

UNITED STATES OF AMERICA  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
RABAT, MOROCCO

PD-ABG 128

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**MEMORANDUM**

**DATE:** 7 July, 1993  
**TO:** Patty Swahn, POL/CDIE/DI Acquisitions  
**FROM:** Mary Reynolds *MR* Regional Contracts Officer  
**SUBJECT:** Family Planning and Maternal Child Health Phase V  
Project (608-0223) Documentation

Attached please find excerpts from the Project Agreement and detailed project description for the USAID/Morocco Family Planning and Maternal Child Health Phase V Project (608-0223), signed July 2, 1993.

USAID/Morocco plans to issue an RFP for an institutional contactor under this project prior to November, 1993. USAID/Morocco requests that POL/CDIE/DI Acquisitions provide copies of the enclosed documents to potential contractors, on request, employing CDIE's standard procedures. Please also include a notice that these documents are available in its upcoming issue of the **New Acquisitions Newsletter**.

Thank you for your assistance.

PD-ABG-128

*A.I.D. Project Number 608-0223*

**PROJECT GRANT AGREEMENT  
BETWEEN THE KINGDOM OF MOROCCO  
AND THE UNITED STATES OF AMERICA  
FOR  
FAMILY PLANNING/MATERNAL AND CHILD HEALTH  
PHASE V**

*Projet de l'A.I.D. No. 608-0223*

**ACCORD DE DON POUR UN PROJET  
ENTRE LE ROYAUME DU MAROC  
ET LES ETATS-UNIS D'AMERIQUE  
EN FAVEUR DE  
LA PLANIFICATION FAMILIALE ET DE  
LA SANTE MATERNELLE ET INFANTILE  
PHASE V**

**DATE: \_\_\_\_\_**

**A.I.D. Project No. 608-0223**

**PROJECT GRANT AGREEMENT**

**Dated \_\_\_\_\_**

**Between**

*The Kingdom of Morocco, acting through the Ministry of Public Health "Grantee", and the Ministry of Finance as provided in Section 8.5 hereof,*

**and**

*The United States of America, acting through the Agency for International Development (A.I.D.).*

**ARTICLE 1  
THE AGREEMENT**

*The purpose of this Agreement is to set out the understandings of the Parties named above ("Parties") with respect to the undertaking by the Grantee of the Project described below, and with respect to the financing of the Project by the Parties.*

**ARTICLE 2  
THE PROJECT**

**SECTION 2.1.  
DEFINITION OF THE PROJECT**

*The Project, which is further described in Annex 1, is designed to improve the health of children under five and women of childbearing age bringing about a reduction in the number of children under five who die from major preventable diseases and complications of delivery and to ensure opportunities for women to have fewer, healthier, pregnancies and safer deliveries. Project assistance will support effective*

**Projet A.I.D. No. 608-0223**

**ACCORD DE DON POUR LE PROJET**

**En date du \_\_\_\_\_**

**Entre**

*Le Royaume du Maroc, agissant par l'intermédiaire du Ministère de la Santé Publique ("Bénéficiaire"), et du Ministère des Finances comme le stipule la Section 8.5 du présent Accord,*

**Et**

*Les Etats-Unis d'Amérique, agissant par l'intermédiaire de l'Agence Américaine pour le Développement International (A.I.D.).*

**ARTICLE 1  
L'ACCORD**

*L'objet du présent Accord est d'arrêter les obligations que doivent remplir les Parties désignées ci-dessus ("Les Parties") quant à l'exécution par le Bénéficiaire du Projet décrit ci-dessous et quant au financement du Projet par les Parties.*

**ARTICLE 2  
LE PROJET**

**SECTION 2.1.  
DEFINITION DU PROJET**

*Le Projet, dont une description plus détaillée figure en Annexe 1, a pour objet d'améliorer la santé des enfants âgés de moins de cinq ans et des femmes en âge de procréation, afin de réduire le nombre de décès d'enfants de moins de cinq ans dus à des maladies évitables et à des complications en cours d'accouchement, et pour garantir aux femmes la possibilité d'avoir moins de grossesses et des accouchements*

*W*

*utilization of family planning/maternal child health (FP/MCH) services and will permit program sustainability. Annex 1, attached, amplifies the above definition of the Project. Within the above definition of the Project, and except as provided in Section 8.5 hereinbelow, elements of the amplified description stated in Annex 1 may be changed by written agreement of the authorized representatives of the Parties named in Section 8.2, without formal amendment of this Agreement.*

**SECTION 2.2.  
INCREMENTAL NATURE OF THE  
PROJECT**

*A. A.I.D.'s proposed life-of-project contribution to the Project is fifty-two million United States dollars (\$52,000,000 US). A.I.D.'s contribution to the Project will be provided in increments, the initial one being made available in accordance with Section 3.1 of this Agreement. Subsequent increments will be subject to availability of funds to A.I.D. for this purpose, and to the mutual agreement of the Parties, at the time of a subsequent increment, to proceed.*

*B. Within the overall Project Assistance Completion Date stated in this Agreement, A.I.D., based upon consultation with the Grantee, may specify in Project Implementation Letters appropriate time periods for the utilization of specific funds granted by A.I.D.*

**ARTICLE 3  
FINANCING**

**SECTION 3.1.  
THE GRANT**

*moins risqués. Le Projet soutiendra l'utilisation efficace des services de planification familiale/santé maternelle et infantile (PF/SMI), et permettre la viabilité du programme. L'Annexe 1, ci-jointe, élargit la définition ci-dessus du Projet. Dans les limites de la définition ci-dessus du Projet et exception faite de ce qui est stipulé à la Section 8.5 ci-après, des éléments de la description détaillée du Projet figurant en Annexe 1 pourront être changés par un accord écrit des représentants autorisés des Parties nommées à la Section 8.2, sans avenant formel au présent Accord.*

**SECTION 2.2.  
FINANCEMENT DU PROJET PAR  
TRANCHES SUCCESSIVES**

*A. La contribution prévue de l'USAID pendant la durée du Projet est de cinquante deux millions de dollars américains (52.000.000 dollars US). Cette contribution se fera par tranches successives. La première sera disponible selon les termes de la Section 3.1 du présent Accord. Les tranches suivantes seront allouées sur une période de six ans, durée du Projet, en fonction de la disponibilité des fonds alloués à l'A.I.D. pour ce financement. Les fonds seront débloqués sur la base d'accords entre les Parties pour procéder à l'utilisation d'une nouvelle tranche.*

*B. Avant la date finale d'achèvement de l'assistance au Projet arrêtée dans le présent Accord, l'A.I.D., après consultation avec le Bénéficiaire, pourra spécifier, dans des Lettres d'Exécution du Projet, les périodes appropriées pour l'utilisation de certains fonds octroyés par l'A.I.D.*

**ARTICLE 3  
FINANCEMENT**

**SECTION 3.1.  
LE DON**

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*To assist the Grantee to meet the costs of carrying out the Project, A.I.D., pursuant to the Foreign Assistance Act of 1961, as amended, agrees to grant the Grantee under the terms of this Agreement an initial increment not to exceed Eight Million Twelve Thousand United States ("U.S.") Dollars (\$8,012,000) ("Grant").*

*The Grant may be used to finance foreign exchange costs, as defined in Section 6.1, and, as specifically authorized by A.I.D., to finance local currency costs, as defined in Section 6.2, of goods and services required for the Project.*

**SECTION 3.2.  
GRANTEE RESOURCES FOR THE  
PROJECT**

*A. The Grantee agrees to provide or cause to be provided for the Project all funds, in addition to the Grant, and all other resources required to carry out the Project effectively and in a timely manner.*

*B. The resources provided by the Grantee for the national FP/MCH program will be not less than the equivalent of U.S. One Hundred Eight Million Four Hundred Thousand Dollars (\$108,400,000) representing a contribution of Fifteen Million Eighty Thousand Dollars (\$15,080,000) to the Phase IV Project and Ninety Three Million Three Hundred Ninety One Thousand Dollars (\$93,391,000) to the Phase V Project, including costs borne on an in-kind basis for the period of the Project. The Grantee agrees to provide annually, in a form agreeable to the two Parties, a report delineating Grantee contribution provided to the Project for the reporting period.*

*Pour aider le Bénéficiaire à financer les coûts de l'exécution du Projet prévus à la Section 2.2.A., l'A.I.D., conformément à la loi de 1961 sur l'Assistance aux Pays Etrangers, telle qu'elle a été amendée, convient d'accorder au Bénéficiaire, aux termes du présent Accord, une première tranche qui dépasse pas Huit Millions Douze Mille dollars des Etats-Unis (\$8.012.000) ("Le Don").*

*Le Don peut être utilisé pour financer les coûts en devises, comme définis à la Section 6.1, et, par autorisation spécifique de l'A.I.D., les coûts en monnaie locale, comme définis à la Section 6.2, des biens et des services nécessaires à l'exécution du Projet.*

**SECTION 3.2.  
RESSOURCES DU BENEFICIAIRE POUR  
L'EXECUTION DU PROJET**

*A. Le Bénéficiaire convient de fournir ou de faire fournir pour l'exécution du Projet tous les fonds, outre le Don, et toutes les autres ressources requises pour exécuter le Projet efficacement et en temps utile.*

*B. Les ressources fournies par le Bénéficiaire pour le programme national de PF/SMI ne seront pas inférieures à l'équivalent de Cent Huit Millions Quatre Cent Mille dollars américains (\$108.400.000), qui représentent une contribution de Quinze Millions Quatre-Vingt Mille dollars américains (15.080.000 dollars) pour le projet de la Phase IV, et Quatre-Vingt-Treize Millions Trois-Cent-Quatre-Vingt-Onze Mille dollars américains 993.391.000 dollars) pour le projet de la Phase V, y compris le coût des apports "en nature" pendant le Projet. Le Bénéficiaire convient de fournir annuellement, sous une forme agréée par les deux Parties, un rapport spécifiant sa contribution au Projet durant la période couverte par le rapport.*

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## C. DETAILED PROJECT DESCRIPTION

### 1. Project Goal and Purpose

The goal of the project is to improve the health of children under five and women of childbearing age—that is, to reduce the number of children under five who die from major preventable disease and complications of delivery and to ensure opportunities for women to have fewer, healthier, pregnancies and safer deliveries. Achievement of the project goal will be measured by a reduction in the perinatal, infant and child mortality, a reduction in maternal mortality, and a reduction in the total fertility.

