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USAID/RABAT ASSISTANCE FOR CDD  
RECOMMENDATIONS FOR INTERVENTION

MOROCCO

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## I. CONTROL OF DIARRHEAL DISEASES IN MOROCCO -- THE CONTEXT

### A. The Arguments for USAID Involvement.

- (1) Diarrheal diseases are the leading cause of child mortality in Morocco, accounting for an estimated 18,650 child deaths per year. Reducing Morocco's infant and child mortality rates are specific objectives for the USAID Mission.

USAID/Rabat has played an important role in successful efforts to reduce overall infant and child mortality in Morocco. However, the number of deaths due to diarrheal diseases in the 0-4 age group remains high; diarrheal diseases are responsible for an estimated 26.7% of infant and child deaths in Morocco. The majority of these deaths are preventable through correct case management of diarrhea cases in the health system and through the application of Oral Rehydration Therapy (ORT) at home. Diarrhea morbidity is also very high -- 7.8 episodes per child per year according to the 1990 Household Survey conducted by WHO and the National Program for the Control of Diarrheal Diseases (CDD).

- (2) The Ministry of Public Health has made the control of diarrheal diseases a very high priority.

Recognizing the problems of high child mortality and morbidity linked to diarrheal diseases, in July 1992 King Hassan requested a strong effort to resolve these problems. This political commitment has been fully supported by the Ministry of Public Health. A Program Review of the National CDD Program in December 1992 and a subsequent detailed planning session in January 1993 have produced an effective and realistic plan of action for the National CDD Program for the 1993-1995 time period.

The MOPH has created a high-level committee for CDD within the Ministry, has promoted the Manager of the National CDD Program, and has added two full-time physicians to his staff. For the 1993-1995 plan, the MOPH is committed to purchasing IV solutions, antibiotics and automobile fuel for the Program.

- (3) Other donors are also making CDD a priority, enabling a high level of donor coordination.

UNICEF will provide ORS for use in the public health system (an estimated 12 million packets over the 1993-1995 time period), and will financially support the National CDD Program in the major areas of training and health education. WHO will provide technical support and financial assistance for research and evaluation. There exists currently an excellent opportunity for

USAID/Rabat to coordinate its priorities with those of other donors and those of the Ministry of Public Health.

- (4) Targeted support for CDD will complement and reinforce USAID/Rabat's current portfolio of assistance for Health and Population.

Strong support for CDD will increase the scope of USAID/Rabat's assistance to the Ministry of Health. Together with anticipated support for other maternal and child health initiatives such as Safe Motherhood and Breastfeeding, USAID will offer the MOPH a coordinated and self-reinforcing package of health assistance which will complement assistance for family planning.

The activities in support of CDD described in the following pages emphasize the strengthening of the primary health care system itself, including case management at the health center level and supervision at all levels of the health system. Support for CDD will be integrated with, and will benefit, the family planning program and other maternal and child health initiatives supported by USAID.

- (5) Support for CDD responds to several specific USAID/Rabat objectives.

USAID/Rabat has the following specific objectives related to the control of diarrheal diseases:

- To reduce infant mortality from 57/1,000 to 50/1,000 by 1997;
- To reduce child mortality from 20/1,000 to 17/1,000 by 1997;
- To increase ORS use rates at health centers and at home;
- To increase the number of ORS packets distributed to retail outlets;
- To increase the percentage of women practicing diarrhea prevention techniques.

## B. Background Concerning the National CDD Program.

The Morocco National CDD Program began in 1979, and has been active nationwide since 1983. Since 1987 the Program has led a concerted effort to promote the utilization of ORS, but these efforts have been somewhat diluted by substandard case management in health centers and a lack of well-coordinated IEC efforts (per the 1992 CDD Program Review). Key statistics for the Program include:

### Morbidity:

Percentage of children aged 0-4 having diarrhea in an average 24 hour period:

- 28.9% or 7.5 episodes per child per year (DHS 1987)
- 27.0% or 7.8 episodes/child/year adjusted for seasonal variation (MOPH/WHO 1990)
- 12.6% or 3.3 episodes/child/year (DHS 1992)

