

*AGENCY FOR INTERNATIONAL DEVELOPMENT*

*Washington, D.C. 20523*

*PROJECT PAPER*

*MOROCCO*

*FAMILY PLANNING*

*MATERNAL AND CHILD HEALTH*

*PHASE V, (608-0223)*

*DATE*





137, avenue Allal Ben Abdallah  
B.P. 120  
Rabat, Morocco

American Embassy Rabat  
PSO 74 BOX 022  
APO AE 09718

**ACTION MEMORANDUM FOR THE MISSION DIRECTOR USAID/MOROCCO**

**FROM:** Frederic Scott, Project Development and Private Enterprise

**SUBJECT:** Request for Authorization of the Family Planning and Maternal Child Health, Phase V, Project (608-0223)

Problem: Your approval is requested for (a) the Project Paper for the Family Planning and Maternal Child Health Project, Phase V (608-0223), and (b) the Project Authorization.

Background: USAID/Morocco has been assisting the Government of Morocco (GOM) health and family planning sectors since 1971. The current major activity, Family Planning and Child Survival Phase IV (608-0198), was authorized in 1989 for a \$31.0 million, seven year life-of-project (LOP). In order to provide mid-course corrections, the Mission planned to execute a project amendment to Phase IV in FY 1993. As the result of an intensive analysis and in response to rapidly changing circumstances in Morocco, the Mission decided to curtail Phase IV and prepare a new Phase V project which will intensify programmatic efforts and focus on sustainability of the family planning/maternal child health (FP/MCH) program. Dramatically increased support for family planning efforts at the very highest levels of the GOM, increased visible demand for FP/MCH services provided by both public and private sources, the potential visibility of an immediate major effort and the potential for implementing sustainable interventions into the 21st century all argue for increased targeted resources beginning in FY 1993.

Discussion: 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 neonatal, infant and child mortality, a reduction in maternal mortality, and a reduction in 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 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.

The project will be implemented under the general sponsorship of the MOPH, Directorate of Preventive Services and Health Training through a Project Management Unit in the Division of Population. A U.S. institutional contractor, with long-term resident staff, will assist the MOPH with most project activities, including provision of technical assistance, training and commodities, and disbursements of funds supporting local activities. U.S. procurement of contraceptives and project vehicles will be handled by AID/Washington central procurement. Other procurement of commodities will be handled by the institutional contractor. For special expertise, there will also be a limited number of buy-ins with centrally-funded projects. The USAID Mission through its Population and Human Resources Division will have overall responsibility for project supervision and will monitor project implementation.

Near East Development Advisory Committee (NEDAC) ISSUES: USAID prepared and submitted the Project Identification Document (PID) for AID/W approval in May 1993. The NEDAC approval cable (State 159763, dated 26 May 1993) gave Project Paper approval authority to the Mission Director, subject to resolution of the following issues:

1. Is it really feasible to consider a complete phase-out of public sector support for FP/MCH services by 1999?

The Mission will work toward the twin objectives of increased efficiency of public sector health care delivery and diversification of funding. The project will enable private sector health care service delivery to increase through policy reform and through a series of pilot projects focussing on private sector health care activities. One Condition Precedent to disbursement of local costs for the project will be submission to USAID by the GOM annual reports showing its increased proportion of budgetary support to this project relative to USAID's contribution. This is subject to the caveat that other GOM preventive health care activities will not be affected through budgetary transfers. The objective will be phase-down of USAID support, not necessarily pphase-out.

2. Given the under-utilization of currently available services - is it appropriate to consider increased funding at this time?

The Project Paper points to several analyses which detail reasons for under-utilization of services. The reasons revolve around lack of awareness on the part of the certain client population and lack of the ability to respond adequately on the part of the MOPH service providers. Increasing access to and quality of services is one of the main components

*of the project. The project will support development of information and education programs, decentralization of decision-making, integration of services, better management, and increased training among other activities, precisely with the objective of increasing utilization of health care services. Tightly focussed and targeted increased levels of funding are necessary to ensure successful realization on increased utilization objectives.*

*3. Has the Phase IV been evaluated?'*

*A report will be prepared that consolidates the findings of the numerous studies undertaken during Phase IV. This report will include lessons learned and will analyze the project's impact.*

*4. Should strategic program and project goal include the population objectives of family planning?*

*The Project Paper incorporates the NEDAC's guidance and includes demographic impact indicators such as contraceptive prevalence rate, fertility reduction, among others. Although the NEDAC recommended the Mission consider changing the strategic objective of, "improved health of children under five and women of child bearing age" to include demographic objectives, the MOPH has specifically requested that, given potential political or religious sensitivities, the strategic objective remain the same. They have agreed to the inclusion of demographic indicators as impact measurements. USAID agrees with this approach which is reflected in the logical framework.*

*5. Is there adequate justification of need and a sound procurement plan for the purchase of vehicles?*

*The Mission will use technical assistance to draw up necessary vehicle specifications. AID/Washington central procurement will purchase them following A.I.D. rules and regulations. There is strong rationale presented in the Project Paper for purchase of vehicles. The argument is developed around the need for de-centralization, increased management efficiency, and the need for a strong regional capability.*

*6. Is there any Agency guidance on the safe and proper disposal of project-funded syringes?*

*There is no specific Agency guidance on the safe and proper disposal of syringes. The GOM'S rules and regulations for such disposal will be followed for this project. The project's monitoring plan includes plans for periodic monitoring of this disposal. A Negative Environmental Determination was signed by the Bureau Environmental Coordinator on June 7, 1993.*

*The Mission Review Committee met on June 10, 1993, to discuss the FP/MCH Project Paper. The Committee recommended approval of the Project Paper subject to certain final revisions in the draft as follows.*

1. The Project Paper will note that when, through normal project monitoring, certain private sector health care activities are identified as being extremely successful, the Mission will consider re-programming project funds to reinforce these activities.

2. The Project Paper will clarify the section on diversified funding to indicate that this includes two approaches: using public sector approaches, including allocation of greater MOPH budgetary resources to FP/MCH activities, health insurance reform and exploration of potential models such as fee-for-service; and the expansion of private sector delivery of preventive FP/MCH services to assure a larger responsibility in the private sector for the delivery of these services, thus relieving the burden of the MOPH.

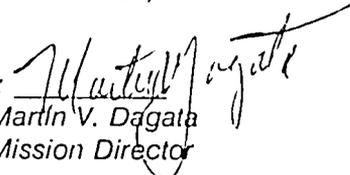
3. Policy reforms should provide for increased GOM efficiency and facilitate private sector delivery of preventive health goods and services.

4. The Project Paper will note that sustainability through institution building includes such activities as integration of services including integrated management systems, decentralized decision-making and the development of relevant policy reform.

All of the above language has been incorporated into the final draft.

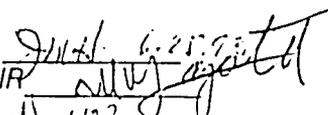
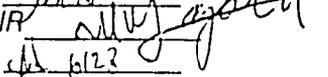
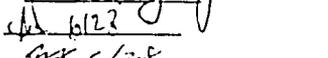
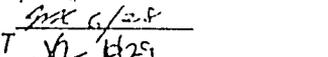
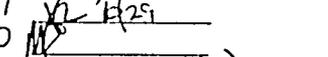
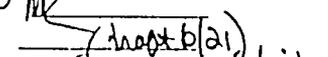
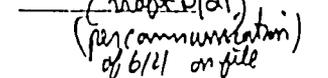
Congressional Notification (CN): The CN for this project was submitted to Congress on May 28, 1993 and expired without objection on June 12, 1993.

Recommendation: That, according to the authority granted to you in A.I.D. Redefinition of Authority 654, you sign the Project Paper Data Sheet and the attached Project Authorization, thereby approving the Family Planning and Maternal Child Health Phase V project with a life-of-project funding of \$52.0 million and a Project Assistance Completion Date of December 31, 1999

Approved:   
Martin V. Dagata  
Mission Director

Disapproved: \_\_\_\_\_  
Martin V. Dagata  
Mission Director

Date: .