The successful achievement of the project goal depends on the population's use of family planning and maternal/child health services, and Morocco's continuing ability to provide them. Therefore, one purpose of project assistance is to increase the effective use of FP/MCH services by improving access, quality and information. The other purpose is to increase program sustainability by ensuring a favorable policy environment, reinforced decentralized institutional capacity, and a diversified resource base. The conceptual framework for the project design is schematically presented as follows:

### IMPROVE HEALTH OF MOTHERS AND CHILDREN

#### EFFECTIVE USE OF FP/MCH SERVICES

- INCREASE ACCESS
  - Research
  - Organization/Range
  - Expanded Channels
- IMPROVE QUALITY
  - Standards of Practice
  - Technical Competence
  - Supervision
  - Environment
- EXPAND AND IMPROVE IEC

#### SUSTAINABILITY OF FP/MCH SERVICES

- FAVORABLE POLICY  
ENVIRONMENT
- DECENTRALIZED INSTITUTIONAL  
CAPACITY
  - Management Systems
  - Managerial Skills
  - Logistics Management
  - Equipment/Materials
- DIVERSIFIED FUNDING
  - Public Sector
  - Private Sector

The project purposes are derived from collaborative planning efforts of the USAID Mission and the MOPH over the past year and a half and the project directly contributes to MOPH strategies detailed in recent planning documents for safe motherhood, breastfeeding, family planning, and control of diarrheal disease as well as for health sector reform and organization. The project interventions constitute a cohesive strategy that will improve existing FP/MCH services, and broaden the base of program management responsibility, in an environment of reduced external support for recurrent costs. The strategy also supports health policy reforms currently underway within the MOPH such as decentralization and broadening of the funding base for health services delivery. Thus the project's successful implementation will greatly support the GOM drive toward more effective and less donor-dependent provision of quality family planning and child survival services by the year 2000.

### 2. Project Components and Major Activities

This project will consist of two components which will directly correspond to the project purposes, they are: (a) increase the effective use of FP/MCH services, and (b) increase program sustainability.

Support under this project is primarily directed toward a full range of family planning services as well as certain aspects of diarrheal disease control and safe motherhood services, including breastfeeding. On specific request, the project will provide limited support other child survival and preventive services such as HIV/STD, immunization, and acute respiratory infection (ARI). Interventions eligible for selective support in these service areas include those which promote integration into the priority FP/MCH services; those which address problems of a special nature or respond to a special need; and Moroccan participation in international training and conferences.

To increase use of FP/MCH services, primary responsibility will be with the Directorate of Preventive Services and Health Training including the DPES divisions responsible for IEC, Population and MCH services; and regional managers and provincial delegates supported by their technical units. The entire MOPH ambulatory structure within provincial level hospitals/maternalities, and health centers and dispensaries as well as the outreach network of field agents and mobile unit will be mobilized to deliver information and services. Certain

actions will be implemented on a national scale, and in some cases there will be pilot testing at the regional and provincial levels. MOPH divisions beyond the DPES will be substantially involved in development, delivery and introduction of clinical services and training, including the National Training Center for Reproductive Health and the medical and nursing Schools. In the expansion of service delivery channels, other ministries (e.g., Agriculture, Youth and Sports, and Education), non-governmental organizations (professional associations, technical groups, women's groups, community groups, leadership groups) will be implicated.

The Minister of Public Health and other high-level supporters will play the central role in policy development efforts designed to increase program sustainability. The major parties responsible for implementing component two will continue to be the DPES and the DPES divisions responsible for IEC, FP and MCH services. Several MOPH units at the central level which have responsibilities in planning, evaluation, research, management information systems (MIS), training, and personnel management, will collaborate with the DPES in strengthening those aspects of the FP/MCH program. These entities include the Division for Statistics and Information Systems Planning (DPSI) with its Service for Statistical Information and Documentation (SESI) and Service for Studies and Treatment of Information (SETI) as well as the National Institute for Health Administration (INAS). Strengthening decentralized management capabilities will involve the regional level and provincial delegates and the decentralized health network. Private sector partners, including industrial health units, pharmaceutical companies, professional and non-governmental organizations, and private sector health providers, will be responsible for implementing and evaluating specified private sector activities.

#### **Component One: Increase Effective Use of FP/MCH Services**

While progress has been made in extending FP/MCH services throughout Morocco, many potential clients are still not using services, especially in the rural areas. In addition to the large discrepancies already stated in terms of infant mortality, over 60% of urban women receive some prenatal care, compared to only 17.5% of rural women. Contraceptive prevalence is almost twice as high among urban as rural women. In addition there is a gap between desired childbearing and use of family planning services. Although services exist, there are low use rates for long-term and permanent methods of contraception, underutilization of prenatal and postpartum services, and continued high mortality due to childhood diarrheal disease.

If FP/MCH are to be effectively used, they must be readily accessible when a health care need arises; the level of quality of services must be high enough to attract and retain clients and promote improved health practices; and the population must be informed and motivated to use the services appropriately.

The project will contribute to increased use of services by identifying and resolving access problems, supporting MOPH efforts to improve quality, and addressing past weaknesses of IEC efforts. The specific results will be:

- more women correctly using effective contraceptive methods of their choice (as evidenced by an increase in contraceptive prevalence from 41.5 in 1992 to 54.0 in 2000, a more diversified method mix, including a greater percentage of long-term methods, and increase in the use effectiveness rate).
- more women receiving prenatal care and maternity services (as evidenced by an increased in the use of prenatal and maternity services from 30% in 1992 to 50% in 2000).
- more women practicing diarrheal disease prevention and rehydration techniques for the protection of their children (as evidenced by an increase in the use of oral rehydration salts in diarrheal episodes from 12% in 1992 to 25% in 2000).

#### **A) Increase Access to Services**

Since 1984 Morocco has created a broad health infrastructure with an important outreach component. The percentage of the population residing within the catchment area of this network has doubled to 80% over the past ten years, although some estimates of rural population coverage are as low as 50%. To further increase access, the MOPH now needs to focus on activities and services which, with minimal additional support, can be significantly more responsive to health needs.

There is strong evidence that the current organization and range of MOPH services inhibit access to health care because they do not optimally address local practices and perceived needs of potential clients. When clients do use a service, it is frequently not integrated to serve as an entry point into a full range of FP/MCH services. MOPH national strategies in safe motherhood, breastfeeding, and diarrheal disease control have particularly emphasized closer integration as being critical to holistic care for mothers and infants. Access also appears to be constrained by clinic and outreach location and schedules. This is especially true for rural populations with respect to distance, transportation, and geographical barriers.

Progress in these areas can be made by identifying and strengthening weaknesses in the organization and range of services offered in both fixed and outreach facilities, for example the variety of contraceptive methods available, and through supporting integration of services so that each vertical program becomes an entry point into the health care system. Other sectors, both within and outside of the GOM also need to be encouraged to help provide additional avenues into FP/MCH services.

The project will increase access by obtaining additional information to better understand and act on problems of access, by selectively

reorganizing and expanding the range of FP/MCH services offered by the MOPH, and by expanding the channels of service delivery using existing resources outside the MOPH. While quality of care and availability of private sector services figure prominently in the issue of access, they are addressed as separate objectives in this project description. In addition, actions to improve access, quality and IEC and to expand FP/MCH, may have policy implications. These are addressed in the section of this document under Component Two entitled, "Favorable Policy Environment."

### 1) Research Problems of Access

To better understand access problems and determine possible solutions, project inputs will include technical assistance, on-the-job training, and financial and material support for field work to conduct the following activities:

- develop research tools and methodology for needs assessments, diagnostic or special studies.
- collect, organize, and analyze data for two assessments per year in such subject areas as illustrated below:
  - \* general service delivery issues: geographically inaccessible areas with concomitant high infant mortality rates and low contraceptive prevalence rates; fixed facility procedures including organization of client flow, schedules, referral mechanisms, and staffing patterns; effectiveness of current outreach strategies, including comparisons of home visits, points of contact, and mobile clinics.
  - \* safe motherhood: pregnancy and childbearing practices and attitudes; appropriate settings, staffing and organization of maternity services to best respond to clients needs; training needed for prenatal, delivery and postpartum services; breastfeeding in clinical settings;.
  - \* childhood diarrheal diseases: practices related to diarrheal disease, home treatments, case management, provider care and ORS use.
  - \* family planning: use of family planning services and reference centers; attitudes, practices, and impact of availability of long-term and permanent contraceptive methods; factors underlying heavy dependence on oral contraceptives, and continuation rates.
- translate research results into proposed solutions by printing and distributing results; holding seminars for dissemination and discussion at all levels of management; developing national strategies and provincial action plans which incorporate research findings;
- test alternative strategies to better respond to client needs, such as use of family planning reference centers for other purposes; different criteria for the location and equipping of maternities; and improved organization of prenatal and child care consultations and type of services offered through outreach; and
- identify and correct special problems occurring in the routine provision of FP/MCH services including changes in protocols, clinic policies, product choice, provider skills, and client eligibility.

As a result, through the practical application of research, FP/MCH services will be reorganized, revised and reinforced to better meet client needs. For instance, based on research, maternities may be located and equipped to provide the range of services most effective to ensuring safe deliveries, and methods used by health workers to promote use of oral rehydration therapy may be practical for the target population to implement.

### 2) Organization and Range of Services

To expand the range of FP/MCH services available, technical assistance, commodities, project inputs will include technical assistance, training and commodities and service subsidies to conduct the following activities:

- continue current family planning services, systematically introduce new contraceptive methods, and implement phased expansion of long-term and permanent methods, including Norplant, injectables, laparoscopy, minilap, and IUDs;
- reinforce comprehensive maternity services especially prenatal and postpartum information and services;
- reinforce control of diarrheal disease educational and services activities, particularly case management and oral rehydration therapy;
- develop skills required by providers and conditions under which reinforced FP/MCH services are offered; and
- modify policies related to client eligibility, categories of professionals authorized to provide services, and service setting as appropriate.

To provide for a more integrated organization of FP/MCH services, project inputs will include technical assistance, materials, equipment,

and selected local costs to conduct the following activities:

- analyze and design an improved organization of services within generalized and specialized health facilities, and between fixed and outreach sites, including: client flow; integrated health cards and client records; referral mechanisms; and proposed changes where needed in staff deployment, job descriptions, and staffing patterns;
- test and demonstrate alternative integration strategies, including provision of postpartum family planning in maternities, use of family planning reference centers for prenatal consultations; inclusion of breastfeeding education in family planning, prenatal/postpartum, and well-baby clinics; and
- develop, with lessons learned, models that can be adapted nationwide for in-service and pre-service training and for supervision.