### Mortality:

0-1 years: 57.4/1,000 (DHS 1992)

1-4 years: 20/1,000 (DHS 1992)

Percentage of child mortality due to diarrheal diseases:  
26.7% (1992 estimate)

Number of child deaths/year: 18,650 (1992 estimate)

### Home treatment:

ORS use rate:

15.0% (DHS 1987 - using 2 week time period)

8.0% (MOPH/WHO 1990 - 24 hour period)

13.9% (DHS 1992 - 2 weeks)

Average amount of ORS administered per day:

372 ml. (MOPH/WHO 1990)

C. The 1993-1995 Plan of Action for the National CDD Program. The plan of action has the following major objectives:

- (1) Reduction of infant and child mortality due to diarrheal diseases by 33%. Success in meeting this objective would result in saving approximately 6,000 children per year -- and a reduction through CDD alone in the combined rate of infant and child mortality from 77/1,000 to 70/1,000.
- (2) Reduction of diarrhea-related morbidity in the same age group by 20%. The principal preventative measure to be promoted is exclusive breastfeeding to the age of four months.

To meet these objectives, the plan envisions greatly improved case management of diarrhea cases in health centers, to be achieved through continued training of health workers and supervision which will be both more frequent and more focused on case management and communication techniques. Health education has an important role in the plan, particularly face-to-face communication at the health center and "social mobilization," or campaigns, at the national level.

The plan has 10 specific objectives to be achieved by the end of 1995:

Home treatment:

- (1) 60% of children with diarrhea will receive an increased amount of fluids.
- (2) The ORS use rate will be 20%.
- (3) 50% of children given ORS will receive at least 500 ml. in volume for a 24 hour period.
- (4) 90% of children with diarrhea will receive at least as much food as they received prior to the onset of the diarrhea.
- (5) 100% of children who are breastfed and who become sick with diarrhea will continue to be breastfed during the episode.
- (6) 40% of mothers will know when they should take their child with diarrhea to a health worker.

In the health system:

- (7) 70% of diarrhea cases will be correctly evaluated.
- (8) 70% of diarrhea cases will be correctly rehydrated.
- (9) 70% of mothers accompanying a child with diarrhea will be correctly advised concerning home treatment for diarrhea.

Other:

- (10) ORS will be provided for diarrhea cases in 90% of private pharmacies.

In addition to strengthening case management and health communication, the CDD plan of action calls for increased efforts in social marketing of ORS and efforts to target the treatment and prescribing practices of private physicians and pharmacists. The activities described in the following pages coincide with the priorities, and the activities, of the 1993-1995 National CDD Program plan of action.

## II. PROPOSED STRATEGY FOR USAID/RABAT INTERVENTION

For the time period 1993-1999, USAID/Rabat support for CDD in Morocco will be delivered through the following major channels:

- The Family Planning and Child Survival IV project as amended, including the health IEC component of this project.
- Centrally-funded health projects, including the Population Services International (PSI) grant from the FVA/PVC office of AID/W for social marketing of ORS for the 1993-1995 time period.
- The upcoming private sector health initiative.
- Other projects supported by USAID/Rabat working towards related goals, including the Catholic Relief Services (CRS) project for water, sanitation and health education in Tata and Tiznit provinces.

In order to capitalize on the current prioritization of CDD by the MOPH and to ensure a coordination of donor efforts, USAID will plan to invest as many resources as possible into CDD in the 1993-1996 time period.

By targeting its assistance for CDD, USAID/Rabat can both efficiently support the plan of action of the CDD Program and also coordinate this assistance with other USAID priorities. This document proposes assistance to the CDD Program in the following major areas (each area is described in more detail in the following pages):

- A. A Project Manager who will coordinate assistance and assist the MOPH in planning and implementation for CDD and other maternal and child health care activities.
- B. Technical assistance to strengthen and reinforce CDD supervision and training systems.
- C. Support for integrated IEC activities at the national and provincial levels.
- D. Support for specific interventions to address private sector physicians and pharmacists.
- E. Commodities, including materials for health centers and vehicles for supervision, to strengthen diarrhea case management and supervision within the context of the integrated primary health care system.