Clearance: JHolfeld, PHR   
JLowenthal, DDIR   
FScott, PDPE   
WRiley, PROG   
KRomwall, CONT   
MReynolds, RCO   
KODonnell, RLA   
(except b(2))  
(per communication of 6/11 on file)



137, avenue Allal Ben Abdallah  
B.P. 120  
Rabat, Morocco

American Embassy Rabat  
PSO 74 BOX 022  
APO AE 09718

PROJECT AUTHORIZATION

NAME OF COUNTRY: MOROCCO  
NAME OF PROJECT: FAMILY PLANNING MATERNAL CHILD HEALTH V  
NUMBER OF PROJECT: 608-0223

1. Pursuant to Section 531 of the Foreign Assistance Act of 1961, as amended, subject to the availability of funds and in accordance with the A.I.D./operating year budget (OYB) allotment process, I hereby authorize the Family Planning/Maternal Child Health Care Phase V Project for Morocco (the "Cooperating Country") involving planned obligations not to exceed Fifty Two Million United States Dollars (52,000,000) to help finance foreign exchange and local currency costs for the project. The planned life-of-project is six and one half years from the date of initial obligation.

2. The Project consists of assistance to Morocco to increase the effective use of family planning and maternal and child health care services by improving access, quality, and information. The project will also increase sustainability of family planning and maternal and child health services by ensuring a favorable policy environment, reinforcing decentralized institutional capacity, and by developing a diversified resource base, including expansion to the private sector, for these types of activities.

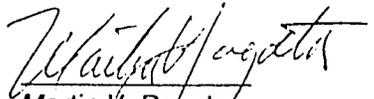
3. The Project Agreement(s) which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and delegations of authority shall be subject to the following essential terms and covenants together with other terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Commodities, Nationality of Services

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

1

To the extent permitted under the Agency's Buy America Initiative guidance procurement of Moroccan source and origin will be permitted. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

Signature:   
Martin Y. Dagata  
Mission Director  
7/31/93

Clearance:

JHolfeld, PHR DMH 6.28.93  
JLowenthal, DDIR 7/6/93  
RScott, PDPE RScott 6/28/93  
WRiley, PROG MC 6/28/93  
KRomwall, CONT KR 6/28/93  
MReynolds, RCO MR  
KODonnell, RLA (draft) 6/21  
(re communicating dated 6/21 on file)

*FAMILY PLANNING*  
*MATERNAL AND CHILD HEALTH*

*PHASE V*

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*(608-0223)*

*PROJECT PAPER*

*USAID/MOROCCO*

*JUNE, 1993*

**FAMILY PLANNING  
MATERNAL AND CHILD HEALTH  
PHASE V, (608-0223)**

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**LIST OF PROJECT DESIGN AND MISSION REVIEW COMMITTEE MEMBERS**

**Project Design Committee**

<i>Cherie Bellamy</i>	<i>Program Analyst, NE/DR/MENA - AID/W</i>
<i>Richard Burns</i>	<i>Chief, Project Development/Private Enterprise (PDPE)</i>
<i>Najib Guedira</i>	<i>Health Care Financing Specialist, PHR</i>
<i>Joyce M. Holfeld</i>	<i>Chief, Population and Human Resources (PHR)</i>
<i>Zohra Lhaloui</i>	<i>Project Officer, PHR</i>
<i>Michele Moloney</i>	<i>Technical Advisor for Child Survival, PHR</i>
<i>Carol Payne</i>	<i>Population Development Officer, PHR</i>
<i>Mary Reynolds</i>	<i>Regional Contracting Officer</i>
<i>William Riley</i>	<i>Deputy Program Officer</i>
<i>Keith Romwall</i>	<i>Controller</i>
<i>Frederick Scott</i>	<i>Project Development Officer, PDPE</i>
<i>Jinny Sewell</i>	<i>Chief Family Planning Services Division, R&amp;D Pop</i>

**Mission Review Committee**

<i>Martin V. Dagata</i>	<i>Mission Director</i>
<i>William Riley</i>	<i>Program Officer</i>
<i>Richard Burns</i>	<i>Chief, Project Development and Private Enterprise</i>
<i>Joyce M. Holfeld</i>	<i>Chief, Population and Human Resources</i>
<i>James B. Lowenthal</i>	<i>Deputy Director</i>
<i>Keith Romwall</i>	<i>Controller</i>
<i>Mary Reynolds</i>	<i>Regional Contracting Officer</i>
<i>Charles Uphause</i>	<i>Chief, Agriculture and Natural Resources</i>

## ACRONYMS AND ABBREVIATIONS

<i>A.I.D.</i>	<i>Agency for International Development</i>
<i>AID/W</i>	<i>Agency for International Development/Washington</i>
<i>USAID</i>	<i>United States Agency for International Development</i>
<i>ARI</i>	<i>Acute Respiratory Infection</i>
<i>CDD</i>	<i>Childhood Diarrheal Disease</i>
<i>CQI</i>	<i>Continuous Quality Improvement</i>
<i>DA</i>	<i>Development Assistance</i>
<i>DES</i>	<i>Division de l'Education Sanitaire/Health Education Division</i>
<i>DHS</i>	<i>Demographic and Health Survey</i>
<i>DPES</i>	<i>Direction de la Prevention et de l'Encadrement Sanitaire/Direction for Prevention and Health Training</i>
<i>DPSI</i>	<i>Division de la Planification de la Statistique et de l'Informatique/ Division for Statistics and Information System Planning</i>
<i>EC</i>	<i>European Community</i>
<i>FP/MCH</i>	<i>Family Planning/Maternal and Child Health</i>
<i>FSN</i>	<i>Foreign Service National</i>
<i>FY</i>	<i>Fiscal Year</i>
<i>GOM</i>	<i>Government of Morocco</i>
<i>IEC</i>	<i>Information, Education and Communication</i>
<i>INAS</i>	<i>Institut Nationale de l'Administration Sanitaire/National Institute of Health Administration</i>
<i>IPPF</i>	<i>International Planned Parenthood Federation</i>
<i>IQC</i>	<i>Indefinite Quantity Contract</i>
<i>IUD</i>	<i>Intra-Uterine Device</i>
<i>HIV/STD</i>	<i>Human Immunodeficiency Virus/Sexually Transmitted Disease</i>
<i>KAP</i>	<i>Knowledge, Attitudes and Practices</i>
<i>LOP</i>	<i>Life-of-Project</i>
<i>MIS</i>	<i>Management Information Systems</i>
<i>MOPH</i>	<i>Ministry of Public Health</i>
<i>NGO</i>	<i>Non-Governmental Organization</i>
<i>ORS</i>	<i>Oral Rehydration Salts</i>
<i>OYB</i>	<i>Operating Year Budget</i>
<i>PACD</i>	<i>Project Assistance Completion Data</i>
<i>PHR</i>	<i>Population and Human Resources</i>
<i>PID</i>	<i>Project Identification Document</i>
<i>PMU</i>	<i>Project Management Unit</i>
<i>PRISM</i>	<i>Program Performance Information for Strategic Management</i>
<i>PSC</i>	<i>Personal Service Contract</i>
<i>RFP</i>	<i>Request for Proposal</i>
<i>SEIS</i>	<i>Service d'Etude de l'Information Statistique et la Documentation</i>
<i>SETI</i>	<i>Service d'Etude et du Traitement de l'Information</i>
<i>TAACS</i>	<i>Technical Advisor in AIDS and Child Survival</i>
<i>TQM</i>	<i>Total Quality Management</i>
<i>TOT</i>	<i>Training of Trainers</i>
<i>UNFPA</i>	<i>United Nations Fund for Population Activities</i>
<i>UNICEF</i>	<i>United Nations Children's Fund</i>
<i>VSC</i>	<i>Voluntary Surgical Contraception</i>
<i>WHO</i>	<i>World Health Organization</i>

## I. PROJECT SUMMARY AND RECOMMENDATION

### A. PROJECT BACKGROUND

*The U.S. Agency for International Development (USAID Morocco) has been assisting the Government of Morocco (GOM) health and family planning sectors since 1971. The current major activity, Family Planning and Child Survival Phase IV (608-0198), was authorized in 1989 for a \$31.0 million, seven year life-of-project (LOP). Its primary objectives were to support sector goals of reducing rapid population growth and early child death in Morocco. Evaluations of Phase IV and the previous phases, including the Morocco Child Survival Impact Assessment in 1990, and the 1987 and 1992 Demographic and Health Surveys (DHS), demonstrated that these projects were highly successful in contributing to increased contraceptive prevalence rates and reduced fertility and infant mortality rates.*