As a result of these interventions, access problems will be better understood and resolved. IUD insertion, Norplant, laparoscopy and minilap, and injectables, will be available in an increased number of locations and related services provided by more categories of professionals; family planning reference centers will offer a wider range of contraceptive and related reproductive health services; postpartum family planning will be offered in maternities; client eligibility criteria will be revised for permanent and long-term methods reflecting client demand and acceptability; and pill discontinuation rates will be reduced and pill clients transferred to other methods where necessary. Knowledge concerning target populations desires and needs related to maternity services will be increased. The knowledge base regarding the control and treatment of diarrheal disease will increase. Health workers and supervisors will use new service delivery, referral, and follow-up tools to ensure that clients receive a wider scope of FP/MCH services under new clinic policies in general service and specialized health facilities, and outreach sites.

### 3) Expansion of Channels of Service Delivery

To expand outreach, services, IEC, and referral points into the service system and to target hard-to-reach populations, project inputs will include technical assistance, funding for seminars and overseas study tours, per diem and transportation for pilot field work, materials, supplies, and equipment to conduct the following activities:

- analyze existing data and conduct further studies and research to identify geographic, socio-economic, and other pertinent characteristics of underserved populations;
- organize and disseminate data in practical form to all collaborating parties to facilitate use in intersectorial planning and program implementation, including services delivery, IEC, and policy reform;
- evaluate and present findings regarding relevant experiences of other agencies;
- design, implement, and evaluate innovative MOPH outreach strategies which draw on community-based and other non-MOPH resources;
- test delivery of IEC, FP/MCH supplies, and other aspects of services by outreach agents of other ministries, non-governmental organizations (NGOs), collectivités locales, and collaborators; and
- support study tours to other countries in multi-sectorial groups to observe innovative collaboration in FP/MCH programs.

As a result of project activities, a common data base about underserved populations will facilitate intersectorial collaboration. Target populations will find more avenues into existing services, and more distribution points for IEC and FP/MCH services.

### **B) Improve Quality of FP/MCH Services**

Quality services promote effective utilization and, consequently are a priority in Morocco and key to overall program sustainability. Fundamental components of quality include technically competent workers who are provided with adequate support and supervision. In addition the condition of the physical environment is a component of quality, with the potential to either attract or detract clients.

Not all FP/MCH services have developed or disseminated standards of practice which are essential to effective training and service delivery. Where service protocols do exist, they have been recently developed and not yet thoroughly and systematically applied throughout the system. Service providers are not yet trained in all aspects of service delivery. Supervision is extremely problematic in that supervision systems do not address current realities of preventive FP/MCH service delivery. For example, they exclusively reflect vertical programs, are not systematically carried out, and are not designed to ensure adherence to service standards where they do exist. Finally, supervisors lack tools and training to be effective.

Efforts are already underway within the MOPH to improve quality. The project will continue to reinforce the MOPH in this direction, including the practical application of service protocols, and the expansion and up-dating of in-service and pre-service training, including training in interpersonal communications, and significant revision in supervision methodology as well as an increase in overall supervision

practices. In addition, the project will improve the quality of the physical environment through the procurement of clinic equipment and materials, and improvement in conditions of client privacy.

Long-term sustainability of a quality health delivery system requires that program managers at all levels have the commitment, skills and authority to identify and resolve problems; and that health care workers have the proper technical skills, are properly supervised and are afforded adequate working conditions. The need for managerial skills, up-graded facilities, and material support are addressed as part of separate objectives to achieve program sustainability, described in the component two section of this project description.

### 1) Standards of Practice

To ensure that FP/MCH services and IEC messages are based on widely accepted standards of care, project inputs will include technical assistance and financial support for development and refinement of protocols, training materials, delivery of training, on-site field visits, and production and dissemination of documents, to conduct the following activities:

- develop/refine, test, and disseminate "user-friendly" protocols for incorporation into FP/MCH services delivery, training programs, routine supervision, and IEC activities;
- produce and disseminate standards of care and other provider guidelines and service manuals;
- conduct supervision of family planning, safe motherhood and control of diarrheal disease programs; and
- design and implement mechanisms for evaluation and up-dating protocols.

As a result of these activities, standards of practice will be developed for various aspects of family planning, control of diarrheal disease and safe motherhood programs, including breastfeeding. Uniformity in the quality of services and IEC can be assured. Service protocols will provide a mechanism to integrate important cross cutting prevention themes into FP/MCH service delivery, including for example infection prevention, breastfeeding, nutrition and STD/HIV prevention.

### 2) Technical Competence of Service Providers

To furnish health workers with reasonably up-dated technical skills for delivering FP/MCH services according to standards of care, the project will provide technical assistance, materials, equipment, and local costs for training, to conduct the following activities:

- conduct training needs assessment for family planning, control of diarrheal disease and safe motherhood and other select child survival interventions;
- develop national and regional training plans for in-service training, and for training of a special nature such as new skill areas, training of trainers, and supervisory training;
- identify FP/MCH training resource needs, develop a training evaluation component, prepare training facilities and preceptorships;
- develop standardized in-service curricula and training materials, based on service protocols and the concept of integrated services, including interpersonal communications;
- develop standardized curriculum in select FP/MCH areas for medical and nursing education;
- conduct in-service training to enhance various FP/MCH technical skills;
- support overseas training for the development of special or new technical skills; and
- adapt training programs for use with private sector health providers.

As a result of these interventions, health workers will have the technical skills to provide clients with a full range of quality FP/MCH services.

### 3) Supervision

To ensure that health workers have sufficient support and follow-up to deliver services according to standards of FP/MCH care, project inputs will include technical assistance, materials production, and some local costs for training and supervision to conduct the following activities:

- develop, introduce, evaluate and disseminate supervision tools that reflect standards of practice and integrated program focus;

- train supervisors in improved supervision tools and techniques;
- conduct central and provincial level supervision of the various FP/MCH services;
- develop systems to resolve problems identified through supervision and to provide feedback to improve management, services, and training.

As a result of these interventions, skills of service providers throughout the MOPH ambulatory system will be reinforced and quality of their services improved, problems will be identified early and systems developed for corrective action.

#### 4) Health Delivery Environment

To ensure that clients are attracted to and continue to use services, the quality of the physical environment will be improved through project inputs to include materials, equipment and local costs to carry out the following activities:

- procure and deliver materials and equipment to improve waiting areas for clients and ensure privacy for both counseling and examinations.
- improve interpersonal communication skills of health care workers to facilitate comfortable relationships with clients.

As a result of these interventions, the service delivery environment will be improved thereby both attracting and retaining clients.

#### C) Expand Quality Information, Education, and Communication

Information can be an effective tool leading to increased use of services and adoption of favorable health practices, if the needs of underserved populations are well understood, sound messages are communicated through multiple IEC channels, and health workers have strong interpersonal communication skills. IEC activities must have clear objectives and be designed to reach a particular audience with a specific message. IEC strategies must also take into account the possibility that more vigorous activities will provoke latent opposition to FP/MCH, and must therefore include opinion leaders among the target groups to reach.

Evidence that IEC needs are particularly relevant in Morocco are found in the 1992 DHS which demonstrated a considerable gap between knowledge of services and actual use of services that has been aptly referred to as the "knowledge, attitudes and practice (KAP) gap." To address this gap, IEC activities need to be targeted, tested and evaluated to develop messages and channels directed toward providing information on the benefits of services, where they can be obtained, and how they are used. Further educational messages should be aimed at changing behavior that underlie poor health indicators. In addition, assessments of IEC efforts to date have suggested that the structure of IEC programs in the MOPH may be reorganized and supported to facilitate an integrated IEC program, through greater utilization of the health education unit, better coordination with vertical technical divisions and increasing the capabilities of regional and provincial staff to implement IEC activities.

The MOPH has strongly endorsed the revitalization of IEC as a high priority, and is committed to addressing past weaknesses. The project will improve the quality of IEC by supporting sound message development and strengthening and coordinating multiple channels of communication. To sustain quality IEC activities for FP/MCH, the project will also strengthen the ability of the MOPH central and provincial levels to plan, manage, and evaluate IEC efforts, as described in a later section of this paper, on institutional capacity.

To develop a strong capability to deliver effective, consistent and accurate IEC messages that will effect health behavior change, project inputs will include long and short-term technical assistance, costs of production of materials, support for training and supervision, audio-visual equipment, and financing to use outside expertise in selected areas, to conduct the following activities:

- conduct IEC program needs assessments at the national and provincial levels and develop appropriate IEC action plans;
- research the informational needs of target populations, including analysis of existing data and further KAP and market segment studies as needed;
- develop and implement IEC guidelines for interpersonal, community and mass education;
- develop and test FP/MCH messages designed for different audiences which are appropriate to the characteristics of the audience and which reflect FP/MCH standards of practices;
- develop appropriate curricula and train trainers in counselling and interpersonal communications;
- produce and disseminate for adaptation to the local context, educational materials (slide sets, flip charts), certain print materials designed for specific audiences (brochures for doctors) for provider and client education;

- develop, test and disseminate video programs, national and regional radio and TV spots and programs, and print materials supporting mass communication of health messages;
- develop and implement training programs for health workers, collaborative agency personnel, and media personnel, in use of IEC guidelines, communications skills, development and use of IEC materials, and media programming;
- conduct specified IEC activities for health and non-health agents, as well as public, private, NGO, and community organizations;
- inform and educate, via RAPID-style presentations and other techniques, opinion leaders whose support is needed to successfully expand FP/MCH services;
- conduct central and provincial level supervision of IEC activities; and
- evaluate IEC program activities and develop system to feedback information to reinforce on-going IEC efforts.

As a result of these activities, informational needs of target populations will be met, media information will be consistent with communications from health workers and outreach agents, and opinion leaders will support expansion of IEC and clinic services. IEC at the provincial level will be delivered through interpersonal education and counselling reinforced by radio and television spots. IEC strategies and materials will be used by personnel of the MOPH, other ministries, the private sector, NGOs, and local decision-makers and opinion leaders to effect health behavior change. Integrated messages will strengthen the relationship among FP/MCH services. More clients will be motivated to seek out services and adopt good health practices to meet their perceived needs, and a positive environment will exist in the community for the expansion of FP/MCH services.

#### **Component Two: Increased Program Sustainability**

Progress in FP/MCH programs has been highly encouraging in recent years. However, the GOM faces a multiple challenge between now and the year 2000 of meeting a greater proportion of health and human service needs of a growing population in an environment of substantially reduced amounts of foreign assistance. It is therefore of serious concern that the GOM currently depends heavily on external assistance for procurement of contraceptives and other commodities, technical assistance, the provision of training, and local financing for other activities such as research, special studies, supervision and construction.