- A. A Project Manager who will coordinate assistance and assist the MOPH in planning and implementation for CDD and other maternal and child health care activities. The majority of USAID's assistance for CDD will come in the 1993-1996 time period; during this time a project manager will work directly with the MOPH to help plan and implement CDD activities and to coordinate and manage USAID assistance for the Program. The Project Manager will also support USAID assistance for other maternal and child health care activities under the amended Family Planning and Child Survival IV project, including support for nutrition, breastfeeding and safe motherhood.
- B. Technical assistance to strengthen and reinforce CDD supervision and training systems. The main priority for the National CDD Program is improving the assessment and treatment of diarrhea cases, including interpersonal communication techniques, within the health system. Observation shows that although ORS is available in most health centers, health personnel in many cases do not have the requisite skills to treat diarrhea and dehydration cases beyond the simple act of giving ORS packets to the mother. Little emphasis is placed on giving advice to the mother regarding home treatment -- yet this advice is a critical part of good case management of diarrhea cases.

Although no major studies have been led to evaluate the quality of diarrhea case management in the health system (such a study is planned for 1994), available data confirms observations of weak case management. A 1989 study on child mortality shows that 35.9% of children who died as a result of diarrheal diseases had been seen in a health center or hospital prior to their death (an additional 17.8% had been seen by a private physician). Additionally, the 1987 DHS study shows that 15% of all children with diarrhea were referred to the health system. The health system has access to children suffering from diarrheal disease; the case management of these children needs to be improved.

The CDD Program is moving ahead with plans for the clinical training of health workers in all provinces. Most of this training will take place at the provincial level, with those already trained at the national level acting as trainers. Additionally, the Program plans to train all health personnel with supervisory responsibilities at the level of the province and circonscription sanitaire (health district) in supervision techniques. At the central level, the National CDD Program will actively participate in supervision at the periphery in order to support and strengthen supervision at all levels.

USAID will support these efforts by providing technical assistance to improve technical aspects of training and supervision activities. Considering the speed with which the CDD Program is planning to implement these activities, technical assistance for quality assurance will be invaluable. Specific aspects of this technical assistance will include: (1) development and review of technical guides for supervision and training materials, (2) participation in supervisory visits led by

the central-level CDD Program with an emphasis on supporting supervision of case management at the health facility level, and (3) participation in training courses to provide technical support to trainers.

C. Support for integrated IEC activities at the national and provincial levels. At the national level, the CDD Program will develop more specific and applicable messages concerning home treatment and prevention of diarrhea. These messages will be transmitted to mothers and other caretakers by trained health personnel and by means of annual national campaigns using mass-media and other available channels of communication. At the provincial level, emphasis will be placed on coordinated planning of health education activities for CDD and other primary health care programs.

(1) National Level. The emphasis for technical assistance to the National CDD Program in IEC will be on the development of consistent messages of sound technical quality, as well as efficient investment in channels of communication to transmit those messages. Specific USAID assistance will include:

- Technical assistance to the National CDD Program for the revision of messages regarding home treatment and prevention of diarrhea. The Program is currently planning in-depth qualitative research concerning current practices and attitudes of caretakers; when this research is completed the Program will develop appropriate messages regarding prevention, use of ORS, home available fluids, the importance of feeding and breastfeeding, and referral to the health system. Additional technical assistance over the 1993-1999 time period will permit further revision of these messages to reflect improvements in caretakers' behavior and changing priorities of the National CDD Program.
- The development, testing and printing of educational guides, including flip charts with messages on prevention and home treatment for diarrhea (for use in health facilities and by mobile health personnel) and flyers for distribution to caretakers.
- The development and production of radio and TV spots, and of other appropriate mass media. TV spots will be used in support of the CDD Program's social mobilization campaigns; radio spots will be aired regularly on national and regional radio stations. Although research on the impact of previous mass media efforts is lacking, the 1992 DHS study shows that 90% of urban households and 80% of rural households have a radio set. For TV sets, the corresponding figures are 85% and 33%.

