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MOROCCO

**IMPLEMENTATION PLAN FOR
USAID ASSISTANCE
IN
POPULATION AND HEALTH
1992 - 1996**

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ACRONYMS

A.I.D.	- Agency for International Development (Washington)
AMPF	- Association Marocaine de la Planification Familiale (Family Planning Association of Morocco)
ARI	- Acute Respiratory Infections
CERED	- Centres des Etudes et Recherche Demographique (Demographic Research Center)
CNOPS	- Caisse Nationale des Organismes de Prevoyance Sociales (National Insurance Fund)
CNSS	- Caisse Nationale de la Securite Sociale (Social Security System of Morocco)
CPS	- Contraceptive Prevalence Survey
CQI	- Continuous Quality Improvement
CYP	- Couple Years of Protection
DES	- Division de l'Education Sanitaire (Health Education Division)
DHS	- Demographic and Health Survey
DPES	- Direction de la Prevention et de l'Encadrement Sanitaire (Preventive Health Services Directorate)
DPT	- Diphtheria, Pertussis and Tetanus
EEC	- European Economic Community
FP	- Family Planning
GOM	- Government of Morocco
IEC	- Information, Education Communication
INAS	- Institut National de l'Administration Sanitaire (National Institute of Health Administration)
IPPF	- International Planned Parenthood Federation
IUD	- Intrauterine device
MCH	- Maternal and child health
MIS	- Management information system
MOPH	- Ministry of Public Health
NGO	- Non-governmental agency
OR	- Operations Research
ORS	- Oral Rehydration Solution
ORT	- Oral Rehydration Therapy
PSI	- Population Services International
SCPF	- Service Central de Planification Familiale (Division of Family Planning Services)
SEATS	- Services Expansion and Technical Support
SMI	- Sante Maternelle et Infantile (MCH)
STDs	- Sexually Transmitted Diseases
TQM	- Total Quality Management
UNDP	- United Nations Development Program
UNFPA	- United Nations Population Fund
USAID	- U.S. Agency for International Development (Mission)
UNICEF	- United Nations Children's Fund
VCS	- Voluntary surgical contraception
VDMS	- Visites a Domicile de Motivation Systematique (MOPH Outreach)
WFS	- World Fertility Survey

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This implementation plan is the product of intensive discussion, reflection, and debate during several weeks of April and May, 1992 among representatives of the principal partners for population and health program development in Morocco -- the Ministry of Public Health (MOPH) Directorate of Preventive Health Services (DPES), USAID/Morocco Population and Human Resources Division, A.I.D./Washington Research and Development Bureau/Office of Population, and centrally funded Cooperating Agencies. DPES staff, including top level leadership in the person of the Director, Professor F. Hakkou; the Chief of the Family Planning Unit (SCPF), Dr. M. Zarouf; the Chief of the Mother and Child Health Unit (SMI), Dr. Najia Hadji; the Chief of the Health Education Unit (DES), Dr. Essolbi; and Dr. R. Belouali, Director, Institut Nationale de l'Administration Sanitaire (INAS), gave unstintingly of their time and experience, first, in providing input for this exercise, and second, in reviewing and critiqueing preliminary results. Additional input was provided throughout this exercise by other DPES staff. Special appreciation is also owed to MOPH staff working in Kenitra Province which was the site of a field visit conducted during the course of this exercise.

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The team of external experts who visited Morocco during the period April 20 to May 8 included two senior staff of R&D/POP, Elizabeth Maguire, Associate Director, and Harriett Destler of the Family Planning Services Division. They were joined by James Knowles of the Futures Group (Options/Evaluation Projects) and Don Lauro of the SEATS Project, John Snow, Inc. Time and transportation for the team to participate in this exercise was paid for through central A.I.D. resources. The external team was responsible for drafting the report and completing final edits.

SECTION I
EXECUTIVE SUMMARY

The centerpiece of USAID support for health and population in Morocco has been -- and remains -- family planning program development. USAID assistance to family planning in Morocco began in the mid-1970s with a pilot project to test community-based household-level provision of family planning services. Initial success of this approach, Visites à Domicile de Motivation Systematique (VDMS), led to its subsequent expansion and evolution. Today, extensive outreach remains the hallmark of this nationwide program that provides an integrated package of services: family planning, immunization, diarrheal disease control, and growth monitoring.

Since 1976, USAID has invested over \$50 million in population and health in Morocco, contributing significantly to achievement of the following results:

- contraceptive prevalence has increased from approximately 20% in 1979 to 42% (36% modern methods) in 1992;**
- total fertility has declined from 5.9 in 1979 to 4.2 in 1992;**
- vaccination coverage has increased from 40%-50% in 1985 to over 70% in 1989 (fully documented);**
- mortality of children age 1-4 has decreased from an estimated 77 per 1000 in the early 1970s to 20 in 1992; and**
- infant mortality has declined from an estimated 122 per 1000 live births in the early 1970s to 57 in 1992.**

As impressive as these results are, there are continuing needs for both program development and donor support. That family planning services are not yet available to all who may need or want them is evinced by 1992 Demographic and Health Survey (DHS) data indicating that 49% of women want no more children than they already have and another 24% prefer spacing children by at least two years. Similarly, according to the 1992 DHS data, only 31% of deliveries throughout the entire country are attended by medical practitioners, and only 32% of pregnant women receive modern prenatal care.

Improving the quality of the services that are available is also essential. Family planning has to date been largely a one-method program in Morocco with 80% of modern method mix in 1992 attributable to oral contraceptives; efforts have recently been launched to make IUDs and voluntary surgical contraception more readily available. Oral rehydration therapy, a key component of the child survival effort, reportedly was used by only 16% of 1992 DHS respondents whose children recently had diarrhea. A notable program weakness has been and continues to be the lack of information in the form of messages and materials to educate and motivate clients and prospective clients for effective use of FP/MCH services.

In addition to such immediate program needs, there are also broader institutional considerations. Long term sustainability of FP/MCH services in Morocco cannot be achieved without continuing political support and substantial financial resources for the public sector program as well as an increased role by the private sector.

The review of A.I.D. and USAID supported population and health programs in Morocco upon which this Implementation Plan is based was conducted during the period April 20 to May 8, 1992 by a four person team of external experts working in close collaboration with USAID and MOPH counterparts. This team consisted of Harriet destler and Elizabeth Maguire, both of R&D/POP, and James Knowles and Don Lauro, of The Futures Group and John Snow Inc.

This Implementation Plan also builds upon a recent review of the overall USAID/Morocco development portfolio, the Prism Review. This review provided, within the context of the overall goals and objectives of USAID/Morocco, a clear statement of outputs and sub-outputs relevant to health and population. In the implementation plan, these outputs and sub-outputs are transformed into specific objectives and related strategies for achieving the health and population sector goal of improving the health of children under five and women of childbearing age. These objectives and the related strategies provided the following structure for developing the implementation plan:

OBJECTIVE 1: INCREASED USE OF EFFECTIVE FP/MCH SERVICES

STRATEGY 1: INCREASE ACCESS TO FP/MCH SERVICES

STRATEGY 2: IMPROVE QUALITY OF FP/MCH SERVICES

STRATEGY 3: INCREASE ACCESS TO EFFECTIVE INFORMATION

OBJECTIVE 2: SUSTAINING FP/MCH SERVICES

STRATEGY 1: INSTITUTIONAL DEVELOPMENT

STRATEGY 2: IMPROVE MANAGEMENT SYSTEMS FOR FP/MCH

STRATEGY 3: FINANCIAL SUSTAINABILITY

In thinking about how A.I.D. resources could make the maximum contribution, the Team considered the resources available under Bilateral Project 608-0198 and those available from centrally funded A.I.D. projects or those which could be made available under future USAID/Morocco projects. The Implementation Plan includes two kinds of activities: 1) activities already ongoing or planned; and 2) activities proposed to strengthen efforts to achieve respective objectives.

The major ongoing and planned activities included in the Plan are the following:

OBJECTIVE 1: INCREASED USE OF EFFECTIVE FP/MCH SERVICES

- Provide contraceptives and supplies
- Improve facilities, transport and training
- Expand coverage of key FP/MCH services
- Increase delivery of long-acting methods
- Expand social marketing
- Improve information on available services
- Develop/implement service delivery protocols
- Implement national IEC strategy
- Develop materials and training in counseling
- Introduce STD/AIDS interventions
- Support safe motherhood initiative

OBJECTIVE 2: SUSTAINING FP/MCH SERVICES

- Strengthen MOPH planning and coordination
- Support INAS
- Support decentralization and regional facilities
- Continue policy dialogue and constituency building
- Expand private sector activities
- Design new private sector project
- Train private sector providers
- Contribute to MOPH/UNICEF Childhood vaccination fund

Among the priority activities proposed in the Implementation Plan, the following are of highlighted:

- Prepare MOPH to assume responsibility for contraceptive procurement

Current plans call for the termination of USAID contraceptive procurement in 1994 (with the pipeline expected to sustain the program through 1996). The highest priority attaches to the development of a realistic phaseout plan for USAID assistance. Although it is recommended that USAID support continue beyond the previously planned cut-off date (1994), such continuing assistance should be part of a well-conceived, systematic phaseout plan.

- Test alternative approaches to outreach

The backbone of FP/MCH in Morocco has always been the extensive outreach provided through the VDMS program. With program maturity and nationwide expansion, along with integration of more services and mounting costs in maintaining a household distribution program, other, more cost-effective approaches need to be explored. Point-of-contact and mobile units already being implemented can be complemented by community agent, community doctor, and/or other approaches to serve both rural and urban areas through both the public and private sectors.

- Expand prenatal and postpartum services

Prenatal services remain underutilized (fully 68% of women reporting in 1992 that they had used no prenatal services) and postpartum family planning remains largely unavailable. As the Safe Motherhood Initiative gathers momentum in Morocco, particularly with development of a national strategy for Maternité sans Risque and the infusion of \$900,000 from the European Economic Community (EEC) for programs in 12 maternities, USAID resources should be directed to strengthening the family planning component of these efforts, particularly to adding prenatal and postpartum components to the family planning reference centers (established with USAID funding), which appear to be underutilized for service provision.

* Information, Education and Communication Initiative

While the FP/MCH program has a strong record of accomplishments, more needs to be done in IEC to take the program to its next level of success. An overall strategy for health education is still to be finalized and successful implementation will require additional financial and technical resources. Private-public sector partnerships in the area of IEC should be forged to take fuller advantage of capabilities which exist in both. Counseling for services is a particularly important component of health education to which some attention is already being paid. Within the context of improving overall quality of services more concerted efforts will have to be made to improve counseling. Mass education campaigns could clearly also be a part of broad new health care efforts, such as the Safe Motherhood Initiative. To secure adequate funding for strengthening IEC, an amendment in the amount of \$15 million to the existing project is proposed for FY 1993.

* Improve Service Delivery Quality

Improving the quality of FP/MCH services is critical to future program success in Morocco. In addition to improving specific elements of quality such as method choice, counseling, and provider technical competence, More attention needs to be paid to strengthening leadership, motivation, and commitment at all levels. Among the activities proposed to improve quality are the establishment of model quality sites, introduction of performance based programs, and initiation of quality awards. By supporting such activities, USAID assistance will serve not only to provide support for what needs to be done, but also will provide guidance on how this may be approached.

* Improve Management Systems

Involving managers and service providers at all levels in decisions about what they do and how they can do it better is a key element of quality management. It is also key to engendering commitment for improving the quality of services. Existing management systems may be improved by broadening the base of program responsibility and facilitating collaboration for integration of related FP/MCH program efforts. Priorities for assistance in improving management

systems include (1) provision of leadership training and team building, (2) development of more effective ways to use existing data to encourage further decentralization of program decision-making, and (3) introduction of new management approaches and tools, such as Total Quality Management and Continuous Quality Improvement.

*** Strengthen MOPH Institutional Capabilities**

During the past ten years, the Morocco FP/MCH program has made great strides in developing a strong institutional framework. An integrated service delivery program has expanded to the national level, covering approximately 80% of the population through a network of fixed facilities and outreach efforts. Family planning is a strong central element of this program. However, at this stage of development administrative structures and decision-making remain highly centralized and integration of program efforts not always well coordinated. Some key institutions within the MOPH need further strengthening. In addition to providing broad support for the Health Education Unit, targeted institutional support will be provided to the Institut National d'Administration Sanitaire (INAS) to enable it to more effectively support MOPH efforts in management training, operations research, program evaluation, and quality improvement.

*** Stimulate Increased Private Sector Involvement**

Private sector assistance has largely focused on the social marketing program, through which impressive gains have been made. However, for long term financial sustainability of FP/MCH services, the private sector must play a stronger role. Building upon success to date, the social marketing product line should be expanded to include additional products, such as a more competitively priced oral contraceptive, more effective, longer term contraceptives (e.g. injectables, NORPLANT) and other MCH products (e.g. ARI treatment). In addition, there needs to be more concerted and systematic involvement in FP/MCH service delivery of private sector providers, such as employers, private practitioners, insurance companies, and the social security system.

*** Support Research and Evaluation**

Much progress has been achieved in developing data collection and processing capabilities of the MOPH. Nevertheless, much more needs to be done in developing those data analysis capabilities which are critical for a mature program to undertake effective evaluation and research. An appropriate institutional base for research and evaluation within the DPES (Preventive Health Directorate) of the MOPH needs to be identified and supported. INAS is a potential candidate for this role, but it, like other units with potential in this area, would need considerable technical and financial support to realize this potential.

