined to a significant extent by the number of children women bear, the age at which they begin and complete this childbearing, and the intervals between births. The most practical way to affect the health risks posed by these factors is through the use of family planning. Findings from the Morocco portion of the World Fertility Survey and the Morocco Contraceptive Prevalence Survey have identified a large unmet demand for family planning.

These surveys show, for example, that approximately 50% of Moroccan women who currently do not use a modern contraceptive method would accept and use such a method if it were made available to them. If these women did practice family planning, most of the pregnancies/births which would be avoided would occur among the riskier, high parity mothers, leading to a significant decline in both infant and maternal mortality.

It should be noted that current rates of infant mortality in Morocco are higher than might be predicted on the basis of the country's near-middle-income status: overall, infant mortality is approximately 110/1000 births, including an urban rate of 100/1000 births and a rural rate of 119/1000 births.

The role of FP services as a basic public health measure in this context is evident particularly when FP services are combined with such life-saving and health-enhancing measures as ORT and increased immunization. Less immediately obvious but just as meaningful in the larger run, will be the reactions of parents to declining infant mortality in Morocco. It is generally presumed that high fertility -- in Moroccan and in other developing countries -- is at least in part a response to high infant and child mortality.

That is, improved child survivorship will (eventually) lower the probability that parents will want additional children, this strategy of lowering fertility by reducing child mortality has in fact retained considerable appeal to those GOM policy-makers who continue to perceive political/cultural barriers to the widespread acceptance of modern contraceptive practices.

2. Family Planning and Illegal Abortion

Moroccan law permits a therapeutic abortion if the mother's health is in danger and if the husband and attending physician both give their permission for the procedure. While this law might seem relatively liberal in theory, in practice abortion is generally considered to be illegal. And beyond this popular perception of abortion as being formally illegal it is almost universally-regarded as sinful within the Muslim community. Put briefly, legal abortion is not available in Morocco.

The incidence of illicit abortion is not known, given the difficulty of obtaining information about illegal/sinful acts. Moroccan health officials privately concede that illegal abortion is widespread -- one physician suggesting that about one-half of the ob-gyn beds in most major hospitals were occupied by women suffering from the sequaeli of induced abortions initiated by non-medical practitioners.

The potential for preventing deaths (both maternal and fetal) from illegal abortion through family planning is clearly very great, since these pregnancies are unwanted. On the premise that the primary purpose of family planning is to permit couples to have wanted children, abortion -- in addition to its moral and ethical considerations -- must be viewed as a consequence of the non-use (or incorrect use) of contraceptive services.

Efforts to extend the availability of contraceptive information and services in Morocco are therefore seen by the GOM as, inter alia, a means to reduce the incidence of abortion as both a public health problem, and as an assault upon the Moroccan social conscience.

3) Family Planning and the Role of Women

The status of women is markedly ambivalent at every level of the Moroccan social structure: several female members of the Moroccan Royal Family hold prominent positions as honorary heads of various social welfare organizations (including Patroness of the Moroccan Family Planning Association); but there are no women at the highest level of government, no female ministers of state, no members of parliament.

Women are entering the professional levels of government and commercial service in increasing numbers, and women now account for almost 40% of the work force. But women frequently hold jobs that men will not accept because of low wages and the routine nature of the work.

The ambivalent status of women is reflected in the law. A woman's right to vote is guaranteed by the constitution; but she must have male authorization to accomplish any official act. She needs the permission of a husband or brother to manage the inheritance of her children, to obtain a passport, or to travel abroad. A husband can legally prevent his wife from working after marriage.

The Moroccan Federation of Business and Professional Women has presented recommendations to parliament calling for changes in the law, and particularly of statutes covering divorce, alimony and polygamy (still practiced by five per cent of the population). Other Moroccan observers feel, however, that it is custom and tradition, rather than the law, which more effectively bind Moroccan women to the household -- and to their role as wife and mother.

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The inaccessibility of education facilities to Moroccan women has reinforced the effects of law, custom and tradition. Moroccan girls first entered the school system in 1943; and at present, less than 60% of eligible girls are enrolled in primary schools. Moroccan society reflects this legacy of educational neglect of women: the illiteracy rate for females is almost 80 percent nationally, and about 96 percent in rural areas.

Family planning has frequently been advocated in this context as a "liberating" factor which would enable women to establish and realize their own fertility goals, and to thereby participate far more fully in a country's economic and social development. Other observers have pointed, however, that the promotion of family planning to, and adoption by, poor uneducated women is a priori hindered by their non-literacy and adhesion to "traditional" fertility norms.

This latter argument implies that provision of FP information and services per se is an inadequate response to the problem of excess fertility, and that prior/alternative expenditures for female literacy training, skills development, job creation etc. would represent a stronger investment toward reduction of a country's high rate of population growth.

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Survey data in Morocco do in fact reveal the differential patterns of contraceptive use frequently reported in other developing countries: Contraceptive use in Morocco rises with educational level (as well as with age, urban residence and family income). The Morocco WFS (1980) for example, reported contraceptive prevalence to be approximately 16% among illiterate women, and about 45% for women who completed primary or primary and secondary school. Similarly, the Contraceptive Prevalence Survey (1982) reported contraceptive practice ranging from 20.2% among women sans instruction, to 45% among woman who completed primary school, and to 66% among women who completed secondary school. Although a causal relationship cannot be inferred to exist between level of education and level of contraceptive practice, the strong correlation between these factors suggest careful consideration of female education and literacy training as appropriate "population" investments.

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A second look at the Morocco data suggests caution, however, in embracing that conclusion. As noted previously, the Morocco WFS and CPS indicate that approximately 50% of current non-users of contraceptives would accept/use a FP method if it were made available to them -- suggesting a theoretical contraceptive prevalence for Morocco of about 60% (25% current prevalence plus 50% of current non-users) if FP methods were universally- available. In more practical terms, contraceptive prevalence in the VDMS provinces is already between 40% and 50% -- or about double the prevalence found in these areas pre-VDMS -- without any accompanying change in other socio-economic factors.

The point to be made is that investments in female education, skills training, job development, etc. have absolute merit if and by themselves, but not necessarily as essential means to reduce fertility. This point is especially pertinent given the differential cost needed to achieve a change in a socio-economic factor, such as education, which would result in a specific fertility decline, as against the far less costly investment needed for the development of FP service delivery systems.

AID's Population Assistance Policy Paper notes this distinction in observing that ".... contraceptive use has the greatest potential impact on fertility; indeed, in the absence of modern family planning services, some socio-economic changes (e.g., improved child health and changing patterns of breastfeeding) may actually lead to higher birth rates. In short, modern contraceptives provide the means by which individual couples can achieve their desired family size most effectively, safely, and humanely." (p.4).

The approach set forth under this project, then, is a "family planning" approach to fertility reduction in Morocco. It is acknowledged, however, that the largely - FP strategy described herein represents only one portion of a "population" program -- the latter being defined as including other elements of the U.S. assistance program in Morocco designed specifically to enhance the role of women in the development process. These latter activities have included an industrial and commercial job training project for women with the Ministry of a skills-development/income-generating project with the Union des Femmes Marocaine; and specialized training programs in the U.S, for women from various GOM and private organizations.

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These complementary activities, along with other positive social changes under way in Morocco, will possibly reinforce the fertility-reduction effect of the FP program which this project supports directly. As Fatima Mernissi has pointed out, however, the "direct" role of family planning on women's rights, freedom of action and self-expression in Morocco is in itself a potent force for social change in the country.

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ANNEX VII

ADMINISTRATIVE ANALYSIS

Implementation of this project will require the coordinated action of AID (including, primarily, USAID/Morocco, and various AID/W-funded grantees/ contractors); GOM institutions (including primarily the Ministry of Public Health, with additional participation by the Ministries of Plan, Handicrafts and Social Affairs, Youth and Sports, and Agriculture); the Moroccan private sector (primarily the IPPF-affiliated Moroccan Family Planning Association - AMPF); and other donors (including primarily UNFPA). The respective structure and responsibilities of these parties are as follows:

A. AID

USAID direct-hire personnel will continue to exercise primary responsibility for the management of activities discussed in this Project Paper. Specific project management responsibility will rest with the Population, Health and Social Services (PHSS) Division of USAID. PHSS USDH staffing will include a Division Chief/Population Officer; and Assistant Population Officer; and a Health/Nutrition Officer. As in the past, the Division Chief and the

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Assistant Population Officer will act as project officers for each of the several sub-projects, with the specific division of such responsibilities to be jointly agreed to by the two officers in consultation with the USAID Director and Deputy Director. The Assistant Population Officer will also manage the on-going Statistical Services Project -- a census, survey and data analysis activity with the Ministry of Plan -- currently projected to continue through FY 1985.

The Health/Nutrition Officer will manage the Health Management Improvement Project (also expected to continue through FY 1985); the PL-480 Title II program (thru FY 1988); and the Social Services Training Project (until early FY 1985). He (she) will also assist in providing technical oversight for health/nutrition elements (ORT, breastfeeding, growth monitoring) of the population project, with particular reference to the VDMS program.

USAID experience with the predecessor project 608-0155 demonstrated that the distribution of tasks described above will fully engage the time of three USAID professional staff, but will leave little opportunity for the staff to engage in forward planning, program development, and coordination of the diverse activities of the Division. Moreover, the addition to the project of new, labor-intensive activities -- particularly the private sector subproject -- creates a need for additional contract staff.



In view of the special nature and skill-requirements of the (AMPF) contraceptive sales projects, USAID proposes to execute a contract for a technical specialist who will manage these private sector activities. This contract may be either a PSC or an institutional contract depending on the outcome of a project feasibility study to be conducted in early FY 1985. USAID has included funds for a 24-month PSC in this Project Paper. An institutional contract, if necessary, would presumably be co-funded by USAID and the AID/W-financed Contraceptive Retail Sales (CRS) project.

Several AID grantee/contractor organizations will also participate in the project. These include:

1. The Association for Voluntary Sterilization (AVS), which will assist in the implementation of the national reproductive health/ surgical contraception project described under Output 4. AVS will purchase medical supplies and equipment, provide operating expenses for the program, and provide technical supervision for hospitals participating in the sub-project. Funding for this activity will be provided by USAID/Morocco, via a supplement to AVS' existing grant agreement with AID/Washington.

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2. Johns Hopkins PIEGO will continue to support training costs for Moroccan and other francophone/arabic-speaking professionals at the National Training Center for Reproductive Health, Rabat. Funding for this activity will be made available under the AID/W-JHPIEGO grant agreement.
  
3. Westinghouse (or successor-contractor) will provide technical assistance for the execution of two contraceptive prevalence surveys (CPS') during the life-of-project. Costs for these surveys will be shared by USAID (local costs) and by the AID/W contract (for contractor core costs and analysis work performed in the U.S.).

Other technical assistance will be provided under AID/W-funded agreements in such areas as IE+C materials development (Johns Hopkins, PRICOR); operations research (Family Health International, Johns Hopkins); FP records and data management (CDC); and private sector project design (Futures); and analysis and evaluation of FP/health interventions (MSH). USAID will also draw on personnel from these and other organizations to assist in the performance of project evaluations, as described in the Evaluation Plan, Section