- Specific support for annual social mobilization campaigns to be led by the CDD Program in the June-August time period to correspond with the onset of the high morbidity diarrhea "season." This support will include sponsoring the participation of high profile CDD experts at national conferences organized by the Program, and financing efforts by the Program to sensitize private physicians and pharmacists, and to target employees of large private and para-statal companies.
- Targeted studies concerning the impact of mass communication and social mobilization IEC activities.

These activities will be closely coordinated with the Health Education Division in the MOPH (Division de l'Education Sanitaire -- DES). There exists already a good working relationship between the DES and the CDD Program; the head of the DES has been included in a high-level MOPH committee on CDD formulated as a result of the Program Review of December 1992. The DES has printing facilities and currently produces a weekly show broadcast on the national radio. Additionally, one of the primary goals of the upcoming USAID health IEC initiative is to reinforce the capacities of the DES to undertake high quality material development, pretesting, and impact evaluation.

- (2) Provincial Level. USAID support for CDD IEC activities at the provincial level will be targeted to certain provinces and also integrated with IEC activities for other primary health care programs and for family planning. Together with the upcoming USAID health IEC initiative, support for CDD will focus on health education at the service delivery point -- face to face communication -- with an emphasis on communication techniques. Face to face communication is currently considered a weakness in the public health system; the USAID IEC Strategy points to interpersonal communication as an area needing reinforcement. Additionally, health education through mobile health personnel ("infirmiers itinerants" and "équipes mobiles") will be emphasized.

Provincial IEC action plans, conceived in coordination with the DES at the central level, will take into account local language and cultural realities as well as potential alternative channels of communication, such as regional radio stations, women's associations, "foyers féminins," and other community representatives. While channels of communication will vary from province to province, the central level CDD Program and the DES will ensure that the CDD health education messages being communicated at the provincial level are the same as those developed by the National Program.

- D. Support for specific interventions to address private sector physicians and pharmacists. There is enormous potential to promote positive case management of diarrhea through the private sector in Morocco. There are an estimated 2,200 pharmacy outlets in the country; private physicians are influential and see a large number of patients (per the 1989 study on infant mortality in Morocco, 17.8% of children who died from diarrhea-related causes had been seen by a private physician). Anecdotal evidence and high numbers of anti-diarrheal drugs imported into the country indicate the prescription practices for diarrhea and dehydration in the private sector are far from rational.

The 1993-1995 plan of action for the National CDD Program recognizes the potential of working with the private sector and calls for specific actions in this area, including the continuation of the PSI social marketing initiative. Private sector activities within the framework of USAID assistance to the Program will include:

- CDD activities as part of the upcoming USAID private sector health project, particularly in the context of training of pharmacists and physicians, and as an element of health care packages introduced into enterprises employing large numbers of people. The CDD Program plan of action provides a mandate for additional private sector initiatives, as yet not planned. One suggested activity is to work with soap manufacturing companies for a hand washing campaign.
- Support for a CDD newsletter targeting doctors and pharmacists. The CDD Program will produce a newsletter every three months containing technical articles and explaining program developments. The audience for this newsletter will include physicians and other health personnel in the public and private sectors, pharmacists, and international organizations.
- Continuation of the PSI initiative for social marketing of ORS. The MOPH fully supports the BIOSEL initiative and has included an objective for the availability and prescription of ORS in pharmacy outlets in the 1993-1995 CDD plan of action. The PSI initiative has strong potential to reach private physicians and pharmacists.

The grant to PSI by the FVA/PVC office for social marketing of BIOSEL during the time period 1993-1995 will thus be helpful to the CDD Program. PSI should insure that its communication activities are closely coordinated with, and approved by, the CDD Program. Together with the CDD Program, PSI should train private physicians and pharmacists concerning the rational use of drugs in the treatment of diarrhea and the importance of home treatment. Pharmacists and pharmacists' assistants should be encouraged to, when selling ORS, give correct advice to caretakers concerning the correct preparation and use of the product.

E. Commodities, including materials for health centers and vehicles for supervision, to strengthen diarrhea case management and supervision within the context of the integrated primary health care system. In order to strengthen CDD case management and supervision at all levels of the health system, USAID/Rabat will provide the following materials to the MOPH. Many of these items will directly benefit other health programs which USAID is supporting.