To enhance sustainability, the GOM must provide support to a number of initiatives which include decentralization, integration of activities, policy reform, strengthening of management and logistics systems and diversification of financing through the public sector, the private sector and other donors. The MOPH must strengthen and decentralize its institutional capacities in planning and management and develop technical expertise at all levels of the service delivery system. Costs for activities which have historically been donor funded, such as contraceptive procurement, must be more fully supported by public resources at the central and decentralized levels. Delivery of FP/MCH services must be expanded in the private sector to reduce the financial burden on the GOM of providing services to those who are able to pay for them.

The project will contribute to program sustainability by identifying key legal and policy issues and developing strategies for reform in both the public and private sector; reinforcing selected areas of MOPH management systems which have the potential for providing greater support to FP/MCH program managers at the central, regional, and provincial levels; building support for public resources; and expanding the role of the private sector. Support will include use of institutional linkages to promote long-term relationships, which have greater potential for technology transfer and mutual benefits in technical support. The specific results will be:

- A policy climate favorable to the rapid expansion of public and private sector FP/MCH services.
- An institutional capacity at the central, regional and provincial level to plan, execute and evaluate FP/MCH programs.
- FP/MCH services continue to expand with increased public resources and policy support, as donor assistance for recurrent costs is scaled down.
- Private sector share of family planning services increases from 36% to 50%.

#### **A) Favorable Policy Environment**

Long-term sustainability of FP/MCH services will depend in great part on the ability of the GOM to ensure that laws, regulations, and policies are supportive, and to anticipate and address potential policy barriers as the program expands. Existing laws, regulations, professional practices, MOPH discretionary policies, and other practices present no significant constraints to expanding FP/MCH services. The MOPH has, nevertheless, expressed particular concern about clarifying and reforming, if necessary, the legal and regulatory framework in areas which impact on both resources and functioning of public sector preventive health care service delivery as well as issues impacting on private sector service delivery of FP/MCH services. Examples of potential key policy issues for the public sector include the creation

of structures to support decentralization, health care financing reform initiatives such as national health insurance, and regulations concerning service delivery personnel. Private sector issues relate to overall liberalization of the sector, and regulations concerning conventions with the public sector. Furthermore, family planning programs have the potential for provoking opposition, as has been shown in other countries. Although to date this has not been the case in Morocco, response to the expansion of FP/MCH services will be closely monitored as more vigorous IEC activities draw greater attention to them, and they place greater demands on public resources.

In the absence of additional data and experience, it is not possible to predict the impact of policies related to project interventions, whether legal and policy change will be required or even desired, or what strategies might be effective to ensure that any changes are supportive. Furthermore, it is not yet known whether support for service strategies will take the form of removing barriers, or of introducing new laws and policies to encourage service expansion. Consequently, project assistance will be provided for policy and to establish, as appropriate, a policy agenda to ensure the rapid expansion of FP/MCH services.

To **systematically identify policy issues and develop alternatives**, project inputs will include technical assistance, funding for field work, overseas observational travel, and short-term training to conduct the following activities:

- institute a mechanism within the MOPH to develop and up-date a policy reform agenda which ensures timely identification of issues and implementation of appropriate strategies;
- compile a comprehensive inventory of laws and policies related to the health sectors as appropriate, and conduct a comparative analysis with selected countries;
- conduct an institutional assessment of MOPH capabilities in planning and evaluation and identify the regulatory and internal policy modifications necessary to support MOPH organizational changes;
- incorporate legal and policy questions in the evaluation components used for pilot studies;
- carry out field work necessary to design and test alternative policies and practices, using interagency and intersectorial collaboration; and
- visit countries with contrasting or desired policies;

To **mobilize support for favorable policies**, project inputs will include technical assistance to conduct the following activities:

- institute a planning process for conducting policy dialogue which includes the identification of policy objectives, which tailors the content, timing, target audience and subject matter of the dialogue to FP/MCH program needs, and which broad-based participation including the FP/MCH intersectorial commission;
- develop and implement selected strategic planning tools such as target-cost model, retrospective benefit-cost studies, demographic models, financial forecasting and budget projections, to support policy dialogue;
- disseminate, at the national regional provincial and local levels, results of DHS, KAP and other studies and operations research which supports policy reform in selected areas, e.g., findings from evaluation of contraceptive method trials, showing high level of client acceptability of a contraceptive method for which access is currently restricted by medical practice;
- develop strategies for identifying and educating latent opposition to FP/MCH which may be activated by publicity surrounding national or regional IEC campaigns and expansion of services at the local level; and
- prepare an advocacy strategy for the national and decentralized level that assists the MOPH to lobby effectively for a fair share of public resources for FP/MCH.

As a result of these interventions, the MOPH will identify policy issues in a timely fashion and mobilize the necessary support to ensure a favorable environment for expanding FP/MCH services. An illustrative list of legal and policy issues, which the project may consider for review, is contained in the "Summary of Analysis" Section of this paper.

#### **B) Reinforce Decentralized Institutional Capacity**

The challenge of improving the health status of a growing population at the same time that critical donor support for preventive services is being reduced, requires dynamic decentralized leadership and direction from the MOPH. Although the MOPH has identified decentralization as a new compelling initiative, they are fully aware that a move from the central level to 60 provinces/prefectures is clearly problematic. Regionalization, however, utilizing the regions already in place for economic development purposes of the GOM, offers a viable mechanism for decentralization and provides a stepping stone to full decentralization.

The project will assist the MOPH to fully develop institutions which incorporate regional structures as well as improve provincial level

planning and management capabilities to systematically support service delivery, training, IEC, logistics and supervision activities. The project will strengthen the institutional capacity to provide leadership by reinforcing and decentralizing essential planning and evaluation functions, providing staff with training and tools in program operations, development of the procurement function of the logistics and supplies system, upgrading selected facilities, and providing material support for priority aspects of service delivery.

#### 1) Management Systems Reinforcement

To **strengthen the strategic and program planning capabilities for FP/MCH programs**, project inputs will include technical assistance, equipment and materials, computer programs and software, training and seminar costs, field and international travel, to realize the following activities:

- develop and test processes that promote decentralized action planning, implementation, and decision-making; develop and disseminate tools that support decentralization, such as the "carte sanitaire," regional/provincial action plans, training and supervision plans, target-cost models, financial forecasting, and personnel modeling; and
- provide study tours and other opportunities for MOPH officials to gain insights into successful use of decentralized strategic and program planning methodologies in other FP/MCH programs.

As a result of these project activities, DPES will provide the necessary guidance for peripheral program managers to develop and implement annual action plans based on actual program needs and resources. Critical policy issues which determine the success of FP/MCH program strategies, will be identified and addressed in a timely fashion; and program managers at central, regional and provincial levels will apply strategic planning techniques.

To **strengthen the central, regional and provincial and capacity for evaluating FP/MCH program performance**, project inputs will include technical assistance, training, materials, seminar/meeting costs, and field travel to:

- assess the MOPH institutional capacity for program evaluation, and develop an evaluation function within the DPES capable of routinely monitoring performance and directing a research agenda; provide selected technical support to MOPH units with evaluation-related responsibilities (SEIS, SETI, and INAS) that can subsequently provide greater support research and evaluation support to DPES; and
- strengthen the skills of central, regional and provincial staff with evaluation responsibilities to identify operations research needs and design and carry out operations research; strengthen the ability of INAS to participate in the design, implementation, and follow-up of operations research in FP/MCH, as well as to provide operation research training.

As a result, central, regional, and provincial program managers will employ evaluation and operations research findings to periodically modify program management and improve implementation.

To **strengthen the capacity for planning, implementing and evaluating FP/MCH training programs and planning for other human resource needs**, project inputs will include technical assistance and field-related travel costs to conduct the following activities:

- develop and implement formal linkages between the DPES and MOPH central and provincial units responsible for training and deployment of personnel, and between DPES and pre-service training institutions, for the purpose of joint planning related to training, job descriptions, staffing pattern, work conditions and other personnel issues;
- project financial needs and substantiate budget requests for FP/MCH human resources development that reflect reduced donor assistance for recurrent and local costs;
- design and test a decentralized FP/MCH training process, which clearly defines the responsibilities of the central, regional, and provincial levels for training needs assessments, development of training schedules, curricula, and materials, and conducting and evaluating training; and
- develop training of trainer modules for use at the regional and provincial level, and support strategies which strengthen decentralized training capacity.

As a result of project interventions, MOPH human resources planning will be more closely coordinated so that personnel actions and training are supportive of FP/MCH personnel needs. Program managers will be able to meet basic in-service training needs at their own level, and more specialized, low-volume, high cost skill needs will be met at the regional and central level. The MOPH will substantiate the need for and assume increasing responsibility for recurrent and local costs related to training.

To **develop the capacity for planning, implementing and evaluating of IEC activities** by the central and provincial levels, project inputs will include short and long-term technical assistance, training, study tours, and equipment, materials, and financing related to pilot testing, to conduct the following activities:

- provide strategic planning, research, pre-testing, and evaluation skills to DES central and regional/provincial staff; establish and assist at least five model provincial education units capable of conducting IEC needs assessment, developing corresponding action plans, and supporting other public and private sector agencies to assume specific, functional IEC roles; and
- assist the DES to develop models for use in the national program, including provincial needs assessment, supervision tools, training of trainers, prototype print materials and radio programs to be adapted in individual provinces;

As a result of these activities, provincial health education units capable of assessing and IEC needs and developing targeted IEC programs with DES support will be created. The DES will be better able to direct, support and evaluate a quality, decentralized national IEC program.

To **strengthen the effectiveness and use of the FP/MCH service information system**, the project will coordinate with UNFPA to provide technical assistance, computer equipment and software, costs of reproducing MIS manuals and materials, and costs related to field testing and training, to conduct the following activities:

- evaluate the effectiveness of the current MIS, and provide select assistance to make the MIS more responsive to FP/MCH needs; assess DPES automation requirements and purchase basic computer equipment and software for all levels; and design and produce instruments for recording FP/MCH services data, data analysis and data presentation;
- train regional/provincial SIAAP personnel in basic computer use and data collection and analysis;
- implement training and model activities for program managers at all levels in effective use of information in FP/MCH program planning, implementation and evaluation; and
- strengthen the ability of SETI, SEIS and INAS to collaborate with DPES and support the FP/MCH component of the national health management information system.