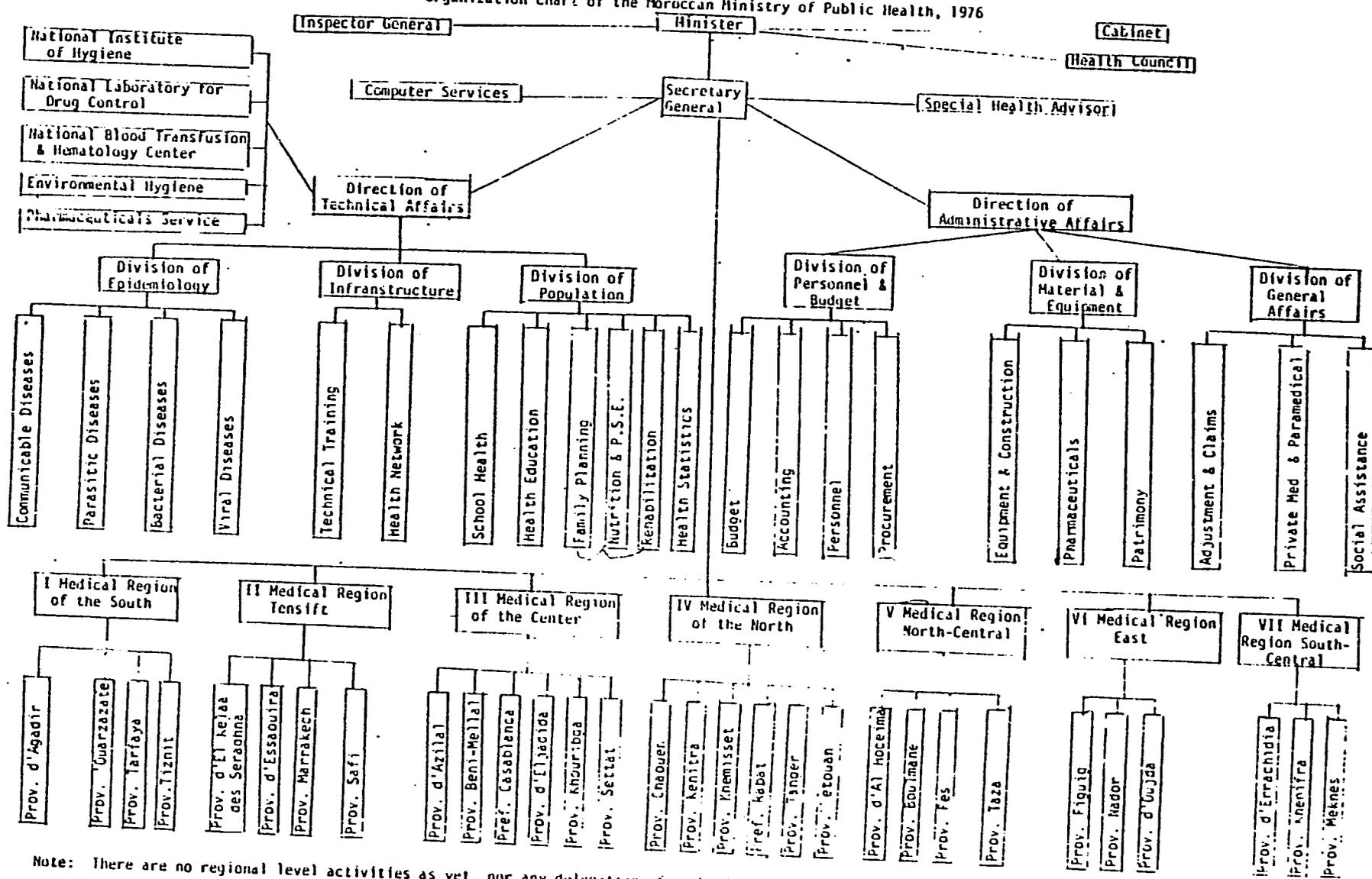
B. GOM

1. The Ministry of Public Health (MOPH) will continue to be the primary recipient of U.S. assistance under this project. The formal structure of the MOPH has been described in detail elsewhere (The Morocco Syncrisis, 1977; Project Paper 608-0155 for the Health Management Improvement Project, 1981) and will not be repeated here. The organization chart reproduced on the next page will facilitate the following discussion of USAID-MOPH relationships concerning administration of the population assistance program.

The Minister of Public Health is the Ministry's signatory to the USAID Project Agreement concerning the major elements of this project. While the Health Minister has not routinely participated in project negotiations or reviews, he has been vigorously, and publicly, supportive of the project. In 1983 the Minister made a RAPID-assisted presentation to the Prime Minister and Cabinet.

The Secretary-General is the senior most career civil servant in the MOPH. He too, has been very

Organization Chart of the Moroccan Ministry of Public Health, 1976



Note: There are no regional level activities as yet, nor any delegation of authority, responsibility, etc. This is still in the planning stage.

Source: "20 Years of Public Health," Ministry of Public Health, 1976.

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supportive of the project since 1978. A public administrator by training, the Secretary-General is USAID's project counterpart for the Health Management Improvement Project.

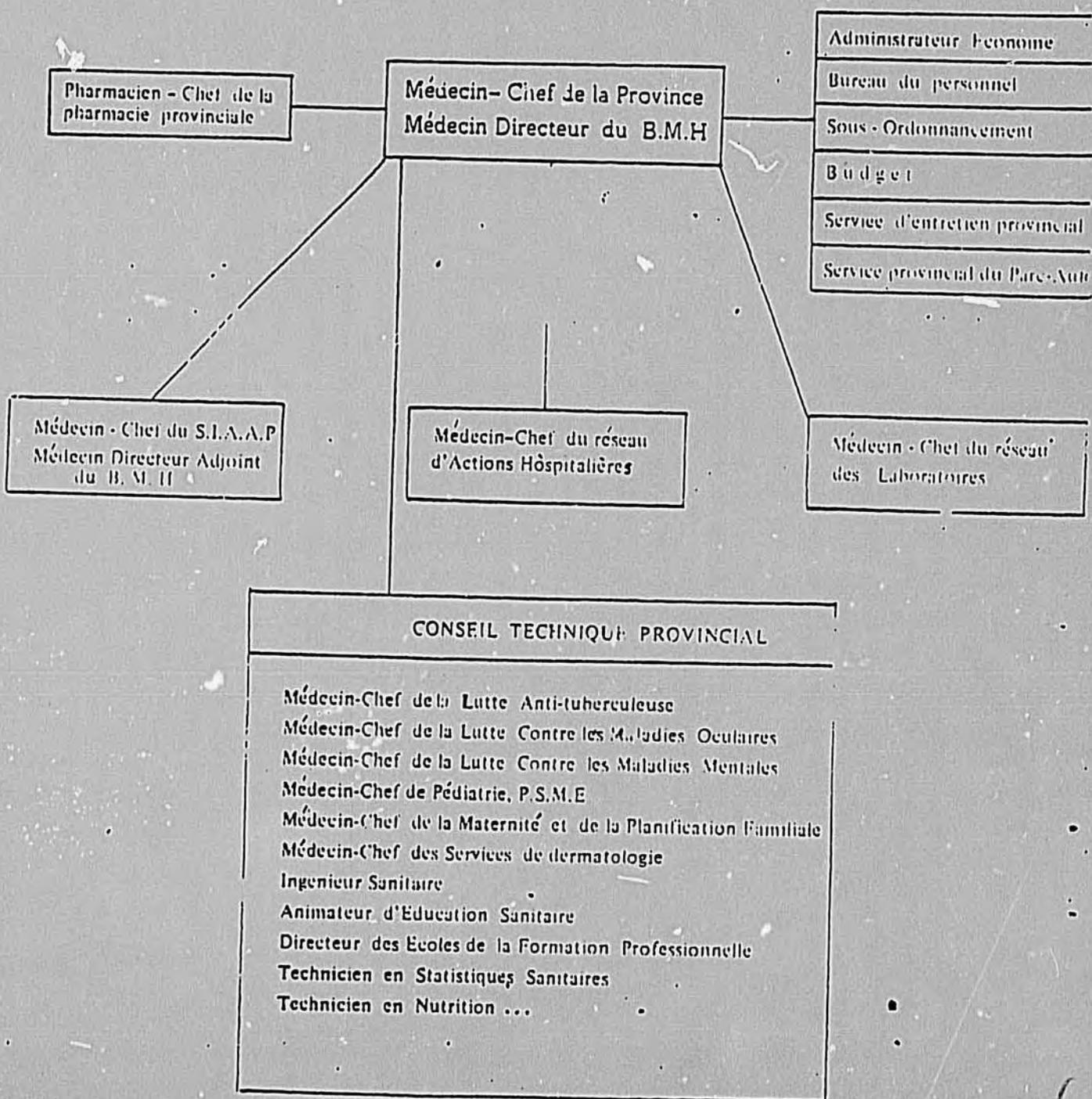
The Director of Technical Affairs is directly responsible for the Ministry's curative and basic health care programs, and is the direct counterpart of the USAID PHSS Division chief for the bulk of activities under this project. He is also the chairperson of the MOPH Comité Technique, which has been designated by the Health Minister to oversee implementation of the MOPH family planning program. That Committee includes the Chief of the MOPH Population Division and the Directors of the Offices of Family Planning, Health Education, Nutrition and MCH, Health Statistics, and as an ex officio member, the Chief of the Infrastructure Division (responsible for long-term planning of MOPH human and physical resources). The Technical Committee meets on an at least monthly basis with USAID/PHSS staff. While the Director of Technical Affairs is clearly responsible for the general direction established by the Committee, the group itself is unusual for the vigor -- and occasional dissent -- with which it examines program performance and options.

USAID maintains day-to-day liaison on project matters with the Chief of the Family Planning Office and/or with his supervisor, the Chief of the Population Division. The family Planning Office serves as the secretariat for the FP Technical Committee; collects and summarizes FP services statistics from the provinces; oversees the disbursement of USAID and other-donor funds in support of the program; compiles fiscal and progress reports; schedules in-country training programs; clears and warehouses imported contraceptive commodities; and serves as liaison on FP matters between the MOPH Technical Committee and provincial health personnel.

At the province-level (see charts, following pages) the MOPH health system is managed by a medcin chef who reports to the province governor and to the MOPH Director of Technical Affairs.

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# ORGANISATION SANITAIRE D'UNE PROVINCE MEDICALE

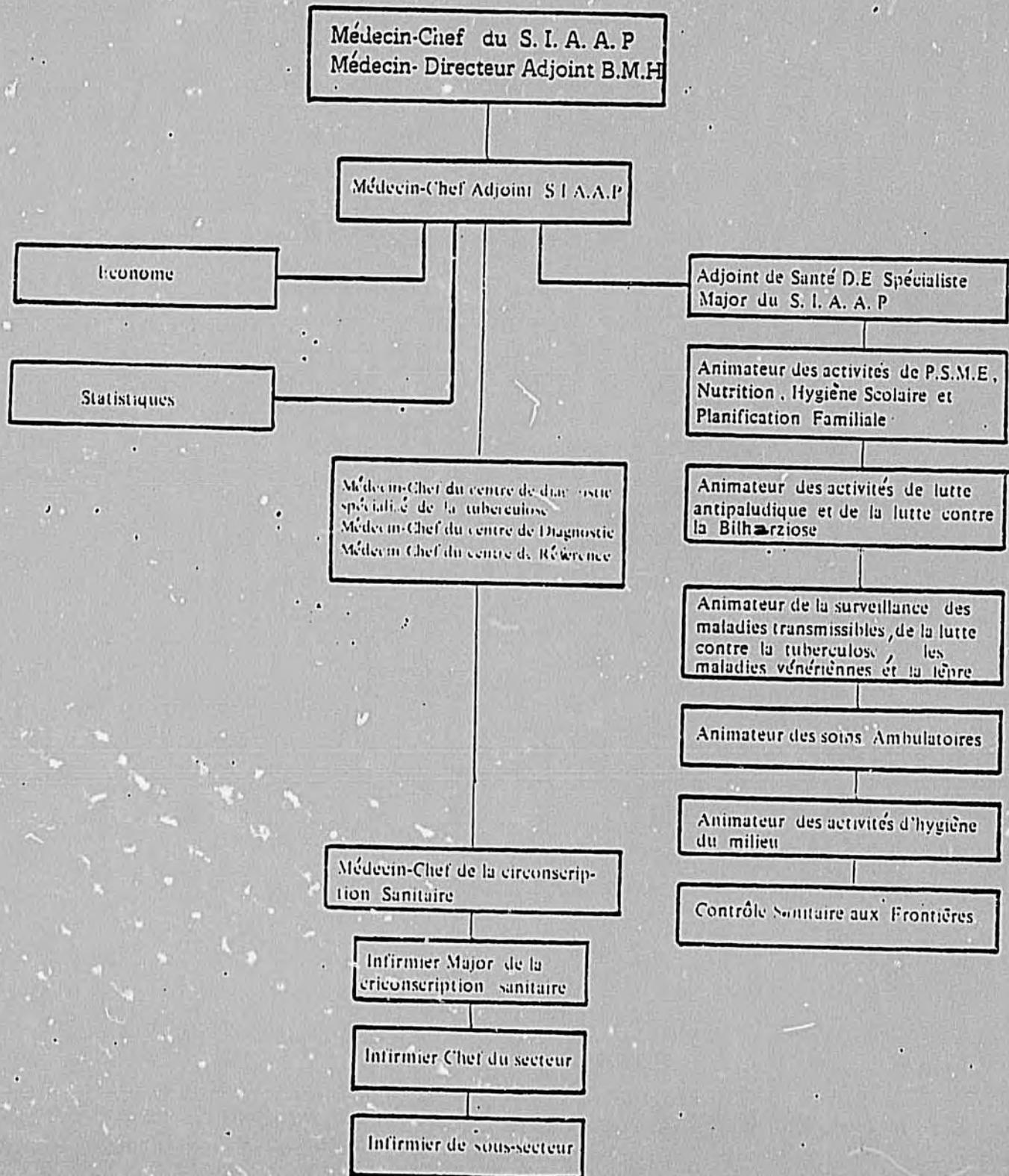


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# Best Available Document

## ORGANISATION DU SERVICE DE L'INFRASTRUCTURE D'ACTIONS AMBULATOIRES PROVINCIAL OU PREFECTORAL

( S. I. A. A. P )



The provincial health network includes three components; hospitals, laboratories, and the primary health care system (SIAAP), each of which is headed by a functional medecin chef. The latter service -- SIAAP -- is responsible for the network of health clinics and dispensaries (typically about 25-30 per province) located throughout each province; the MCH clinics attached to each hospital; the outreach workers based at these facilities, and mobile health/FP vans. This SIAAP network represents the delivery system for the MOPH FP program, including the VDMS project.