*In order to provide for some mid-course corrections and make a number of programmatic changes, the Mission had planned to execute a project amendment to Phase IV in fiscal year (FY) 1993. In preparation for the amendment, over twenty four special studies, analyses or strategies were completed by USAID, the Ministry of Public Health (MOPH), the United Nations Fund for Population Activities (UNFPA), and United Nations Children's Fund (UNICEF). USAID, the MOPH and a team of consultants conducted an options analysis to determine the most feasible interventions for achieving family planning and maternal/child health (FP/MCH) objectives over the next decade. The result of this intensive analysis, as well as a review of changing circumstances in Morocco, led the Mission to decide to wind down Phase IV and prepare a totally new Phase V project which will intensify programmatic efforts and attempt to put FP/MCH on a more sustainable basis. Dramatically increased support for family planning efforts at the very highest levels, increased visible demand for FP/MCH services, provided by both public and private sources, the visible impact of an immediate major effort and the potential for implementing sustainable interventions into the 21st century all argue for a high resource project starting in FY 1993.*

*Key among the changing circumstances in Morocco is a significantly altered political environment relative to health and population. Although Morocco has long had an unspoken policy of support for family planning, 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 just drafted a new 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. Strong evidence exists 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. With the basic infrastructure in place, 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.*

*On the child survival side, it has also become increasingly clear over the last few years that many Moroccan social indicators lag far behind what would be expected in a country at its general level of development, for example, maternal mortality rates in some areas are estimated to be as high as 400 per 100,000. Child survival programs, particularly concerning safe motherhood and childhood diarrheal disease (CDD), have not received the level of U.S. or other donor support which family planning has, and therefore are far less advanced. The effect of this lag has major implications on infant, child and maternal morbidity and mortality. Consequently, there is heavy internal and external pressure for the GOM to focus more on social sectors. It is now clear that Phase IV did not include enough support for child survival activities. With targeted inputs for family planning, safe motherhood and other child survival interventions, it is conceivable to reduce infant mortality due to diarrheal diseases by at least one third and to significantly reduce maternal mortality and morbidity.*

*Another evolving change is the increased interest in the Ministry of Public Health 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.*

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

*The decision to proceed with a new project rather than a major 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.

## **B. PROJECT SUMMARY**

### **Grantee:**

A project Grant Agreement will be signed with the GOM's Ministry of Public Health and the Ministry of Finance. The Ministry of Public Health, Directorate of Preventive Services and Health Training, will be designated as the responsible GOM agency for project implementation.

### **Implementing Agencies:**

As indicated above, the project will be implemented under the general sponsorship of the MOPH, Directorate of Preventive Services and Health Training through a Project Management Unit which will be responsible for project administration, programming and ongoing evaluation. A U.S. institutional contractor, with long-term resident staff, will assist the MOPH with most project activities, including provision of technical assistance, training and commodities, and disbursements of local support costs. U.S. procurements of contraceptives and vehicles will be handled by AID. All other procurements will be carried out through the institutional contractor. For special expertise, there will also be a limited number of buy-ins with centrally funded projects. The USAID Mission through its Population and Human Resources (PIHR) Division will have overall responsibility for project supervision and will monitor project implementation.

### **Total Project Cost:**

The total project cost is estimated to be \$160.4 million. A.I.D. will provide \$52.0 million from Development Assistance (DA) Funds, to be obligated and expended over a 6.5 year period, FY 1993-2000. The Moroccan contribution will be approximately \$108.4 million over the life-of-project. The GOM contribution is the sum of the projected Phase IV contribution (\$15.0 million) and the Phase V contribution (\$93.4 million).

### **Project Goal and Purpose:**

The project will directly support the Mission's health/family planning Strategic Objective, as developed through the PRISM system. Specifically the project goal will be to improve the health of children under five and women of childbearing age. The two-fold purpose of the project is: 1) to increase the effective use of family planning and select child survival services by improving access, quality and information and 2) to increase the sustainability of those services by ensuring a favorable policy environment, reinforced decentralized institutional capacity and a diversified resource base, the central aspect of which is expansion of private sector services.

### **Project Activities:**

*The new project will: 1) take advantage of the changed environment and new opportunities to make an even greater impact on family planning and maternal child health programming; 2) target specific family planning, safe motherhood, control of diarrheal diseases and other child survival interventions to effect an immediate reduction of maternal and infant morbidity and mortality; 3) diversify the financial resource base, particularly involving the private sector in health service delivery; and 4) prepare for overall program sustainability by developing institutional capabilities to plan, implement evaluate and finance preventive health services.*

*Phase V will include a number of new elements and modified emphases from Phase IV. Activities in the new project will have as overlying themes the priorities of the GOM concerning decentralization and integration of preventive FP/MCH services. The actual activities which are either new or are to receive much greater support are;*

- *Information, education and communication (IEC)*
- *Quality of family planning and maternal/child care programs*
- *Expanding the range of family planning services including long term methods and postpartum family planning*
- *Child survival services, particularly safe motherhood and childhood diarrheal diseases*
- *Policy reform, particularly on issues which affect the provision of services by the private sector, phase over of contraceptive and local costs, decentralization, and health care personnel.*
- *Development and pilot testing of private sector based family planning and child survival services, expanding financing where warranted.*
- *U.S. commodity procurements, particularly vehicles and clinical equipment*

*Previously planned Phase IV activities, including construction of facilities and significant support to the HIV/STD prevention program, will be fully carried out as originally conceived in the Phase IV project paper; however, no further construction and only limited support to HIV/STD activities will be continued in Phase V. Of the \$31 million authorized for Phase IV, \$24 million has been obligated and \$17.5 million committed. The uncommitted balance will be used to complete Phase IV activities which are in process and to continue on-going activities until the implementation mechanisms of Phase V are in place. There will be no further Phase IV obligations.*

*Major inputs to the project include technical assistance; training; vehicles, contraceptives and other commodities; and local support costs for IEC, training and research activities. Phase V will involve substantially more procurement of U.S. commodities than previous projects, including about \$8.0 million for contraceptives, \$5.0 million for trucks and other utility vehicles and \$6.25 million for U.S. origin clinic, IEC, and automation equipment.*

*Family Planning and Maternal Child Health, Phase V does not represent any change in the USAID Morocco strategy described in the 1992 Action Plan. Rather it strongly supports that strategy by forcefully responding to a changing environment and emerging opportunities, and will reinforce A.I.D.'s position as a lead donor and supporter of family planning and child survival in Morocco.*

### **Expected Achievements:**

*This project will enable the GOM to reduce infant, child and maternal morbidity and mortality, and to reduce fertility by expanding and improving quality family planning and select child survival services in Morocco, with added emphasis on efforts to ensure long-term sustainability of these programs. The expected achievements of the project are as follows:*

*Increased Access to FP/MCH Services.* *The project will increase access by providing assistance which will enable the GOM to identify and resolve access problems, selectively reorganize and expand the range of family planning and maternal child health services offered by the MOPH, and expand the channels of service delivery. It will also support integration of preventive services in order to assure that each service becomes an entry point into the health system through establishment of clinical, supervision, training and management tools which incorporate a comprehensive care approach.*

*Improved Quality of FP/MCH Services.* *The project will reinforce current MOPH efforts to improve program quality by focussing on the development and application of service protocols, expansion and updating of pre-service and in-service training, revising procedures for supervision and the application of quality management techniques. The project will also enhance the quality of the physical environment by providing improved equipment and materials, by improving patient flow to respect privacy, and by improving counselling and interpersonal interaction to allow informed choice and active participation of the client.*

*Strengthened IEC Programs Complementing FP/MCH Programs.* *The project will support decentralized IEC programs based on clear goals and objectives, audience research, and targeted message development. Both mass communications and interpersonal counseling will be employed.*

*Identification and Removal of Policy and Regulatory Barriers.* *The project will support efforts to clarify and reform, as necessary, the legal and regulatory framework related to private sector delivery of FP/MCH services, increasing resources for MOPH service delivery, decentralization, and service delivery personnel.*

*Strengthened, Decentralized Institutional Capacity.* *The project will improve sustainability through the development of institutional capacity which meets the challenge of improving the health status of a growing population as outside resources are being reduced. The project will focus on reinforcing and decentralizing essential planning and evaluation functions for contraceptive commodities, and facilities support. The decentralization will support MOPH plans to use a regional concept in order to support efficiency and quality in management and service delivery.*