- Vehicles. An important and necessary aspect of improved supervision at the health facility level is to improve the means of mobility of supervisors at the level of the circonscription sanitaire. Typically, provinces and provincial health promotion units (Service d'Infrastructure des Activités Ambulatoires Provinciales -- SIAAP) have a number of vehicles sufficient to carry out supervision activities. But at the level of the circonscription sanitaire vehicles are rarely available for supervision of health centers and dispensaries. The CDD Program cannot of course change this situation single-handedly. However, by choosing certain rural provinces with limited means of mobility and providing vehicles for use at the level of the circonscription sanitaire in these provinces, the CDD Program, and USAID, can have a measurable impact on the quality and frequency of supervision in these areas.

In coordination with UNICEF and with other targeted projects, such as USAID's health IEC initiative, USAID will provide a limited number of vehicles for supervision at the level of the circonscription sanitaire. Although these vehicles will be provided through the CDD Program, supervision at this level of the health system is necessarily integrated; other health programs would also benefit from the use of the vehicles. It will be important to work with the MOPH to ensure that these vehicles are indeed assigned to the level of the circonscription sanitaire and not to the provincial level.

- Support for the central level CDD Program. In order to enable the central level CDD Program to adequately reinforce supervision and manage program activities, USAID will provide a vehicle and portable computer for use by the CDD Program Manager and his staff.
- Materials for health centers. An essential element for improved case management of diarrhea cases is the equipping of health centers with basic materials, including weighing scales, containers for mixing ORS, cups, bowls and spoons. USAID will provide such materials to equip up to 1,800 health facilities (many health facilities already have weighing scales).
- Materials for training centers. In 1994 the National CDD Program will have completed initial clinical training of health personnel

at all levels. At that time the Program intends to create approximately eight regional training units which will conduct training in CDD for health workers identified through supervision as needing such training. USAID will provide support for the creation of these regional training units, which will whenever possible be integrated with the Family Planning regional reference and training centers already supported by USAID. Support for CDD regional training units will include training and audio-visual materials, as well as support for applied research projects taking place at these regional units.

- Supervision and training guides. To reinforce supervision and training led by the CDD Program, USAID will provide funds for the printing of CDD supervision forms, training materials, and case management guides.

### III. PROGRAM LINKAGES

USAID/Rabat assistance for CDD will be closely linked with related USAID assistance for health and population activities. The support for CDD described in this plan emphasizes the strengthening of systems within the Ministry of Public Health, particularly for supervision and health education. By strengthening systems, USAID assistance will contribute to the long-term sustainability of the CDD Program and of related primary health care programs. Specific program linkages for CDD include:

- A. Links with other USAID/Rabat program priorities. The amended Family Planning and Child Survival IV Project integrates USAID support for CDD with support for nutrition, breastfeeding and safe motherhood programs. The Program Manager responsible for daily management and implementation of support for CDD will provide the same support for these programs, and will ensure that USAID's input for these programs is well coordinated. An additional aspect of this coordination will be the involvement of the WELLSTART Project to implement training of health personnel for the promotion of breastfeeding.

The health IEC initiative included in the amended Family Planning and Child Survival IV Project will further reinforce this integration by supporting the Health Education Division (DES) at the central level and by developing solid health education capacities at the provincial level. These improvements will benefit each of the primary health care programs in the MOPH. CDD and family planning will be pilot interventions under the USAID health IEC initiative.

A potential additional link between USAID support for CDD and family planning will be the coordination of regional training centers for the two programs. The regional training centers for CDD described in Section II-E above could be in the same cities as the existing family planning regional reference centers currently supported by USAID. Although the location of clinical training will be different (the pediatrics ward of the hospital instead of the maternity), the equipment used for the didactic sections of the training can be shared by the two programs. Such coordination would make the management of the centers and the training more efficient for the MOPH.