All together, MOPH (non-hospital) health facilities include 860 dispensaries (650 rural, 210 urban) each staffed by 4-5 nurses and practical nurses; and 260 Health Centers (150 rural, 110 urban) staffed by a physician and 8-10 nurses and practical nurses. All of these facilities offer FP information and services to walk-in clients. In VDMS provinces, the practical nurses in these facilities are trained and equipped as VDMS outreach workers, and deliver health/FP/nutrition services on a door-to-door basis approximately 20 days per month. The nurse-supervisors are also trained as VDMS supervisors, and make periodic field visits to oversee the work of the outreach agents.

Nurses in most (600) of the 860 dispensaries have been trained and equipped to do IUD-insertions.

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Another UNFPA Needs Assessment Mission will probably be fielded in late 1985 early 1986. As was the case with the 1979 team visit, USAID expects to consult closely with the UNFPA mission, and that their report will reflect UNFPA-AID a division of labor in keeping with the special competencies of our two organizations.

In 20 of Morocco's 45 provinces, Family Planning Reference Centers (generally attached to provincial hospitals) provide FP training to health personnel; provide FP services to walk-in clients; and provide follow-up care to persons referred to the Center by other facilities (e.g. for FP side effects or complications).

The Medecin Chef of SIAAP and ultimately, the provincial Medecin Chef are also responsible for all administrative aspects of the FP program, including the collection/summarization and forwarding of service statistics; receipt, storage and distribution of contraceptives and other project supplies (Actamine, ORS, diet supplements, IE+C materials, etc); arranging in-service FP training for provincial health personnel; and -- in VDMS provinces -- the receipt and accountability of USAID-provided funds for the VDMS project. This latter responsibility is shared with the province-level délégué of the Ministry of Finance. (USAID funds provided by USAID to support VDMS field activities are transmitted by check from USAID to the Ministry of Finance, Rabat.

The Finance Ministry subsequently authorizes its representatives in the VDMS provinces to establish MOPH lines of credit for the VDMS program in accordance with provincial VDMS budgets agreed to previously by USAID/Rabat and the MOPH. The provincial medecin chef is thereafter provided monthly advances by the province-level office of the Finance Ministry. Subsequent allotments for VDMS activities are provided by the Finance délégué upon receipt of proof of expenditure of the prior release.

Summary records of these releases and expenditure reports are forwarded on a trimester basis to the MOPH/Rabat, which provides them to USAID as bases for MOPH requests for additional tranches of USAID funds for VDMS.

USAID support for the various FP activities of the MOPH will continue to be provided indirectly -- through the Ministry of Finance -- for most costs, and directly to the MOPH and/or local vendors of goods and services for selected items/activities. These latter instances will include USAID in-country purchase of off-the-shelf or locally-produced supplies and equipment (IE+C materials, Actamine V, medical supplies, etc.); support for local conferences and training sessions; and support for the

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National Training Center for Reproductive Health. (The NTCRH is a quasi-autonomous institution of the MOPH, and is authorized by the MOPH to maintain direct relationships with various donor agencies).

All of the elements of this project which involve the participation of the MOPH will be included in Project Agreements negotiated with the MOPH and signed by the Health Minister. These Agreements will be approved/signed by the Ministry of Finance on behalf of the GOM.

Two points should be noted concerning the foregoing discussion of USAID-MOPH administrative procedures: 1) the MOPH administrative system which will support this project has been tested and refined in the process of implementing the predecessor-project 608-0155, and has demonstrated its capacity to function effectively. Implementation of the former project required that hitherto lacking or inadequate procedures be installed or improved, including, inter alia, the establishment of a funding mechanism for the VDMS project; the creation of a special bank account for the NTCRH; application of a Fixed Amount Reimbursement procedure for construction of FP Reference Centers; and the development of improved fiscal and performance reporting procedures within the MOPH. Overall, the MOPH is still troubled by serious management shortcoming and archaic administrative systems.

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But the MOPH has shown a capacity to effectively undertake the FP program, including a willingness to experiment with the management innovations needed to do so. 2) The Health Management Improvement Project is addressing many of the Ministry's management frailties. Special problem areas being treated by the management project include personnel administration/manpower planning; pharmaceutical logistics; motor pool management; and financial reporting. The project is also assisting the MOPH in the design and installation of a computerized management information system (MIS) which will link many of the Ministry's disparate elements into a more coherent -- and manageable -- organization. By design, the Management Project focusses on these broader sub-systems which serve as the administrative underpinning for MOPH programs.

Conversely, the management project has not been oriented in any special sense toward family planning program management. Nonetheless the systematic improvements wrought by this project will most likely reinforce the organization's overall capacity to field a vigorous FP program.

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2. Other GOM Ministries/Agencies: Under the predecessor project 608-0155, USAID supported the introduction of population/FP components into the programs of several non-MOPH ministries and agencies. This support included assistance for ANPF's series of FP training programs for personnel from the Ministries of Agriculture, Social Affairs, and Youth and Sports; provision of support for other ministry personnel to attend U.S. and third-country conferences and training programs; and technical assistance and some commodity support (a microcomputer plus peripherals and software -- including RAPID), and user training for the Ministry of Plan. These activities were carried out within the overall rubric of USAID's Project Agreement with the MOPH, and were modest in their scope and cost.

The new project will continue to support ANPF's other-ministry training programs, with particular emphasis on training of extension and outreach workers of these ministries in FP communications and service delivery. To the fullest extent possible, USAID will direct post-training assistance to these ministries to enable them to expand their own FP programs.

This support will be provided via project agreements with these ministries, or if that proves impractical, via supplemental USAID assistance for AMPF (see below). It must be noted, however, that the likelihood of an expansive, other-ministry FP program is rather low. The GOM has given the MOPH sole responsibility for provision of public sector FP services; and the MOPH is quick to point out that its own extensive FP program obviates the need for the duplicative efforts of potentially-damaging "non-professional" FP agents. A practical compromise being explored by AMPF and USAID is to utilize AMPF-trained outreach workers from other ministries as the CBD (Contraceptive Sales) agents described under Output 7.

USAID relationships with the Ministry of Plan are more direct. A separate project, "Statistical Services" (608-0162) is covered by its own project agreement, which includes technical assistance, participant training and commodity support for data collection, and planning. The U.S. Bureau of the Census will provide consultant assistance under that project through FY 1985; and Research Triangle Institute is helping incorporate methodologies to improve long-term planning with special reference to the effects of population growth across various development sectors.

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(RTI assistance is provided under a USAID funding supplement to the AID/W-funded IPDP contract. Project 608-0171 will continue direct support for population activities at the MOP via project-funded technical assistance from IPDP and/or RAPID-II; USAID sponsorship of MOP participation in population conferences and workshops; and training grants for mid-level MOP analysts and planners.

C. Private Sector

1. The Association Marocaine de Planification Familiale (AMPF)

AMPF is the Moroccan affiliate of the International Planned Parenthood Federation (IPPF). Founded in 1966, accorded IPPF-affiliate status in 1971, AMPF is recognized by the GOM as a "société civile" -- a non-government organization engaged in socially beneficial activities. Its primary functions are to: "1) motivate, inform and educate the Moroccan people about the advantages of family planning; and 2) provide family planning services to the Moroccan people, especially the rural population who do not have access to the Ministry of Public Health facilities" (AMPF constitution, 1974).

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AMPF has a staff of 65, including 9 administrative personnel, 12 IE+C staff, and 44 persons involved in FP service provision. Working out of Rabat Headquarters and branches in Marrakech, Fes, Tangier and Casablanca, the organization operates 12 FP clinics; an FP service delivery program using mobile units; and an extensive FP IE+C program, including radio, TV, public exhibitions and training workshops for personnel from various Moroccan agencies, both government and non-government.

The AMPF annual budget is approximately \$540,000, including an annual IPPF grant of \$400,000; USAID (IE+C) annual support totalling \$100,000; a GOM grant of \$75,000; and sales/service income totalling \$35,000.

The organization has been exempted by the GOM from paying taxes. Commodities imported by the AMPF for use in its programs are similarly exonerated from import taxes. AMPF is audited annually by the Morocco officers of Price Waterhouse and Co.

In October, 1983 USAID/Morocco certified that AMPF met the basic conditions for eligibility to seek U.S. Government resources. USG funding for AMPF has to date been provided under the aegis of a USAID Project Agreement with the MOPH.

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This Project Paper proposes to 1) continue USAID support for AMPF's IE+C program described under Output 5; and 2) initiate and provide support for the three FP service activities (contraceptive sales using CBD agents, kiosks and souk tents) described under Output 7.

Funding for AMPF IE+C activities will continue under the same arrangement followed by project 608-0155 -- i.e., as part of USAID's overall Project Agreement with the MOPH. (This mechanism encourages MOPH-AMPF coordination of IE+C activities). The contraceptive sales activities, however, will be funded and administered under a separate agreement between USAID and AMPF. The specific nature of this agreement (Field Support Grant, OPG, contract, etc.) will be determined following a sub-project feasibility to be conducted in early FY 1985.

Continuing the practice of the predecessor project, funds provided by USAID for AMPF activities will be kept separate from funds received by AMPF from IPPF and from domestic sources. AMPF has established a separate bank account for USAID project funds; and the disposition of AID funds has been/will continue to be included in the annual AMPF audit conducted by Price Waterhouse and Co.

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As discussed in the opening paragraphs of this Administrative Analysis, USAID proposes to recruit resident contract technician (PSC or institutional contract: to be determined in early FY 1985) to manage/monitor the AMPF contraceptive sales program. This technician will be knowledgeable in the pertinent aspects of marketing; product and concept promotion; logistics; and project performance evaluation. He will be located at the offices of USAID/Morocco, but will work on a close day to day basis with the staff and technicians of AMPF. As mentioned previously, prior to the recruitment of this technician, USAID

and the AMPF will conduct a joint assessment of the feasibility of the contraceptive sales subprojects which have been proposed by AMPF. This assessment will include the participation of the USAID Population Officer and/or Assistant Population Officer, and short-term consultant Assistance from the AID/W-funded organization (Futures Group, as of this writing) contracted by AID/W to conduct such pre-project studies

This pre-project assessment will also examine the management and administrative implications of an expanded program burden for the AMPF. In May, 1983, IPPF/London conducted a management audit of AMPF, and identified what the auditors felt to be meaningful constraints to broader action by AMPF. These included

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the absence of a full-time Executive Director (the current ED works part-time); the lack of clear lines of responsibility for program operations or administration; inadequate representation of regional branches on the AMPF National Council; and a weak evaluation procedure for assessing project performance. The management audit team proposed a reorganization plan to AMPF -- a plan which the Association declined in favor of its own, alternative plan. AMPF is still in the process of adapting its alternative reorganization plan, which nonetheless reflects some key elements of the IPPF report. The outcome of this effort will be a factor in USAID's decision concerning the scope of our assistance program with AMPF.

USAID's pre-project assessment of AMPF's project proposals will consequently include an assessment of the organization itself, and a determination concerning AMPF's capacity to undertake those projects.

4. L'Heure Joyeuse

L'Heure Joyeuse is a Moroccan PVO affiliated with the International Federation for Family Life Promotion (IFFLP). USAID plans to support the National Family Planning program of L'Heure Joyeuse (see Output 8) via an Operational Program Grant (OPG) or Field Support Grant to be executed between USAID and L'Heure Joyeuse.

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USAID/Morocco certified l'Heure Joyeuse' eligibility to seek U.S. Government resources in October, 1983.

3. Other Private Sector Considerations

- a. The predecessor project 608-0155 drew heavily upon the Moroccan private sector as a vendor of goods and services in support of the project. In-country manufacturers provided most of the medical equipment and supplies purchased for 600 MOPH dispensaries, for the 10 FP Reference Centers, and for the National Training Center for Reproductive Health. A Moroccan cooperative produced the shoulder-sacks used by VDMS fieldworkers; and a Moroccan private company produces the weaning food (Actamine V) distributed by MOPH clinics and VDMS agents.

Oral rehydration salts (ORS), introduced into Morocco by UNICEF/MOPH, are now being produced for the consumer-market by a private manufacturer (Cooper-Maroc). The new project will continue this practice of looking to/stimulating the Moroccan private sector as a vendor of first recourse for project goods and services.

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b. The predecessor project has stimulated a multitude of small-scale, private-sector activities, no single one of which carries significant development potential, but which together suggest a healthy trend in the evolution of the overall project. Examples include the provision of training to private physicians, on a fee-basis, by the NTCRH; AMPF's training/installation of FP service personnel in the health units of factories in and around Casablanca; AMPF's introduction of FP into some 40 Red Crescent facilities around the country; and the sponsorship, by local pharmaceutical companies, of a physicians' conference on contraceptive technology, held in Casablanca in late 1983. The new project will continue to seek out such events/trends in an effort to expand private sector participation in the Morocco FP program.

D. Other Donors

UNFPA is the only other major donor to the Morocco population program.