The activities described above comprise the major elements of the Implementation Plan. As such, however, the plan is but the first step toward directing USAID resources to meet FP/MCH program and institutional needs. The next step is incorporation and inclusion of the various activities indicated in this Implementation Plan into the Plans d'Action of respective Division Chiefs within the DPES of the MOPH. Subsequently, implementation of these activities in the field and evaluation of the results will be the final arbiter of the usefulness of this planning exercise.

The Implementation Plan builds upon several broad conclusions reached by the Team about the past, current, and future role of USAID assistance. These conclusions include:

- USAID assistance plays a major and critical role in Morocco;
- The FP/MCH program is at an important juncture;
- Major opportunities lie ahead; and
- The potential for outstanding achievements is great.

Finally, implicit in the Implementation Plan which has been developed are several recommendations for future USAID support for health and population. These are:

- Amend the current Bilateral Project 608-0198.
The current project should be amended to increase funding and extend the project to 1999.
- Provide other funding.
Additional funds should be made available for new projects, such as the Private Sector Health Care Initiatives Project (608-0220).
- Implement Priority Initiatives.
Quality improvement, safe motherhood, health education, and management improvement are among the priority initiatives to be implemented under the Bilateral.
- Avoid Premature Phaseout.
USAID assistance has been critical and productive to date. USAID needs to "stay the course" to assure continued program development and long-term sustainability.

With this report, USAID has undertaken a mid-course review of activities initiated under Bilateral Project 608-0171 and continued under Bilateral Project 608-0198. By delineating various ongoing/planned as well as proposed activities in terms of specific USAID objectives and strategies for population and health, this report elucidates the

broader context in which specific activities are being undertaken. In short, this report provides a roadmap for future USAID investment in health and population in Morocco. In concert with overall USAID objectives as specified in the recent Prism Report and building upon achievements in population and health to date, continued USAID support in this sector through the 1990s will provide the basis for a diversified and sustainable program by the year 2000.

SECTION II
OVERVIEW

BACKGROUND

In Morocco, USAID is the major donor in population and health and has provided sustained, significant assistance over time. For almost two decades, USAID has been working with the Government of Morocco (GOM) to lower fertility and improve the health of mothers and children. Since 1976, USAID has provided more than \$50 million for FP/MCH activities.

This assistance has been well used and has contributed to the development of:

- A national network of MOPH ambulatory health facilities with more than 2200 delivery sites. An estimated 80% of the total population lives within the catchment area of a service delivery site or outreach worker.
- An innovative outreach program which uses multiple approaches, including household visits, mobile units, and community service sites to deliver FP/MCH services.
- A national FP/MCH program which uses the combination of fixed facilities and outreach to deliver an integrated package of FP/MCH services: family planning, immunization, diarrheal disease control, and growth monitoring.

USAID assistance has had an impact. With it and other donor assistance, the GOM has been successful in lowering fertility and infant and child mortality. Achievements include:

- A decline in the infant mortality rate, from an estimated 122 deaths per 1000 live births in the early 1970s to 57.4 in 1992;
- A decrease in child mortality, from 77 deaths per child 1-5 in the early 1970s to 20 per 1000 in 1992;
- An increase in contraceptive prevalence, from approximately 19% percent in 1978 to 42% (36% modern methods) in 1992;
- A decline in the total fertility rate, from 5.9 in 1979 to 4.2 in 1992; and
- An increase in vaccination coverage rates, from 40-50% in 1985 to over 70% in 1989.

CURRENT SITUATION

USAID assistance is critically important in helping Morocco achieve the next level of success in FP/MCH by accomplishing these important program goals:

- * Consolidate gains and add depth to the program by improving service delivery, information, education, and communication efforts, and the underlying management, supervision, logistics, and evaluation systems.**
- * Improve access to services for rural and other underserved populations. Much of the current progress has been achieved in urban areas.**
- * Assure that key services are not only accessible but available and used. There is still considerable unmet demand for family planning and child survival, and important services are not readily available or fully used. Almost all the Moroccans practicing family planning are using temporary or supply methods, though most do not wish to have another child. Too few Moroccan mothers are receiving prenatal or postpartum services and too few are giving birth under the care of a trained provider.**
- * Shift some of the burden of health care to the private sector. Currently, an estimated 75-80% of FP/MCH services are provided by the MOPH.**

Although there remain these important program concerns, Morocco has the potential to develop one of the most outstanding family planning, child survival and maternal health programs in the world. Some of the factors contributing to future success include:

- * Demand for family planning and child survival is strong and increasing.**
- * The program has support at the highest level. The King personally signed the Children's Summit Agreement and, in a May 1992 speech, said that "The population growth that the planet is currently experiencing is a time bomb which threatens life as nothing since the flood". There is considerable involvement of the Royal Family in events promoting child survival.**
- * There is a strong and established health infrastructure involving fixed facilities and outreach programs throughout the entire country.**
- * There is a strong MOPH with a very competent and dedicated staff. This competence and dedication is notable at both the national and local service delivery level.**

- There is also an active private sector and recognition by the MOPH that the private sector should play a larger role.
- The program is flexible and innovative: (1) Senior officials are willing to test and apply new approaches. (2) Morocco's innovative outreach program evolved from a pilot family planning-only operations research project. (3) Current social marketing programs are state of the art. Morocco is one of the first countries in the world to develop a self-sustaining condom social marketing program.

ASSISTANCE REQUIREMENTS

A Major Role for USAID

At this juncture, USAID can play a critical role in enabling Morocco to achieve success with its FP/MCH program and develop a model program. To do this, USAID must engage in policy dialogue, continue to provide appropriate, targeted assistance, and "stay the course."

Senior Embassy and USAID officials need to seek out opportunities to raise key policy, regulatory and programmatic issues, such as budgetary support for preventive health and outreach activities, removal of tariffs on contraceptives and other essential drugs, as well as restrictions on advertising, medical practice, and eligibility for sterilization.

Broad Support and Funding

To be substantial and targeted, assistance needs to continue. USAID's assistance is provided from four accounts: (1) Population, (2) Child survival, (3) Health, and (4) AIDS, all drawn from both bilateral and central funds. The current bilateral project, approved in August 1989, is a seven-year \$31 million project. In addition, several million dollars a year are provided through A.I.D./Washington-managed projects. The implementation plan that follows identifies areas where additional bilateral or central support is recommended. Table 1 shows actual and proposed funding.

In considering future funding needs, senior USAID management needs to review the decision made several years ago to cease all support for the public sector FP/MCH programs and for contraceptives after 1996. It is critical that resources needed to develop an effective, sustainable national program continue to be provided. It is also important that concerns about sustainability not lead to premature decisions to truncate or limit services or support for key activities. Morocco cannot achieve its national development goals at its current population growth rate. Fortunately, the strength of Morocco's program in this sector is well recognized, both within USAID/Morocco and A.I.D./W. Furthermore, Morocco's status as a child survival and population-priority

country entitles it to broad support. Extending the current project PACD to 1999 would be an appropriate means to support both successful program development and long-term sustainability.

Targeted Assistance

The centerpiece of USAID/Morocco's strategy in the health and population sector has been and remains support for family planning. Child survival interventions, in particular vaccination, oral rehydration therapy, growth monitoring, prenatal care, and birth surveillance, are also important, particularly in the context of outreach service delivery.

USAID's assistance is systemic as well as strategic. While much of the assistance under the current project is directed toward family planning as a principal child survival intervention, this support concomitantly strengthens systems which support a full range of maternal and child health services. In addition, on a selective basis, USAID assistance has been and will continue to be directed toward particular child survival interventions.

The objectives and strategies in health and population flow from and are fully consistent with overall USAID goals. Broad-based and sustainable economic growth for Morocco lies at the heart of USAID's strategy. A related sub-goal is improvement of the quality of Moroccan life. An objective tree (see Fig. I) from a recent Mission Program Performance Plan shows the overall population and health outputs and sub-outputs in relation to these higher level goals. In the five-year implementation plan, these outputs and sub-outputs have been transformed into population and health objectives and strategies (see Fig. II).

The implementation plan describes six specific strategies to expand use and promote sustainability of FP/MCH services. These strategies may be summarized as follows:

- * Access, quality, and information to expand the efficient use of services; and
- * Institutional strengthening, management improvement, and financial diversification for program sustainability.

Figure III depicts linkages and interlinkages among these objectives and strategies. The inner triangle represents the first objective, increased use of FP/MCH services. As indicated at the three points of the triangle, this objective is achieved through the mutually reinforcing strategies of increasing and improving access, quality, and information. The outer triangle represents the second objective, program sustainability, as achieved by institutional strengthening, management improvement, and financial diversification. The diagram has been so structured as to align mutually reinforcing strategies on the same sides of the triangle. Thus, quality and access are shown as being synergistically related to institutional strengthening; quality and information as related to

management improvement; and information and access to diversification. Activities supporting specific strategies, which will be the subject of Section III of this paper, also relate to this clustering of strategies. For example, social marketing, while clearly a component of diversification, also relates to information (through the advertising that accompanies social marketing) and to access (by the private sector channels for contraceptive distribution which are correspondingly opened up). Similarly, institutional strengthening through infrastructural development, e.g., construction and renovation of facilities, will have concomitant impact on access to and the quality of services. Consequently, activities described in Section III may also be seen to relate to a broader array of strategies impinging on FP/MCH services.

SECTION III
IMPLEMENTATION PLAN

OBJECTIVE 1: INCREASED USE OF EFFECTIVE FP/MCH SERVICES

Although the GOM has made major progress in extending FP/MCH services through an integrated service delivery system, many Moroccans are still not receiving family planning and maternal and child health services. In some cases services are simply not available; in others prospective clients may not use potentially available services because they lack the information, means, or motivation to do so. Of particular concern are the low use rates for long-term and permanent methods of contraception, prenatal and postpartum services, and diarrheal disease treatment. Morocco's age structure and growing population require that service delivery increase just to maintain current contraceptive prevalence and MCH use levels. For example, the number of women of reproductive age will increase from an estimated 5.6 million in 1991 to 8.1 million in 2000. Achieving desired increases in prevalence and use of other MCH services requires reaching many more with improved and expanded services, as well as information.

In addition to providing more services to more people, the program must overcome important socio-economic differences in knowledge of, access to, and use of FP/MCH services. In 1992, contraceptive prevalence was almost twice as high among urban (54%) than among rural women (32%). The infant mortality rate was 44 per 100,000 live births in urban areas and 65 in rural areas. Over 60% of urban women received some prenatal care, compared to only 17.5% of rural women. Recently, the MOPH extended outreach to 12 more provinces. With extended program coverage, service quality is a concern and both clients and providers often lack sufficient information to make informed choices about MCH/FP practices. The institutional base for FP/MCH service delivery also needs to be broadened. At present, the MOPH provides an estimated 75-80% of all FP/MCH services. Increasing effective use of key FP/MCH services requires:

- (1) increased access to FP/MCH services,
- (2) improved quality of FP/MCH services, and
- (3) increased access or availability of appropriate FP/MCH information.

STRATEGY 1. INCREASED ACCESS TO FP/MCH SERVICES

Access will be increased by (1) improving the effective use of existing services in the public and private sectors; (2) integrating family planning with other MCH services; and (3) targeting areas that are underserved and/or have substantial unmet needs.

Rationale: This strategy recognizes the importance of building upon current investments and gains in FP/MCH service delivery. Morocco has created a broad health infrastructure through the MOPH national network of health facilities and an innovative and important outreach program. The latter has contributed importantly to access.

Analysis of the 1987 DHS findings found major differences in the use of FP/MCH services between mothers and children living in areas with outreach services and those living in areas without outreach. Subsequently, the MOPH has sought to overcome these differences by improving fixed facilities and extending outreach to all provinces. Since 1984, the percentage of the population within the MOPH network has increased from 40% to 80%, with over 2200 service delivery sites.

Having expanded service delivery, the MOPH now needs to add depth to the program by focusing on those activities with the greatest impact on health and fertility and on those women and children most at risk and least able to pay. Such a focus requires:

- (1) Increasing the supply of key FP/MCH services with long-acting methods of contraception and prenatal and postpartum care.
- (2) Promoting linkages between services and interventions like breastfeeding that contribute to multiple health improvements.
- (3) Testing and refining outreach approaches so that resources are targeted at underserved and other special populations.
- (4) Ensuring that there are adequate GOM and donor resources. It is important that the gains already realized in reaching low-income populations, and those that need to be achieved to meet national FP/MCH goals not be jeopardized by premature requirements for project sustainability.

Finally, the GOM cannot and should not meet all FP/MCH needs. Greater attention has to be paid to developing, refining and replicating successful private sector approaches. If the private sector could serve more middle- and low-income consumers, public resources could be targeted at key services and poor consumers which may not feasibly be delivered through the private sector. An estimated 30% of the population has limited or almost no purchasing power. Applying USAID resources to increasing private sector delivery of FP/MCH is dependent on the design and approval of a private sector health care project in 1994.

Ongoing/Planned Activities: On-going and planned activities contribute to increased access by doing the following:

- * Strengthening the nationwide delivery of FP/MCH services through upgrading facilities; providing vehicles, equipment, contraceptives and other commodities and supplies; and supporting research and other special studies.
- * Improving the delivery of key FP/MCH services through support for long-acting and permanent methods of contraception, safe motherhood,

STD/AIDS prevention, and other child survival interventions on a special-case basis.

- **Making FP/MCH services available through private sector programs such as social marketing, support for private providers, and workplace health care.**

Assisting with facilities, transport, contraceptives and other commodities

USAID is providing major technical and financial support for the improvement of fixed facilities through construction and renovation, the installation of photovoltaic power systems, and the provision of other equipment and supplies. This support includes help with warehouses, vehicle maintenance centers, family planning reference centers, cold rooms for the vaccination program, rural health centers, and rural dispensaries.