As a result of these activities, the central level will be equipped to guide the provinces in data collection and use; provincial SIAAP personnel will be trained and equipped to make better use of data in planning and managing services; greater coordination and communication among participating MOPIH units in data collection, analysis, and dissemination will reduce delay and duplication and promote decentralized information use.

## 2) Managerial Skills Development

To **develop greater managerial and technical expertise** throughout the MOPH at the central, regional and provincial levels, project inputs will include in-country and U.S. short-term training, technical assistance, a long-term resident advisor with management expertise, and funding for linkages with a U.S. based institution, to conduct the following activities:

- develop expertise of INAS staff and key MOPH personnel at the central and provincial levels in total quality management (TQM), continuous quality improvement (CQI), the "team problem-solving" approach formalized by WHO, and associated analytical tools;
- develop, implement, and evaluate quality management approaches in at least five provinces where quality management techniques will be fully implemented, and apply lessons learned in other provinces as appropriate;
- develop the capability within appropriate MOPH units for offering workshops and short-term training in other management areas such as strategic planning, training management, IEC management, logistics, and supply management; and
- assist managers to acquire expertise through linkages with U.S. firms, for developing quality management systems, private sector initiatives, and other strategies; linkages would be through long-term associations with U.S.-based technical assistance, academic and training organizations.

As a result of these activities, in-country quality management courses will be provided by INAS, follow-up technical assistance will be provided to training participants by key central and provincial level personnel, and in-country managerial and technical expertise will generally be increased. Service delivery personnel will routinely participate in the process of identifying and resolving service quality issues.

## 3) Contraceptive Logistics and Supplies Management

To **strengthen the MOPH capacity for assessing and meeting contraceptive and commodity needs** as USAID financing phases down, project inputs will include technical assistance from consultants with direct experience in contraceptive phase-over to conduct the following activities:

- propose goals, objectives, and a specific action plan for the MOPH to phase into contraceptive procurement; develop a strategic planning

framework for achieving procurement objectives; assist in selection of source and financing of contraceptives; propose mechanisms for encouraging and monitoring the private sector role;

- strengthen the MOPH system for ensuring a stable flow of contraceptives and other commodities to health facilities without donor assistance, including the capability for forecasting, ordering, purchasing, importing, storing, distributing, and reordering;
- provide necessary training in logistics and supply management; and
- provide, based on a negotiated phase-over schedule, a stable flow of contraceptives to the national program using USAID financing through 1998, and assist the MOPH to develop financing alternatives, and to identify and secure the least costly contraceptive suppliers thereafter.

To avoid an abrupt termination of funding, a plan such as the illustrative phase-over plan below, to be reviewed on an annual basis, will be instituted:

CONTRIBUTION (in millions)

YEAR	AID	GOM	Private Sector
1994	\$1.89	\$0.00	\$1.07
1995	\$1.98	\$0.22	\$1.39
1996	\$1.90	\$0.63	\$1.75
1997	\$1.41	\$1.41	\$2.16
1998	\$1.00	\$2.08	\$2.57
1999	\$0.00	\$2.31	\$2.99
<b>TOTAL</b>	<b>\$8.19</b>	<b>\$6.65</b>	<b>\$11.93</b>

As a result of these interventions, dependency on donors will be reduced, procurement relationships with current suppliers will be strengthened, and The MOPH will have an efficient contraceptive and commodities logistics management system in the absence of donor support.

4) Equipment and Material Support

To ensure **physical access to services and sufficient material support for providers to function effectively and managers to plan and evaluate programs**, project inputs will include technical assistance and commodity support to:

- purchase vehicles (approximately 220 utility vehicles) for program management, implementation, and supervision (estimated 3 all-terrain utility vehicles or pickup truck for each province; vehicles for program management, training and supervision at the regional level; specially equipped IEC mobile units for regional IEC teams; vehicles for central level program supervision and management; and two large trucks for use at the central level for distribution of contraceptives, equipment, and materials and supplies to the regional and provincial levels.);
- purchase basic equipment kits, furniture and expendable supplies for family planning, safe motherhood and CDD programs for all provinces;
- provide medical and clinical equipment and furniture to upgrade existing or equip new voluntary surgical contraception (VSC) centers, family planning reference and maternity services, and provide spare parts for existing medical equipment (eg., laparoscopes, autoclaves etc.);
- purchase, in coordination with the overall MOPH automation plan, automation equipment to include micro-computers, communications linkage hardware and a range of software and other related furniture for the central, regional and provincial levels;
- purchase audio-visual equipment for the central, regional and provincial service and training sites; and
- purchase basic office equipment, furniture and supplies necessary for project operations.

As a result of this material support, services will be routinely assured, and disruptions caused by lack of transport or materials will be reduced. The delivery system will receive a timely and stable flow of supplies, materials, and equipment. Supervision capability will be enhanced. Quality of services will be improved with installation of better clinical equipment and supplies. The management information system will produce more timely and relative data. Training and IEC programs will be equipped to supply training and IEC objectives.

C) Diversify Resource Base/Private Sector Participation

Sustainability in the face of uncertain donor resources in the future will require a diversified funding base. Two approaches to achieve this diversification are both logical and essential. Firstly, public sector approaches must be explored, for example, FP/MCH services must increase their share of the government budget. Secondly, the private sector must assume greater responsibility for the delivery of preventive FP/MCH services. Both of these initiatives have the full backing of the Minister of Public Health as he, and other key leaders, have recognized that a diverse resource base rooted in both the public and private sector offers the greatest promise for future FP/MCH sustainability.

In terms of public sector financing, the MOPH has already embarked on an effort to replace donor support with its own budget. To further develop a diversified base of resources, the MOPH now needs an organized advocacy effort at all levels to ensure public sector support from key national and local decision-makers for budgetary support as well as development of other funding sources, such as fee for service, local cost financing and health insurance reform.

Furthermore, the GOM and MOPH have demonstrated their commitment to encourage and facilitate a private sector role in delivering FP/MCH services, however, it needs more experience and information about the private sector before its potential can be more fully exploited.

Consequently, the project will strengthen the ability of the MOPH to secure public resources and will expand the role of private sector provision of services and supplies.

#### 1) Public Sector Resource Allocation

To strengthen the MOPH capacity for accurately projecting FP/MCH budgetary needs, advocate for an adequate share of public resources at the national, provincial, and local levels of decision-making, project inputs will include technical assistance and financial support to conduct the following activities:

- analyze recurrent and local cost implications of increased use of FP/MCH services, and develop tools to project budgetary needs of the MOPH on the basis of volume and pattern of utilization; and
- develop an advocacy strategy for budgetary and other public resource support within the MOPH at the central and provincial levels, and within the GOM, including development and presentation of analytical and graphical materials to Parliament, Ministry of Finance, and other national budget decision-makers.

As a result of these activities, the GOM will be able to rationally plan and budget for line items formerly funded by donors, and raise the awareness among decision-makers of the benefits and costs of FP/MCH and other preventive health services.

#### 2) Private Sector Development

Experience in the private sector has been primarily in the areas of social marketing and NGO services through an affiliate of International Planned Parenthood Federation (IPPF). Other private sector activities are confined to analytical studies and some small-scale experimental activities. To pave the way for a significant future investment of USAID assistance, the project will support analytical and feasibility studies, MOPH actions to promote private sector participation, and testing of effective strategies for expanding FP/MCH services through social marketing, the workplace, and private group practices.

It is expected that a year and a half into the project better information and a wider range of experience with delivering FP/MCH services in the private sector will provide a more solid basis for designing a larger and longer term private sector service delivery program. The Mission will draw on lesson learned during the implementation of these activities to design a new private sector project in FY 1995 or 1996. USAID will also review the experience of other Missions currently designing or implementing private sector health and family planning activities, as well as other experience in working with the Moroccan private sector. Should any of the pilot activities mentioned below be particularly successful to accelerate private sector participation in FP/MCH service delivery, USAID may choose to reprogram funds to expand or replicate activities.

To generate needed information about the potential role in FP/MCH of various segments of the private sector, project inputs will include technical assistance, material support, and financing to conduct the following activities:

- conduct studies and surveys in topics which include but are not limited to the following activities:
  - the worldwide private sector experience
  - Morocco's private sector experience
  - characteristics, capabilities, and needs of health care professionals including physicians, nurses, and midwives
  - prepayment plans and other financing mechanisms available for FP/MCH

- consumer demand, and ability to pay for services
- market segmentation for potential target audiences;

- conduct feasibility studies to identify strategies for participation of collectivités locales in the delivery, management or financing of FP/MCH services; and

- conduct feasibility studies to identify strategies for encouraging private practitioners to work in underserved areas, including identification of characteristics of suitable locations for setting up practice; required investments in materials and equipment; identification of determinants of self-sufficiency; and potential partners to manage the projects in their early stages.

**To strengthen the public-private partnership and garner support within the GOM for greater involvement of the private sector,** project inputs will include financing to conduct the following activities:

- establish multi-sectorial coordination, oversight, and leadership for private sector initiatives in FP/MCH services;
- inform and update private sector professionals about technical issues, MOPH and international private FP/MCH programs, and the private sector project development, through mailings, seminars and other communications strategies; and
- train private sector health professionals to provide FP/MCH services through the public sector training programs.

**To consolidate and extend the experiences with existing social marketing products,** project inputs will include technical assistance, material support and financing to do the following activities:

- identify the determinants of sustainability in the three existing product lines (Protex, Kinat Al Hilal and BIOSEL);
- increase and enhance the education of pharmacists and related professionals about the existing products;
- market the existing products through those private companies and provider networks that will be involved with the other options being tested under this project;
- examine the role of social marketing in provider-dependent methods, such as IUDs, Norplant, and injectables, and answer questions on whether or how much to subsidize these products and devices, and what channels should be used to distribute them; and
- analyze policy implications of social marketing, such as import taxes, advertising, prescription requirements, and distribution authority.

**To test a range of workplace services,** project inputs will include financing to do the following activities:

- design projects and seek partners to test strategies for sustainable workplace services including delivery of IEC for employees and for employers; distribution of contraceptives and ORS; delivery of clinical services and through contract mechanisms;
- furnish a basic package of materials for all sites, including IEC curricula and educational materials, in-service training curricula; motivational materials for employers; prototype "memoranda of understanding"; and training, equipment or supplies for facilities proposing to offer certain FP/MCH services;
- develop referral mechanisms to FP/MCH services within the reach and means of factory employees participating in projects, and develop linkages with on-going educational and social marketing activities; and
- identify and support a partner, such as the Employers Confederation, to direct and oversee project activities; and seek involvement of employer and employee groups, labor unions, and other parties in the monitoring and evaluation process.