The current UNFPA assistance program was designed on the findings of a comprehensive Needs Assessment Mission fielded in Morocco in late 1979. Initial assistance further to that assessment was provided in 1981, following the review/approval of the UNFPA Governing Council in June of that year. The UNFPA project portfolio amounts to approximately \$5 million over the period 1981-86 and includes the following activities:

1. Household-Based FP/MCH Services: \$438,000 provided to the MOPH during CY 1983-84 primarily to support the VDMS project. Includes funds for 700 mopeds and about 15 four-wheel vehicles.
2. Census mapping and rural data bank: \$968,000 provided to the Ministry of Plan during the period CY 1981-83, primarily to support preparation of the 1982 census, and the costs of a resident cartographer.
3. FP/MCH Equipment: \$469,000 provided to the MOPH during 1981-82 to furnish medical supplies and equipment to 150 Health Centers.

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4. Professional training: \$811,000 provided to the MOPH during 1981-83 to support in-service FP training, and to develop/revise the curricula at nursing and midwifery schools.
  
5. Population Education in Rural and Slum Areas: \$520,000 to be provided to the Ministry of Youth and Sports to support FP/IE+C through the Ministry's mobile units. This activity has not yet been launched as of early 1984.
  
6. Demography Instructions at the National Institute for Statistics and Applied Economy (INSEA): \$307,000 provided to INSEA, Ministry of Plan, during 1982-84 to fund the costs of a demography instructor, and to develop a demography option within INSEA's master degree program.
  
7. Population Education: \$446,000 provided to the Ministry of Education during the period 1982-85 to develop population education curricula for primary and secondary schools.
  
8. National Household Survey Capability Program (NHSCP): \$210,000 provided to the Ministry of Plan during the period 1983-86 to conduct a series of specialized post-census surveys.

9. Assistance to the Center for Demographic Studies and Research: \$331,000 provided to the Directorate of Statistics (DS) Ministry of Plan over the period 1983-85 to support the costs of a demographic analysis unit within DS.
  
10. Population Education within Health Education: \$480,000 provided to the MOPH during the period 1982-83 to develop the physical and human resources at the MOPH IE+C production unit.

USAID-UNFPA coordination is very close in Morocco. Both agencies routinely share project documents and correspondence, and undertake joint programming of project funds in areas where our assistance is mutually-complementary (VDMS, IE+C, commodity procurement, professional training, and assistance for the Ministry of Plan). Constraints to more effective coordination have included a perhaps too-frequent turnover of UNFPA/Morocco staff (three UNFPA Representatives have served in Morocco during the tenure of the current USAID Population Officer, 1980-84); and a particularly-rigid and time-consuming requirement that UNFPA defer to UNFPA/New York for relatively minor variations in its assistance program. However, these factors have not seriously affected an excellent history of open, practical collaboration between USAID and UNFPA.

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ANNEX VIII

TECHNICAL FEASIBILITY ANALYSIS

This section will consider the project's practical feasibility of attaining its overall purpose, and of achieving its specific outputs.

A. The Project Purpose is to establish a broad-based population program capable of producing a significant reduction in Morocco's rapid rate of population growth. The key objective indicators of Project Purpose attainment will include:

1. The regular availability of FP information and services for at least 70% of eligible couples in Morocco;
2. Contraceptive prevalence in Morocco of at least 35% of MWRA.
3. The incorporation of population analyses, planning and forecasting into the GOM development planning process.

1. Population Coverage: Project 608-0155 greatly expanded the availability of FP information and services in Morocco primarily by 1) installing FP services in all 1200 MOPH health facilities; 2) training and equipping nurses to provide IUDs at 600 rural and urban dispensaries; and by establishing the (household-level) VDMS project in 13 of the country's more populous



Project 608-0171 will further augment the existing coverage primarily by 1) extending VDMS to five additional provinces; 2) launching an "urban-variant" of VDMS in Morocco's larger cities; 3) establishing commercial sales activities in selected villages, bidonvilles and peri-urban areas; 4) establishing sterilization services in provincial hospitals. Still estimates of the actual population coverage attained by 1984 -- and to be attained by 1988 -- must be suggested with caution. For example, although FP services were routinely available throughout the MOPH's national health delivery system by 1984, the "thinness" of the clinical elements of that system, and its less-than-universal use by potential clients, compel the use of a modest "coverage" factor for these health facilities. Similarly, the recent availability of IUD services and the planned introduction of sterilization services represent significant increases in program coverage, but do not lend themselves to confident estimations of the incremental program "reach" which they represent. Other elements of program activity are far more susceptible to such estimations. VDMS, with

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its village maps, household lists and individualized record-keeping system, easily lends itself to analysis of population coverage. Indeed, the 1983 evaluation of project 608-0155 referred essentially to the VDMS project when it reported that the project had reached approximately 40% of the Moroccan population. (The 13 VDMS provinces have a population of approximately 8,800,000 persons, or 40% of Morocco's 22 million people).

The 70% coverage target established for the new population project preserves this rather narrow definition of population coverage. That is, the population covered by over 1200 fixed facilities offering pills, condoms, IUDs, NFP, and sterilization services are counted as within, rather than additional to, the population served by VDMS and other outreach-type activities. Thus, the projected increase in population coverage -- from 40% coverage in 1984 to 70% coverage in 1988 -- refers only to accretions in coverage due to the extension and/or establishment of household-level activities such as VDMS, urban services and the CBD/sales program. Increased coverage represented by the introduction of sterilization services and the enhanced "drawing power" of static health facilities will remain -- as was the case with clinic-based services under project 155 -- a non-add.

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The 70% population coverage projected for this project therefore represents a conservative estimate, much as the 40% coverage reported for project 155 was modest in its disregard for coverage represented by the MOPH static delivery system. Moreover, by retaining a similar definition of program coverage in 1983 and 1988 subsequent evaluations of program performance will be more meaningful.

Program coverage according to this narrow definition is therefore considered to include the proportion of the total population which resides in an area effectively served by an active outreach program. In 1984, approximately 40% of the Moroccan population resided in 13 VDMS provinces. By 1988, approximately 70% of the population will reside in such "service areas" as a result of the extension of VDMS to additional provinces, and the launching of new outreach programs in Morocco's larger cities and in rural and semi-urban areas not served by VDMS. The impact of these new activities on population coverage is illustrated by the following table:

An Estimate of the Population Coverage to be  
Attained by Selected Elements of  
Project 608-171, 1984-88.

<u>Activities</u>	<u>Pop. Served 1984</u>	<u>% of Total</u>	<u>Pop. Served 1988</u>	<u>% of Total</u>
VDMS (13 provinces)	8,800,000	40	9,800,000	40
VDMS (5 provinces)	-	-	3,750,000	15
FP services in Rabat-Salé, Casa, Tangier	-	-	4,900,000	20
Non-adds: Clinic- based FP services provided by MOPH, AMPF, other ministries			-	
CBD/sales	-	-	(680,000)	(3)
TOTAL	8,800,000	40	18,450,000	75
Total Population	22,000,000		24,500,000	

Note: CBD/Sales were not counted because some of the population in the four pilot provinces will also be "covered" by the VDMS program. This component may be expanded to include an additional 2,000,000 persons depending on the outcome of the pilot project.

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2. Contraceptive Prevalence: The level of contraceptive practice targetted for this project, 35%, is conservative. According to the December, 1983 project evaluation, contraceptive practice in Morocco was about 27% MWRA at the time of the evaluation. (Calculated on an estimated 3,500,000 MWRA in Morocco in late 1983). This prevalence figure reflected contraceptive prevalence averaging 45% in three provinces where the VDMS project was fully operational during the period for which prevalence was estimated, and a lower prevalence level in non-VDMS portions of the country.

The components of this national prevalence of 27% MWRA therefore included:

45% prevalence (in Meknes, Beni Mellal and El Jadida) among 332,500 women representing 9.5% of MWRA in Morocco; and

25% prevalence among @ 3,200,000 MWRA elsewhere in the country (or 80.5% of MWRA)

So that

$.45(332,500 \text{ MWRA}) + .25(3,200,000 \text{ MWRA}) = 949,625 \text{ MWRA}$  were practicing contraception at the end of CY 1983.

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As discussed above, (Population Coverage), the proportion of the Moroccan population to be covered by FP outreach activities will be about 70% by the end of 1988. Assuming that levels of contraceptive practice in these new project areas will be more-or-less the same as that attained in the "original" VDMS provinces (45% average), than national prevalence in 1988 should be comprised of the following elements:

45% prevalence among 2,730,000 MWRA (or: 70% of the projected 3,900,000 MWRA in Morocco at the end of 1988); plus

25% prevalence among 1,170,000 MWRA (30% of the projected MWRA) who reside in "non outreach" areas in 1988;

So that:

$.45(2,730,000 \text{ MWRA}) + .25(1,170,000 \text{ MWRA}) = 1,521,000$   
MWRA practicing contraception at the end of 1988

Or:  $1,521,000 \text{ MWRA} : 3,900,000 \text{ eligible women} = 39\%$   
contraceptive prevalence nationwide.

The 35% contraceptive prevalence targetted for this project is therefore a feasible objective, assuming effective implementation of the major elements of the project.

#### Estimating Project Effect on the Crude Birth Rate (CBR)

USAID is not proposing a specific CBR as a project objective to be attained by 1988, primarily because changes in the CBR over time can be attributed tenuously at best to the various activities of a population project.

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The linkage between project activities and contraceptive prevalence, however, is more direct -- as demonstrated by the example of the Morocco VDMS project, which nearly doubled levels of contraceptive practice in VDMS project areas. Some analysts (most notably Dorothy Nortman, Population Council) have nonetheless examined the relationship between the CBR and contraceptive prevalence in several developing nations, and found that prevalence is a generally good indicator of the CBR. In a study of contraceptive practice in 23 developing countries,\* Nortman found that the relationship between prevalence and CBR could be expressed as the regression line

$$Y = 46.7 - .43X,$$

where Y = CBR and X = contraceptive prevalence.

The predictive value of this equation for Morocco would of course be very rough, as it disregards such variables as contraceptive mix, continuation rates, age structure, fecund females exposed to risks of pregnancy, etc. Morocco's fit to this regression line is fairly close, however: using WFS/Morocco data for 1980 (CBR: 41; contraceptive prevalence: 19%) the equation produces a predicted CBR of 38.53 vs the actual CBR of 41. If we presume that this relationship of predicted-to-actual CBR obtains for other prevalence values

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\* Population Council Factbook, p. 101. 1976

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(i.e., predicted CBR = 94% of actual CBR), we can project an estimated relationship between the 35% prevalence targetted for this project and the CBR in 1988. This would be expressed by the modified equation:

$$.94 Y = 46.7 - 43X.$$

Substituting the 35% prevalence target for 1988,

$$.94 Y = 46.7 - 43(.35)$$

$$Y = 33.7$$

Recalling the caution with which this indicator should be approached, we can suggest that the increased levels of contraceptive practice produced by this project may result in a CBR of +34 by end-of-project 1988. This would be a promising beginning, given Morocco's probable CBR of 44 in 1978. The country would still face a considerable demographic challenge, however: replacement fertility for Morocco (assuming a Crude Death Rate - CDR - of 13 per thousand) would only be reached when some 80% of MWRA were practicing a contraceptive method.

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POPULATION DATA/PROGRAM IMPACT, 1978-88

	1978 <sup>1/</sup>	1984 <sup>2/</sup>	1988 <sup>2/</sup>
Population	18,500,000 (est)	22,000,000	24,500,000
Crude Birth Rate	44/1000	38/1000 <sup>3/</sup>	32-34/1000 <sup>3/</sup>
Crude Death Rate	13-14/1000	12-13/1000	12-12/1000
Rate of Natural Increase	3%	2.6% <sup>3/</sup>	2.2% <sup>3/</sup>
Total Females, 15-49			
Year of Age	4.1 million	4.9 million	5.5 million
Married Females, 15-49	2.9 million*	3.5 million	3.9 million
Estimated Contraceptive Prevalence	360,000	950,000	1,365,000
Estimated couples as % MWRA	12.5%*	27%	35%

1/ USAID/Morocco estimates, 1978 (Source: Project Paper 608-0155 dated 08/14/78).

2/ USAID/Morocco estimates, 1984.

3/ Derived estimates based on a presumed relationship between CBR and contraceptive prevalence expressed by the regression equation  $.94 Y = 46.7 - 43 X$ . The actual relationship may vary as the contraceptive mix, continuation rates, etc: change over time. These estimates should be approached with caution.

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3. Population and Development Planning: The predecessor project 608-0155 and the associated project 608-0162 (Statistical Services) initiated a number of activities which have created a stronger GOM "population" orientation toward development planning. The consequences of these previous efforts will become apparent during Project 171. Specifically, the Ministry of Plan has indicated its intention to conduct in-depth analyses of the Morocco portion of the World Fertility Survey, and to integrate these analyses into the Ministry's related work with the 1982 Morocco census. As a first step in this process, Morocco WFS data were included in a census data workshop with USAID and U.S. census Bureau assistance at the Ministry of Plan in early 1984.

Secondly, the Ministry of Plan is currently participating in an Integrated Population and Development Project (IPDP) with assistance from USAID and Research Triangle Institute. That activity is specifically designed to strengthen the Ministry's capacity to carry out population analysis, planning, modeling and forecasting as part of overall development

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planning efforts. When the IPDP project ends in late 1984, the Ministry of Plan will possess the augmented technical skills (and disposition) needed to continue this integrative approach to population planning. Technical assistance and training resources being made available under project 171 will capitalize on this prior activity and will further encourage and promote a broader population perspective within the ministry.