USAID assistance for CDD is directly related to several other ongoing and planned projects including: ORS social marketing (by PSI), the CRS project for water, sanitation and health education in Tata and Tiznit provinces, and the upcoming health private sector initiative. The importance and pertinence of the PSI social marketing project is discussed above in Section II-D. The CRS project fits very well with the targeted approach to IEC activities for CDD at the provincial level, and this project will benefit from the development of effective health education messages for diarrhea prevention by the central level CDD Program.

- B. Links within the Ministry of Public Health. In addition to the program linkages between CDD and other maternal and child health programs such as nutrition, breastfeeding and safe motherhood, assistance to CDD will reinforce the overall primary health care service delivery system of the MOPH. As discussed above, improved capacities for health education at the central and provincial levels will benefit a wide variety of MOPH programs.

A major priority for USAID assistance to CDD is in the area of supervision. By improving supervision techniques, with an emphasis on the supervision of service delivery rather than health statistics, and by providing a limited number of vehicles for supervision at the level of the Circonscription Sanitaire, USAID support for CDD will be closely related to overall improvements of the MOPH supervision structure.

An important recommendation of the recent CDD Program Review and planning session is to provide computers and computer training at the provincial level for the collection and analysis of health statistics. Key staff responsible for supervision at the provincial level, who currently spend much of their time with the many different MOPH health information forms, would therefore be free to dedicate more time to supervision in the field.

USAID/Rabat will help to realize this recommendation by providing a limited number of computers for provinces as part of the amended Family Planning and Child Survival IV Project. Together with computers to be provided by UNICEF and by UNFPA, and with appropriate training of provincial staff, these computers will streamline the system of data collection and analysis at the provincial level, allowing more attention to be paid to service delivery within the health system.

- C. Links between the public and private sectors. USAID assistance for CDD will reinforce specific links between the MOPH and private sector health providers. Support for social marketing of ORS through PSI will be closely coordinated with the National CDD Program and will provide a channel to reach private sector physicians and pharmacists with messages on appropriate case management of diarrhea cases and the rational use of drugs for diarrhea. Support for the newsletter to be produced by the National CDD Program (described in Section II-D above) offers an additional means to influence the same audience.

The upcoming USAID project to promote private sector health care will create further possibilities for cooperation between the CDD Program and the private sector.

**USAID/RABAT ASSISTANCE FOR CDD  
OPTIONS ANALYSIS AND STRATEGIC ISSUES**

(References to the document "USAID/Rabat Assistance for CDD -- Situation Analysis and Planning" are noted by Section, i.e. Section II-C.)

- A. Mechanism for USAID/Rabat Support for CDD activities. The most likely avenue for support of CDD is through the upcoming amendment to the Project Paper for the Family Planning and Child Survival IV project. In the existing Project Paper and Project Authorization for this project no CDD activities are included other than social marketing for ORS. Support for CDD will also be included in upcoming USAID/Rabat initiatives for health IEC and private sector health care.

The majority of the activities as described in the document "USAID/Rabat Assistance for CDD -- Situation Analysis and Planning" lend themselves to implementation through an institutional contractor. Ideally, this contractor would also have the mandate and technical expertise to conduct activities for other maternal and child health programs which USAID/Rabat intends to support, such as Safe Motherhood, EPI, Nutrition and Breastfeeding. Combining support for these activities in one project would significantly reduce the management burden of the USAID Mission and would also make coordination of USAID support for these activities much less complex for the MOPH.

It is important to note that USAID support for CDD should begin as soon as possible in order to coincide with, and benefit from, the push that the MOPH and UNICEF are giving to the National Program. Materials for health facilities, described in Section II-E, could be purchased prior to the onset of an integrated child survival project. Additionally, it may be desirable to provide technical assistance for quality assurance of supervision (Section II-B) and for the development of IEC messages (Section II-C) before the project begins.

- B. Project Management. As discussed in Section II-A, it will be desirable to have a project manager for the CDD assistance. Such a person would need to have at least a strong familiarity with the technical issues related to CDD; an option remains to have an individual in this position who would be more technically qualified and would be able to provide technical assistance to the CDD Program for quality assurance of supervision and training as described in Section II-B. The feasibility of this option depends in large part of the willingness of the MOPH to accept such a person. If the project manager is not a highly technically qualified person, he or she could most likely also manage support for other USAID child survival programs as outlined above; this person would likely need to spend a minimum of 50% of his or her time to manage CDD assistance.