**To test a number of models for private sector FP/MCH service delivery,** especially for provision of long-term and permanent contraceptive methods, project inputs will include technical assistance and financing to do the following activities:

- conduct a feasibility study to establish private sector FP/MCH reference centers, focusing particularly on long-term methods, and which have the potential to serve as training sites;
- develop and deliver a clinical training program in all contraceptive methods and counselling, and a management training including TQM and CQI approaches;
- develop a referral system with other private practitioners in the area, in which the service centers would participate;
- examine feasibility of making available FP/MCH equipment and supplies in return for FP/MCH services for low-income women; and

- test strategies to encourage on-going participation of the private sector providers such as offering contraceptive updates, U.S.-based training, and additional equipment and support.

As a result of these analytical, diagnostic, and field studies, the project will generate sound data for developing lesser known channels of private sector FP/MCH services. The MOPH and GOM will support the concept of a national program transcending the boundaries of the public health system. Private providers will remain abreast of professional developments in the FP/MCH field as well as opportunities for participation in on-going project activities. Lessons learned from social marketing experiences to date will pave the way to market additional products. The conditions for optimal workplace participation will be identified. Strategies will be developed which encourage employers to allow adequate employee participation in workplace services; purchase contraceptives and ORS to distribute to their employees or allow it to be sold at social marketing prices at the work-site; and offer other services, such as STD or HIV screening or IUD insertions. Long-term and permanent methods of contraception will be more available. Service centers will reach primarily urban, middle class women who have frequently taken the lead in adopting long-term contraceptives. Strategies and methodology will be tested for development under a follow-on private sector project.

## **B. EVALUATION ARRANGEMENTS**

Evaluations planned under this project include an early project review in 1995. A Demographic and Health Survey is scheduled for early 1997 with a project impact evaluation scheduled to coincide with release of the DHS findings in late 1997. A full end of project evaluation will occur in 2000.

### **1. Project Implementation and Management Review**

This project implementation and management review will be similar to that carried out in 1992. I will include intensive review of project activities by USAID and MOPH staff and other consultants as required. The review will serve to:

- Assess implementation progress in each of the project's major components and identify barriers to success. Identify solutions to major or persistent problems affecting implementation.
- Review assumptions made during design and determine their continued validity.
- Review progress toward phase-over of financing responsibility for local costs and contraceptive commodity purchases and estimate the probability for sustained MOPH financing.
- Review progress in development and implementation of the policy agenda and make recommendations for modifications, as required.

### **2. Demographic Health Survey and Impact Analysis**

To date, one evaluation of program impact, **The Child Survival Impact Evaluation (1990)**, has been conducted. An evaluation of the impact of the Family Planning and Child Survival program will be conducted in 1997, following publication of the 1996 DHS data. The objective of this evaluation will be to measure the impact of USAID assistance under this and previous projects.

The AID/Washington Office of Population was charged with the task of measuring the impact of family planning programs worldwide following a 1990 Inspector General Audit of A.I.D.'s population and family planning program. The centrally-managed Evaluation Project was developed in response to this mandate. USAID/Morocco will call on the methodologies developed and experience gained under this worldwide effort to develop an impact evaluation strategy. This plan will identify the methodology, data sources, and technical assistance required to conduct the impact evaluation.

This evaluation will be conducted by a team composed of external evaluators, including technical experts, senior direct hire health technical staff, and at least one health economist.

### **3. Final Impact Evaluation**

The end of project evaluation is scheduled for 1st quarter FY 2000 and will measure the extent to which the activities succeeded in achieving their stated purpose. Moreover, it will evaluate the extent to which the project series I-IV contributed to the achievement of health and family planning sector goals and objectives, e.g., coverage, efficiency, policy objectives, private sector share of services and products, and sustainability. This evaluation will be contracted through a buy-in or an A.I.D./Washington technical services IQC. Topics that will be addressed in the context of the final evaluation include:

- The effectiveness and efficiency of the FP/MCH public and private delivery systems;
- The extent of GOM compliance with its responsibility to absorb recurrent costs associated with the program and to assume responsibility for contraceptive commodity purchases;
- The lessons derived from USAID's assistance in the FP and MCH sector that can be useful to A.I.D. worldwide in the design and implementation of health sector projects; and
- An assessment of program sustainability, including recommendations to the GOM on actions it might take to further promote continuity and development.

### **4. Audit Plan**

One mid-term full performance audit has been budgeted and will be arranged with RIG/Dakar. It will take place in the second quarter of FY 1997. RIG/Dakar will include this in its audit plan for the fiscal year, will prepare the scope of work, and will supervise the audit.

Most project activities will be implemented by an institutional contractor. Normally such institutions are subject to financial audits in the U.S. Responsibility for these types of audits will be with the cognizant AID/W office. Project buy-in institutions will be subject to similar audits. USAID/Morocco will conduct periodic in-country financial reviews of the contractor, using a local qualified IQC firm. USAID is responsible for assuring that any direct local procurements of more than \$25,000 per year are made to auditable entities. These types of direct contracts will also be subject to periodic financial reviews. Audit and evaluation plans for each contract are included in Section III, Implementation Plan.

## VII. SUMMARY OF PROJECT ANALYSES

### A. POLICY ISSUES

Long-term sustainability of FP/MCH services will depend in great part on the ability of the GOM to ensure that laws, regulations, policies and budgetary allocations are supportive of program implementation and expansion. In addition, the GOM must be able to identify and address potential policy barriers as the program expands. Although legal and policy barriers do not currently present significant constraints to the delivery of FP/MCH services, a supportive policy environment will be crucial to achievement of FP/MCH Phase V objectives. In particular, successful implementation of three of the new directions envisioned under Phase V – contraceptive phase-down, introduction of and emphasis on new and long-term methods, and private sector provision of services and products – will be highly dependent on the policy environment. Relatedly, A.I.D. will support development of appropriate policy and MOPH structural changes to decentralize planning and management efforts down to the regional level to bring about more effective program implementation and expansion. In addition, long term program sustainability will require increased budgetary allocations directed to FP/MCH. Finally, the MOPH should also take the opportunity to capitalize on the high level GOM support for family planning programs recently articulated by King Hassan. A clearly articulated policy agenda will address existing constraints, aid the MOPH to anticipate potential constraints, and encourage high level support leading to increased budgetary allocations for FP/MCH. Before the first disbursement of project funds, the GOM and A.I.D. will jointly develop a mutually agreed upon policy agenda. During the initial phases of project implementation this agenda will be further refined and then worked upon throughout the life of project to achieve significant policy changes supportive of the achievement of the project goal and purpose. To facilitate this process, a team of policy and policy communications experts will work with USAID/Morocco and the MOPH in July, 1993 to elaborate policy-related issues and develop a policy agenda and action plan for Phase V. Recognizing that Phase V cannot address every policy issue affecting FP/MCH programs, this team will be called on to assess the local policy environment, prepare a detailed summary of policy issues and constraints, and develop a policy agenda that reflects both the importance of the constraint to successful program implementation, but the likelihood that policy dialogue will influence or lead to a policy or regulatory modification. The team will develop a plan of action for implementing the policy agenda, which prioritizes the issues, outlines methods for addressing the issues, and determines options for USAID involvement. This plan will be developed in the context of other health sector reform in progress within the country.

A summary of policy issues, both existent and potential, that may be considered by the team is as follows.

#### 1. MOPH Internal Policies

- Will current MOPH personnel policies and related laws or policies regulating public sector health workers (MDs, nurse midwives, nurses) be consistent with changes in training, supervision, staff assignments and job descriptions required to facilitate access, promote integration of services, and improve technical competence and supervision of health workers?
- Do laws or regulations governing the use and staffing of public facilities (maternities, family planning reference centers) interfere with expanding service delivery?
- How can the regulatory framework support intersectorial collaboration, i.e., how can collaboration be formalized, commitments secured and FP/MCH service responsibilities delegated? What policy role might an intersectorial body have?

#### 2. MOPH Organizational Structure

- Can the FP and MCH programs function effectively at their current administrative level within the MOPH? Should policy efforts be directed to raising the administrative status of these units to the division level?
- What organizational changes will be required to strengthen program planning and management at the DPES, within vertical units supervised by the DPES, and in provincial units?
- What legislative, policy and organizational changes will be required to regionalize planning and management capacity as part of a decentralized structure for FP/MCH service delivery?

#### 3. Legal and Regulatory Reform

##### **Public Sector:**

- How will medical practices of the MOPH and the medical profession affect the expansion of VSC, NORPLANT, injectables and IUDs, specifically those governing client eligibility, category of provider required to prescribe the method, policy for follow-up and resupply, and other practices governing access to these methods?

##### **Private Sector:**

- What is the regulatory climate affecting an expanded private sector role in FP/MCH, and what incentives can be introduced, or constraints removed, taking into account the following:
- Legal and discretionary practices affecting MOPH collaboration with the private sector; requirements imposed on the private sector, e.g., reporting on service volume and client characteristics, that might hinder collaboration.
- Laws and standards governing the private practice of medical professionals (physicians, nurses, nurse midwives and allied health professionals), licensing of private clinics, licensing of group practices.
- Social marketing issues: regulations on generic and brand name advertising of medical and non-medical contraceptive products and devices in the different media; product price structure, including profit margins at the wholesale and retail level, taxes and duties on imported products and raw materials; laws and taxes affecting local production; regulations governing sale of FP/MCH products and devices in pharmacies, depots, shops and other outlets; policy implications of encouraging retailer sale of essential FP/MCH products such as ORS.
- The legal and regulatory framework for providing FP/CS services at the work site.

#### 4. Program Resources

- What is the competitive impact of the policy of free public health services on the efforts of the private sector to attract fee-paying clients, and on the MOPH goal of reserving its resources for those who are least able to pay?
- What resources are available to the MOPH to support its ongoing program as AID phases down its financial support for contraceptives and local costs? Which of the following offers the most potential for generating resources and should be pursued:
  - Policy dialogue regarding the proportion of public sector resources allocated to curative as opposed to preventive services; the proportions allocated to individual FP/CS programs.
  - the implications of hospital fee and national health insurance fee collection for budgetary support to preventive health programs.
  - the legal and policy implications of an active role for collectivities locales in providing or managing local resources.
  - public sector social marketing, i.e., the sale of coupons that could be redeemed for goods and services at public sector facilities.
  - policy dialogue directed to increasing the MOPH share of the national budget.
- How will AID phase-down of support for contraceptive procurement and local costs affect program performance goals, e.g., goals for prevalence rates and method mix, and for the types of methods to be shifted to the private sector (and possibly other donors) as a means of reducing procurement costs.