USAID is also providing vehicles, other equipment, contraceptives, and other health supplies. In addition to almost all of the contraceptives for the national program, USAID also provides much more limited support for other essential medicines or commodities, such as antibiotics, oral rehydration solution, or vaccines in response to GOM requests.

Improving information on service delivery

As Morocco seeks to both extend and strengthen service delivery, more information is needed on the successes of service delivery providers, client concerns, barriers to access, and effective use of MCH/FP services in the public and private sectors. On-going or planned research activities, such as the 1992 DHS, social marketing client surveys and focus groups, cost studies, situation analyses and operations research will provide information that must be made available to those making decisions about service delivery and outreach activities.

Better information on current outreach activities is a priority, as the MOPH transforms its national FP/MCH outreach strategy. A hallmark of Morocco's program has been the effective MOPH outreach program, which delivers an integrated package of services: family planning, immunization, diarrheal disease control, and growth monitoring services. In addition, outreach program workers implement other MOPH programs, such as sanitation and malaria, when needed. The expansion of the outreach program, gradual assumption of full responsibility for recurrent costs by the GOM, and the medicalization of MOPH services have resulted in shortages in outreach workers, supervisors, transport, and other service delivery essentials – all of which may be limiting outreach. The MOPH needs general information on the status of outreach and more specific information on the relative effectiveness and costs of the three current outreach approaches: household visits, mobile units, and community service sites (points de contact) in different settings with different populations.

Increasing delivery of long-acting methods of contraception

According to the DHS, in 1992 Morocco's contraceptive method mix was very skewed, with 68% of women contracepting using oral contraceptives and less than 15% using IUDs or sterilization. There needs to be greater access to long-acting and permanent methods of contraception, especially for those 49% of married women of reproductive age who do not wish to have another child. USAID is working with the MOPH to increase access to IUDs, sterilization, and the availability of NORPLANT. Current activities include the provision of equipment and supplies, training for providers in clinical methods and counseling, and research and special studies. The latter includes operations research on medical barriers to sterilization and demonstration or pilot projects introducing minilap and NORPLANT. Some private providers have received training along with MOPH staff.

Supporting safe motherhood and STD/AIDS prevention and other MCH Interventions

Selective support is being provided or planned for other key MCH services that can be linked to or integrated with family planning services. Such support includes the development of HIV/AIDS prevention, the treatment of other sexually transmitted diseases at model clinics, and support for the GOM's Safe Motherhood Initiative and breastfeeding promotion.

Fostering social marketing

With USAID assistance, Morocco has launched innovative social marketing projects for condoms, oral contraceptives, and ORS. Morocco is one of the first countries in the world to develop a self-sustaining condom social marketing program. Launched in September 1989, the PROTEX condom social marketing project has doubled condom sales and reached low-income and new consumers. There are on-going studies on the feasibility of extending sales beyond pharmacies to "tabacs" (small tobacco shops/newsstands) and on the impact of marketing the condoms for HIV/AIDS prevention as well as family planning.

In the fall, oral contraceptives will be launched in an innovative social marketing project which:

- Employs no donor product;
- Promotes two commercial brands of low-dosage pills through a common logo;
- Markets a product with the same formulation as the public sector pill.

USAID is working with the MOPH and other ministries to see if the products could be exempted from tariff imports, thereby permitting a further reduction in the sales price, which might facilitate more switching from the public sector. Other planned social marketing activities include the expansion of a PSI pilot marketing project for ORS and, possibly, social marketing programs for weaning foods and/or ARI.

Examining other private sector service delivery options

In preparation for the design and implementation of the private sector health care project, there will be further analysis of prior experience, opportunities, and constraints to increased FP/MCH service delivery through workplace and private provider programs. In the past, some companies have received modest assistance in adding family planning to workplace health care services from A.I.D./W projects and AMPF (the local IPPF affiliate). Both the MOPH and AMPF are providing some training in family planning to a limited number of private service providers. In 1991, USAID commissioned two studies: (1) to examine the structure of the private sector; and (2) to explore the potential for the private sector.

Proposed Activities: Proposed activities focus on:

- Improving access for under-served populations through the refinement of current outreach approaches and the testing of alternative strategies, such as the use of community members to distribute contraceptives.
- Increasing access through the private sector by the further expansion of social marketing and workplace programs and by providing targeted assistance to key private sector and other providers.
- Increasing choice and access to services through the introduction of injectables and postpartum services.

Support for most of these activities would require additional resources from A.I.D./W, a project paper amendment, and/or design of a new private sector project.

Testing alternative approaches to outreach

Additional information on current service delivery and access to FP/MCH services will be forthcoming from further analysis of the 1992 DHS and conduct of a quality assessment. This information will likely result in identification of needs for testing refinements of current service delivery and outreach as well as new approaches. Given the variation within Morocco in socio-economic status as well as access to services, it is unlikely that any single approach will meet all needs. Potentially less costly and more sustainable approaches need to be tested. For example, an operations research study could examine the cost-effectiveness of using community members to reach rural and

other isolated populations. A study might examine this approach both within the public sector and the private sector, using non-governmental organizations.

Expanding the social-marketing product line

Over the next two or three years, consideration should be given to the addition of other family planning and child survival products to the social marketing product line. Current USAID-assisted social marketing programs in four other countries include IUDs and/or injectables. Sales in 1991 of these two products accounted for more than 3.2 million couple years of protection (CYP) or more than half the CYPs generated by all USAID-assisted contraceptive social marketing programs worldwide. The MOPH has expressed interest in a pilot test of socially marketed IUDs. Social marketing's use of existing distribution systems and medical detailers appears to be an effective way of reaching private doctors and other providers who could make family planning services available at a low price in return for training, access to commodities, product promotion, and/or referrals. In Mexico, program managers are exploring with private suppliers the feasibility of socially marketing NORPLANT at half the current private sector price. In other countries, consideration is being given to the inclusion of other important child survival products, including antibiotics for treatment of ARI.

Encouraging private providers to offer FP/MCH Services

Presently, Morocco has a large and growing supply of physicians, pharmacists, midwives, and health paraprofessionals who are under- or unemployed. They are an important but underutilized national resource. Policy and financial barriers to the increased participation of private providers in FP/MCH service delivery, including the delivery of long-acting methods, need to be explored. Are there, for example, private physicians who could take the lead in providing new methods of contraception? Are there others, including general practitioners, pharmacists, midwives or nurses, who have particular access to low-income populations or women for whom pregnancy is a high risk? In addition, operations research or pilot projects should test the impact of different types and levels of support to private providers. This support could range from technical assistance and training to direct assistance (e.g. community doctors, franchising schemes) to physicians, nurses, and midwives in developing private practices directed to low-income populations.

Expanding postpartum sterilization and IUD insertion

In Morocco, sterilization and IUD insertion are not provided immediately postpartum. In other developing countries, postpartum sterilization is widely practiced and contributes significantly to the overall prevalence of this method. With careful prenatal counseling to ensure informed consent, this can be a very appropriate and safe way to provide voluntary surgical contraception. Pilot studies of the acceptability, safety, and efficacy of

postpartum IUD insertion are being carried out in several other countries. The EEC is providing \$900,000 for a pilot program in Morocco of postpartum family planning service delivery. This pilot study, together with other successful experiences with postpartum sterilization in other countries, could serve as the basis for the review and modification of policy and procedural constraints to postpartum service delivery. Over time and when feasible, these can provide the foundation for postpartum program expansion. This may be an area where private sector providers could take the lead.

Introducing injectables

Injectables are not available in Morocco. This reflects both the lack of commodities and concerns about local acceptability. The convenience of the method and its privacy have made it very popular in other countries. Recent approval by the Federal Drug Administration Advisory Committee of a leading injectable, depoprovera, for use in the U.S. may open the way for wider acceptance and use of this method internationally. Morocco's public and private health infrastructure, and its success in national immunization programs, suggest that it would be possible to make injectables widely available with existing health personnel. A donor or commercial source should be identified and a pilot study designed to test the acceptability and cost-effectiveness of injectables. The study could also test service delivery, which could perhaps be implemented earlier in the private sector through an organization like AMPF.

Adding FP/MCH to workplace health care

Existing large work-based health programs and groups of medium-sized employers offer another potentially important venue for FP/MCH service delivery, a possibility which requires further analysis and investment. Industrial and commercial establishments employing more than 50 salaried workers are required to organize work-based health care at the employer's expense. Firms with fewer employees are required to provide such health care if the work performed could cause physical harm or illness. To do so, these firms set aside space for small clinics or dispensaries at or adjacent to the work site. Firms which offer housing benefits often have community-level dispensaries. A recent private sector study reported that interviews with employers suggested that they would favor the addition of FP/MCH services to workplace health programs and that such services could be incorporated without great difficulty. Further analysis of current experience and opportunities should identify ways to test and expand FP/MCH service delivery at workplaces. Strengthening FP/MCH services at companies that are receiving other USAID-financed assistance could have an important synergistic effect. Using existing health insurance networks such as CNSS for public employees and CNOPS for private sector employees may provide viable avenues for widespread expansion of services.

STRATEGY 2. IMPROVED QUALITY OF FP/MCH SERVICES

Quality requires the availability of such principal elements as method choice, technical competence, and client counseling. However to be fully implemented, it also requires leadership, motivation, and commitment at all levels. With this strategy, USAID assistance will serve not only to provide support for what needs to be done to improve the quality of services, but also will provide guidance on how this may be approached.

Rationale: Improving the quality of FP/MCH services is a priority for Morocco and the gateway to future program success. The quality of FP/MCH services can be improved by providing access to a range of appropriate contraceptive methods, promoting adequate counseling which respects client sensibilities and responds to client concerns, ensuring technically competent providers who adhere to proper medical standards, and making quality as well as quantity the basis for routine program performance assessment.

Ongoing/Planned Activities: USAID has embarked on a program of technical and financial assistance to improve the quality of family planning services by both strengthening the service delivery infrastructure and supporting specific elements and means to achieve quality. Of primary importance is not only what is being done (e.g. increasing the numbers of technically competent IUD providers) but how it is being done (i.e., through decentralized training). Various ongoing and planned activities suggested to improve quality are listed below.

Development and proper use of protocols nationwide

Recent MOPH standardization of fixed-site facility requirements will be complemented by development of family planning service delivery protocols. These protocols will cover technical as well as other aspects of quality service (e.g., counseling needs, follow-up considerations, supervision).

Provision of quality-related training

Training relevant to improving quality covers a broad spectrum. Management training consistent with improving quality has been provided by the National Institute of Health Administration (INAS) and a large IUD training (800 providers) includes technical as well as counseling and supervisory competence. To reinforce FP/MCH service quality, in-service training will be provided for various cadres and levels of service managers and providers in such areas as technical competence, counseling skills, and management.

Strengthening of supervision system

Regional training for providers in IUD insertion and development of a preceptor system are initial steps in introducing new approaches compatible with quality program management. Supervision of periphery health staff needs to be strengthened to assure not only that work is being done but that it is being done well. Reorganization of

responsibilities and development of attitudes to move supervisors from "control" to "support" modes will require in-service training and managerial restructuring.

Upgrading of fixed facilities

A comprehensive effort to improve the quality of and access to FP/MCH services focuses on the physical aspects of fixed facilities. A program to upgrade approximately 27 facilities, including health centers, dispensaries, family planning reference centers, and vehicle repair and maintenance centers, is underway. The upgrading will be carried out through building renovations, refittings, and/or extensions. In addition, 9 family planning reference centers will be constructed in provinces and prefectures which do not yet have one or where the facility in use is inadequate or should be used for other services.

Support to decentralization

Regional IUD training marks a major commitment by the MOPH to decentralization. Recent experiences of INAS in conducting operations research (OR) by provincial teams is a parallel move in the direction of a team approach to studying service delivery problems. More concerted and concentrated efforts building on experiences to date will be undertaken with external technical support for problem-solving training and implementation.

Provision of training in more effective use of data for monitoring and improving the quality of service delivery

While impressive use is made of MIS data to monitor, review, and analyze program accomplishments, more needs to be done in this area. A recent INAS-supported OR study indicated that while health site data in one province are well charted, almost no decisions for program improvement are made on the basis of these data. A careful review of existing data and how they are used will provide the basis for developing short, focused training sessions for clinic-level managers and providers in analyzing existing data to improve program performance.

Provision of training in provider and management team building

District Team Problem-Solving Process, a specific methodology for involving teams of health care providers and managers in identifying and solving particular service delivery problems, has been developed by WHO and successfully implemented in a number of countries, including Tunisia. This methodology encompasses periodic training and monitoring over a one-year period to develop – in decentralized fashion – a group process approach to improving service delivery. A strict requirement of the approach is that no additional resources be provided to facilitate solution of the particular service delivery or related problem identified. Because of its previous experience with Health System Research, INAS is the likely institutional home for organizing this effort.

Technical assistance must be provided by consultants experienced in the methodology and in Morocco. It is proposed that this effort concentrate initially on four or five locales and that it be initiated in late 1992 or early 1993.

Conduct of a Quality Assessment Survey

The MOPH focus on quality requires timely assessment of the current status of the services being provided. Given the relatively solid data base that already exists, the survey should go beyond an inventory of services to an assessment of their quality. Equally as important as what this assessment will reveal is the development of a methodology that will be available for use on a regular or periodic basis, including provincial and clinic-level personnel. This quality assessment will be undertaken by the MOPH with external technical assistance using private sector organizations and individual consultants as required.