The option also exists to have the project manager involved in the

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management of PSI's BIOSEL initiative (thus reducing the USAID Mission's management burden). At the minimum, a close coordination of activities will be necessary.

- C. Upcoming USAID/Rabat Initiative for Health IEC. This project, as described in the January 1993 strategy document, fits very well with the IEC initiatives for CDD proposed in Section II-B above. The IEC Strategy suggests that family planning and CDD be pilot activities for IEC at the provincial level. At the national level, the family planning program and all of the child survival programs suffer from the same constraints in IEC -- poor targeting, lack of pretesting and lack of impact evaluation. Support for the DES as described in the USAID IEC Strategy is a promising approach to correct this situation.

The IEC Strategy is an excellent, well thought out document. At the provincial level, it may be desirable to expand beyond the 4-5 provinces or pilot areas described in the Strategy in order to increase coverage. It would also be useful to describe the role of the provincial SIAAPs in the execution of the project.

In Section II-E, the purchase of vehicles for the circonscription sanitaire level in certain provinces is proposed. The option remains to target these vehicles in support of the IEC initiative (i.e. in the IEC pilot provinces) instead of for supervision. In effect, what counts is that the vehicles be in provinces where their impact will reinforce other USAID supported activities -- supervision or IEC -- and, hopefully, where their impact can be measured. At the circonscription sanitaire level, the vehicles will almost certainly be used both for supervision and for IEC.

Collaboration between the CDD Program and the DES is very important. As long as this collaboration is strong, it should not make a great deal of difference whether USAID finances CDD IEC activities directly through the CDD Program or through the DES. The DES probably has more technical capacity but the CDD Program has many good ideas and a greater sense of urgency. Development of messages specific for CDD, including related research, should be financed through the CDD Program. Activities at the provincial level will probably be more manageably financed through support to the DES, which would enhance coordination with the USAID Health IEC initiative.

- D. Private Sector and Social Marketing Issues.

- (1) Issue of Sales Outside of Pharmacies. Sale of ORS in venues such as "tabacs" has three principal drawbacks: (1) there are potential negative effects for the image of ORS as an effective drug, (2) it is unlikely that sound advice on preparation and use will accompany the sachet, and (3) such sales are not sustainable if the distribution and the marketing are paid for by an outside

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organization such as PSI. If PSI is convinced of the effectiveness of sales outside of pharmacies, it may be appropriate to ask PSI to do a study regarding the effects of such sales on the image of the product, and to provide a plan for educating the consumers on the use and preparation of ORS.

- (2) Local Production of ORS. It appears that PSI may look for a company different than SOTHEMA to manufacture ORS for the next phase of the BIOSEL project; quality assurance will be essential. With the several different initiatives already undertaken for local production in Morocco, it seems unlikely that USAID will want to get involved in this issue beyond what PSI will do. UNICEF will likely supply ORS for the public sector at least through 1995.
- (3) Long Run Sustainability. In the long run, provision of ORS for the public sector is an issue that the MOPH must address, perhaps with the support of UNICEF in a phase-out approach. In the private sector, it will be very important that for the demand created by the BIOSEL initiative there be a corresponding increase in the capacity to supply (manufacture/import, distribute and market) ORS within the private sector.

It is unlikely that a completely sustainable marketing and distribution system for BIOSEL will be created by 1995. Upon the completion of the PSI project, USAID should continue to support social marketing of ORS, working with local manufacturing and marketing companies to ensure that the product is fully sustainable and operated completely within the private sector by, or before, 1999.

- E. Integration of CDD and Acute Respiratory Infections. Integration of CDD with other MOPH programs and USAID projects is described in detail in Section III. However, integration of ARI and CDD appears unlikely at this time due to the location of the two programs in different directorates in the MOPH. There remains the possibility of including ARI IEC messages in integrated IEC activities at the provincial level in coordination with the Division de l'Education Sanitaire (DES). ARI remains a high priority, accounting for 12% of child deaths in Morocco (per the 1989 mortality study).

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