RAPID, meanwhile, has been installed at the Ministry of Plan Institute for the Scientific Analysis of Economic Statistics (INSEA), and is used as a teaching tool for all INSEA-trained demographers and economists.

B. Outputs: Technical Feasibility of Achievement

The various outputs, or subprojects, of this project can be gathered into two groups. These are 1) continuing activities whose feasibility and performance have been established under project 155; and 2) new activities which are still untested in practice.

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The first group of technically proven activities includes the following:

- VDMS
- National Training Center for Reproductive Health (NTRH)
- Improved FP Services (Commodity Supply)
- Professional Skills Development (Training)
- Information, Education and Communications (IE+C)
- Operations Research and Data Collection/Analysis
- Population Policy Development.

VDMS, of course, will be expanded during the 1984-88 period; but this expansion will duplicate the budget, training, logistics, etc., of the existing program. The NTRH, commodity support, training and IE+C activities will also follow the patterns established under project 155, albeit with relatively minor refinements suggested by the December, 1983 project evaluation. The institutional competence of the GOM to conduct operations research and perform data analysis has been satisfactorily demonstrated by the VDMS/Marrakech pilot project, the Morocco/WFS, and two contraceptive prevalence surveys. And as discussed above, USAID and the GOM Ministry of Plan have begun a fruitful collaboration toward the development of a broader GOM perspective re: population policy issues, including MOP participation in an IPDP project.

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The second group of activities are new. They benefit, however, from a considerable amount of preparatory experience. These subprojects include:

- Urban Family Planning/MCH
- Sterilization/Reproductive Health Services
- Private Sector Activities
- Natural family Planning
- Other Ministry FP Activities

Urban Family Planning/MCH Services: The categorization of "urban FP/MCH services" as a separate subproject/output is arguable. Since its inception, the VDMS project has had "rural" and "urban" components, each of which utilized different workplans, budgets and resources. VDMS urban household visitors, for example, work on foot rather than use mopeds; their daily "contact rate" is higher (e.g. 20-30 houses/day, rather than the VDMS rural worker's 12-15 houses per day); and the daily "indemnization" or incentive payment for urban VDMS workers is 10DH\*, as opposed to 15DH for VDMS rural workers. This urban aspect of the VDMS project has already been extended to 13 of Morocco's larger cities -- i.e., the provincial capitals of the 13 VDMS provinces.

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As a practical matter, the subproject described in this section is an extension of the urban component of VDMS to Morocco's three metropolitan centers of Casablanca/Mohammedia, Rabat-Salé and Tangier. These three centers are treated separately for two essential reasons. First, they are "VDMS" project areas which happen to be 100% urban and therefore reflect different population characteristics than "mixed" urban/rural VDMS provinces. Such characteristics include a higher pre-project contraceptive prevalence rate; higher population densities; and proximity to alternative sources of supply for FP services. These factors suggest that a lesser per capita investment would be required to implement a program -- and, as implied previously, that will indeed be the case. USAID assistance for the urban services project will not include funds for moped operations, or repairs, and will provide household visitor subsidies at the lower, urban rate used in the VDMS provinces.

\*8DH = \$1.00

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Secondly, the pre-project levels of contraceptive practice are, as mentioned, higher in cities than in rural areas. The increment in contraceptive practice to be attained by this project will therefore be less than that achieved by VDMS activities elsewhere. The lower-cost approach used in urban areas will however keep the return-on-investment (i.e., cost per new acceptor) of this activity from straying too far from that realized by the provincial VDMS program.

Thirdly, the "urban" subproject is treated separately from VDMS because the areas served by the former activity will include large population settlements -- bidonvilles and smaller squatter areas -- which will require special adaptations to the "standard" VDMS household approach. (The latter, for example, maps and numbers the households in legally-recognized towns/villages and draws up household lists/visitation schedules based thereon. The VDMS project is a "daytime" activity, but in urban areas, the eligible adults might all be at work, requiring special efforts during evenings, weekends, etc.).

The adaptations required by these special characteristics will be relatively minor, however, relative to the larger body of prior VDMS-derived experience which will be brought to the implementation of this activity.

The physical infrastructure in place in these urban areas is fairly strong. Each of the three metropolitan centers has a network of urban dispensaries at which the household visitors will be based; each is served by a hospital and at least one Family Planning Reference Center.

Administratively and logistically, the Casablanca/Mohammedia area presents the greatest challenge. That "urban strip" includes 5 prefectures, each of which would figure separately in the project's administrative and reporting system. The area also includes the most daunting of Morocco's slum settlements. Project activity in Rabat-Salé and Tangier, by comparison, will be relatively less difficult -- although these cities share many of the Casablanca areas's fundamental characteristics.

The MOPH has declared its intention to launch a VDMS-style program in these large metropolitan areas; and the provincial/prefectural medecin-chefs responsible for these areas have indicated their readiness to cooperate. As was the case with the VDMS project in the participating provinces, the MOPH and provincial/prefectural staff will pursue ± one year, i.e., thru FY 1985, of preliminary study, personnel-orientation, and budget preparation prior to initiating formal training and fieldwork in the areas.

USAID will participate in this preparatory phase of activity, possibly to the inclusion of specialized technical assistance as needed. That planning period may reveal special problems requiring adjustment in the scope and timing of the subproject.

Sterilization/Reproductive Health Services: The December, 1983 evaluation of project 0155 found a substantial latent, but as-yet unmet demand for voluntary sterilization (VS) services in Morocco. Waiting-lists for VS procedures at provincial hospitals were (are) frequently six months or more. Where VS services have been made available, e.g., at the NTCRH, popular demand for VS has promptly risen to the full absorption capacity of these institutions. (The NTCRH is currently performing about 100 VS procedures per month).

The aim of this subproject is to permanently install VS and related health services in the surgical and/or ob-gyn departments of 30 provincial hospitals. The approach is straightforward: The AID grantee organization AVS will follow NTCRH "graduates" back to their provincial hospitals; and assist these hospitals to identify the specific commodity, space and financial requirements necessary to institutionalize VS/health services; and provide this assistance in conjunction with the NTCRH, which will be responsible for in-country management and technical oversight of the program. As mentioned, the approach is conventional, and has been employed with considerable success by AVS in several countries.

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USAID accepts the technical premise of this project -- that acceptance of VS services in Morocco will increase markedly as these services are emplaced around the country. USAID is also confident of AVS' managerial competence to undertake primary responsibility for this project, based on that organization's record with similar activities worldwide over the past 12 years. The major concern shared by both USAID and AVS in approaching this subproject is the coordinative capacity of the NTCRH. The NTCRH is an excellent services-and-training facility. Moreover, the NTCRH Director has indicated his intention to establish an internal project management unit within the NTCRH, solely responsible for the execution of this project. Overseeing the VS/health activities of up to 30 provincial hospitals will nonetheless represent a major new responsibility for the Center -- and will bear careful monitoring/continuing assessment by USAID and AVS.

The draft assistance agreement prepared by AVS reflects this concern by calling for a gradual phasing-in of participating hospitals over three years. This approach will provide an opportunity to observe the administrative capacity of NTCRH as it takes on this task, charges, and to make such changes as might be necessary prior to the expenditure of the bulk of sub-project funds.

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Private Sector Activities: A 1979 market feasibility study in Morocco\* reported that a subsidized contraceptive marketing program could conceivably be mounted by the Moroccan private sector. However, the report noted two particular, unresolved objections on the part of the MOPH: an aversion to public, and especially TV, advertising of contraceptive products; and concern over the potential objections by pharmaceutical companies currently providing contraceptives in the commercial market. (The study did not remark on the refusal of the MOPH to meet with the study team during the first week of their 10-day stay in Morocco).

The position of the MOPH toward commercial sales of contraceptive products has remained essentially unchanged over the five years since the feasibility study. Largely because of these continuing objections, USAID has sought to re-design a private-sector contraceptive sales activity in a manner which would both 1) test the practical feasibility of contraceptive sales; and 2) permit the MOPH to assume a more benign posture toward such activities. The "package" of AMPF sales initiatives described under Output No. 7 is therefore modestly ambitious in scope and coverage: it would reach 680,000 persons in its early phases, and would be extendable to a total of more than 2,000,000 persons if practicable.

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\*A Preliminary Assessment of the Feasibility of a Subsidized Contraceptive Marketing Program for Morocco." John U. Farley and Steven J. Samuel, January, 1979.

The activity would differ from conventional social marketing programs, however, in that it would add commercial sales outlets to the existing retail system, rather than introduce contraceptive products into the existing system. Moreover, these new elements -- CBD agents, kiosks, and movable souk/exposition tents -- would complete with, rather than co-opt, other elements of the private sector (i.e., pharmacies) currently selling contraceptive products.

The capacity of AMPF to effectively manage an expansive commercial sales program is also untried. As discussed in Section VII, "Administrative Analysis," AMPF is in the process of re-organizing to improve its overall management strength. Their steps toward that end cannot be considered separately from the technical merits of the subproject.

As of this writing (Spring, 1984), AMPF and USAID have acknowledged a mutual commitment to the principle of expanding availability of contraceptive services via sales to the public. Further to this mutual understanding, USAID and AMPF have developed the set of activities presented under Output 7. However, that proposed package of sales activities -- plus AMPF's management capacity to execute them -- have not yet been subjected to hard critical scrutiny. USAID

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plans to conduct this assessment early in FY 1985, with technical assistance from the Futures Group (an AID/W contractor retained to carry out preliminary feasibility studies of contraceptive sales projects). If that study is positive, USAID will proceed to recruit a contractor (PSC or institutional, as suggested by the feasibility study) to work with AMPF on project implementation.

The scope of work for the feasibility study will not, however, be limited to an assessment of AMPF and the three activities proposed under Outputs Number 7. USAID will invite the study team to consider/recommend such other private sector sales initiatives as might warrant further development in Morocco, and will be prepared to consider alternative uses, if necessary, of project funds currently identified for the three AMPF activities.

Natural Family Planning: The NFP program proposed by L'Heure Joyeuse is carefully designed, reasonably phased, and modest in its overall targets.

L'Heure Joyeuse itself is a well-established PVO in Casablanca, and currently conducts a wide range of MCH, indigent feeding and social welfare programs. Its competence to undertake this subproject is evidently strong.

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The specific family planning method to be presented by this subproject (the so-called "Billings" or vaginal mucosa method) has its relatively major drawbacks. These have been documented in the FP literature. These technical, i.e., low method-reliability, factors must be put in the context however, of compelling ethical/moral reasons for making NFP available to couples who prefer to use such methods. Thus, while USAID is ambivalent concerning the potential effectiveness of this subproject, i.e., as a family planning activity, these technical considerations are deferred in the interest of ensuring a full range of FP services for all persons, consistent with their personal beliefs and preferences.

Other-Ministry FP Activities: The technical feasibility of individual FP activities with various GOM agencies will depend on the implementing institution, type of project, calibre of personnel, etc. These basic questions can only be considered in light of specific project proposals from GOM ministries/agencies.

A more fundamental issue will be the extent to which major initiatives in FP service-delivery will be feasible in view of the Health Ministry's proprietary approach to this subject. Modest forays in this direction will continue under project 171 as they have under project 155, e.g. training/supplying perhaps 200 social workers and extension workers per year as FP motivators and occasional suppliers. More ambitious programs will follow when the MOPH decides, or is instructed, to facilitate broader GOM participation in FP service activities.

The feasibility of conducting non-service population activities with other GOM entities has been well-established under projects 155 and 162 (Statistical Services). These activities will continue to focus on population policy development with the Ministry of Plan; training of other-ministry personnel as FP motivators; and sensitization of public-interest groups (journalists, religious/political/union leaders, women's groups, etc.) to the dimensions of Morocco's population problem.

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ANNEX IX

ECONOMIC ANALYSIS

A. Macro-Economic Modeling Approach to Measuring Benefits

Morocco is one of the first countries for which a RAPID presentation was devised. Futures Group updated this presentation in early 1983, so the data are the best available from that time.\* The following analysis used the simple macro-economic model in RAPID to compare the results of three different scenarios for fertility rates. In an optimistic projection "A" the crude birth rate declines from almost 41 per thousand in 1985 to 36.5 per thousand in 1990. This is the presumed trend line in the absence of project 608-0171 if the existing program is maintained at minimal levels by the GOM, reflecting the withdrawal of external support. In a second pessimistic projection "B", contraceptive prevalence declines precipitously from the current 27% to about 20% of NWRA in the absence of continued AID assistance. In this scenario the FP service network collapses for lack of a well-established family planning clientele, lack of political will to make family planning a national policy issue and to

\* Results from the 1982 post-census survey will provide more accurate baseline data for RAPID. We propose to do this once the results are published and available for analysis. Until then, we are relying on the official baseline developed for the RAPID presentation.