Proposed Activities: Improving quality is not a one-time effort; rather it is a long-term process. Simply providing managers and providers with additional training will not be enough to activate a quality model. What is required is a change in management orientation to make quality a priority and to support local and continuous improvement of quality as the means.

While the quality agenda has been initiated, as evidenced by MOPH commitment to decentralization of training, it has not yet been fully developed. This is as true for the MOPH as it is for USAID's program of assistance. With the proposed activities listed below, USAID will provide the MOPH with additional avenues for learning about and developing capabilities for achieving quality. Institutional development of a full-quality program may take from five to ten years. Therefore, understanding the process is as important as achieving the final goal of quality.

Development of model quality sites

Growing interest in and experience with quality family planning services provides a rich basis for formulating a service-provision model for improving quality within the context of Morocco. The MOPH Family Planning Service Division (SCPF) is especially interested in establishing model sites where lessons learned through family planning service provision in Morocco over the last fifteen years could be applied. The model would be based on this rich background of information, as well as on specific findings that emerge from the assessment of service quality to be conducted in late 1992. A model quality site could include the comprehensive range of service provision, from reference centers to outreach efforts. It also should encompass both specific elements of quality to be improved (technical competence, choice, access, counseling, etc.) and the particular techniques (quality circles, problem solving groups, site-level data analysis) to improve those elements on a continuing basis.

The quality model developed must, of course, be adapted to the conditions and needs of particular locales and settings. There is great diversity both within Morocco in general and within MOPH programs operating in different parts of the country in particular. One way of accomplishing this adaptation is to directly involve local managers and providers in formulating the model and subsequently implementing it. This could be accomplished by involving them in conducting a situation analysis or quality assessment to serve as the basis for formulating the quality model. Empowering them to implement and adjust the model to their needs should be an integral part of the process.

Given the time frame for conducting the quality assessment and for subsequently conducting in January, 1993 an impact evaluation of USAID's population and health program in Morocco, the quality model approach will not be developed and implemented until 1993. The cluster sampling used for the DHS survey provides an added opportunity for selecting at least some areas for implementation of the model that would enable follow-up analysis in the form of subsequent survey data (1997). It is expected that the quality model will be implemented in four or five sites, with support from the current bilateral project. Expansion would require additional funding.

Initiation of quality awards for providers and managers

Rewarding quality is a low-cost and effective means to signify that quality is a program priority and to recognize specific achievements in quality. To support decentralization and team building, it is important that these awards be used to reward workers and managers at the periphery, as well as those in more central positions. The very process of determining criteria for the awards will require the leadership to determine what quality means in the Moroccan context. Awards could range from ceremonial plaques to tangible resources (training opportunities, computer, vehicle, etc.) that would serve to further improve program quality. Further discussions will be needed to ensure that such awards are compatible with MOPH structures and procedures.

Creation of a performance-based fund to support province-level quality initiatives

Performance-based programs link funding to performance achievements on a step-by-step basis. For example, satisfactory completion of a clinic-level resource allocation plan to improve program performance could be required to release a set amount of funds to be used to implement that plan. Subsequent infusions of funds could be tied to specific benchmarks of program achievement. The size of the fund would depend upon the extent of the area in which this approach would be initially applied. However, substantial funds for either an initial or subsequent applications of this approach would be sought from A.I.D./W central resources.

Performance-based programs offer the distinct advantage of directing resources to service provision sites themselves. In the Moroccan context, this effort may be directed to increase and improve services at the family planning reference centers. At this level,

performance-based resources could be allocated to implementing/improving postpartum services at nearby maternities and/or to finding solutions for transporting prospective long-term method clients from distant domiciles to the reference center. The approach may also be applied at other levels of service delivery and would provide interesting results if compared to the resource-constrained District Team Problem Solving Process described above. Careful attention to, as well as input from, countries such as Yemen and Turkey, where this approach is currently being applied, may be useful to appropriately adapt performance-based programming to the Morocco situation.

STRATEGY 3. INCREASED ACCESS TO EFFECTIVE INFORMATION

Access will be increased and effective information made more readily available by developing and disseminating appropriate information to all target groups.

Rationale: Despite impressive results in the last decade in decreasing fertility and maternal and infant morbidity and mortality, there remains a considerable gap between knowledge and use of family planning and of other important MCH interventions and practices. A major challenge for the Moroccan Government is to bridge the gap between knowledge and actual use. Efforts must be directed not only at increasing the accessibility and quality of effective use of FP/MCH services but also at greatly expanding the availability of information on the benefits of these services, where they can be obtained, and how they are used.

IEC has been an important component of USAID assistance to the Moroccan FP/MCH program for many years. Under earlier projects, USAID has assisted the MOPH with their promotion strategies for family planning, vaccination, oral rehydration therapy, pregnancy monitoring, birth surveillance, breastfeeding, and infant nutrition programs. USAID has also provided support for training in counseling for outreach workers and other health providers. In addition, USAID has supported AMPF over an extended period of time in the development of educational materials and radio and TV spots. However, despite substantial financial and technical assistance in this area, much more remains to be done to strengthen IEC activities and local institutional capabilities.

The 1988 USAID mid-term evaluation of the Moroccan family planning program indicated that IEC was a particularly weak component of what was generally a very successful FP/MCH program. Program weaknesses identified included:

- * Lack of specific IEC objectives and goals on the part of the MOPH
- * Poorly targeted information efforts
- * Lack of pretesting of messages and materials

- **Inadequate audience research and program evaluation**
- **The need for refresher training of clinic and outreach personnel in IEC and counseling**

Having recognized these weaknesses, USAID and the MOPH have begun to address them.

Ongoing/Planned Activities: Under the current bilateral project, the following areas have been targeted:

- **Development of a family planning IEC strategy**
- **Research and pretesting of communication materials**
- **Production of selected print materials for health workers and clinic staff**
- **Production of radio spots**
- **Training of providers in client-counseling techniques**
- **Support to social marketing and AIDS communications campaigns**
- **Targeted health education related to all child survival interventions and hygiene and safe water (pilot projects)**

Progress to date in strengthening IEC activities has been slower than anticipated. Major developments over the past two and a half years include:

- **Preparation of a draft "Family Planning IEC Strategy" and proposed three-year plan of action (document by Population Communications Services, Fall 1991);**
- **"Assessment of Communications and Social Marketing in the Moroccan Health and Population Sector" (report by the HEALTHCOM Project, Academy for Educational Development, February 1992);**
- **Preparation of a national family planning logo to be launched in July 1992 with a major press conference and media campaign;**
- **Preparation, production, and distribution of 10,000 copies of a Pill booklet for use by health workers and illiterate women (the booklet is currently being pretested);**

- Production of a "Training of Trainers Family Planning IEC Manual"; and
- Successful media campaigns to support the social marketing project and other health campaigns.

Proposed Activities:

Health Education Initiative

In view of the continuing weaknesses and substantial needs in the IEC area, USAID should launch a major health education program, to be funded with additional resources under an amendment to the current project. This new health education effort (to be launched in late FY93) would focus on the development and implementation of a comprehensive IEC action plan supporting integrated FP/MCH services. Family planning would be the priority intervention, but IEC initiatives would also be developed for AIDS/STDs, diarrheal disease control, Safe Motherhood, acute respiratory infection, immunization and breastfeeding.

In developing a major new health education effort, USAID should coordinate closely with the United Nations Population Fund (UNFPA), which has recently developed a proposal to improve the IEC capacity of the Health Education Division (DES) of the MOPH Directorate of Preventive Health Services (DPES). UNFPA's project is funded for 30 months at \$497,000 and includes support for:

- A resident technical advisor in the DES;
- Increasing capacities in message development and testing;
- Conducting applied research;
- Producing materials and radio spots;
- Strengthening working relations with other Ministries and NGOs involved in IEC; and
- Introducing/strengthening health communication in the curricula of national training institutes.

The proposed new USAID-funded health education initiative would be designed to strengthen IEC capacities in the public and private sectors as well as to provide intensive IEC support in different MCH program areas. All media will be considered: print materials, radio and TV, as well as interpersonal communication and approaches such as student theater performances, Koranic teachers, songs, soap operas, comics, videos and film. Improved interpersonal communication between service providers and clients is

critical to increasing knowledge and use of service delivery points, correcting misinformation, and reinforcing correct use of contraceptives and other key MCH interventions.

In developing the action plan for this new initiative, a careful analysis is needed of existing data to identify the needs of the different target audiences. There is an extraordinarily rich body of existing data, including a 1966 KAP survey, the 1978-79 World Fertility Survey, the 1983 CPS, the 1987 and 1992 DHS surveys, a quality assessment planned for 1992, a rumors-and-false-information study, and information presented at the 1989 Mohammedia National Family Planning Conference. Additional focus group work should be carried out among each of the target audiences -- FP/MCH clients, service providers, program managers, decision-makers, and the general public.

Following a careful analysis of audience needs, appropriate media approaches can be identified and messages developed and pretested. Systematic monitoring of program activities is important, along with substantially increased emphasis on process, outcome, and impact evaluation.

In the area of institutional development, USAID would provide short-term technical assistance to the DES in the areas of research, message development, and pretesting. Private local research firms would be involved as partners in this process. AMPF also has a major role to play in materials development and the production of radio and TV spots. The capabilities of INAS should also be strengthened to support research and evaluation of IEC activities.

Another major component of the strategy is strengthening pre-service and in-service training in IEC and counseling. Itinerant health workers as well as clinic staff in all provinces need training in interpersonal communications and counseling in family planning and other priority child survival interventions. The recently developed trainers manual in counseling should be further adapted to specifically address family planning methods and MCH programs. The curricula of the nursing schools and INAS in health education and counseling should also be strengthened.

Mechanisms for the exchange of information

A number of mechanisms should be used to promote the systematic exchange of information on FP/MCH service delivery employing IEC initiatives. A newsletter on FP/MCH should be developed and widely disseminated to health personnel and program managers. Periodic seminars on IEC, motivation, and counseling should be held for different levels of health personnel. And clinic staff should meet regularly to review procedures, problems, and counseling techniques. Of course, strengthened supervision at all levels is critical.

Model IEC sites

Employing the DHS data and sampling framework presents an excellent opportunity for setting up model sites (selected in DHS clusters) where quality FP/MCH services, IEC, and counseling can be introduced and then later evaluated. A model IEC/service delivery site would be one with well-trained and well-supervised service providers equipped with appropriate print and audio-visual materials. Special motivational and Q&A sessions could be organized for groups of clients. The service providers would make a special effort to be courteous to clients, spend adequate time with each one in order to explain family planning methods and other services, answer questions, counter misinformation, and be responsive to their needs. Control sites could be selected with no increased emphasis on IEC and counseling. The impact of the special IEC interventions could then be measured with a post-intervention survey.

OBJECTIVE 2: SUSTAINING FP/MCH SERVICES

Although Morocco has made dramatic progress in family planning and child survival in recent years, the government continues to depend heavily on external assistance, not only for the procurement of contraceptives and other commodities but also for technical assistance. The cost of USAID-financed contraceptives alone is currently running at nearly \$2 million per year. Short-term U.S.-based technical assistance in such areas as social marketing, training, IEC, policy development, research, and evaluation continues at a high level; and USAID has recently added a long-term advisor.

The current Family Planning and Child Survival IV project (608-0198) places considerable emphasis on the development of program sustainability. In fact, direct assistance to service delivery in the public sector is to end with the current project. For example, the project envisages the termination of USAID contraceptive procurement in 1994.¹

Before assistance can be reasonably phased out, however, much work clearly remains to be done in the area of program sustainability. Progress must be made in each of the following areas:

- (1) institutional development;
- (2) managerial capacity; and
- (3) financial sustainability.

Program sustainability should be enhanced significantly by the proposed project amendment, which is designed to strengthen the MOPH's IEC capacity, and by the

¹ Current plans are to procure sufficient contraceptives in 1994 to last through 1996.

planned private sector project, which will simultaneously reinforce the role of the private sector in Morocco's overall FP/MCH program (institutional development) and reduce the financial burden on the MOPH of providing FP/MCH services to those able to pay for them. To allow sufficient time for sustainable program efforts to be fully effected, it is recommended that the proposed project amendment extend the PACD for the Phase IV Bilateral Project until 1999.

STRATEGY 1. INSTITUTIONAL DEVELOPMENT

In the area of institutional development, USAID assistance should focus on: (1) support to MOPH decentralization; (2) strengthening of key MOPH institutions (SMI, SCPF, DES, INAS); and (3) integration of the private sector into the national FP/MCH program.

Rationale: During the past ten years, the Moroccan FP/MCH program has made great strides in developing a sustainable institutional setting for future activities. Among the program's many accomplishments in this area are:

- Integration of family planning into the MOPH ambulatory health system and the provision of family planning services in all MOPH fixed facilities in the entire country;
- Development of an integrated nationwide FP/MCH outreach system covering approximately 80 percent of the population;
- Development of a strong central family planning service within the MOPH; and
- Strengthening of ties between the public and private sectors through such activities as IEC (AMPF), training (factory-based services) and social marketing.

Despite the enormous accomplishments to date, much work remains to be done to address the following issues:

- The MOPH FP/MCH program is still highly centralized. Experience with other programs has demonstrated that decentralized management and decision-making leads to more effective programs. Although decentralization has already been initiated, continuing assistance is required to ensure that the approach taken (regionalization) is compatible and workable with the existing MOPH administrative structure.