#### 5. Political Support and Awareness Raising

- What kind of information and education is appropriate to identify and reduce latent opposition to family planning which may be activated by publicity associated with national or regional IEC campaigns and expansion of services at the local level?
- What should be the content, timing, and target audience for advocacy at the national and decentralized levels for increased allocations of public resources for FP/MCH? Which policy communications tools would most effectively communicate the required messages?
- What is the role of policy dialogue in implementing strategies for policy reform in each of the subject areas analyzed and implemented under Phase V?
- What is the role of an intersectorial body in policy dialogue?
- How can the MOPH best take advantage of the high level support for FP/MCH programs recently articulated by the King of Morocco?
- Which strategic planning tools (Target Cost, other) should be institutionalized in support of refined program planning and management?

## B. TECHNICAL ANALYSIS

(NB. Full technical analysis is included as Annex E of this document)

The GOM faces an enormous challenge in building up its FP/MCH system to serve a growing population while aiming at higher levels of technical performance. With a population growth rate of over 2.4% year and current rates of contraceptive prevalence, FP/MCH service will be placed under increasing pressure to service more clients. To achieve the fertility and health targets set by the GOM for the year 2000 requires serving a larger proportion of this growing target population. Service delivery and IEC capacity will need to be increased, and professional personnel are limited in number compared to what is required for the expanded outreach delivery system. Rural access and utilization of health services lag behind those of their urban counterparts with the result that health status in rural areas is inadequate. The GOM depends heavily on donors for support to finance contraceptives and local costs at existing program levels which places the Government under increasing pressure as the primary provider for FP/MCH programs, even though many clients are able to pay for services.

Thus many Moroccan social indicators lag behind what would be expected in a country at its general level of development. Child survival programs, particularly concerning safe motherhood and childhood diarrheal disease, have not received the level of donor support which family planning has, and therefore are much less advanced. Consequently, there is heavy internal and external pressure for the GOM to focus more on social sectors. Phase IV did not include enough support for child survival interventions. With targeted inputs for family planning, safe motherhood and other child survival interventions, it is conceivable to reduce infant mortality by at least one third and to significantly reduce maternal mortality and morbidity.

Another requirement is to fully incorporate a rational plan to phase down USAID public sector health support and increase concomitantly GOM responsibilities, particularly as concerns financing for contraceptives and local costs. Although the concept appeared in Phase IV, a comprehensive transition plan was never fully elaborated. On the other hand, the new project provides for the incorporation of project foreign exchange costs, more fully than hitherto, into A.I.D. financing.

The decision to proceed with a new project rather than an amendment to the current project was largely dictated by the large amount of additional resources required to meet these expanded needs, to fully respond to the new opportunities in family planning and child survival, and to assure program sustainability. Moreover, in addition to the expanded requirements, the modified focus and increased magnitude of activities indicated that there should be a separate, new project rather than an accretion to the current one.

An evolving change is the increased interest in the MOPH in developing strategies fully involving the private sector. The excessive burden and inherent limitations of delivery of preventive maternal child health services through the public sector, along with heavy and increasing demand for services which can be met and sustained by the public sector health system only at inordinate costs, have created an urgent need to develop the capacity of private sector preventative services. Phase V will permit the Mission to get started immediately by studying and pilot testing a series of new activities which will lay the foundation for expanded funding through a private sector project, likely in FY 1996.

Building on the experience and achievements of the previous project phases, Family Planning and Maternal Child Health Phase V will be designed to specifically address these constraints as well as continue activities initiated in Phase IV.

The GOM recognizes the need for providing a sustainable, quality health care system, and has targeted health as one of four major areas of social development. The MOPH has made family planning, diarrheal disease control, safe motherhood high priorities for expansion and improvement, and has signalled its intention of committing financial, material, and human resources to achieve its goals. Family planning enjoys broad support, and there are no significant policy barriers to its continued expansion.

The need for expanded USAID assistance is great. The project is feasible because it is tailored to the needs, conditions in the country, reflects thorough and extensive analysis of all available options and additional funding can be efficiently utilized by both the public and private sectors. The achievement of objectives is likely because there is a health delivery infrastructure in place with strong leadership and competent staff, the GOM is supportive, and the overall policy is positive.

## C. ADMINISTRATIVE/INSTITUTIONAL ANALYSIS

(NB. Full administrative/institutional analysis is included as Annex F of this document)

MOPH will receive project inputs for public sector activities. The Directorate of Preventive Services and Health Training, as the lead office within the MOPH for FP/MCH services will have responsibilities for IEC, Population/Family Planning and MCH services. The responsibility for implementing project activities falls to regional managers and provincial delegates who will be backed by their technical units.

Prior to 1987 the MOPH was structured in vertical, centralized fashion, each major office having its own parallel support services. This structure was thought to be bureaucratically and administratively cumbersome, and the MOPH was reorganized. However, reorganization

continues to be closely monitored to determine its effectiveness, since under reorganization some divisions lost direct authority over certain support functions. These organizational changes affect the achievement of FP/MCH goals because of the impact on the DPES.

The DPES has resources and capabilities devoted primarily to the technical aspects. Authority and responsibility for critical support functions such as planning, evaluation, training, personnel deployment, management information are all located in offices outside the DPES, and at the provincial level. Furthermore, the strategy documents for the DPES technical divisions call for resources to strengthen their individual units in such functions as overall programming and operations research. The limited authority and lack of program management structure at the level of the DPES place considerable burden on the DPES to seek cooperation from multiple offices throughout the MOPH, and to seek consensus and coordination among its technical divisions. The MOPH recognizes that the DPES also has needs that must be met so it can provide forceful direction and leadership to a national, integrated FP/MCH program.

The MOPH is committed to a decentralized management structure, and control over resources is being shifted to the provincial level. However, the MOPH continues to be highly centralized. One major obstacle to a faster pace of decentralization is the absence of a middle level of authority - such as a regional management structure - to facilitate communications and operations between the central level and the growing number of provincial-prefectural level units, now totalling 60.

To address these issues, the project will provide support to the DPES, to the regional level and to the provincial level, to strengthen DPES's ability to plan and evaluate national FP/MCH program performance; to promote coordinated, decentralized planning and programming; and to ensure that provincial-level action plans are responsive to local conditions within the context of a cohesive national strategy. Support will extend to INAS and the DPES to strengthen those aspects of planning and evaluation, such as operations research and data analysis, which will contribute to a more effective FP/MCH program.

Morocco has made significant progress in developing a sustainable institutional setting for the FP/MCH programs. A national outreach program delivers services and education through multiple channels, including household visits, mobile units, and community "points of contact". FP/MCH services are provided in all fixed facilities and outreach programs. Furthermore, Morocco has begun to strengthen the public-private partnership in service delivery. In 1992 the social marketing program generated the sale of 2.2 million condoms through private distributors, launched an oral contraceptive program, and has laid the groundwork for commercial sales of oral rehydration salts.

There have been key institutional changes in Morocco which are reflected in a significantly altered political environment relative to health and population. Recent high level public manifestations of support, including a statement by the King that the choice for Morocco is between contraception and poverty are indicative of the new importance being placed on family planning, not only in terms of the health of mothers and children but as a critical demographic and development issue.

The new Minister of Public Health strongly advocates that family planning must be a priority program, and insists that, although progress made to date is admirable, it is insufficient to address the critical problem of population growth in Morocco. In preparation for the new Five Year Development Plan, 1993 - 1997, the MOPH has drafted a five year strategy to strengthen public health services by focussing on quality of services and expanding accessibility of services, particularly in rural and underserved areas, and fostering private sector services and intersectorial collaboration. In order to respond to this new emphasis, the GOM has requested USAID to expand its contribution for family planning and MCH activities. This complements the Prime Minister's request for significant increased USAID assistance for health and family planning made to the A.I.D. Administrator during a 1991 visit, and again repeated by the Minister of Public Health during a 1992 visit to the U.S.

These clear policy signals from the highest levels of the GOM provide an outstanding opportunity for AID to move further and faster in this sector than had been previously thought possible. With the basic infrastructure in place, and strong evidence of enormous latent demand for family planning, as reflected in large gaps (approximately 33%) between women actually practicing family planning and those who state a desire to space or limit their children, there is a solid base from which to move forward quickly and deal with what many consider the most threatening development problem in Morocco, a very rapidly rising population.

The project interventions are feasible and additional funding can be efficiently utilized by both the public and private sectors. FP and child survival is a priority for MOPH, and USAID experience has been that the necessary MOPH staff have been allocated for project implementation. The MOPH was integrally involved in the needs assessments and options analyses activities which lead to the project design. The institutional capacity exists to absorb and use USAID inputs to meet identified needs, and outputs will be translated into more effective FP/MCH programs.

#### **D. ECONOMIC ANALYSIS**

(NB. Full economic analysis is included as Annex G of this document)

**Benefit-Cost Analysis:** The Project Paper for Family Planning and Child Survival IV (608-0198) concluded that the benefits to the GOM from investing in family planning were high in relation to the costs. The use of the more recent and reliable estimates do not alter significantly the conclusions of the earlier benefit-cost analysis.

Indeed, more recently available information on program trends and accompanying costs suggests that the earlier benefit-cost analysis might even underestimate the returns to further investment in family planning. First, the earlier analysis assumed that both the method and source mix would remain essentially fixed over time; second, analysis conducted with data collected from the 1990 OPTIONS/MOPH time use and cost survey suggest that cost per user is likely to decline over time, due to the presence of significantly underutilized labor within the ambulatory health system.

Moreover, this estimate of benefits does not include savings from not having to treat as many women with health problems related to childbearing, whether such acute treatment occurs in the ambulatory or hospital system; nor does it include child-related savings to GOM beyond the ambulatory health system (e.g., hospital costs, primary and secondary education). Whether viewed from such a micro perspective or from the more macro perspective of the earlier Project Paper, it is clear that family planning is a very attractive investment for MOPH and GOM more generally.

Cost-Effectiveness Analysis: The cost-effectiveness analysis carried out under the OPTIONS project concluded that: (1) the cost of FP and other MCH services was higher in rural areas than in urban areas; (2) the cost of FP/MCH service delivery through the rural VDMS outreach program was approximately the same as that of rural fixed facilities; (3) the cost of providing services through FP reference centers and urban VDMS was relatively high; and (4) the lowest service delivery cost was achieved through mobile teams (equipe mobiles).