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allocate scarce foreign exchange for contraceptives in the VDMS provinces and the 1200 MOPH clinics. The private sector and a small public sector program continue to cover 12% of MWRA as the public sector role is cut in half due to the withdrawal of outside support. Some observers contend the FP system is still so fragile that it would collapse all the way back to the situation prevailing in the early seventies, a modest private sector presence and almost non-existent public services. The contention of these observers is that the family planning network is too young to have built up a substantial clientele which would protest reductions in service. Projection "C" shows the results expected from an extension of coverage assisted by project 608-0171. The crude birth rate falls from 41 per 1000 in 1983 to slightly less than 34 per 1000 in 1990. From 1990 to 2030, all the projections converge on a total fertility rate slightly above replacement level.

RAPID Projections

	A Optimistic		B Pessimistic		C With Project	
	Contraceptive Prevalence (% MWRA)	Crude Birth Rate	% MWRA	CBR	% MWRA	CBR
1980	12	43.43	12	43.43	12	43.43
1985	27	40.51	27	40.51	27	40.51
1990	29	36.51	20	40.44	35	33.84
2000	35	33.84	24	38.86	43	30.11

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The results of this projection exercise shows a difference in annual per capita income of almosty fifteen dollars as early as 1990 and over eighty dollars by 2000. When compared with the pessimistic scenario, expanded FP activities yield nearly thirty-five dollars higher per capita incomes in 1990 and result in more than one-hundred forty dollars higher per capita income by 2000.

While the gains are fairly impressive in the near-term of five to fifteen years (less than a generation), the phenomenon of momentum in population growth makes the potential gains even more substantial in one generation (thirty years): In our scenarios, income per capita would be 9.6 per cent higher than the optimistic alternative and 24.3 per cent higher than the pessimistic alternative projection. These ever-widening differences are due in substantial measure to the loss of momentum which would be involved in failing to consolidate and build upon the family planning service infrastructure already existing in 1984.

Crude Birth Rate

YEAR	PROJECTION		
	A	B	C
1980	45.59	43.43	43.43
1985	40.51	40.51	50.51
1990	36.51	40.44	33.84
1995	35.14	42.1	30.21
2000	33.84	38.86	30.11
2005	31.92	35.43	29.23
2010	29.47	32.29	27.39
2015	26.94	29.8	24.96
2020	24.58	27.41	22.62
2025	22.31	24.54	20.69
2030	20.32	21.22	19.03

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Total Population (millions)

YEAR	PROJECTIONS		
	A	B	C
1980	20.3	20.3	20.3
1985	23.41	23.41	23.41
1990	26.67	27.17	26.34
1995	30.37	31.98	29.3
2000	34.54	37.29	32.71
2005	39.06	42.94	36.47
2010	43.72	48.82	40.36
2015	48.42	54.93	44.19
2020	53.08	61.21	47.9
2025	57.54	67.25	51.38
2030	61.53	72.58	54.53

Per Capita Income

YEAR	PROJECTION		
	A	B	C
1980	868.45	868.45	868.45
1985	984.19	984.19	984.19
1990	1128.87	1108.24	1143.05
1995	1295.58	1230.39	1343.01
2000	1488.86	1379.26	1572.14
2005	1721.05	1565.33	1843.04
2010	2009.51	1799.66	2176.89
2015	2371.38	2090.11	2598.23
2020	2826.92	2451.7	3133.18
2025	3408.74	2916.25	3816.93
2030	4166.06	3531.67	4700.55

B. Micro-economic Benefits

The assumed reductions in fertility rates through increases in contraceptive prevalence in the macro-economic analysis are a function of the desire of Moroccan couples to have smaller families than was the case in the past. Without this motivation on the part of Moroccan couples, the macro-economic benefits would simply not materialize.

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Evidence from the "Provincial Contraceptive Survey, 1981-82" published in January, 1983 suggests that there is a high level of unmet demand for contraceptive services. Data reproduced from the survey (Table 7.12, p. 79) shows sixty-one per cent of all married women would like to have no more children. The percentage rises from 11% at ages 15-19 to 85-86% at ages 40-49 as couples attain or surpass their family-size goals.

Distribution (in per cent) of married women wanting no more births according to urban or rural residence.

	<u>Total</u>		<u>Urban</u>		<u>Rural</u>	
	<u>Parity</u>	<u>%</u>	<u>Parity</u>	<u>%</u>	<u>Parity</u>	<u>%</u>
15-19	.92	11	.52	16	1.02	9
20-24	2.01	32	1.68	36	2.18	30
25-29	3.54	55	2.89	60	3.98	51
30-34	5.00	70	4.11	74	5.59	67
35-39	6.49	83	5.85	90	6.97	79
40-44	6.83	86	6.36	92	7.20	82
45-49	<u>6.45</u>	<u>85</u>	<u>6.03</u>	<u>83</u>	<u>6.71</u>	<u>86</u>
TOTAL	4.45	61	4.12	68	4.65	57
Living Children	(3.74)	-	(3.53)	-	(3.88)	-
Deceased	(.71)	-	(.59)	-	(.77)	-

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When these figures are compared with average parity figures for the same age-groups, it appears that there is a general preference among younger women to achieve smaller family sizes than has generally been the case for women now completing their families. Even if women wanting no more children have a slightly greater average parity than the other women in their age group, it appears that achievement of the desire to stop having children would result (in the next generation, about thirty years from now) in completed family sizes which average 2 to 3 surviving children (one deceased) in urban areas (they now average five living, one to two deceased) and 4 to 5 surviving children (one deceased) instead of five to six living, one to two deceased in rural areas. These figures indicate a demand for family planning services to reduce fertility from its current levels, particularly in urban areas.

Hypothetical completed family sizes according to distribution of married women (in percent) wanting no more birth by urban and rural residence

<u>Urban</u>		<u>Rural</u>	
<u>Percent of women</u>	<u>Hypothetical desired average completed family size</u>	<u>Percent of women</u>	<u>Hypothetical average completed family size</u>
16	1	9	2
20	2	21	3
24	3	21	4
14	5	16	6
16	6	12	7
<u>10</u>	<u>7</u>	<u>21</u>	<u>8</u>
(100)	3.28	(100)	5.12

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C. The Human-Investment Approach to Program Benefits

The annual cost of maintaining the VDMS program, fixed-clinic contraceptive delivery, the National Center for Reproductive Health and the motivational and training elements judged essential to keep the rate of contraceptive prevalence at its current level of 27% is \$8.3 million. This figure includes USAID and GOM contributions to the operation and maintenance of the current system. It also includes pro-rated costs of GOM administrative and health officials which we are conservatively not counting as a GOM contribution to the project.

Following the human investment approach of Stephen Enke as extended by George Zaiden of the World Bank,\* we have made some rough estimates of the cost-benefit ratio for a program to maintain the current level of contraceptive prevalence.

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\* Population Reference Bureau, "Population Bulletin: Third World Family Planning Programs: Measuring the Costs," Vol. 38, No. 1, February, 1983.

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In fact some evidence\* suggests that the crude birth rate may have dropped to as little as 38 per thousand with a 27% prevalence rate. Thus we are conservatively estimating only half as many averted births as may truly be the case. In addition, we have taken a range of values for consumption (from a conservative 77% of total output to the actual 89% of output) seeking not to overstate the benefits (savings) from averting a birth. For productivity, we have taken the average output per adult 15 to 54 years of age and excluded children and people over age 55 from the potentially active population.<sup>3</sup>

We have not attempted to estimate the positive, but much smaller effects on wage-productivity or public savings. Excluding these factors reduces the benefit-cost ratio somewhat. The table below shows the results of these calculations. The benefit-cost ratios are clearly and

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Preliminary analysis of the 5% Post Enumeration Sample Survey of the 1982 Morocco census. The age distribution in 1982 seems to reflect falling fertility during the previous 10-15 years. Based on mortality estimates (derived from cumulated survival ratios between 1971 and 1982) a preliminary rejuvenation from 1982 to 1967 reveals a CBR of 43.9 for the period 1967-72; 42.8 for 1972-77; and 37.8 for 1977-82. (Informal communication, Peter Johnson, U.S. Bureau of the Census to Gerard Bowers, USAID Population Officer, March, 1984).

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significantly greater than one even though we have systematically understate the potential benefits. These calculations confirm the benefits derived in the RAPID model above.

Net Present Values

(\$ per prevented birth)

<u>DISCOUNT RATE</u>	<u>10%</u>	<u>15%</u>
<u>Benefits</u>		
Consumption	6,118-6,852	3,575-4,004
Wage-productivity effect	(not estimated)	(not estimated)
Public-savings effect	(not estimated)	(not estimated)
<u>Costs</u>		
Productivity	4,635-5,320	1,690-1,939
FP services	96-115	89-115
TOTAL	4,731-4,750	1,779-1,805
Benefit-Cost Ratio	1.13-1.45	1.74-2.25

C. Economic Considerations Relating to Program Size

The economic desirability of pursuing the project activity of maintaining the current rate of contraceptive prevalence and thus keeping the birth rate down by 3 per 1000 is clearly established. The only serious question remaining is the scaling of the activity. "A Study of Economic Evaluation Procedures for Population-Related Projects" by Warren Robinson and Wayne Schutjes states "At the macro level,

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societal benefits can be gained as long as there is a difference between actual fertility and ZPG or replacement levels." Since the growth rate in Morocco is still above 2%/year there is no question there are significant benefits to reducing the growth rate as the calculations have shown. We have also seen in the micro-economic analysis that there is a large unmet demand for family planning services as evidenced by the high proportion of married women wanting no more children. Thus, the conditions exist for a comprehensive family planning program which reaches into every region of the country in one way or another. Given the demand for services and the high rate of population growth, the limiting factor in expanding services is essentially the cost of providing them. These costs may be higher than potential benefits in very sparsely populated areas or areas with a poor transportation and communications infrastructure. The limiting factor in AID's assistance in expanding VDMS coverage beyond 70% of the population is partly a matter of capacity to manage any greater coverage and partly a matter of changing the methods of service delivery in the remaining areas. To go beyond 70% of the national population may require methods of operation which differ from VDMS and similar outreach efforts to be cost-effective, and this issue should be examined at greater length by other donors and/or by AID if we decide to go

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beyond this project. For the time being, the main constraint for 1984-88 is the rate at which the population coverage can be effectively consolidated in the 13 original provinces and extended to the next 5 provinces and the urban areas of Casablanca, Rabat-Salé and Tangier.

Even at much higher unit costs of family planning services in sparsely populated areas, a convincing economic case can very likely be made for outreach programs to supplement the fixed-clinic coverage of almost the entire population of the country as soon as possible. Data from the nationwide post-census sample survey should be analyzed as quickly as it becomes available to help determine:

- 1) The unmet demand for contraceptive services in provinces with only fixed-clinic facilities; and
- 2) The cost of providing outreach services (these costs will probably be higher in more heavily rural areas).

Then the type of calculations made above to assess benefits and costs should be made for all areas with no outreach program. To the extent these calculations show a positive benefit-cost ratio, the administrative difficulties and other problems or issues involved in expanding faster should be addressed and solutions found.

We have chosen to examine the cost of maintaining established gains in order to demonstrate the high return of the activity to date. The targets for expended coverage have been set conservatively and it is eminently reasonable to assume they will be met and probably surpassed. Since the expansion of the system is expected to have the same average cost per new acceptor as the first group of provinces, a decline of only 2 additional births per thousand in the crude birth rate will be sufficient for the expansion to have a benefit-cost ratio greater than one at discount rates of ten percent or above. This very modest performance "requirement" should be easily surpassed in fact.

To reiterate our basic conclusion, at high rates of population growth (i.e. above 1.5 per cent per year) there are large potential economic benefits from reducing the birth rate. (The same statement cannot be made so unequivocally about raising the death rate because of the loss of investment in an individual up to the time of death, not to mention the moral implications of practicing euthanasia, infanticide and so on). These benefits are sufficiently large that it is rational to spend rather large sums per averted birth because of the considerable savings in both private and public expenditures in educating and maintaining an individual before he or she becomes a productive member of society. With the high rate of population growth and a demonstrated demand for contraceptive services in Morocco, the economic case for investment in family planning services is irresistibly strong.

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ANNEX X

FINANCIAL ANALYSIS

The Financial Analyses for Project 608-0151 (Health Management Improvement) discussed the overall financial structure of the MOPH and the Ministry's procedures for allocating health resources. This section will deal more particularly with the financial components of the Population/Family Planning Project, and the project's financial viability in the context of the current program of GOM economic austerity.