- Key MOPH institutions need strengthening in order to reduce dependency on foreign technical assistance. More attention needs to be given to strengthening the technical capability of the MOPH (particularly in the areas of IEC, management and research/evaluation) and to building an effective network of private sector support services which MOPH can draw upon in lieu of foreign technical assistance.
- The program's private sector component needs to be reinforced. The direct provision and/or financing of FP/MCH services by private providers, employers, insurance companies, and the social security system (CNSS)² needs to be greatly expanded. Coordination between the MOPH and the private sector needs to be institutionalized. In addition, the private sector role as a supplier of technical support services to MOPH and other providers, particularly in the areas of IEC and research/evaluation, needs to be strengthened.

Ongoing/Planned: Through its ongoing Family Planning and Child Survival IV project (608-0198), USAID is currently supporting the following activities, which promote institutional strengthening:

- Strengthening of the MOPH Family Planning Unit (SCPF). A long-term advisor will be provided for a period of 30 months to assist this unit in particular and the DPES in general.
- Support of the MOPH's policy of decentralization. This includes institutional support for nine regional training and research centers. Important issues still remaining include: (1) how such a regional structure will fit into the existing MOPH administrative structure, which is limited to the central, provincial, and circumscription levels (note: the circumscription level is below province and corresponds to the health center, which has its own medicine chef); and (2) how a decentralized MOPH administrative structure will dovetail with the planned devolution of financial responsibility for health services to local governments (*collectivites locales*).

² Although the CNSS is a public sector institution, its health service delivery system (polycliniques CNSS) is not financed out of the MOPH budget. Instead, it is financed partly by fees collected for services rendered and partly by subsidies from the social security system, derived from employer/employee contributions. The future financial status of the CNSS health system is uncertain at this point.

- **Improvement of the MOPH health infrastructure.** This includes the construction and renovation of facilities and the provision of vehicles and other equipment to support a revised outreach strategy.
- **Social marketing.** The project is currently supporting work with several pharmaceutical companies, private pharmacists, and related private sector institutions in the social marketing of condoms, ORS packets, oral contraceptives and weaning food.
- **Support to INAS.** At present, this is limited to project-specific individual training courses and research projects.

Proposed: During the next five years, the following assistance (all of which will require additional funding) is proposed for the further institutional development of Morocco's FP/MCH program:

- **Development of in-service training capabilities;**
- **Broad support to the MOPH Health Education unit;**
- **Targeted institutional support to INAS;**
- **Assistance to redefine and enlarge the role of the MOPH family planning reference centers;**
- **Expansion of the private sector component of the FP/MCH program; and**
- **Development of strong research and evaluation capabilities within DPES.**

Broad support to the MOPH Health Education unit

The five-year strategy recommends placing strong emphasis on developing a broad health communications capability within the MOPH. As discussed above, it is expected that this assistance will be provided through an amendment to the existing Phase IV Bilateral Project, with activities beginning in FY 93. It is important to note that the proposed new USAID health education initiative, which will be focused on the MOPH DES, is designed to strengthen capabilities in the areas of research, message development, testing, and evaluation. USAID assistance to DES in these areas should be closely coordinated with UNFPA assistance to DES. It should also foster close collaboration between DES and the users of its services (i.e., the line services of the MOPH FP/MCH program) and between DES and possible private sector partners and providers (e.g., AMPF, advertising agencies).

Targeted institutional support to INAS

The primary mission of INAS is to strengthen MOPH managerial capacity at the provincial level. It achieves this mission through an innovative package of long-term training, in-service short-term training, and applied research. INAS is expected to play a critical role in the process of decentralizing MOPH management and in developing a focus on quality improvement in preventive services. To date, USAID assistance to INAS has been limited to the funding of select training courses, research projects, and the purchase of resource materials. While this mode of project assistance should continue, it will be important to explore alternative areas of support, including staff development and the provision of material and equipment (computers, library). These efforts should be undertaken in coordination with expected UNFPA support for INAS in the range of \$800,000 - \$ 900,000 during 1992-1995, a recently awarded support grant from the Canadian government in the range of \$700,000, and the WHO Advisor who is already in place.

For INAS to take the lead in providing support to a decentralized operations research capability, priority should be given to developing and strengthening this capacity within INAS. Because operations research should include a strong evaluation component – including the careful design of experiments and the collection and analysis of appropriate survey data – INAS is also a logical institutional base for strengthened research and evaluation capabilities within DPES (see discussion below).

Assistance to redefine and enlarge the role of the family planning reference centers

Under the current project, nine additional family planning reference centers are being constructed.³ These centers were originally designed to provide back-up for the house-to-house distribution of oral contraceptives and condoms under the VDMS outreach project. Their role was to include IUD insertion for patients referred by outreach agents and fixed facilities that did not have staff trained in IUD insertion and to provide screening of women for sterilizations, again on referral. They have, in general, not been well utilized, due largely to the fact that women prefer to receive their health services from the MOPH health facility located closest to them. In addition, the availability of personnel trained in IUD insertion has recently increased dramatically in MOPH health centers and dispensaries, largely eliminating the need for reference centers as they were originally conceived.

Although the training role of the reference centers has been expanded considerably in recent years, especially in connection with the development of regional training centers,

³ Two of these reference centers will be built in the maternity clinics of the two university hospitals in Casablanca and Rabat, in which FP services were not previously available. These two reference centers will be the focus of an innovative postpartum program.

the family planning reference centers remain underutilized. A thorough examination is needed to define their role within the FP/MCH program. Such a review may point to an expanded role of the reference centers in one or more of the following directions:

- ★ As the focus of attempts to improve the quality of care and IEC within the program, family planning reference centers can be the focal point for training in such topics as counseling, provider-client interaction, diagnosis and treatment of STDs, and breastfeeding.
- ★ Staff of reference centers may assist provincial- and regional-level supervisory staff in monitoring the quality of family planning and possibly child survival services.
- ★ The reference centers can take primary responsibility for providing postpartum family planning and breastfeeding services, working closely with the staff of maternities.
- ★ The services provided by reference centers might be broadened to include an array of FP/MCH services in the context of an integrated FP/MCH program, such as Safe Motherhood.
- ★ The reference centers might be more closely integrated into the outreach system, providing point-of-contact or mobile unit services in areas underserved by fixed facilities.

Some experimentation will probably be necessary at the province level to find the most cost-effective use of family planning reference centers. Proposals that involve attempts to increase the utilization of these centers should be given priority for performance-based funds.

Expansion of the private sector component of the FP/MCH program

Because a stronger private sector role is required to finance FP/MCH services in the future, a viable institutional environment for Morocco's program must include the strengthening of private sector service delivery capacity and the forging of effective links between the program's public and private sector components. Private sector assistance to date has largely focused on the social marketing program, through which impressive gains have been made. A smaller pilot program of assistance has been provided to a few major employers to initiate family planning service delivery in their factory clinics. Future assistance, in the context of a new private sector project, should:

- ★ Continue support to institutions involved in social marketing (e.g., pharmacy associations, pharmaceutical producers, advertising agencies, market research organizations) and promote a good working relationship

between these private sector institutions and key public sector entities (e.g., MOPH, Ministry of Finance);

- Encourage and support employers, both individually and through employer associations, to provide factory-based FP/MCH services to their employees, including forging links between employer providers and public sector providers (e.g., use of public sector training and IEC to support expanded employer services);
- Motivate and assist private providers, both individually and through private medical associations, to increase the availability and quality of private FP/MCH services through the provision of training, equipment, IEC materials and other means. Emphasis should be given to long-term methods, particularly postpartum services provided in private maternity clinics, and to developing links between private providers and the social marketing program (e.g., IUDs, injectables);
- Encourage and assist the social security system (CNSS and CANOPS) to provide high-quality FP/MCH service—including sterilization. Emphasis should be given to long-term methods, including postpartum services; and
- Support AMPF in becoming an innovator in family planning service delivery. Possible areas for AMPF innovation include the provision of interval sterilizations using the mini-lap technique, the imposition of less stringent criteria for sterilization eligibility than are currently in force at MOPH facilities, the sale of NORPLANT at cost for insertion at MOPH facilities, and a pilot project to introduce injectables.

It is expected that much of the proposed institutional support will be provided to private sector institutions under the new private sector health care initiatives project, planned for design in FY 93.

To facilitate the rapid expansion of the private sector component of Morocco's FP/MCH program and its integration with the public sector component, a public-private coordinating committee should be formed and should meet on a regular basis.

Development of strong research and evaluation capabilities within DPES

Although much progress has been achieved in developing the data collection and processing capabilities of the MOPH, little progress has been made in developing the data analysis capabilities which are so critical to effective evaluation and programmatic research.

INAS may be an appropriate institutional base for research and evaluation activities within the DPES. Having such a unit based in INAS should also improve the methodological content of the DPES operations research program. To fulfill this expanded role INAS will need to have additional staff and resources, including at least one highly qualified sociologist/demographer on its staff, who could become the focal point for assistance and training in evaluation and research during the next years. In addition, INAS should be assisted in forging effective ties to line services (e.g., SCPF, SMI) and to DES, to ensure that its evaluation and research program is relevant and timely and that its conclusions are appropriately acted upon. Ideally, a standing FP/MCH evaluation and research committee or working group should be formed for this purpose. A thorough assessment of needs and resources required is needed prior to INAS undertaking this broader role.

STRATEGY 2. IMPROVE MANAGEMENT SYSTEMS FOR FP/MCH

Management systems will be improved by broadening the base of program responsibility, facilitating collaboration for integration of related program efforts, continuing support of tools, such as operations research, and introducing new approaches, such as Total Quality Management (TQM) and Continuous Quality Improvement (CQI)

Two distinct though related challenges have arisen with the evolution and expansion of the family planning program to its current stage of development: (1) maintaining an effective system of outreach as the program expanded to cover larger areas with proportionally fewer outreach personnel; and (2) maintaining managerial efficiency as the program evolved to encompass a broader range of child survival and health interventions.

In response, program leadership has encouraged decentralization of the program through such activities as regionalized training and operations research. Regional training centers have been created at nine sites and regional operations research teams are being developed in three provinces (one central). At the same time, program leaders have recognized a need for greater coordination among what have been largely vertical program sectors for family planning, maternal and child health, vaccination, and health education. Finally, program managers at many levels and within different sectors are increasingly focusing upon quality as the means to increase and improve program performance levels. Taking all this together, the USAID strategy consists of not only assisting the MOPH to find ways to implement and manage quality services, but also of providing direct support for introducing and fostering approaches to quality management. Such approaches should encompass decentralized decision-making, team building, and better use of available data at all levels to improve program performance and the quality of services.

Rationale: Involvement of workers and managers at all levels in decisions about what they can do and how they can better do it is the key to engendering commitment for

improving service quality. It is a mark of the maturity of the Moroccan program that quality has been placed high on the agenda and that program leaders encourage broad involvement in strategic planning for new program directions such as the Safe Motherhood Initiative. Decentralization of operations research capabilities and regionalization of training have also been strongly supported by top program managers. While USAID assistance will continue to provide support for such positive developments, it is important at this stage to help the entire program move more systematically toward quality. Consequently, the ongoing/planned and proposed activities for improving management systems listed below are, in all cases, closely linked to support for quality services presented earlier under Objective 1.

Ongoing/Planned Activities: Effective leadership and solid management systems have moved preventive health care in Morocco to where it is today – a notably outstanding program of family planning service delivery with demonstrated capability for making rapid advances in other child survival components as well (e.g. vaccination). USAID assistance will provide continuing support to program management from the highest levels where overall program planning and coordination occur at the periphery where greater involvement in management decision-making is needed. Ongoing and planned activities are listed below.

Support a FP/MCH coordination committee

The range of family planning activities and initiatives (from specific child survival interventions to safe motherhood initiatives) all largely involve the same personnel and physical structures. In addition, effective programs for reducing maternal mortality and morbidity and infant deaths clearly coincide and are synergistic with family planning as an MCH intervention. Given these facts, and the number and magnitude of interventions to be undertaken in the various MCH sectors, the need for an FP/MCH coordinating committee is increasingly clear. Such a committee will ensure collaboration, connection, and coordination among the various program components. This committee should meet on a regular basis and have periodic opportunities for retreats and high-level management exposure to state-of-the-art approaches in modern health care management outside of Morocco.

Refinement of management systems (i.e., MIS, logistics, supervision, manpower, training, planning).

While the program is built upon solid management systems, these systems can be improved to promote better management. For example, while the MIS produces good data on family planning program performance, improvements can be made in how the data are used for decision-making at various levels. Similarly, while the logistics system appears to be functioning well, higher levels of expertise will be required for the government to undertake its own procurement. USAID is committed to helping the MOPH improve its own systems by supporting analytical studies, providing selective

technical assistance as indicated, training in systems implementation, and providing commodity support for systems development.

Strengthen decentralized management

Support will continue for ongoing development of decentralized and regionalized organization, conduct, and follow-up of training. Current experiences with decentralized IUD training will be assessed as a basis for regionalizing other aspects of the program. For instance, conducting studies of or training in other areas will continue broad support for other decentralized management efforts, including operations research, team problem-solving, and other approaches consistent with and useful for improving the quality of services.

Provide management training

INAS has been and will continue to be the primary location for management training directly relevant to health care provision. However, management training for top level professionals, such as is available to corporate executives of large health systems in the U.S. and Europe, may well also be of benefit to Morocco program managers. Given the time constraints of CEO and other senior management levels, these courses are often highly concentrated and of short duration. While such courses are provided on a regular basis in both Europe and the United States, special courses adapted to local MOPH managerial needs may be developed to be held within Morocco.