*Diversification of the Resource Base for the Delivery of FP/MCH Services/Developing Private Sector Participation.* *In the public sector, the project will assist the MOPH to accurately project budgetary needs and advocate for an adequate share of public resources. In the private sector, the project will finance analytical and feasibility*

*studies and testing of strategies for expanding FP/MCH services through social marketing, the workplace, training of private sector based family planning service centers.*

*Considered together, these achievements will contribute to the following specific results by the end of project:*

- *more women correctly using effective contraceptive methods of their choice*
- *more women receiving prenatal care and maternity services*
- *more women practicing diarrheal disease prevention and rehydration techniques for the protection of their children*
- *a policy environment favorable to sustained public and private sector support of FP/MCH programs*
- *an increased institutional capacity to plan, implement, and evaluate FP/MCH programs*
- *continued expansion of increasingly efficient FP/MCH services as outside support is scaled down*
- *increased private sector share in FP/MCH services delivery.*

*At the end of the project, the program will be more sustainable as evidenced by the GOM assuming significantly increased responsibility for financing contraceptive procurement and local costs and the private sector assuming greater responsibility for the delivery of preventive FP/MCH services. The implication of this phase down as concerns ongoing A.I.D. assistance to public sector service delivery support after Phase V will be determined as project activities and policies evolve.*

### **C. RECOMMENDATION**

*The USAID Mission Review Committee has determined that the proposed activities are technically, administratively, economically and financially sound within the seven year project. Consequently, the committee recommends that the Mission Director authorize a grant of \$52.0 million for the Family Planning and Maternal and Child Health V Project.*

## **II. PROJECT RATIONALE AND DESCRIPTION**

### **A. PROBLEM**

*The GOM, with USAID and other donor assistance, has achieved significant gains in lowering fertility as well as infant and child mortality, as reflected in the following:*

- *A decline in the infant mortality rate, from an estimated 122 deaths per 1000 live births in the early 1970's to 57 in 1992;*
- *A decrease in child mortality, from 77 deaths per 1000 children 1-5 in the early*

1970's to 20 per 1000 in 1992;

- *An increase in contraceptive prevalence, from approximately 19% percent in 1978 to 41.5% (35.5% modern methods) in 1992;*
- *A decline in the total fertility rate, from 5.9 in 1979 to 4.2 in 1992; and*
- *An increase in fully documented vaccination coverage rates, from 40-50% in 1985 to over 70% in 1989.*

*Morocco has made significant progress in developing a sustainable institutional setting for the family planning program. A national outreach program delivers services and education through multiple channels, including household visits, mobile units, and community "points of contact." Family planning and maternal/child health services are provided in all fixed facilities and outreach programs. Furthermore, Morocco has begun to strengthen the public-private partnership in services 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.*

*Much work, however, remains to be done. The GOM faces an enormous challenge in building up its system to serve a growing population while aiming at higher levels of performance. The following are the major problems facing Morocco in the preventive health sector:*

- *Because the population is growing at over 2.4% a year and more women are coming into childbearing age, merely sustaining current rates of contraceptive prevalence and FP/MCH service utilization means serving more clients.*
- *Achieving GOM year 2000 fertility and health targets, including reducing infant mortality to 50 per 1000 and maternal mortality by 10%, requires serving a larger proportion of this growing target population. Although the service delivery and IEC capacity need to be increased, there are already proportionately fewer professional personnel than are needed for the expanded outreach delivery system.*
- *Statistics reflect persistent, significant urban-rural differences in health status and pattern of service utilization.*
- *Full utilization of available services and failure to adopt health practices are of serious concern. Only half of women expressing a need for family planning are using modern methods; many maternities are vastly underutilized; few respondents in a recent survey used oral rehydration therapy for a child who had a recent episode of diarrhea.*
- *The GOM depends heavily on donors for support to finance contraceptives and local costs at existing program levels.*

- *The primary burden for providing FP/MCH services for the vast majority of the population rests with the MOPH even though many clients are able to pay for services. To date the GOM has been unwilling to institute fees for service in the public sector and the private sector generally does not play a significant role in provision of preventive services.*

*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 Mission had originally planned to execute a project amendment to Phase IV in order to provide for some mid-course corrections and make a number of programmatic changes. Over the past year, however, multiple studies, analyses and strategies were carried out by USAID, UNFPA, and UNICEF, culminating in an options review by USAID, the MOPH and a team of consultants on the most feasible interventions for achieving FP/MCH objectives over the next few years. The result of this intensive analysis, as well as a review of changing circumstances in Morocco, led to a Mission decision to wind down Phase IV and prepare a totally new Phase V project which intensifies programmatic efforts and attempts to put FP/MCH on a more sustainable basis.*

## **B. PROJECT RATIONALE**

*In a February 1993 interview, His Majesty King Hassan II of Morocco stated that the choice for his country is between contraception and poverty. In an April 1993 public address, the King's daughter, Princess Lalla Meriem, repeated the King's earlier statement and added that the success of family planning and maternal child health programs will require close collaboration between the public and private sectors and expanded channels for services delivery. These statements reflect a significant change in policy concerning family planning in Morocco. Although there has long been an unspoken commitment by the Government of Morocco to lower fertility and improve the health of mothers and children, these statements from the King and the Royal family, as well as similar ones from the new Minister of Public Health, not only highlight the new sense of importance and urgency these programs are now being given, but expand their context to one including demographic and global development issues. They also reflect the GOM's keen interest in testing and implementing innovative service financing models through private sector and intersectorial collaboration. Increased magnitude in the family planning program will be required to meet an escalating demand for quality services, for example, although 73% of married women want no more children or want to postpone another child for at least two years, and most of them know of at least one modern method and where to obtain it, only 35.5% are currently using a modern method. Areas which must be addressed include contraceptive method mix (Morocco is highly dependant on short term methods, with 80% of contraceptors utilizing oral contraceptives) and significant unmet demand for family planning services, for example in the Voluntary Surgical Sterilization (VSC) program, for which provinces indicate substantial waiting lists.*

*The GOM is also facing vast urban/rural discrepancies evidenced by a significant lag in all health indicators in rural areas, making this a target population. Although this problem is evidenced in all programs, for example total fertility rates in rural areas are*

5.5 as opposed to 2.5 in urban areas, it is particularly critical in child survival programs. Infant mortality is 64.8 per 1,000 in rural areas as opposed to 43.5 per 1,000 in urban areas. Diarrheal diseases are a leading killer of children in Morocco; 26.7% of deaths of children below five years of age are due to diarrhea. Over 50% of infant mortality occurs in the first 28 days of life, due to causes linked to prematurity, neonatal tetanus, and fetal distress. Although there are no solid numbers related to maternal mortality, in some areas they are estimated to be as high as 400 per 100,000 live births. At the same time, the DHS has demonstrated low health practices related to prevention of these problems. Less than 14% of children with diarrhea received oral rehydration salts (ORS). Only 32% of women had even one prenatal visit and only 31% delivered with a trained health care provider. It is for these reasons that the GOM has requested USAID assistance also be increased in the area of child survival and safe motherhood.

In preparation for the GOM five year development plan 1993-1997, the MOPH has developed a series of programmatic strategies for Family Planning, Safe Motherhood, and Childhood Diarrheal Diseases, as well as an approach to IEC. These strategies are designed using a two-pronged approach which: further improves public sector services delivery focussing on quality and sustainability; and increases partnership and coordination with private sector institutions. Increased public sector focus on quality and sustainability will promote the delivery of improved, efficient services to the growing population dependent on these services. Private sector partnerships will encourage expansion of delivery of preventive health goods and services through private entities offering an alternative to those able to afford services.

**Public Sector Programs:** To date, Morocco has made significant progress in developing a sustainable institutional setting for family planning and maternal child health programs. Approximately 80% of the population resides in the catchment area of MOPH ambulatory health facilities, now numbering more than 2200 delivery sites. With a contraceptive prevalence rate of 42%, potential demand approaching 75% and a solid service infrastructure, Morocco's public sector program has entered a second generation. Worldwide experience has shown that programs at this level of achievement tend to plateau, and in order to achieve the required substantial increases in contraceptive prevalence, full access to improved, quality, and sustainable services must be assured.

On the other hand, there remains the potential for rapid decrease in infant mortality. Ambitious objectives of the GOM to reduce infant mortality to 50 per 1000 and maternal mortality by 10% by the year 2000 can be achieved through integrated, targeted interventions, particularly in CDD and safe motherhood. Implementation of these measures could conceivably reduce infant and child mortality related to diarrheal diseases by at least one third and significantly reduce maternal mortality and morbidity.