More recent and reliable cost estimates support some of these conclusions, but not all. The more reliable data available for 1989 support the earlier conclusions about the relatively high cost of services provided by FP reference centers and the relatively low cost of services provided by mobile teams. They do not support the earlier conclusions concerning the relatively high cost of services provided through rural fixed facilities and rural VDMS. Rural fixed services are seen to be as cost-effective as urban fixed services; whereas the cost of providing FP services through rural VDMS is seen to be significantly lower than that of either urban or rural fixed services. The relatively favorable showing of rural fixed and mobile services in the 1989 estimates reflects relatively low personnel and fixed costs for rural services.

Potential for Transferring Users from the Public to the Private Sector: The oral contraceptive social marketing project holds great promise as an intervention to effect such a transfer. Cross-national analysis of the international oral contraceptive market points to price as the main policy instrument to facilitate such a transfer. It is important to note, however, that careful evaluation will be necessary to determine whether the oral social marketing project is having the intended effect. The SOMARC Project forecasts that the socially marketed oral contraceptive will attain sales of 3.5 million cycles per year by 1997 (i.e., 45% of the private market and 20.5% of the total market). By 1997, SOMARC forecasts that the commercial sector will account for 45.4% of the total oral contraceptive market, as compared to 36% in the 1992 DHS.

The preceding discussion leads to the following conclusions with indicate economic feasibility of the project. First, family planning continues to be an excellent investment for the public sector in Morocco. Second, family planning services and expanded MCH services can be provided cost-effectively to the rural population, whether through fixed facilities or through outreach. Third, expanding the availability of the IUD and other long-term methods in Morocco should increase the overall cost-effectiveness of Morocco's FP program and, additionally, will help to reduce public sector contraceptive costs. Fourth, there is considerable potential for transferring users, particularly of oral contraceptives, from the public to the commercial sector through social marketing and other private sector initiatives. Most economic analysis to date have been on family planning. During the life-of-project, considerable work will be done to evaluate the economic impact of safe motherhood programs and expanded child survival interventions.

## **E. FINANCIAL ANALYSIS**

(NB. Full financial analysis is included as Annex H of this document)

The Financial Analysis section of the Project Paper is composed of four separate, inter-related analyses. The figures generated by these analyses form the basis for the estimated host country contribution to the project, contraceptive commodity procurement requirements, and private sector provision of contraceptive commodities.

The **Strategy for USAID Contraceptive Phasedown** contains precise estimates of public sector contraceptive requirements through 1999. These estimates are based on current estimated consumption and consumption trends over the 1989-1992 period. Public sector contraceptive requirements for the project period take into account projected shifts in method mix towards increased use of long-term methods (IUDs, Norplant and VSC) and injectables, with a concomitant decrease in the proportion of pill users.

Estimates for total public sector contraceptive commodity purchases increase over the life of project, reflecting program growth and increased numbers of users. Contraceptive requirement projections assume that USAID will progressively decrease its share of the funding required to purchase contraceptives and that the GOM will gradually increase its contribution. The estimates also assume that the GOM will be able to purchase contraceptives at the same price USAID currently pays for contraceptives purchased through a consolidated central contract.

The phase-down strategy contains a detailed description of the technical assistance required to achieve a successful phase-down, and a timetable for this assistance. USAID will finance a logistics management expert to work directly with the GOM contraceptive logistics

program manager based at the MOPH. The objectives of phase-down are to promote program sustainability, ensure a steady supply of public sector contraceptives, streamline and refine the current logistics management system, assist the MOPH to institutionalize contraceptive contracting capability, and lobby for increased program resources to finance required contraceptive purchases. Over the life of project, USAID will finance approximately \$8.2 million in contraceptive commodities and the GOM will finance approximately \$6.7 million in purchases.

**The Target Cost Model** for Morocco, a computer modeling program, has been updated to reflect projected shifts in method mix toward long term methods and a gradual increase in private sector provision of contraceptives. In 1992 the estimate of married women of reproductive age in union, and hence at risk of becoming pregnant, was 3,555,790. By 1999, this figure will increase to 4,333,293, an increase of 15% due to population growth alone.

In 1992, at a contraceptive prevalence rate of 41.6% there were 1,479,209 women using family planning in Morocco. Of these women, 64% currently rely on the public sector for their services. If the goals of increasing prevalence to 54% and the private sector share to 47% in 1999 are achieved, 1,122,111 women will be relying upon the public sector for services, an increase of 30% over five years. Employing the figures generated by the target cost model, the **Estimate of Private Sector Contribution to Contraceptive Purchases in Morocco** has been generated. Over the course of the project, the private sector contribution to contraceptive expenditures is estimated at approximately \$12 million.

**The Host Country Contribution** to the program, estimated at \$108.4 million, is based on total projected GOM expenditures for personnel, local costs and contraceptives. The GOM contribution is the sum of the projected Phase IV contribution (\$15.0 million and the Phase V contribution (\$93.4 million). MOPH personnel support costs, which are derived from time-cost estimates of MOPH project-related personnel, are currently estimated at \$10.3 million per year. Local cost support projections are based on the GOM's actual 1993 local cost contribution, with a 5% annual increase through the PACD.

#### **F. SOCIAL/BENEFICIARY**

This project is designed to benefit the women and children of Morocco, particularly those living in the underserved rural areas of the country. Like any FP/MCH project, the primary targets are women of childbearing age (between 15 and 44) who represent approximately 20% of the population and young children who represent another 20% of the population. A significant portion of this population lives in rural areas with difficult access to health care facilities. They have high levels fertility, low contraceptive prevalence and high infant mortality. Similar high rates are also seen in the slums surrounding major urban areas. The activities of this project are designed to respond to regional differences, factoring in specific data on beneficiaries to the design and implementation of service delivery mechanisms.

The Moroccan socio-cultural climate is very receptive to family planning and Child Survival health initiatives. Increasingly, women are recognizing the relationship between birth spacing and mother and child health. The 1992 Moroccan Demographic and Health Survey reports extensive knowledge (97.3%) of at least one modern method of family planning and a contraceptive prevalence rate of 41.5% among married women 15-49. One important incentive is the acceptance of family planning programs by the country's religious and political leaders, most notably in public statements by the royal family. However, there are certain socio-cultural constraints which must be addressed in the design and implementation of project activities targeting FP/MCH services in underserved rural areas if they are to be effective.

A Social Soundness Analysis commissioned by USAID in 1988, together with recent Ministry and other donor reports have highlighted certain social constraints on the project's target activities. However, the following obstacles confronting the new project are easily addressed within the context of the programmed activities.

- Inadequate usage and access to FP/MCH care in the rural areas will be improved by reorganization of the system to facilitate access, integrating existing services, and expanding the range of services provided to meet a variety of needs. USAID will also finance research to provide key information regarding access and usage issues.
- Inadequate information on family planning, ORS and other health related issues will be improved through an increased emphasis on IEC activities pertaining to project components. This includes the social marketing of condoms and ORS as well as mass media interventions. The focus will be on developing innovative, culturally acceptable approaches to communication.
- Poor client perceptions of services will be addressed through better quality-control procedures. USAID will support efforts to develop service protocols and improve supervision and technical competence. In addition, a new emphasis on private sector development will provide alternative choices and broaden the resource base.
- MOPH worker motivation will be stimulated through decentralized management, increased training to meet perceived needs, better integration into the existing system. Efforts will also be made to improve logistics and supply management.

Finally, information on the socio-cultural conditions of project beneficiaries has been collected during the four predecessor projects and will continue to be collected during this project as well. Specifically, a combination of the ministry's Management Information System,

special studies and operations research will be used to assure that the mix of interventions is effective in delivering FP/MCH services to the target populations. This project is in line with locally expressed needs and does not conflict with any cultural beliefs. It is therefore deemed to be a socially sound initiative for health care in Morocco.

**SECTION 3.3.  
PROJECT ASSISTANCE COMPLETION  
DATE**

- A. The "Project Assistance Completion Date" (PACD), which is December 31, 1999, or such other date as the Parties may agree to in writing, is the date by which the Parties estimate that all services financed under the Grant will have been performed and all goods financed under the Grant will have been furnished for the Project as contemplated in this Agreement.*
- B. Except as A.I.D. may otherwise agree in writing, A.I.D. will not issue or approve documentation which would authorize disbursement of the Grant for services performed subsequent to the PACD or for goods furnished for the Project, as contemplated in this Agreement, subsequent to the PACD.*
- C. Requests for disbursement, accompanied by necessary supporting documentation prescribed in Project Implementation Letters are to be received by A.I.D. no later than nine (9) months following the PACD, or such other period as A.I.D. agrees to in writing. After such period, A.I.D., giving notice in writing to the Grantee, may at any time or times reduce the amount of the Grant by all or any part thereof for which requests for disbursement, accompanied by necessary supporting documentation prescribed in Project Implementation Letters, were not received before the expiration of said period.*

*The remaining sections of the PROAG contain A.I.D. specific requirements such as Conditions Precedent.*

**SECTION 3.3.  
DATE D'ACHEVEMENT DE  
L'ASSISTANCE AU PROJET**

- A. La Date d'Achèvement de l'Assistance au Projet (DAAP), à savoir le 31 décembre 1999, ou toute autre date dont les Parties peuvent convenir par écrit, est la date à laquelle les Parties estiment que tous les services financés au titre du Don auront été exécutés, et que tous les biens financés au titre du Don auront été fournis pour l'exécution du Projet comme le prévoit le présent Accord.*
- B. A moins qu'elle n'en convienne autrement par écrit, l'A.I.D. n'émettra, ni n'approuvera de document autorisant le déboursement du Don pour la prestation de services exécutés après la DAAP, ou pour des biens fournis aux fins du Projet, comme le prévoit le présent Accord, après la DAAP.*
- C. Les demandes de déboursement, accompagnées des pièces justificatives nécessaires indiquées dans les Lettres d'Exécution du Projet, doivent parvenir à l'A.I.D. au plus tard neuf (9) mois après la DAAP ou toute autre période dont l'A.I.D. peut convenir par écrit. Après cette période, l'A.I.D., après notification écrite au Bénéficiaire, pourra, à tout moment, réduire le montant du Don en tout ou en la partie de ce montant pour lequel les demandes de déboursement, accompagnées des pièces justificatives nécessaires indiquées dans les Lettres d'Exécution du Projet, n'ont pas été reçues avant l'expiration de ladite période.*