Support evaluation and research (e.g., DHS, impact evaluations)

USAID is supporting the DHS, including analysis of data from this and previous surveys to measure long-term program performance. Program impact evaluations based on this and other studies (quality assessment) will be periodically funded by USAID. A follow-up DHS survey scheduled for 1996 will also be supported. In addition, as part of on-going assistance programs to make long-term methods more widely available, both JHPIEGO and AVSC have evaluations built into their respective activities. Similarly, SOMARC conducts extensive diagnostic and research activities as part of its social marketing efforts.

Proposed Activities: The following proposed activities, which in order to be carried out will need more funding, are clearly extensions of the ongoing/planned activities for improving management systems of FP/MCH. In each case, however, they are more specifically focused on particular needs for improving management.

Provide assistance in more effective use of data for program management

Impressive fixed-facility-level efforts are made to collate and chart MIS data on highly visible and attractive wall posters. As was shown in a recent operations research study,

these data and what these wall charts depict are not normally or routinely used to make decisions to improve program performance. Given this solid basis in hands-on use of data to display program performance, it is a natural further step to provide periphery health service managers and providers with encouragement and practical analytical tools to use this data for better local level program management. This could be done in the context of training clinic-level teams in the use of existing data sets to identify and find practical solutions for particular service delivery problems. Subsequent monitoring of trends over time will then enable local staff to judge if the particular solution they proposed actually made a difference. At its core, this approach is essentially the same as Continuous Quality Improvement (CQI), for which a number of useful manuals and guides have been developed that could be adapted to the Moroccan situation. Consultants experienced with CQI statistical techniques would be contracted to help make adaptations from experiences elsewhere to fixed-facility operations in Morocco.

Introduce new management tools and approaches

CQI embodies a wide range of practical analytic techniques that have been developed for use by lower level managers and workers. CQI is an adjunct of Total Quality Management (TQM), an approach to management widely used to produce high quality industrial and electronic products. In recent years, TQM has been applied successfully within many European and American companies, including several notable health care systems in the U.S., Canada, and Europe. Similar approaches to achieving quality have also more recently been applied to family planning program management in Mexico, Togo, and Indonesia.

TQM embodies many of the same principles to which FP/MCH program leadership in Morocco is already committed, namely quality and decentralization. It also, however, places great emphasis on viewing clients as customers, promoting team work, analyzing work processes, and monitoring results. Given where the Morocco program is in terms of its own rapid development and future direction, facilitating connections and infusions from broader approaches to quality such as TQM and CQI afford great promise as means to further improve program management.

Provide leadership training/team building

Various efforts within the Moroccan family planning program, such as regionalization of training and decentralization of operations research, are already providing a strong base for team building. To lead this effort, as well as to strengthen capabilities to integrate and coordinate a wide variety of activities, program managers could benefit from participation in team-building training and exercises. There are a variety of corporate executive-level courses (usually of short duration) that concentrate on strengthening collaboration and cooperation among managers. Participating in such courses and adapting them to the Moroccan situation will provide a means for strengthening this important aspect of management throughout the system.

Provide technical assistance in contraceptive procurement

The current USAID bilateral project stipulates that the last purchase of contraceptive commodities for Morocco will be made in 1994. The pipeline will be filled through 1996, at which time AID hopes to withdraw from further contributions to commodity purchase. However, caution must be exercised about removing commodity purchase support too quickly from what has up until now been a very successful program. Clearly, the GOM and the MOPH must prepare for eventual self-sufficiency. To assist in this effort and to develop an orderly plan for phasing out USAID assistance in commodity purchase, logistics experts will be used to provide assistance to the Morocco program.

STRATEGY 3. FINANCIAL SUSTAINABILITY

Assistance designed to promote financial sustainability during the next five years should focus on the following two objectives: (1) shifting contraceptive users (particularly of supply methods) from the public to the private sector; and (2) strengthening MOPH capacity and commitment to assume the burden of financing and procuring contraceptives for the public program. A new private sector project should become the focal point of private sector activities by FY 95.

Rationale: The Moroccan FP/MCH program is notable for its strong public sector component. Unfortunately, a significant share of the public sector program is supported by donor contributions, including almost \$2 million in contraceptives annually provided by USAID. The planned phase-out of U.S. assistance for direct FP/MCH service delivery, including donated contraceptives, raises questions about the financial sustainability of the program.

The options available to the FP/MCH program to achieve financial sustainability include:

- ★ Increasing the resources available in the MOPH budget for preventive services in general and FP/MCH services in particular;
- ★ Introducing cost recovery, i.e., either charging fees for FP/MCH services or cross-subsidizing FP/MCH services with revenue collected from fees charged for curative services;
- ★ Improving the efficiency of existing FP/MCH resources;
- ★ Increasing the share of FP/MCH services financed by the private sector.

The long-run prospects for increased FP/MCH MOPH budgetary support to preventive services are linked to progress in health finance reform within the public sector. Presently, the urban middle class captures the bulk of scarce public sector health

resources. This situation could only be reversed by the imposition of cost-based fees for hospital care, which in turn would need to be linked to dramatic increases in health insurance coverage. Although the MOPH has taken the lead in initiating discussions of such reform during the past few years (supported by a number of studies funded by USAID) there are many important political issues which have yet to be resolved. There is little basis for expecting dramatic increases in the availability of resources for the FP/MCH program within the MOPH budget during the next five to ten years.

Unfortunately, the MOPH appears to be wedded to the principle, at least at this time, that there should be no cost recovery within the ambulatory system. In the long run, however, policies already initiated to transfer responsibility for financing health services to local governments (collectivites locales, i.e., local communities) may create an environment more open to financial reform of the ambulatory system. Based on an earlier cost study (James Knowles and Laurie Emrich, The Estimation of Family Planning and Primary Health Service Costs in Morocco, OPTIONS project, Draft: October, 1990.), it is clear that the bulk of even the ambulatory health system's resources are absorbed by low-cost, high-volume curative care. If only 1-2 Dirham were charged for these services per visit, there would be ample resources available within the curative system to provide high-quality preventive care.

The scope for increasing the efficiency of existing resources is significant and is being pursued under the current project. The outreach system has already been revised to place more emphasis on relatively efficient point-of-contact services as compared to house-to-house distribution. Changes in the contraceptive method mix away from supply methods toward more cost-effective long-term methods (especially the IUD) should also contribute to increased financial sustainability through increased efficiency. Improved IEC and better quality services should also promote program efficiency by increasing utilization of currently under-utilized facilities (through demand creation) and raising contraceptive effectiveness by lowering discontinuation rates. Decentralization should also promote efficiency by reducing training costs and improving managerial decisions at the local level.

The greatest potential for promoting FP/MCH financial sustainability most likely lies with efforts to transfer as many users as possible out of the public sector and into the private sector. Social marketing, particularly of oral contraceptives, has an enormous potential for reducing the public sector contraceptive bill. The policy of increasing the private sector share of oral contraceptive distribution has been actively supported by GOM for several years. In addition to social marketing, there is considerable scope for transferring users of FP/MCH services out of the public sector and into the private sector by (1) promoting factory-based FP/MCH services by employers, (2) ensuring that social security (CNSS) clinics provide FP/MCH services, (3) supporting private providers through training and by providing needed IEC materials and equipment, and (4) negotiating with insurance companies to include FP/MCH services among their covered services.

Ongoing/Planned: The Family Planning and Child Survival IV project is supporting the following activities, which promote financial sustainability:

- **Constituency building.** This activity primarily involves graphic presentations of DHS and service statistics data documenting the achievements and future needs of Morocco's successful FP/MCH program to a broad audience of key decision-makers. It is hoped that broader support for the FP/MCH program will translate over time into the availability of increased budgetary resources.
- ★ **Policy dialogue.** USAID seizes every opportunity to discuss the financial needs of the FP/MCH program, as well as the need for broad health finance reform.
- ★ **Contraceptive logistics support.** Technical assistance is provided to MOPH to develop its capacity to manage contraceptives, thereby helping to prepare for the planned termination of USAID contraceptive procurement (1994).
- ★ **Continued support for social marketing.** The social marketing of condoms is already well-established and on-track toward becoming self-sustaining; the social marketing of oral contraceptives will be introduced later this year. ORS packets are currently being socially marketed, and the social marketing of a weaning food product is under consideration.
- ★ **Design of a new private sector FP/MCH project.** Several studies have already been conducted of the potential for private sector financing and/or delivery of FP/MCH services. This effort is expected to intensify during the next couple of years.
- ★ **Training of private sector providers.** Pilot training of private sector providers in sterilization and IUD insertion techniques has been initiated.
- ★ **Health-finance studies.** A number of studies have been carried out or are on-going on hospital costs and insurance to support USAID policy dialogue for health-finance reform. These studies were launched in preparation for a new health-finance project, which has since been dropped from USAID's Action Plan. The remaining funds for these studies should be reprogrammed to support other proposed activities.
- ★ **Contributions to an MOPH Vaccination Capitalization Fund.** The vaccination program has been singularly successful in Morocco. However, as pointed out in the recent Child Survival Impact Evaluation, there is a need to ensure that the cost of purchasing vaccines can be borne by GOM

in the future. UNICEF and USAID have been working with GOM under the Childhood Vaccination Initiative to set up a permanent revolving fund to finance vaccine procurement. USAID will contribute \$600,000 to capitalize this fund.

Proposed: Activities proposed for the next five years to promote FP/MCH program financial sustainability include:

- Preparing MOPH to assume responsibility for contraceptive procurement,
- Expanding the social marketing product line,
- Expanding private sector service delivery, and
- Supporting local communities to reform the financing of ambulatory care.

Prepare MOPH to assume responsibility for contraceptive procurement

Current plans call for the termination of USAID contraceptive procurement in 1994 (with the pipeline expected to sustain the program through 1996). The highest priority attaches to the development of a realistic phase-out plan for USAID assistance. Although it is recommended that USAID support continue beyond the previously planned cut-off date (1994), such continuing assistance should be part of a well-conceived, systematic phase-out plan.

Even with a carefully conceived phase-out plan, doubts remain about the GOM's willingness and financial capacity to finance the purchase of all the contraceptives needed to meet targeted growth in contraceptive use. A permanent fund to finance at least some of the cost of MOPH contraceptive procurement should be considered. Ideally, such a fund would be administered internationally (i.e., for a number of countries) so that all economies of scale in procurement could be exploited (i.e., an account in such a fund would be credited to Morocco). The advantage of setting up a fund now is that it would provide a way for donors to deposit extra funds for family planning into that account in any year in which unexpended or unprogrammed funds are available. Smaller donors would be able to make an important contribution to Morocco's family planning program without having to search for a suitable mechanism or be burdened with the extra costs and effort of developing their own project.

Expand the social marketing product line

The social marketing program is potentially one of the strongest components of Morocco's family planning program. The soon-to-be-launched oral contraceptive social marketing component has great potential for impact, particularly in transferring users from the public to the private sector. Given that the cost of oral contraceptives currently

accounts for about 80 percent of the cost of all contraceptives and family planning-related commodities distributed by the MOPH, the social marketing of oral contraceptives can have an enormous potential impact on future MOPH contraceptive procurement costs.

Current plans are to offer the social marketing product at a price of 7-7.5 Dirham per cycle (the current commercial price for the same product is 10.5 Dirham per cycle). Negotiations are currently underway to get the 37 percent tariff on contraceptives waived for contraceptives sold through the social marketing program. If this waiver is obtained, the commercial price might fall to 6 Dirham per cycle. At this lower price, one might reasonably expect a significant shift of users out of the free public sector to the pharmacy sector. If this does not occur, careful consideration should be given to the introduction of a lower priced pill within the social marketing program to compete more effectively with the public sector.

As a general policy, new contraceptives (e.g., injectables) should not be distributed only by MOPH; instead, they should also be introduced into the social-marketing program or distributed at near-cost by AMPF. The service delivery costs (injections, insertions, removal) can be borne by MOPH. This policy will limit the future contraceptive procurement burden of MOPH and will be equivalent to cost recovery (without the need to collect fees by MOPH). There is already a well-established precedent for this type of cost-sharing in the Moroccan public health sector. The only exception to this rule ought to be made with respect to special target groups (e.g., the rural poor) for whom such new contraceptives are expected to significantly expand levels of use.

In general, more use should be made of OR in the social marketing program (e.g., to test price levels for impact), and evaluations ought to be undertaken with the participation of the MOPH evaluation/research unit. Ad hoc intercept surveys should be replaced by carefully targeted, standard DHS-like surveys with special social marketing modules.

Expand private sector service delivery

Support to date by private providers and financiers of FP/MCH services has been limited to a few projects. Future support should be greatly expanded through a new private sector project. And it should emphasize not only the transfer of users from the public to the private sector but also the use of the private sector as a more flexible provider of services. Support to private providers should emphasize long-term methods (particularly sterilization), high quality, and efficiency (to keep costs as low as possible). One example is the use of the minilap technique for postpartum sterilization in private maternity clinics, utilizing less stringent criteria for eligibility than are currently in force within the MOPH sterilization program. Other examples include IUD insertion and NORPLANT.

The most promising avenues for support to the private sector would appear to include:

- **Social Security (CNSS) clinics.** At present, these are heavily subsidized out of social security taxes. The preventive services offered are quite limited. The introduction of postpartum IUDs and sterilization (using minilap techniques) has a high potential payoff.
- **Private employers.** A start has been made in introducing family planning services, including sterilization, into factory-based clinics. Since many women are employed in the manufacturing sector, the potential for factory-based FP/MCH services should be substantial.
- **Private clinics.** There are numerous private maternity clinics in Morocco. These would appear to be excellent sites for postpartum IUD and NORPLANT insertion, and sterilization programs.
- **Private doctors.** There are significant needs for training and other forms of support to private doctors to enable them to provide high-quality FP/MCH services to their clients.
- **Unemployed doctors.** Recent hiring freezes by MOPH, in combination with significant growth in the number of doctors trained, has resulted in large numbers of young doctors being unemployed. It might be practical to use the "community doctor" model, as developed in Mexico, to help these doctors establish practices in underserved areas, with the stipulation that they provide low-cost, high-quality FP/MCH services.