- A. Financial Viability of the MOPH/FP Program: The Budget and accounting system of the MOPH is not organized in a fashion that allows an accurate determination of the costs of various programs, activities or facilities. The most explicit such cost dis-aggregation attempted by the MOPH is represented by the ministry's Health, Nutrition and Family Planning budget prepared for the 1981-85 Five Year Plan. This is shown on the following page:

MOPH Proposed Budget for Family Planning 1981-85

(DH 000)\*

<u>Costs/Year</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>Total</u>
1. Construction		400	400	400	400	1,600
2. Educational Materials	2,095	1,754	2,528	2,122	2,551	11,050
3. Contraceptives	7,598	5,878	6,516	9,296	11,785	41,073
4. Equipment	1,800	2,600	1,400	1,400	1,400	8,600
5. Operating Costs of 22 Mobil Units	600	600	600	600	600	3,000
6. Record keeping	250	275	303	333	366	1,527
<b>TOTAL</b>	<b>12,343</b>	<b>11,507</b>	<b>11,747</b>	<b>14,151</b>	<b>17,102</b>	<b>66,850</b>

\* Source: Economic and Social Development Plan, 1981-85. A report of the National Commission on Health, Nutrition and Family Planning. Ministry of Public Health, April, 1980.

While not an accurate portrayal of likely annual budgets for the Plan period, the Plan document does serve the dual purposes of establishing (or deleting) budget lines in the overall GOM budget, and in establishing proportional allocations of resources among various programs. In the case of the 1981-85 Plan, Family Planning was for the first time identified as a separate line item on the MOPH budget, and was allocated (the 1981 equivalent of) approximately \$17.6 million, or about 2% of the MOPH budget proposed for 1981-85. The Plan document acknowledges that an unspecified portion of these funds will be provided by external donors (AID and UNFPA), but does not attribute proportionate shares of the total among the MOPH and external sources.

Estimating the actual GOM cost of the family planning program is further complicated by the fact that the delivery of FP services is thoroughly integrated with other health services. USAID and the MOPH have consequently endeavored to estimate MOPH "system" costs attributable to the FP program. This analysis focused on costs clearly supportive of FP activities, including for example, salaries of full-time FP and VDMS workers, but excluding pro-rata salaries of health personnel who provide FP and related services only on a part-time basis. Other major components of GOM costs

include the MOPH budget for the NTCRH and MOPH costs of fielding the Contraceptive Prevalence Surveys. GOM costs estimated on this attribution basis total approximately \$34 million for the Five-Year period FY 1984-88. These are shown on Tables 2-17 in Section II, "Cost Estimate and Financial Plan".

The Total post-project recurrent costs of the expanded family planning delivery system are made up of three components. The first is contraceptive supplies. These supplies are expected to cost \$1.5 to \$2 million per year by 1988 for the eighteen provinces and the urban areas served by the outreach system. The second is supplies, material, replacment of durable equipment and operating costs of VDMS, urban services and hospital-based services. These are estimated to be \$2 million per year in costs added to the current health system operating costs. The third component is personnel costs of the family planning delivery system. This component is given special attention in the paragraph following the table because of the nature of employment in the public health system.

The table below shows the recurrent costs of the VDMS, urban and hospital-based services and their probable funding sources, all expressed in millions of 1984 dollars

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<u>Item</u>	<u>Annual Cost</u>	<u>Source of Funds</u>
Contraceptive Supplies	2.0	Primarily USAID
Equipment and Operating Costs	2.0	GOM
Personnel	4.0	GOM
<hr/>		
Total Recurrent Costs	8.0	6.0-GOM; 2.0-USG

The third component is the bulk of the recurrent costs. This is principally the salary cost of the time devoted to VDMS by the mobile health workers. This group of health workers and their supervisors are largely already in place in all provinces. There has been virtually no requirement to hire new personnel in order to carry out the VDMS project. Nor will the extension of VDMS activities require more personnel in the MOPH. In other words, prior to the advent of VDMS, mobile health workers were underemployed, lacking as they did the means and the organization to carry public health and/or family planning services to the population in their service areas. Nonetheless, in spite of their low productivity, the MOPH did not attempt to reduce the size of its work force. Nor is it likely to do so in the future except through attrition when it is constrained from hiring replacements. In such a situation, most of the recurrent cost of personnel to maintain the service levels attained through this project is not an additional cost to the GOM. It is a cost which would be borne irrespective of the productivity of the personnel. Thus, although this personnel time is a contribution of the GOM to the project, there is no real opportunity cost to utilizing this underemployed resource of MOPH personnel.

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The same reasoning as above does not apply to either of the first two components. However, with respect to the first, contraceptive supplies, it is highly probable the U.S. will continue its policy of supplying contraceptives to keep family planning program operating on as large a scale as possible throughout the world. We do not anticipate significant reductions in contraceptive availability on a grant basis. This recurrent cost will presumably be borne by an external donor and not by the GOM.

The only recurrent costs with a real opportunity cost are those associated with imported commodities, equipment, supplies gas and oil, and premium payments above customary salaries. This is the second component, estimated to be two million dollars per year by the end of the project. Since this amount is only 1.7% of the total MOPH budget, and in view of the Health Ministry's strong commitment to VDMS and related activities as a proven program, USAID does not anticipate significant difficulties in the GOM meeting these costs fully. In other words, the amounts involved are relatively small and there is an increasingly stronger commitment to the activity on the part of the MOPH and the GOM. For these reasons, we are confident the recurrent costs of the program will be met.

During the project itself we will have ample opportunity to witness the strength of the MOPH commitment, first as the initial three provinces are phased out of USAID support, and later as the next ten provinces are weaned from USAID financing. This progressive testing of the willingness and

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ability of the GOM to provide adequate financing to maintain program levels will permit USAID to intervene and propose remedial actions if the GOM proves unable to maintain previously attained program levels. Among the available options is the possibility of using PL 480 Title I counterpart funds as mentioned in the NEAC Review of the Concept Paper (State 264368). Thus far, counterpart funds have been used strictly in support of a dryland agriculture strategy. The uses are negotiated for each funding tranche with the Ministry of Finance and the Ministry of Agriculture and Agrarian Reform. However, if USAID were to observe a weakening of resolve or a tightening of the MOPH budget which reduced program levels in "graduate" provinces, USAID would propose a remedy to this situation to restore adequate funding levels. One such approach could be the earmarking of PL 480 Title I counterpart funds. However USAID does not anticipate having to resort to this alternative in the near future and expects to rely on increasing levels of MOPH financing as a result of the strength of GOM commitment to the program.

The financial implications of the Project assume a different dimension when considered in the longer term, and across the overall GOM budget. That is, the "externalities" of family planning/fewer births impact significantly on the financial resources required in other sectors (education, agriculture, water; housing, etc.) From this latter perspective, the project will result in a major cost savings to the GOM (See

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B. Financial Viability, Private Sector: The financial viability of the AMPF Contraceptive Sales Project is not yet clear, pending completion of a project feasibility study in the fall of 1984. The experience of sales programs in other countries is too varied to allow firm predictions for Morocco, beyond the observation that program (sales) receipts will not be sufficient to cover total program costs. These receipts will nonetheless contribute significantly to the payment of such costs, excluding the cost of contraceptive products. The sales project is itself a pilot activity, a key object of which is to determine the pricing of contraceptives and related health products in a manner which will optimize the trade-offs between price, sales volume and revenue.

Methods of Implementation and Financing

<u>Method of Implementation</u>	<u>Method Financing</u>	<u>Approximate Amount (\$000)</u>
1. <u>TA</u>		
a. -AID/W grants, contracts and cooperative agreements	Unknown - Contract <sup>1</sup> specific method of financing	2000 <sup>2</sup>
b. -USAID-PSC	Direct Payment	250
2. <u>Commodities</u>		
a. -AID central procurement (Contraceptives)	Unknown - assume Direct Payment	5955 <sup>3</sup>
b. -Direct AID contract procurement (medical supplies and equipment; audio-visual equipment; ADP supplies	Direct Payment	1400
c. -Purchase Orders (data-processing supplies, weaning food)	Direct Payment	350
d. -H.C. Procurement (expendable medical supplies, printing stock; healthworker supplies).	-  Direct Letter of Commitment	  235
3. <u>Other</u>		
a. -OPG <sup>4</sup> with Moroccan PVO L'Heure Joyeuse for NFP activity	Direct Payment	120

b. -H.C. Agreement with the Moroccan Family Planning Association (AMPF) for IE+C activities	Direct Payment	250
c. -OPG <sup>4</sup> for Private Sector Sales Activity	Direct Payment	1000
d. -Local cost support for various sub-projects. Funds to be forwarded through GOM Ministry of Finance	Direct Payment	4710
e. -Local cost support for National Training Center for Reproductive Health. Funds to be forwarded directly to NTCRH.	Direct Payment	250
f. -Miscellaneous - evaluation, audit, technical assistance, contingencies.	Miscellaneous in accordance with overall Mission Financing Policy and Procedures.	1370
T O T A L.....		<u>17,890</u>

1 The project manager for these AID/W-funded organizations are located in AID/W, resulting in the possibility of diminished USAID financial oversight of contractor/grantee expenditures. USAID will address this potential vulnerability by requesting voucher approval authority for in-country expenditures by these organizations, or if that proves impractical, for regular grantee/contractor financial reports to be reviewed by the USAID Project Officer.

2 Includes AVS purchase of commodities valued at approximately \$600,000 for subproject No. 4, VS/Reproductive Health Services.

3 Fund to be administered by AID/W via non-funded PIO/C to enable AID/GSA procurement. The in-kind value of contraceptives will be shown in the USAID-GOM Project Agreement but funds will not be obligated by this ProAG.

4 Obligation documents. These costs will not be reflected in the USAID-GOM Project Agreement.

N.B. With the exception of Nos. 2.a (Contraceptives); 3.a (NFP); and 3.b (Private Sector Sales), funds for all project activities will be obligated via USAID-GOM Project Agreement(s) for project 608-0171.

Commodity Procurement by Source and Origin

<u>Type of Commodity</u>	<u>Source</u>	<u>Origin</u>	<u>Value</u> ( <u>\$000</u> )
Contraceptives	U.S.	U.S.	5,955
Medical Supplies and Equipment	U.S.	U.S.	800
	Morocco	Morocco	200
Audio-visual supplies and equipment	U.S.	U.S.	240
	Morocco	France/Japan	10
	Morocco	Morocco	40
Data Processing supplies and equipment	U.S.	U.S.	100
	Morocco	U.S.	35
	France	U.S.	50
Weaning food	Morocco	Morocco	200
Printing supplies	Morocco	Europe	35
Health worker supplies (sacks, moped racks, clipboards)	Morocco	Morocco	275
<u>Totals</u>	<u>All Procurement:</u>		<u>\$7940</u>
	U.S. Source/U.S. Origin	:	7095
	Morocco Source/U.S. Origin	:	35
	Morocco Source/Morocco Origin	:	715
	Morocco Source/non-U.S./non-Morocco Origin	:	45
	Non-U.S. Source/U.S. Origin	:	50

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As discussed above, (Population Coverage), the proportion of the Moroccan population to be covered by FP outreach activities will be about 70% by the end of 1988. Assuming that levels of contraceptive practice in these new project areas will be more-or-less the same as that attained in the "original" VDMS provinces (45% average), than national prevalence in 1988 should be comprised of the following elements:

45% prevalence among 2,730,000 MWRA (or: 70% of the projected 3,900,000 MWRA in Morocco at the end of 1988); plus

25% prevalence among 1,170,000 MWRA (30% of the projected MWRA) who reside in "non outreach" areas in 1988;

So that:

$.45(2,730,000 \text{ MWRA}) + .25(1,170,000 \text{ MWRA}) = 1,521,000$   
MWRA practicing contraception at the end of 1988

Or:  $1,521,000 \text{ MWRA} : 3,900,000 \text{ eligible women} = 39\%$   
contraceptive prevalence nationwide.

The 35% contraceptive prevalence targetted for this project is therefore a feasible objective, assuming effective implementation of the major elements of the project.

#### Estimating Project Effect on the Crude Birth Rate (CBR)

USAID is not proposing a specific CBR as a project objective to be attained by 1988, primarily because changes in the CBR over time can be attributed tenuously at best to the various activities of a population project.

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The linkage between project activities and contraceptive prevalence, however, is more direct -- as demonstrated by the example of the Morocco VDMS project, which nearly doubled levels of contraceptive practice in VDMS project areas. Some analysts (most notably Dorothy Nortman, Population Council) have nonetheless examined the relationship between the CBR and contraceptive prevalence in several developing nations, and found that prevalence is a generally good indicator of the CBR. In a study of contraceptive practice in 23 developing countries,\* Nortman found that the relationship between prevalence and CBR could be expressed as the regression line

$$Y = 46.7 - .43X,$$

where Y = CBR and X = contraceptive prevalence.

The predictive value of this equation for Morocco would of course be very rough, as it disregards such variables as contraceptive mix, continuation rates, age structure, fecund females exposed to risks of pregnancy, etc. Morocco's fit to this regression line is fairly close, however: using WFS/Morocco data for 1980 (CBR: 41; contraceptive prevalence: 19%) the equation produces a predicted CBR of 38.53 vs the actual CBR of 41. If we presume that this relationship of predicted-to-actual CBR obtains for other prevalence values

(i.e., predicted CBR = 94% of actual CBR), we can project an estimated relationship between the 35% prevalence targetted for this project and the CBR in 1988. This would be expressed by the modified equation:

$$.94 Y = 46.7 - 43X.$$

Substituting the 35% prevalence target for 1988,

$$.94 Y = 46.7 - 43(.35)$$

$$Y = 33.7$$

Recalling the caution with which this indicator should be approached, we can suggest that the increased levels of contraceptive practice produced by this project may result in a CBR of +34 by end-of-project 1988. This would be a promising beginning, given Morocco's probable CBR of 44 in 1978. The country would still face a considerable demographic challenge, however: replacement fertility for Morocco (assuming a Crude Death Rate - CDR - of 13 per thousand) would only be reached when some 80% of MWRA were practicing a contraceptive method.