The current MOPH policies for public health care delivery are consistent with and promote the delivery of accessible and sustainable, quality services. These policies include: decentralization of responsibility for service delivery to the regional and provincial level; integration of FP/MCH programs and messages; and a focus on underserved rural and peri-urban populations. The MOPH has also called for an

*increased focus on standardized, quality IEC as an integral component of both public and private sector health services delivery.*

*Private Sector Partnerships: The GOM is committed to the development of mechanisms for expanding the financial base of health care in Morocco. The Minister of Public Health has charged his staff to expand partnership and coordination with a wider range of both public and private sector institutions. This is to encourage the private sector to increasingly assume a larger role in satisfying the demand for family planning and maternal child health services. Morocco has already gained considerable experience in social marketing, with the condom program approaching the withdrawal of all A.I.D. support and social marketing of oral contraceptives and ORS recently launched.*

*The MOPH is also aware of the need to create a policy and regulatory environment that will encourage private sector delivery of services. In late 1991 the MOPH commissioned a study to investigate possibilities of expanding the private health sector, and removal of legal and regulatory constraints has been included on the agenda of several recent national conferences. To ensure private sector representation, a private sector subcommittee has been established as one advisory group to the National Family Planning Committee.*

*The interventions proposed by this project are fully consistent with the GOM's priorities in family planning and maternal child health care. Thus, Family Planning and Maternal Child Health V will focus on improving the quality and sustainability of accessible health care programs for women and children. Project focus will be targeted towards family planning, safe motherhood and CDD areas with selected interventions in the area of Acute Respiratory Infections, HIV/STD prevention and vaccination programs. In response to the GCM's stated priority for improved communications programs, IEC programs will be augmented and standardized. This project will assist the GOM in its efforts to undertake new private sector initiatives, thus expanding services and the financial base for health care in Morocco. Development and implementation of a policy agenda that focusses on addressing legal or regulatory constraints will comprise an integral, complementary component of project activities.*

*Given the advances made by the GOM in health care, and given the problem areas described above, FP/MCH will be designed and implemented around the following themes: 1) increase effective use of FP/MCH services through improving access to services; improving quality of services; strengthening information, education and communication; and 2) promote sustainability through creating a favorable policy environment, strengthening decentralized institutional capacity; and diversifying the resource base. The specific rationale for addressing each of these themes and their subcomponents is included in the Detailed Project Description.*

### **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 diarrhoeal diseases: practices related to diarrhoeal 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 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;*

- *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 mirrilap, 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 FM/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 FM/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 FM/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 MOPH 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
TOTAL	\$8.19	\$6.65	\$11.93

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.*

#### **D) RELATIONSHIP TO OTHER DONORS**

*USAID has traditionally been the lead donor in the family planning sector in Morocco, and an important contributor to maternal/child health activities. The MOPH works hard to assure coordination of donor assistance from all sources. It currently utilizes a system in which it, with technical assistance and input of donors, develops national plans and strategies in specific areas and then requests the donors to "buy" selected pieces for implementation. This both avoids problems in terms of duplication of efforts and allows donors to provide assistance in areas of their choice and relative strength. In addition, USAID works closely with other donors to keep abreast of new initiatives*

*and coordinate activities in areas of mutual interest. The following is a summary of the major donors and their areas of focus and collaboration with USAID in the areas of family planning and child survival:*

*The United Nations Children's Fund is a major donor in the area of child survival. USAID and UNICEF have a long history of successful collaboration in Morocco, in such projects as the National Immunization Program and the Childhood Vaccine Initiative. UNICEF has committed \$12.7 million to health related programs for the period 1992-1996. In addition, UNICEF has identified the Childhood Diarrheal Disease program as a priority and anticipates programming up to \$5 million (in conjunction with USAID) for activities through 1995. In this area USAID is viewed as an equal partner and all activities are planned in collaboration with the MOPH to assure they are mutually supportive. UNICEF is also providing some support to the ORS Social Marketing activity. Other areas of mutual interest and effort include acute respiratory infection, safe motherhood and breastfeeding programs.*

*United Nations Fund for Population Activities is a major donor in the area of population with anticipated funding levels of \$8 million from 1992 through 1996, including \$500,000 for IEC activities and \$1.6 million for Safe Motherhood. UNFPA contributes to the MOPH through technical assistance for which it is the primary contributor to the MOPH's National Management Information System. USAID is collaborating with UNFPA in the procurement of computers and the financing of technical assistance to refine this system. UNFPA also supports INAS and special analyses of the USAID financed DHS.*

*World Health Organization provides assistance in terms of financing, contributing approximately \$4 million for 1990-91. Its technical assistance in AIDS control, public health training, communicable diseases and epidemiology is a most useful complement to the efforts of the other agencies. In addition, WHO finances a technical advisor to the National Health Training Institute, INAS.*

*The European Community (EC) is assuming an increasingly significant role in the area of population and health. A major project to introduce postpartum family planning in twelve provincial maternity hospitals is in the early implementation phase. Assistance to this project amounts to \$800,000 and will run 3 years. In addition, the EC has allocated \$12 million to support for the IPPF Regional Office for North Africa and \$10 million to MCH activities over a 5 year period. The EC also contributes in the areas of vaccine production, control of drug abuse, and Safe Motherhood.*

*The World Bank has been the major lender in the health sector. The current Health Sector Investment Project is a \$104 million loan over the period 1989-95 primarily dedicated to infrastructure development with no direct assistance to population and child survival programs. In addition, two other loans are currently in negotiation. The first is approximately \$100 million devoted to upgrading hospital and health facilities and health insurance reform. The second loan is still in the early planning stages and will focus on social priorities such as health, education, and water and sanitation. USAID maintains a close relationship with World Bank partners, particularly concerning health care financing activities.*

*The African Development Bank is finalizing arrangements for a \$80 million, 5-year project focusing on the extension of health facilities, school health programs, and control of STDs/AIDs and acute respiratory infections.*

*In addition to the major donors/lenders mentioned above, the MOPH has established bilateral cooperation with many donor nations, including France, Germany, Canada and other Arab and African nations. Annex D to this document includes the complete list of health sector donors taken from the report on the National Health Colloquium held in July 1992. Discussions with other donors have been very positive as concerns joint programming to assure there is no duplication of effort, that activities are mutually supportive, and that each donor contributes in its areas of relative strength.*

### **III. IMPLEMENTATION PLAN**

#### **A. IMPLEMENTATION RESPONSIBILITIES AND ADMINISTRATIVE ARRANGEMENTS**

*The project includes a wide range of closely inter-related activities implemented through several public and private sector organizations at the national, regional and provincial levels. The Ministry of Public Health will continue to be the primary recipient of U.S. assistance under the project with the Directorate of Preventive Services and Health Training responsible for implementation through an institutional contractor. During project implementation of Phase IV, the MOPH has demonstrated a high level of sophistication, a technically strong staff, an established infrastructure and a proven track record of coordinating multiple partners in order to successfully translate U.S. assistance in the sector into viable field activities. The MOPH has also proven capabilities in the financial management of USAID assistance as demonstrated by the positive findings of the host country contracting assessment undertaken in 1992, the audit of the previous project, 608-0171 and multiple audits performed of cooperating agency agreements.*

*Past experience under Phase IV has demonstrated that using multiple buy-ins creates an unwieldy management structure for both USAID and the MOPH. Consequently, most technical assistance and support for local currency expenditures in Phase V will be provided through an institutional contractor and by the limited use of buy-ins to centrally-funded projects.*

*Managing the diverse components of this complex project will require careful organization. The various responsible entities will need to cooperate closely to ensure that the project components function smoothly and that the goal and objectives of the project are achieved. The following subsections define the roles and responsibilities of the various project actors.*

##### **1. Project Advisory and Coordination Committee**

*The Project Advisory and Coordination Committee will consist of the USAID staff and the MOPH representatives and other inter and extra ministerial bodies involved in*