Any assistance to the private sector should be carefully evaluated to assure that it is having the intended impact at a reasonable cost.

Support local governments to reform the financing of ambulatory care

It is current GOM policy to gradually transfer responsibility for financing and managing social services to local governments (collectivites locales). A beginning has already been made in the case of construction costs and the hiring of medical and paramedical staff. Local governments are now expected to share in the cost of constructing and renovating health facilities in their jurisdiction. It will be some time, however, before the Ministries of Interior and Public Health reach agreement on exactly how this decentralization will be effected. It is important that USAID monitor this development carefully and stand ready to finance studies and conduct OR to exploit any potential for health finance reform which such decentralization may bring. For example, if local health committees can be formed to establish and collect fees for curative services, some of the revenue they collect might be used to pay for preventive services. At the same time, it will be

important to monitor developments in this area to ensure that the MOPH commitment to preventive services is maintained at the local level.

SECTION IV
FUNDING PLAN

FUNDING PLAN

CURRENTLY AVAILABLE FUNDS

Bilateral Funds: The current \$31.0 million Population and Child Survival IV Project, signed in August 1989, has a project completion date of September, 1996. The project provides funds, technical assistance, training, commodities, and studies, as well as evaluation and local costs in order to improve access to and use of FP/MCH services, increase program efficiency, and promote program sustainability. As of March 31, 1992, the project had committed 35 percent of the available project funds. Many items in the original design were severely underbudgeted, and little money was provided for technical assistance.

Central Funds: Funds for the health and population portfolio have been significantly augmented by central funds. For example, in addition to the buy-in funds, the Office of Population, in FY 1992 committed over \$2.2 million to Morocco, including \$1.0 million for the long-term technical advisor through the John Snow, Inc. SEATS project. Technical and programmatic assistance are also being provided by the Association for Voluntary Surgical Contraception, University of North Carolina's Evaluation Project, Johns Hopkins Program for International Education in Gynecology and Obstetrics, the Institute for Science and Technology's POPTECH Project, the Futures Group Projects - Options and SOMARC. As Morocco is a priority country, R&D/POP has made a commitment to provide an additional \$2.0 million per annum for the next five years.

The Near East Bureau and the Bureau for Voluntary Action provided \$700,000 for Population Services International to social market oral rehydration salts in Morocco. Also the Office of Health has provided \$300,000 through John Snow's REACH project to promote activities in acute respiratory infection. The Office of Health has provided and will provide Morocco limited technical assistance and/or conference support through AIDSCOM, HEALTHCOM, Family Health International and the REACH Projects.

With the above bilateral and central funds, the activities in this report shown as "ongoing/planned" can be funded. However, if Morocco is to assume additional activities as indicated in the "proposed" activities indicated in this document, additional funding will be required.

PROJECT PAPER AMENDMENT

Since the original signing of the 608-0198 project agreement, there have been considerable external and internal factors which have had significant impact on the project as originally designed. These factors include:

- **Current development of the GOM Socio-Economic Development Plan for 1992-97, which involves the review of each component and the development of a strategy for MOPH preventive health services.**
- **Development of a 1992-97 Action Plan by USAID Morocco.**
- **Review of the Action Plan in AID/Washington, which canceled the development of a health care financing project for funding in FY 1993.**
- **The availability of additional resources for Morocco through the Bureau for Research and Development, Office of Population.**
- **Prime Minister Laaraki and the Minister of Public Health officially requested additional support for health education in the area of child survival and family planning.**
- **Increased congressional interest in Morocco as a priority country for population, child survival and AIDS prevention.**
- **Exchanges in budget lines between Phase III and Phase IV so as to maximally utilize available resources.**
- **Significant inflation or underbudgeting of line items in the projected 608-0198 budget.**
- **This internal management and programmatic review which recommends priority actions to strengthen program.**

The Team recommends that USAID amend the current project to accommodate all of the above. The project paper amendment should: add funding for already programmed activities which are under budgeted; adjust the changes effected because of transfers made between budget lines of Phase III and Phase IV; reprogram funds released due to the cancellation of the health care financing project; and add funding for new activities such as the requested health education initiative and other activities recommended during the internal review evaluation. In addition, to provide sufficient means for activities to be institutionalized and allow a smooth transition to the private sector, the Team recommends that the project amendment also extend the project until 1999. It is estimated that approximately \$14.0 million will be needed to accommodate all budget requirements. The team recommends USAID begin analysis for the project paper amendment as soon as possible, and that additional funding for the sector begin no later than FY 1993.

NEW PRIVATE SECTOR INITIATIVE PROJECT

Since the early 1980's, Morocco has made dramatic gains in the reduction of infant and child mortality and reduction of the fertility rate. These gains, however, are at risk, due primarily to rapidly increasing demand for maternal and child health and family planning services; insufficient public sector resources; limited or near non-existent purchasing power of the poor (about 30% of the population); on-going disparities of health services and health status between rural and urban areas; and lessening of direct donor subsidies. If the GOM is to achieve targeted decreases in fertility and in infant, child and maternal mortality and morbidity, it must involve the private sector in the delivery of family planning and ambulatory maternal and child (MCH) services.

As Morocco's private sector health system is entrepreneurial, market driven, and profit oriented, it is recommended that USAID pursue a private sector project to increase the delivery and use of affordable and quality family planning and child survival services in the private sector and to transfer a greater portion of the health care burden from the public to the private sector.

The project can be designed to increase expertise and capability of private and semi-private health care providers and their professional organizations to deliver child survival and family planning services, and to increase the market availability of services through the development or expansion of social marketing programs, factory-based services and private voluntary organizations' service programs. The project could provide financial and technical support to enable the private provision of preventive health services; implement and test different models of sustainable private sector service delivery models; analyze--through assessments, studies and operations research--characteristics of and capabilities for the private provision of preventive health services, especially those services available to urban and periurban poor and to working class communities; and engage in an active dialogue to determine roles and responsibilities for both the public and private sector in the regulation, provision and monitoring of private sector health care.

The project should target different types of private sector service providers, namely private physician practitioners and group practices, midwives and other paraprofessionals, traditional practitioners, pharmacists and pharmaceutical sector organization providers, professional organizations and trade associations, employers and work place providers, and private voluntary organizations.

The end result should be improved policy and regulatory climate which encourages private sector involvement; a vastly expanded private sector market for family planning and child survival services; tested models (private provider, social marketing, workplace services) for the delivery of affordable services through the private sector; improved management capacity of the private sector providers to deliver profitable preventive health services; increased use of quality family planning and child survival services

through the private sector; a greater market share of services available through the private sector.

The team estimates that at least \$20.0 million will be needed to design an innovative private sector project. The team recommends that USAID begin analysis for the new project as soon as possible, and that the project be authorized in FY 1994.

**SECTION VI
EVALUATION PLAN**

The success of Morocco's FP/MCH program will depend critically on the careful evaluation of its components and on the degree to which lessons learned are incorporated into program modifications. According to Reynolds,⁴ evaluation can address a variety of subjects over the lifetime of a program, including:

1. Evaluation of Need. Results in a program of specific actions, or "interventions," designed to attain certain objectives (e.g., reduced fertility, reduced infant mortality).
2. Evaluation of Program Plans or Design. Involves the review of a proposed implementation plan for feasibility and adequacy.
3. Evaluation of Processes or Operations. Reviews the success of individual activities in marshalling inputs to achieve planned outputs (e.g., contraceptives delivered, providers trained). It is similar to standard project evaluations.
4. Evaluation of Effects. Involves looking at the effects of a program's activities on mothers' knowledge and behavior. Increased contraceptive prevalence or increased use of ORS are examples of program effects.
5. Evaluation of Impact. Involves an assessment of the program's contribution to achieving desired objectives. It should involve an attempt to separate program impact from other service and environmental factors which may also have impacted on the same objective during the evaluation period (e.g., changes in socio-economic status, changes in the general level of health services).

The present evaluation plan is concerned primarily with the fourth and fifth types of evaluation (i.e., evaluation of effects and impact). Evaluations of Needs and Plans/Design are part of an ongoing process, of which the current program planning

⁴ J. Reynolds, "Evaluation of Child Survival Programs," in Helen Wallace and Kanti Giri (eds.), Health Care of Women and Children in Developing Countries, Oakland, CA: Third Party Publishing Company, 1990, pp. 154-64.

exercise is an example.⁵

The Evaluation of Processes or Operations is met by standard project monitoring and evaluation activities. In Morocco, such monitoring and evaluation have been done routinely and effectively by the MOPH, USAID staff and (periodically) by external evaluators. Although this type of evaluation is not the current focus, it is important to note that sound approaches to effect and impact evaluation involve collection and use of reliable data about changes in program processes and operations (e.g., changes in the actual availability or quality of services).⁶

This evaluation plan addresses the following topics:

- * The Current Status of Evaluation Activities and Resources
- * Evaluation and Research Needs
- * Proposed Indicators
- * Institutional Support
- * Evaluation/Research Work Plan

THE CURRENT STATUS OF EVALUATION ACTIVITIES AND RESOURCES

Morocco enjoys relatively rich data resources for use in evaluating its FP/MCH program. Although there has been considerable project (i.e., process) evaluation within the

⁵ In the context of the Moroccan program, the specification of objectives was done prior to the arrival of the team, in connection with the development of the Mission's Action Plan and the PRISM exercise. The current planning exercise has resulted in an implementation plan to attain these strategic objectives and completes the Evaluation of Need. The review of this health sector implementation plan, by USAID and the GOM, will constitute an Evaluation of Program Plans.

⁶ In the past, it has often been assumed that programmed improvements in services have actually occurred in areas which are surveyed to measure program effects and impact. This may not be the case, however. To the extent that it is not true, it will bias estimates of program effects and impact downward (i.e., it will appear that the program is ineffective when in fact it may not have been implemented).

program to date, there has been little program effects/impact evaluation. There is no evaluation unit as such within the MOPH, and the analytical and research capabilities of MOPH staff are limited.

Data Resources

Morocco has benefitted from a number of household surveys during the past 15 years, including WFS (1979/80), CPS (1983/84), DHS I (1987) and DHS II (1992) surveys. In addition, Morocco had a population and housing census in 1982 (the next census is planned for 1993), a multi-round demographic survey in 1989, and a World Bank-funded Living Standards Survey in 1991. MOPH has also collected extensive data on the health infrastructure throughout the country (e.g., physical characteristics of fixed facilities, staffing, services offered, expenditures), which are available in a computerized data base.

Previous Evaluations

During the past five years there have been two program-level evaluations: (1) a 1988 mid-term evaluation of the Population and Family Planning Support III project (608-0171) and (2) a 1990 impact evaluation of the Child Survival program.

Both of these evaluations made extensive use of service statistics and available survey data (primarily the 1987 DHS).⁷ Special tabulations were prepared for both evaluations, which highlighted observed differences in both effects (e.g., contraceptive prevalence, knowledge of contraceptives, method mix, use of ORS, vaccination rates) and impact (fertility, infant mortality) between VDMS and non-VDMS areas.⁸

⁷ The 1988 Mid-term Evaluation of project 608-0171 also commissioned a series of evaluation studies, which were carried out under the supervision of the MOPH by the private consulting firm, EXPERDATA. See MOPH, Direction des Affaires Techniques, Le Programme de Visites a Domicile de Motivation Systematique (VDMS), Rapport de Synthese, Rabat: 1988.

⁸ The VDMS program is an integrated FP/MCH outreach program, which constituted the principal service delivery program intervention during the period covered by both evaluations. Under the VDMS program, trained nurses made house-to-house visits in rural areas to motivate couples to use contraceptives, to distribute oral contraceptives and condoms and to make referrals for IUD insertions and sterilization. Child survival activities include immunization, growth monitoring, nutrition education and provision of nutrition supplements and diarrheal disease control (distribution of ORS and instruction in its use).

In the Child Survival impact evaluation, an attempt was made to control additionally for education and urban-rural residence within these comparison tables.

There has been little or no multivariate analysis of fertility or mortality determinants in Morocco using the available survey data, nor has there been analysis of the determinants of women's decisions concerning use or choice of contraceptive method and source for various FP/MCH services. Similarly, there have been few systematic attempts to collect data on the types and quality of services provided.⁹

Demographic research, which is principally carried out by CERED (Ministry of Plan), has been limited to estimation of historical trends in fertility and mortality. No attempt has been made to link programmatic interventions to changes in these variables over time.

Institutional Resources

The principal public institution conducting demographic research is the Centre des Etudes et Recherche Demographique (CERED), which is located in the Statistics Directorate of the Ministry of Plan. CERED is well-supported by UNFPA and other organizations and has pursued an active research agenda in recent years. Unfortunately, there is no tradition of cooperation between CERED and the MOPH, and CERED shows little interest in conducting research on the effectiveness of MOPH program interventions.

There are currently few, if any, Moroccan researchers skilled in the multivariate analysis of survey data. USAID does not provide training at the Ph.D. level in its long-term training program, and there has been no masters-level training in sociology or demography in recent years. There are, however, a number of well-trained Moroccan demographers, some of whom have studied in Canada, Belgium, and France, who are interested in the analysis of survey data and who could presumably benefit from supplementary training in multivariate analysis.