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POPULATION DATA/PROGRAM IMPACT, 1976-88

	1978 <sup>1/</sup>	<u>1984</u> <sup>2/</sup>	<u>1988</u> <sup>2/</sup>
Population	18,500,000 (est)	22,000,000	24,500,000
Crude Birth Rate	44/1000	38/1000 <sup>3/</sup>	32-34/1000 <sup>3/</sup>
Crude Death Rate	13-14/1000	12-13/1000	12-12/1000
Rate of Natural Increase	3%	2.6% <sup>3/</sup>	2.2% <sup>3/</sup>
Total Females, 15-49			
Year of Age	4.1 million	4.9 million	5.5 million
Married Females, 15-49	2.9 million*	3.5 million	3.9 million
Estimated Contraceptive Prevalence	360,000	950,000	1,365,000
Estimated couples as % MWRA	12.5%*	27%	35%

1/ USAID/Morocco estimates, 1978 (Source: Project Paper 608-0155 dated 08/14/78).

2/ USAID/Morocco estimates, 1984.

3/ Derived estimates based on a presumed relationship between CBR and contraceptive prevalence expressed by the regression equation  $.94 Y = 46.7 - 43 X$ . The actual relationship may vary as the contraceptive mix, continuation rates, etc: change over time. These estimates should be approached with caution.

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3. Population and Development Planning: The predecessor project 608-0155 and the associated project 608-0162 (Statistical Services) initiated a number of activities which have created a stronger GOM "population" orientation toward development planning. The consequences of these previous efforts will become apparent during Project 171. Specifically, the Ministry of Plan has indicated its intention to conduct in-depth analyses of the Morocco portion of the World Fertility Survey, and to integrate these analyses into the Ministry's related work with the 1982 Morocco census. As a first step in this process, Morocco WFS data were included in a census data workshop with USAID and U.S. census Bureau assistance at the Ministry of Plan in early 1984.

Secondly, the Ministry of Plan is currently participating in an Integrated Population and Development Project (IPDP) with assistance from USAID and Research Triangle Institute. That activity is specifically designed to strengthen the Ministry's capacity to carry out population analysis, planning, modeling and forecasting as part of overall development

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planning efforts. When the IPDP project ends in late 1984, the Ministry of Plan will possess the augmented technical skills (and disposition) needed to continue this integrative approach to population planning. Technical assistance and training resources being made available under project 171 will capitalize on this prior activity and will further encourage and promote a broader population perspective within the ministry.

RAPID, meanwhile, has been installed at the Ministry of Plan Institute for the Scientific Analysis of Economic Statistics (INSEA), and is used as a teaching tool for all INSEA-trained demographers and economists.

B. Outputs: Technical Feasibility of Achievement

The various outputs, or subprojects, of this project can be gathered into two groups. These are 1) continuing activities whose feasibility and performance have been established under project 155; and 2) new activities which are still untested in practice.

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The first group of technically proven activities includes the following:

- VDMS
- National Training Center for Reproductive Health (NTRH)
- Improved FP Services (Commodity Supply)
- Professional Skills Development (Training)
- Information, Education and Communications (IE+C)
- Operations Research and Data Collection/Analysis
- Population Policy Development.

VDMS, of course, will be expanded during the 1984-88 period; but this expansion will duplicate the budget, training, logistics, etc., of the existing program. The NTRH, commodity support, training and IE+C activities will also follow the patterns established under project 155, albeit with relatively minor refinements suggested by the December, 1983 project evaluation. The institutional competence of the GOM to conduct operations research and perform data analysis has been satisfactorily demonstrated by the VDMS/Marrakech pilot project, the Morocco/WFS, and two contraceptive prevalence surveys. And as discussed above, USAID and the GOM Ministry of Plan have begun a fruitful collaboration toward the development of a broader GOM perspective re: population policy issues, including MOP participation in an IPDP project.



The second group of activities are new. They benefit, however, from a considerable amount of preparatory experience. These subprojects include:

- Urban Family Planning/MCH
- Sterilization/Reproductive Health Services
- Private Sector Activities
- Natural family Planning
- Other Ministry FP Activities

Urban Family Planning/MCH Services: The categorization of "urban FP/MCH services" as a separate subproject/output is arguable. Since its inception, the VDMS project has had "rural" and "urban" components, each of which utilized different workplans, budgets and resources. VDMS urban household visitors, for example, work on foot rather than use mopeds; their daily "contact rate" is higher (e.g. 20-30 houses/day, rather than the VDMS rural worker's 12-15 houses per day); and the daily "indemnification" or incentive payment for urban VDMS workers is 10DH\*, as opposed to 15DH for VDMS rural workers. This urban aspect of the VDMS project has already been extended to 13 of Morocco's larger cities -- i.e., the provincial capitals of the 13 VDMS provinces.

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As a practical matter, the subproject described in this section is an extension of the urban component of VDMS to Morocco's three metropolitan centers of Casablanca/Mohammedia, Rabat-Salé and Tangier. These three centers are treated separately for two essential reasons. First, they are "VDMS" project areas which happen to be 100% urban and therefore reflect different population characteristics than "mixed" urban/rural VDMS provinces. Such characteristics include a higher pre-project contraceptive prevalence rate; higher population densities; and proximity to alternative sources of supply for FP services. These factors suggest that a lesser per capita investment would be required to implement a program -- and, as implied previously, that will indeed be the case. USAID assistance for the urban services project will not include funds for moped operations, or repairs, and will provide household visitor subsidies at the lower, urban rate used in the VDMS provinces.

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\*8DH = \$1.00

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Secondly, the pre-project levels of contraceptive practice are, as mentioned, higher in cities than in rural areas. The increment in contraceptive practice to be attained by this project will therefore be less than that achieved by VDMS activities elsewhere. The lower-cost approach used in urban areas will however keep the return-on-investment (i.e., cost per new acceptor) of this activity from straying too far from that realized by the provincial VDMS program.

Thirdly, the "urban" subproject is treated separately from VDMS because the areas served by the former activity will include large population settlements -- bidonvilles and smaller squatter areas -- which will require special adaptations to the "standard" VDMS household approach. (The latter, for example, maps and numbers the households in legally-recognized towns/villages and draws up household lists/visitation schedules based thereon. The VDMS project is a "daytime" activity, but in urban areas, the eligible adults might all be at work, requiring special efforts during evenings, weekends, etc.).

The adaptations required by these special characteristics will be relatively minor, however, relative to the larger body of prior VDMS-derived experience which will be brought to the implementation of this activity.

The physical infrastructure in place in these urban areas is fairly strong. Each of the three metropolitan centers has a network of urban dispensaries at which the household visitors will be based; each is served by a hospital and at least one Family Planning Reference Center.

Administratively and logistically, the Casablanca/Mohammedia area presents the greatest challenge. That "urban strip" includes 5 prefectures, each of which would figure separately in the project's administrative and reporting system. The area also includes the most daunting of Morocco's slum settlements. Project activity in Rabat-Salé and Tangier, by comparison, will be relatively less difficult — although these cities share many of the Casablanca areas's fundamental characteristics.

The MOPH has declared its intention to launch a VDMS-style program in these large metropolitan areas; and the provincial/prefectural medecin-chefs responsible for these areas have indicated their readiness to cooperate. As was the case with the VDMS project in the participating provinces, the MOPH and provincial/prefectural staff will pursue ± one year, i.e., thru FY 1985, of preliminary study, personnel-orientation, and budget preparation prior to initiating formal training and fieldwork in the areas.

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USAID will participate in this preparatory phase of activity, possibly to the inclusion of specialized technical assistance as needed. That planning period may reveal special problems requiring adjustment in the scope and timing of the subproject.

Sterilization/Reproductive Health Services: The December, 1983 evaluation of project 0155 found a substantial latent, but as-yet unmet demand for voluntary sterilization (VS) services in Morocco. Waiting-lists for VS procedures at provincial hospitals were (are) frequently six months or more. Where VS services have been made available, e.g., at the NTCRH, popular demand for VS has promptly risen to the full absorption capacity of these institutions. (The NTCRH is currently performing about 100 VS procedures per month).

The aim of this subproject is to permanently install VS and related health services in the surgical and/or ob-gyn departments of 30 provincial hospitals. The approach is straightforward: The AID grantee organization AVS will follow NTCRH "graduates" back to their provincial hospitals; and assist these hospitals to identify the specific commodity, space and financial requirements necessary to institutionalize VS/health services; and provide this assistance in conjunction with the NTCRH, which will be responsible for in-country management and technical oversight of the program. As mentioned, the approach is conventional, and has been employed with considerable success by AVS in

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USAID accepts the technical premise of this project -- that acceptance of VS services in Morocco will increase markedly as these services are emplaced around the country. USAID is also confident of AVS' managerial competence to undertake primary responsibility for this project, based on that organization's record with similar activities worldwide over the past 12 years. The major concern shared by both USAID and AVS in approaching this subproject is the coordinative capacity of the NTCRH. The NTCRH is an excellent services-and-training facility. Moreover, the NTCRH Director has indicated his intention to establish an internal project management unit within the NTCRH, solely responsible for the execution of this project. Overseeing the VS/health activities of up to 30 provincial hospitals will nonetheless represent a major new responsibility for the Center -- and will bear careful monitoring/continuing assessment by USAID and AVS.

The draft assistance agreement prepared by AVS reflects this concern by calling for a gradual phasing-in of participating hospitals over three years. This approach will provide an opportunity to observe the administrative capacity of NTCRH as it takes on this task, charges, and to make such changes as might be necessary prior to the expenditure of the bulk of sub-project funds.

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Private Sector Activities: A 1979 market feasibility study in Morocco<sup>#</sup> reported that a subsidized contraceptive marketing program could conceivably be mounted by the Moroccan private sector. However, the report noted two particular, unresolved objections on the part of the MOPH: an aversion to public, and especially TV, advertising of contraceptive products; and concern over the potential objections by pharmaceutical companies currently providing contraceptives in the commercial market. (The study did not remark on the refusal of the MOPH to meet with the study team during the first week of their 10-day stay in Morocco).

The position of the MOPH toward commercial sales of contraceptive products has remained essentially unchanged over the five years since the feasibility study. Largely because of these continuing objections, USAID has sought to re-design a private-sector contraceptive sales activity in a manner which would both 1) test the practical feasibility of contraceptive sales; and 2) permit the MOPH to assume a more benign posture toward such activities. The "package" of AMPF sales initiatives described under Output No. 7 is therefore modestly ambitious in scope and coverage: it would reach 680,000 persons in its early phases, and would be extendable to a total of more than 2,000,000 persons if practicable.

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"A Preliminary Assessment of the Feasibility of a Subsidized Contraceptive Marketing Program for Morocco." John U. Farley and

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The activity would differ from conventional social marketing programs, however, in that it would add commercial sales outlets to the existing retail system, rather than introduce contraceptive products into the existing system. Moreover, these new elements -- CBD agents, kiosks, and movable souk/exposition tents -- would compete with, rather than co-opt, other elements of the private sector (i.e., pharmacies) currently selling contraceptive products.

The capacity of AMPF to effectively manage an expansive commercial sales program is also untried. As discussed in Section VII, "Administrative Analysis," AMPF is in the process of re-organizing to improve its overall management strength. Their steps toward that end cannot be considered separately from the technical merits of the subproject.

As of this writing (Spring, 1984), AMPF and USAID have acknowledged a mutual commitment to the principle of expanding availability of contraceptive services via sales to the public. Further to this mutual understanding, USAID and AMPF have developed the set of activities presented under Output 7. However, that proposed package of sales activities -- plus AMPF's management capacity to execute them -- have not yet been subjected to hard critical scrutiny. USAID

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plans to conduct this assessment early in FY 1985, with technical assistance from the Futures Group (an AID/W contractor retained to carry out preliminary feasibility studies of contraceptive sales projects). If that study is positive, USAID will proceed to recruit a contractor (PSC or institutional, as suggested by the feasibility study) to work with AMPF on project implementation.

The scope of work for the feasibility study will not, however, be limited to an assessment of AMPF and the three activities proposed under Outputs Number 7. USAID will invite the study team to consider/recommend such other private sector sales initiatives as might warrant further development in Morocco, and will be prepared to consider alternative uses, if necessary, of project funds currently identified for the three AMPF activities.

Natural Family Planning: The NFP program proposed by L'Heure Joyeuse is carefully designed, reasonably phased, and modest in its overall targets.

L'Heure Joyeuse itself is a well-established PVO in Casablanca, and currently conducts a wide range of MCH, indigent feeding and social welfare programs. Its competence to undertake this subproject is evidently strong.

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