*Specific responsibilities of the Committee include the following:*

- *development of policy guidelines for the project,*
- *determination of technical themes and fields for project emphasis and ensuring that private sector needs are adequately addressed,*
- *identifying priority training audiences and activities,*
- *recommending implementing entities and interventions,*
- *providing guidance for and review annual work plans,*
- *monitoring implementation performance and progress toward achieving project goals,*
- *recommending adjustments in the project following periodic reviews and evaluations,*
- *servicing as a point of coordination for the various actors of the project and serving as a forum where views are exchanged between the GOM, USAID and the private sector, and*
- *determining if progress being made toward the financial phase-over targets for local costs and contraceptive costs.*

## 2. Host Government Counterpart Management

*As in the current project, the MOPH, through the Directorate of Preventive Services and Health Training, will be the lead GOM agency responsible for implementing the project. Within DPES, the responsibilities will be as follows:*

*Project Director:* *The Director of the DPES will be the Project Director and will serve as the loci for policy direction and project coordination, planning, and implementation oversight. Specifically the project director will be responsible for the following:*

- *guidance and follow-through of policy agenda,*
- *oversight of project planning and implementation, including assuring that project activities support the overlaying themes of decentralization integration and long-term sustainability,*
- *coordination and linkages with other divisions within the DPES, other Directions within the MOPH, other Ministries within the GOM, provincial and regional staff and other project partners such as the private sector and relevant technical committees,*
- *oversight and coordination of project activities with the institutional contractor, and*
- *oversight of project impact evaluation.*

*Project Management Unit:* *To manage the daily functioning of project activities, a project management unit will be established with staff designated specially for project administration, programming, and ongoing evaluation. Although the unit will be under the supervision of the Division of Population, owing to the expanded technical aspects of this project, the functional aspects of this unit will now extend beyond the Division of Population and include strong implementation ties with the Divisions of Maternal/Child Health and Health Education. The Project Management Unit will operate under the technical direction of the Project Director/Director of DPES, and*

- and relevant technical committees,
- oversight and coordination of project activities with the institutional contractor, and
- oversight of project impact evaluation.

**Project Management Unit:** To manage the daily functioning of project activities, a project management unit will be established with staff designated specially for project administration, programming, and ongoing evaluation. Although the unit will be under the supervision of the Division of Population, owing to the expanded technical aspects of this project, the functional aspects of this unit will now extend beyond the Division of Population and include strong implementation ties with the Divisions of Maternal/Child Health and Health Education. The Project Management Unit will operate under the technical direction of the Project Director/Director of DPES, and under the direct supervision of the Chief of the Division of Population. The Project Management Unit will work closely as a unit with the Project Contract Team. The responsibilities of Unit include the following:

- oversight of daily management of project activities, including supervision of provincial and regional activities, coordinate project implementation with the institutional contractor,
- development of annual global work plans and annual project status reports,
- programming of project activities, handling all implementation arrangements,
- coordination and oversight for all implementation activities,
- development of procurement and financial documentation for local cost expenditures,
- monitoring the technical quality of the program,
- monitoring and evaluation of performance progress and project impact
- planning and managing all aspects of contraceptive logistics supply
- financial review and budget allocation of activities
- address problem solving related to implementation,
- maintenance of records and dates both for evaluation and project impact purposes and auditing requirements.

A conditions precedent to disbursement of project funds will be the formal establishment of this Project Management Unit. The MOPH will be required to provide to USAID a formal configuration of the unit, with supporting job descriptions. At least one person on the Project Management Unit must be specially designated to work with U.S. technical experts in the planning and execution of the contraceptive logistics management and contraceptive phase-over.

### 3. USAID/Morocco Management

Within USAID, the Office of Population and Human Resources will have primary responsibility for project management. These responsibilities include:

- monitoring project planning, implementation and evaluation,

- reviewing sector assessments,
- reviewing and approving for funding annual work plans,
- ensuring that A.I.D. policy and procedures are adhered to,
- managing the Institutional contractor, and
- coordinating with A.I.D./W on policy, funding and implementation issues.

*Current PHR staffing is one division chief, one population/health officer, one project-funded Technical Advisor for Aids and Child Survival (TAACS), one project-funded foreign service national (FSN) health financing specialist/private sector advisor, and two FSN direct hire professional staff. Staffing pattern for the project will resemble this arrangement. Project funds will provide support for the TAACS and a PSC/FSN Technical Advisor.*

*The USAID Controller's Office will provide budget and fiscal support, including the financial processing of PIO/T, PIO/C's, and PIO/P's, amendments and vouchers, and assist, where appropriate, with the pre-award reviews of various in-country entities involved with project activities. The Regional Contracting Officer will provide administrative and logistical support to the project, by soliciting, negotiating, awarding and monitoring all USAID direct contract actions. The Executive Office will provide administrative and logistical support to the PHR and the project as necessary.*

#### 4. U.S. Contractors

*U.S. Institutional Contractor: USAID will engage a U.S. institutional contractor to assist the MOPH to plan, execute and evaluate programmatic and operational aspects of the project. The contractor will contribute to the continued successful collaboration between the MOPH, private sector partners and USAID through effective management of project planning, implementation and evaluation. The contractor will provide technical, logistical and administrative support for project management and will serve as a conduit of funds from USAID to the MOPH and other relevant agencies for implementation of project activities.*

*This structure is similar to that currently used by FP/CS IV, except that there will be only one institutional contractor, as opposed to the multiple cooperating agencies currently involved. Following the selection and establishment of the institutional contractor, the process for financing project activities will be undertaken in the following manner. Detailed annual workplans will be developed in coordination with the MOPH staff after receiving guidance from the Project Committee. These workplans will contain details related to objectives to be achieved, means of implementation, and funding levels. All workplans will be approved by both the Project Director and USAID. Any required sub-contracting or procurement will be carried out by the institutional contractor following A.I.D. regulations. In addition, funds approved for local cost activities will be disbursed by the institutional contractor to the MOPH or sub-contractors. The contractor will have a financial monitoring structure in place to assure correct disbursement and payment for activities.*

*In order to facilitate implementation of activities the institutional contractor will provide a team of expatriate and local staff. The objective of this structure is not to supplant*

*pre-existing expertise within the host country, but rather to facilitate project implementation and technology transfer. Working hand-in-hand with the project management unit, the contractor will provide long-term expatriate technical assistance in the form of a technically qualified chief-of-party (5.5 person years), an IEC specialist (3.5 person years) and a management/quality specialist (3.5 person years). Intermittent technical assistance in the form of a clinical specialist (4 person months per year) and a private sector specialist (4 months per year during the initial three years of project implementation) will also be provided. Local hire contractor staff will include three professionals and two administrative staff (for budgeting purposes estimated at one FSN 12 level, two FSN 10 level professionals for 5.5 person years each and two administrative staff FSN 8 level for 5.5 person years each). In addition, the contractor may engage a financial analyst or an accounting firm to handle all financing aspects of implementation. In addition to the field staff there will be technical, administrative and financial support from the home office. The contractor will also organize 80 months of short-term technical assistance, including both US and Moroccan experts. Moreover, the contractor will recruit, field, supervise and provide logistical support to all short-term and local hire consultants and staff. Specific tasks of the contractor will include:*

- *establish a project management unit in Rabat with the assistance of the MOPH, including procurement of office space, furniture and equipment to support the expatriate and Moroccan professional and support staff,*
- *recruit, hire and train the appropriate national staff to execute the assigned project components,*
- *facilitate the coordination of A.I.D. assistance with Moroccan and donor activities,*
- *assist the MOPH and USAID to develop and update multi-year sector assistance,*
- *work with the MOPH, USAID and other partners to develop global annual workplans,*
- *assist the MOPH to review and monitor workplans implementation and sector data to confirm achievement of objectives,*
- *field and provide full support to long and short-term technical assistance advisors*
- *coordinate and assure completion of technical components of project activities including oversight of design, implementation and evaluation,*
- *provide oversight for all construction activities funded under Phase IV*
- *provide staff assistance to the Project Joint Advisory and Coordination Committee*
- *maintain data and records required for impact evaluation and audit requirements,*
- *comply with all A.I.D. policies procedures, regulations and reporting requirements, and*
- *assure appropriate auditing of all sub-contractors*

*The MOPH will provide suitable space at the Ministry for the institutional contract team.*

*Buy-ins and Centrally-Funded Contractors:* *Buy-ins to cooperating agencies will be*

limited to those agencies which have unique expertise, functions or are designed to address a specific need outside of the scope of the institutional contractor's capabilities. Presently these may include the Demographic and Health Surveys, the Evaluation Project, Social Marketing for Change and the Association for Voluntary Surgical Contraception, and the Technical Advisor for AIDS and Child Survival. It is anticipated that a private sector, centrally-funded project will assume the tasks for the private sector initiative. In some cases, centrally-funded projects or technical assistance may supplement on-going project activities. These activities will be agreed upon in advance by the appropriate office. All centrally-managed activities will be supported within the context of project objectives.