Currently, the MOPH has no evaluation or research unit. The Survey and Health Statistics (SEIS) unit, which is located in the MOPH's central administrative unit, has responsibility for conducting surveys and preparing reports on service statistics. This unit has carried out all of the recent fertility surveys (i.e., WFS, CPS, DHS I and II).

⁹ The 1988 MOPH/EXPERDATA study did collect considerable data on VDMS effectiveness, including client perceptions and assessments of agent effectiveness. Unfortunately, these data could not be linked to DHS data on contraceptive use and fertility changes.

However, it has very little analytical capability and, partly due to its ministry-wide responsibilities, does not maintain very effective communications with the DPES.

The National Institute of Health Administration (INAS), which is part of DPES, has responsibility for management training and operations research and maintains close working ties with both the line FP/MCH service units (Population, MCH, and Epidemiology Divisions) and with the Health Education Division (DES). INAS is a more logical base for FP/MCH research and evaluation activities—although the research skills of its staff are limited.

EVALUATION AND RESEARCH NEEDS

Current Needs

A final evaluation of the recently completed Population and Family Planning Support III Project (608-0171) is needed and has been scheduled, as a program impact evaluation, for January of 1993. A scope of work for this evaluation was prepared in March 1992. It will cover activities of both projects 608-0171 and 608-0198 during the period 1984 to the present. The two projects overlapped by more than two years, with many activities in common; so it is not practical to evaluate their separate impacts.

The program impact evaluation, which will cover both family planning and child survival activities, has been scheduled to make good use of the results from the DHS II (Enquete Nationale Sur la Population et la Sante II), the preliminary results of which will be available in June. Two pre-evaluation studies will be carried out:

- * Special tabulations will be prepared by DHS staff for use by the evaluation team. These will include a number of analyses based on the 5-year calendar and will be presented in such a way as to study the impact of the VDMS project over time. The specifications for these tables were prepared in March, along with the evaluation scope of work, and they have been forwarded to IRD/DHS. Plans for preparing these tables were discussed with the DHS country coordinator during this planning exercise.
- * A quality assessment of FP/MCH services will be carried out prior to the evaluation. This will be coordinated closely with the DHS facility survey, which is scheduled to go into the field in August. A limited number of questions may be added to the facility survey, and it is expected that the more in-depth quality assessment survey will be done in a subset of the DHS-surveyed facilities.¹⁰

¹⁰ There are two advantages in doing the quality assessment study in the DHS-surveyed facilities. First, it will allow an important quality dimension to be added to the access dimension

In addition to the immediate research needs of the program impact evaluation, there is a large agenda of basic research on the family planning and child survival program, which should be carried out as soon as the DHS II data are ready for supplementary analysis. Examples of the many possible topics for study include:

1. A study of the relationship between inputs and outputs in the ambulatory health system, utilizing the detailed service statistics which are available for all health facilities on all programs, as measures of output, and data on the resources employed at each facility, which can be obtained from the MOPH Carte Sanitaire data base, to provide measures of inputs. Such a study might be limited to facilities surveyed in the DHS, in which case it could include both household and individual characteristics, as well as quality-of-care data. One purpose of the study would be to gain a better understanding of the factors which determine the wide variation in utilization one observes between MOPH facilities.
2. A multivariate analysis of the factors determining women's choice of contraceptive method and source, as well as their decisions to seek various child survival services and the source of such services, would be based on the DHS II, supplemented with facility and quality assessment data. One interesting question on which such a study could focus is the extent to which the use of one FP/MCH intervention is associated with the use of other interventions (e.g., is the use of pre-natal care associated with higher rates of postpartum contraceptive use?)
3. Another study based on MOPH service statistics from DHS survey clusters would attempt to find ways to use the former to obtain estimates of population-based indicators, such as contraceptive prevalence and vaccination coverage, for program monitoring purposes. The fact that the DHS I and DHS II surveys used the sample clusters provides a unique opportunity to try to link up changes in service statistics for each cluster to observed changes in population-based indicators between the two surveys. Such a study should also relate changes in pharmacy sales of oral contraceptives in each cluster to changes in survey-based estimates of private sector prevalence.
4. A multivariate study of the determinants of infant and child mortality should be carried out using the relatively rich data provided by DHS II (augmented with the facilities and quality assessment surveys). This study would attempt to identify which child survival interventions are most closely associated with increased survival rates

for in-depth research into the determinants of contraceptive method-source choice in Morocco. Second, it will provide critical baseline data on quality of care for the program's operations research activities (see discussion below).

(controlling for other factors). Such a study might point the way to a more effective mix of interventions for the child survival program.

Future Needs

The five-year implementation plan calls for a number of operations research activities (e.g., model quality and IEC sites, injectables experiment, social marketing pricing experiments). These should be evaluated using special DHS-like surveys, which have been shortened to exclude such features as the five-year calendar, but which are augmented to include special modules, as appropriate (e.g., IEC, quality assessment by clients, social marketing). Whenever possible, OR experiments should be conducted in DHS clusters, so that the DHS surveys provide the necessary baseline data.¹¹ Clusters could be paired to provide a powerful quasi-experimental design methodology, i.e., one of the clusters would receive the experimental treatment, while the other would not. The paired clusters would then be surveyed at appropriate intervals to measure the impact of the experimental intervention.

The implementation of such an approach would require funds for additional surveys during the next five years. The surveys would be relatively small, however, in terms of geographical coverage; and most of the survey instrument would remain unchanged. It would be necessary for the proposed INAS-based FP/MCH evaluation unit to work closely with SEIS in the design and conduct of such special-purpose evaluation surveys. Developing such a capability would also provide the FP/MCH program with a powerful tool to monitor and evaluate the success of new nation-wide initiatives as they are phased in geographically. It is important to point out that such special-purpose surveys would not be a substitute for a larger, nationally representative DHS survey.

¹¹ Such a practice would, of course, necessitate drawing a new sample for the next DHS survey, since the existing sample would no longer be representative.

PROPOSED INDICATORS

The following performance indicators are proposed at this time for use in monitoring USAID's progress in implementing the health sector component of its Country Program Strategy:¹²

Program Sub-goal No. 2: Improved Quality of Life

Proposed Indicator: Improved quality of life index

Data Source: UNDP

Strategic Objective No. 3: Improved Health of Children and Women of Child-bearing Age

Proposed Indicators: Total Fertility rate (urban, rural)

Infant mortality rate (urban, rural)

Child mortality rate (urban, rural)

Private sector share of oral contraceptive market

Share of MOPH budget allocated to FP/MCH services
(capital, recurrent)

Percent of population covered by outreach programs

Data Sources: DHS and other demographic surveys

GOM budget

Program Output No. 3.1: Increased Use of Effective FP/MCH Services

Proposed Indicators: Contraceptive prevalence rate (urban, rural)

Modern method contraceptive prevalence rate (urban, rural)

IUD and sterilization prevalence rates (urban, rural)

¹² USAID/Morocco, Program Performance Assessment Plan, Draft Report (March, 1992).

Continuation rates (IUD, oral contraceptives)

Percent of target population completely vaccinated (DPT, Polio, Measles, BCG, Tetanus)

Percent of medically supervised deliveries

Percent of diarrhea cases treated with ORT (urban, rural)

Percent of pregnant women receiving qualified prenatal care (urban, rural)

Data Sources: DHS and other surveys

MOPH service statistics

UN vaccination coverage surveys

Program Sub-output 3.1.1: Increased Access to FP/MCH Services and Safe Water

Proposed Indicators: Number of FP/MCH service delivery points (public, private) including number of VSC/clinical services sites, training centers, reference centers, AIDS facilities

Percentage of population residing within 10 kilometers of FP/MCH services

Data Sources: MOPH progress reports (public sector)

Contractor reports (private sector)

Program Sub-output No. 3.1.2: Higher Quality FP/MCH Services

Proposed Indicators: Quality-of-care index

Data Source: Periodic quality assessment surveys by INAS/SEIS (MOPH)

Program Sub-output No. 3.1.3: Increased Access to Information

Proposed Indicators: Percentage of women with knowledge of IUDs and sterilization

Percentage of women with knowledge of source of IUDs and sterilization

Percentage of women informed about correct use of oral contraceptives

Percentage of women correctly informed about side effects of the IUD and oral contraceptives

Percentage of women who have heard (seen) FP/CS messages during a given time period

Percentage of mothers who know purpose and how and when to prepare and give ORS

Percent of mothers who know reasons to breast-feed and when to give supplementary food

Data Sources: DHS and other surveys

Program Output No. 3.2: Increased Sustainability of FP/MCH Services

Proposed Indicators: Share of FP/MCH service delivery and support costs financed from domestic sources

Private sector share of oral contraceptive market

Data Sources: GOM budget

DHS and other surveys

Program Sub-output No. 3.2.1: Improved Management Systems for FP/MCH Services

Proposed Indicators: Plans prepared and implemented (public, private)

MIS system in place (public)

Training system in place (public)

Supervision system in place (public)

Logistics system in place (public)

Planning system in place (public)

Data Sources: Annual work plans and progress reports (public, private)

Contractor progress reports

Program Sub-output No. 3.2.2: Strengthened FP/MCH Institutions

Proposed Indicators: Number of MOPH staff trained in national/regional/local training facilities

Number of research/evaluation studies prepared by INAS

Number of operations research experiments carried out by INAS

Number of meetings per year of MOPH FP/MCH coordinating committee

Data Sources: MOPH and contractor progress reports

Program Sub-output No. 3.2.3: Diversify the Financial Base for FP/MCH Services

Proposed Indicators: Share of MOPH budget allocation allocated to FP/MCH services (capital, recurrent) sources

Plan prepared and implemented for phased withdrawal of USAID contraceptive procurement

Proportion of the population receiving FP/MCH services from the private sector

Private sector share of oral contraceptive market

Data Sources: DHS and other surveys

GOM and donor budgets

Contractor and MOPH progress reports

INSTITUTIONAL SUPPORT

Significant institutional support will be needed to strengthen MOPH capability in FP/MCH evaluation and research. Most of this support should be directed to INAS in the form of technical assistance and training, but additional support would need to be provided to SEIS to institutionalize its capability to carry out periodic, targeted surveys to evaluate the results of new initiatives and operations research experiments in FP/MCH service delivery.

INAS

INAS will need to add to its staff at least one full-time, highly trained sociologist/demographer skilled in the multivariate analysis of survey data. This person's role should include: (1) working on the design of operations research experiments to maximize the program-relevant information which can be obtained from them; (2) working closely with line services (Population Division, MCH Division) and DES to develop and execute a programmatically relevant research agenda, with external technical assistance when needed; (3) collaborating with SEIS on the development of periodic, targeted surveys to evaluate new program initiatives and operations research experiments; (4) analyzing the results of such surveys and presenting conclusions and recommendations derived from them to the relevant line services for implementation; (5) developing and refining appropriate indicators for preventive health services and health education; and (6) serving as the focal point for external technical assistance and training in evaluation and research techniques.

INAS should assume the cost of having such a person on its staff. USAID could provide necessary computer equipment and library materials along with external technical assistance and overseas training.

SEIS

Due to its work on several previous surveys SEIS already has developed considerable capability in conducting surveys on a nationwide basis. This capability needs to be augmented to include the ability to conduct much more frequent surveys of limited geographical scope, which would include a core module from the DHS survey (e.g., questions related to current contraceptive use) in all cases but which could be expanded to include special modules as appropriate (e.g., IEC, quality assessments, social marketing). Presumably the next DHS project will be able to work with SEIS to develop this capability.

These surveys will be used for the following purposes: (1) to make quick evaluations of new initiatives and approaches to FP/MCH service delivery, as they are phased in initially in a few provinces; (2) to evaluate operations research experiments; (3) to evaluate the effects and impact of private sector activities (e.g., social marketing) in a

systematic, consistent, and scientifically sound manner (since these are not covered by MOPH service statistics).

EVALUATION/RESEARCH WORK PLAN

1992

- June** Preliminary results of DHS II become available.
- Design of DHS facilities survey finalized.
- Program impact evaluation team selected; scope of work finalized.
- July** Discussions and preliminary design initiated of MOPH Quality Assessment Study, including institutional involvement, site selections, and range of methodologies to be employed. TDY by SEATS project staff.
- Begin special tabulations of DHS II for Nov./Dec. program impact evaluation.
- August** Field work on DHS facilities survey begins.
- Discussions and development of MOPH Quality Assessment continues.
- Field work of DHS facilities survey completed.
- Senior Sociologist/Demographer begins work at INAS. In-depth analysis of MOPH FP/MCH service statistics data begins.
- September** Field work to develop MOPH Quality Assessment Study methodology completed. TDY by Evaluation Project.
- Data processing and tabulation of DHS facilities survey initiated.
- October** Field implementation of MOPH Quality Assessment. TDY by EVALUATION project staff.
- Completion of special tabulations from DHS II for program impact evaluation.

Completion of analysis of MOPH FP/MCH service statistics by INAS staff.

November Data processing and analysis of MOPH Quality Assessment. TDY by Evaluation Project staff.

December Briefing of program impact evaluation team.

1993

January Program impact evaluation of 608-0171 and 608-0198 begins.

Program impact evaluation initiated.

February Program impact evaluation report forwarded to USAID for Mission review. Mission comments forwarded to team leader.

Supplementary analysis of DHS II data begins, to be carried out by INAS, DHS staff and EVALUATION project staff. TDY of EVALUATION project staff.

March Final version of program impact evaluation report forwarded to USAID.

USAID evaluation summary prepared.

Visit of INAS sociologist/demographer to Carolina Population Center.

Seminar to present results of supplementary analysis of DHS II. TDY of EVALUATION project staff.