#### 5. Moroccan Partners

In order to assure technology transfer and long-term sustainability, the project will encourage and support work with a variety of Moroccan partners such as research companies, university groups, consulting firms, enterprises, non-governmental organizations and private voluntary organizations.

The U.S. institutional contractor may subcontract with local Moroccan institutions, professional organizations or private firms to execute specific in-country activities. For example, the contractor may engage the services of a university group to carry out clinical research or curriculum development. Another example would be the use of a consulting firm or research company to work with the MOPH in the production of media materials. These contracts are expected to average \$50,000-\$75,000, but in any case not to exceed \$250,000 without prior approval by USAID.

#### 6. Other U.S. Partners

In order to support linkages, technology transfer and institution building between the U.S. and Morocco in the health care field, partnerships will be encouraged and supported between U.S. and Moroccan professional entities. These will include linkages between professional associations, such as the American College of Nurse Midwives and the Moroccan Association of Midwives, and data sources such as the American Public Health Association Clearing House. In addition, the institutional contractor will subcontract with one or more U.S. university or research groups to collaborate with similar Moroccan institutions on selected activities, such as research or training. In general, within the Mission philosophy long-term linkages of all kind will be encouraged by the project.

### **B. IMPLEMENTATION PLANNING AND SCHEDULE**

For implementation to be successful, USAID and MOPH must carefully plan and coordinate their contributions, and project partners must follow planned schedules. The project has a strong conceptual framework which, for each year, an annual workplan will be developed. This workplan will be the basic management tool for project implementation and performance monitoring.

#### 1. Annual Workplan

USAID and the MOPH, with technical and administrative assistance provided by the PMU and institutional contractor, will prepare an annual workplan for all USAID-financed (bilateral, regional, or central) activities to be implemented by the various project partners. The annual workplan will serve as a reference point for bi-annual and annual progress reports and will permit monitoring of project performance.

The annual workplan will establish objectives by component and specify interventions for the project in the year ahead. It will detail activities and benchmarks to accomplish precise objectives. The annual workplan will determine the manpower required for implementation of activities and designate the responsible parties. The workplan will include an annual training plan with estimate numbers of trainees by type and category of training, location of training (in-country or overseas), training program and potential institutions, and proposed timing for training. In addition, the workplan will include an annual procurement plan with estimate of procurement actions including items to be procured, potential source/origin, recommended procurement mechanisms, and proposed timing and estimated delivery. The annual workplan will budget requirements with a pipeline analysis of costs to be incurred and projections for the life-of-project. Each activity will estimate USAID as well as host country contributions.

With overall program guidance provided by the Project Advisory and Coordination Committee, the institutional contractor will be responsible for the production of the workplan, carefully coordinating input of USAID and the various MOPH entities. The workplan will be prepared on a calendar year basis. The Project Management Unit will review final plan for consistency with GOM policies, and will submit it to the Director of DPES for approval and forward it to USAID for funding approval. At the end of each calendar year the contractor, with MOPH, will submit an Annual Progress Report summarizing the year's activities and accomplishments using the workplan as the starting point. The annual workplan may be modified with the written agreement of USAID and the MOPH.

## 2. Implementation Schedule

Initial funds for the project, will be obligated in July, 1993, the project will continue until December 31, 1999. Project implementation will fall into three distinct phases: Transition, Full Implementation, and Phase-over.

Phase I: Transition, Present to December 1994: During this period, the uncommitted balance of phase IV will be used for planned Phase IV activities which are in process and to continue on-going activities until the implementation mechanisms of Phase V are in place. The MOPH with its partners will implement project activities increasing access, quality and IEC of FP/MCH services and promoting program sustainability. A number of Mission and centrally-funded agencies--including the Association for Voluntary Surgical Contraception, the Futures Group Social Marketing for Change, and Options Project, Carolina/Tulane Evaluation Project, Johns Hopkins Program for International Education in Gynecology and Obstetrics and the Population Communications Education, and the Center for Disease Control--will continue to provide specialized technical and financial assistance to various aspects of the program.

USAID, in coordination with the MOPH, will prepare the solicitation documents for the institutional contractor. It is expected that the contract will be awarded no later than summer 1994. Based on experience it will probably take the contractor 2-4 months to field staff and to organize a functioning office in Morocco.

Phase I for the private sector development will begin with a buy-in to appropriate centrally-funded projects in order to field experts and to initiated pilot work immediately. This contractor will assist with the analytical work, will launch several experimental activities for the private sector, and will assist with the planning for an expanded initiative. For procurement of goods and service, USAID, as appropriate, will buy-in to an existing contract, use the institutional contractor or issue a PIO/C for procurement through AID/W.

Milestone activities of the Transition Phase are as follows:

### 1993

- 6/93 USAID authorizes Project
- 7/93 GOM/USAID sign Project Grant Agreement
- 9/93 MOPH meets conditions precedent for first disbursement
- 9/93 USAID buy-in to appropriate private sector project(s)
- 9/93 Centrally-funded projects start planning for transfer of local activities to institutional contractor
- 10/93 USAID releases request for proposal (RFP) for institutional contractor
- 11/93 USAID/MOPH conducts evaluation review to combine recent assessments and evaluations
- 11/93 USAID/MOPH prepares workplan for combined Phase IV and Phase V projects.

### 1994

- 1/94 Advisory Committee reviews Workplan
- 1/94 High level GOM/USAID officials meet to review progress for phase over
- 1/94 GOM meets condition precedent for annual disbursement of local costs
- 3/94 USAID/MOPH select institutional contractor
- 5/94 USAID signs institutional contract.
- 6/94 SEATS closes out Morocco Office
- 6/94 Institutional Contractor assume project implementation responsibilities
- 10/94 Contractor with USAID/MOPH prepares draft workplan for combined Phase IV and Phase V projects.

Phase II: Full Implementation, January 1995 - December 1999: The MOPH with its partners will continue project activities increasing access, quality and IEC of FP/MCH services and promoting program sustainability. Soon after the arrival of the contractor, USAID and MOPH will transfer to the contractor, technical assistance and financial support for planning, management, and execution of specified project activities. During this period the institutional contractor will initiate planning activities including the development of the workplan, establishing operating procedures, planning and supporting Component One/Two project activities, and establishing relationships. Gradually, the institutional contractor will assume full responsibility of activities which previously had been conducted by centrally/mission funded cooperating agencies.

*USAID will initiate the documentation process for the private sector initiative.*

*In 1996, the Phase IV project will be completed and all residual activities transferred to Phase V. In Spring of 1997 the DHS will be conducted and the Initial Analysis and Impact Evaluation will be conducted later in the year.*

*Milestone activities of the Full Implementation Phase are as follows:*

**1995**

- 1/95 Contractor fully installed and operational*
- 1/95 USAID/MOPH complete PID for Private Sector Development*
- 1/95 Advisory Committee reviews Workplan*
- 1/95 High level GOM/USAID officials meet to review progress for phase over*
- 1/95 GOM meets condition precedent for annual disbursement of local costs*
- 2/95 Contractor submits 1994 Annual Progress Report*
- 6/95 Internal Management Review*
- 11/95 Contractor with USAID/MOPH prepares workplan for combined Phase IV and Phase V projects.*
- 10/95 USAID authorizes Project for Private Sector Initiative*

**1996**

- 1/96 Advisory Committee reviews Workplan*
- 1/96 High level GOM/USAID officials meet to review progress for phase over*
- 1/96 GOM meets condition precedent for annual disbursement of local costs*
- 2/96 Contractor submits 1995 Annual Progress Report*
- 9/96 Phase IV reaches PACD*
- 11/96 Contractor with USAID/MOPH prepares Phase V workplan*
- 12/96 Final Evaluation conducted for Phase IV activities*

**1997**

- 1/97 Advisory Committee reviews Workplan*
- 1/97 High level GOM/USAID officials meet to review progress for phase over*
- 1/97 GOM meets condition precedent for annual disbursement of local costs*
- 2/97 Field Work for DHS completed*
- 9/97 DHS and Initial Impact Analysis*
- 11/97 Contractor with USAID/MOPH prepares workplan Phase V project.*

**1998**

- 1/98 Advisory Committee reviews Workplan*
- 1/98 High level GOM/USAID officials meet to review progress for phase over*
- 1/98 GOM meets condition precedent for annual disbursement of local costs*
- 2/98 Contractor submits 1997 Annual Progress Report*
- 11/98 USAID/MOPH prepares workplan Phase V project*
- 12/98 Contractor submits Annual Progress Report*

*Phase III: Final Phase-Over, January 1999 - December 1999:* *During this phase, all implementation responsibilities will be transferred over to the MOPH and/or the private sector as appropriate. Chief-of-party leaves and all in-country activities are assumed*

by appropriate public and private sector parties. Final impact and final evaluation are conducted.

## C. PROCUREMENT PLAN

### 1. Procurement Responsibilities

The project will finance significant procurement of goods and services. The Regional Contracting Officer or the USAID/Morocco Executive Officer, as appropriate, will handle all direct procurement for goods and services in accordance with A.I.D. procurement policies and regulations. Some large procurements such as for equipment, vehicles, or materials may be procured through the AID/W Office of Procurement. The major procurement will be for an institutional contractor to provide long-term and short-term technical assistance, to assist the MOPH or other related institutions in the planning and implementation of a variety of project activities, to provide administrative and logistical support for project activities, to provide the mechanism for the disbursement of funds for local activities, and to procure commodities and equipment for the project. The institutional contractor will be able to subcontract for activities to be conducted under project auspices. The contractor can make direct grants for tuition support, equipment, seed money for conferences, etc. as part of institutional strengthening for the MOPH or other public sector institution. USAID will also be directly responsible for some smaller direct procurement of services or goods for project management, evaluation, or audits.

For short-term participant training, USAID will utilize the established Office of International Training (OIT) contractors, and will commit funds through the PIO/P mechanism. Similarly USAID will utilize the established R&D/ Office of Population Contract # 936-3057 for consolidated contraceptive procurement. As necessary, USAID will "buy in" to specialized centrally-funded contracts or cooperative agreements (Demographic and Health Survey, the Evaluation Project, etc) to obtain special expertise or services available from a group of proven capability and unique expertise.

### 2. Source/Origin

Commodities and services financed under the project are expected to be procured from suppliers in the cooperating country or in the U.S. Approximately, \$32.0 million worth of goods and services will have their source and origin in A.I.D. Geographic Code 000 within the spirit of "Buy-America." Approximately, \$20.0 million of project funds will be used for local cost activities for technical assistance, training, commodities, local research, and project management. Any local procurement over \$250,000 will require a waiver. As fully discussed in Section IV., the GOM will progressively assume a greater portion of recurrent local costs.

### 3. Gray Amendment Requirements

It has been a longstanding policy of USAID/Morocco to make use of the skills and services offered by Gray Amendment firms in all of its projects. This project will require that a minimum of 10% of funds for the U.S. institutional contractor be

allocated to qualifying Gray Amendment firms. In addition, efforts will be made to utilize historically black colleges and universities in research and training activities to the maximum extent possible.

#### 4. Procurement Arrangement for Goods and Services

The following summarizes technical services and commodity procurement expected and methods of implementation and financing to be conducted under the project during the FY 1994 - 1999 period.

##### *Procurement of Technical Services:*

- *U.S. Technical Services and Goods for Project Management and Activity Implementation*

- a. *Type of Contract: USAID direct institutional contract for goods and services.*
- b. *Brief Description of Goods and Services: Provide technical, administrative and program support for the full range of project activities; provision of long and short-term technical assistance; direct support for implementation of specified local studies, training and materials development; purchase of specific goods and materials for project activities; and development of linkages with U.S. based academic, training, research and professional organizations.*
- c. *Estimated Contract Dates: March 1, 1994 - February 28, 1999. (five-year contract) with possibility of extension through December 31, 1999 PACD.*
- d. *Estimated Cost: \$23.6 million (excluding equipment)*
- e. *Potential for Minority Involvement: RFP will include language that requires the participation and involvement of a minority contractor, or minority participation as part of the contractor consortium. Contract will only be awarded to a contractor/consortium that meets minority participation requirements. At least 10% of the contract must be allocated to qualifying Gray Amendment firms.*
- f. *Need for Waiver: U.S. source and origin is anticipated for the prime contractor. It is expected that all goods and services provided by the contractor will be of U.S. or cooperating country source/origin, unless unavailable from these source/origins. It is the contractor's responsibility to prepare documentation for any waivers and to obtain any waivers from USAID. Also contractor is required to follow all A.I.D procurement regulations for non-American or cooperating country goods and services. Contractor will be discouraged from using any non-American/cooperating country goods and services.*
- g. *Contracting Office: Regional Contracting Office*
- h. *A.I.D. Method of Financing: Direct Reimbursement*

- i. *Audit/Evaluation Analysis: As contractor home office will be U.S. based, AID/W will have cognizant audit responsibilities and AID/W audit procedures will be followed. USAID will closely monitor contractor performance on a routine basis through site-visits, activity assessments, project Implementation reviews and annual performance reviews based on workplan reviews and performance reports. Also USAID will include contractor performance as a major item for scheduled internal management reviews and performance evaluations. USAID may perform a financial review and assessment of the contractor's procedures and local cost expenditures.*
- *U.S. Specialized Technical Services:*
    - a. *Type of Contract: USAID will buy-in to existing AID/W centrally funded cooperative agreements or contracts for specialized services. 6-8 major technical assistance and program buy-ins and some minor targeted technical assistance buy-ins are anticipated over the life-of-project.*
    - b. *Brief Description of Services: Specialized technical services and expertise available through existing RD/Health and RD/Population cooperative agreements contracts, in such areas as demographic and health surveys, evaluation expertise, policy development, private sector development. Buy-ins will made according to availability of centrally funded contracts and subject to their contract dates. Illustrative list of buy-ins include the following projects:*
      - *Demographic and Health Survey III*
      - *Evaluation of Family Planning Program Impact*
      - *Private Sector Initiatives*
      - *Population Technical Assistance.*
      - *Technical Advisors for AIDS and Child Survival*
      - *Social Marketing for Change*
      - *Association for Voluntary Surgical Contraception**The specific needs for buy-ins will be determined at the time of planning for the annual workplan.*
    - c. *Estimated Dates: Buy-in or task orders issued as incremental funding to centrally funded contracts to cover activities over period from October 1, 1993 - December 31, 1999.*
    - d. *Estimated Cost of All Contracts: \$ 4.2 million*
    - e. *Potential for Minority Involvement: Preference will be given to centrally-funded contractors with minority participation.*
    - f. *Need for Waiver: U.S. and/or cooperating country source/origin are anticipated. Contractors will be responsible for preparing documentation and obtaining any necessary waivers for any subcontracts or purchases of goods and supplies. Contractor will be expected to follow all A.I.D. competition and procurement regulations.*

- g. *Contracting Office: AID/W Office of Procurement*
  - h. *A.I.D. Method of Financing: Direct Payment*
  - i. *Audit/Evaluation Analysis: As contractor will be U.S. based, AID/W will have cognizant audit responsibilities and AID/W audit procedures will be followed. On large buy-in with significant local cost expenditure, USAID may conduct a financial review.*
- *U.S. Technical Services for Training Placement, Implementation and Monitoring:*
    - a. *Type of Contract: Utilization of the established AID/W Office of International Training (OIT) contracts for participant placement and monitoring*
    - b. *Brief Description of Goods and Services: Placement and monitoring services for all participant training in the United States*
    - c. *Estimated Dates of Contract: PIO/P funding to central contract for training over period from October 1, 1993 - December 31, 1999.*
    - d. *Estimated Cost of Contract: \$ 0.24 million, to be committed through PIO/Ps mechanism.*
    - e. *Potential for Minority Involvement: To the degree practical, historically black colleges and universities and Gray Amendment entities will be selected for the placement of USAID participants.*
    - f. *Need for Waiver: It is anticipated that the vast majority of the participant training will be in the United States. If third country training is necessary, a waiver will be sought according to HB 10 regulations.*
    - g. *Contracting Office: Office of International Training and AID Office of Procurement*
    - h. *A.I.D. Method of Financing: Direct Payment, through credit transfer system.*
    - i. *Audit/Evaluation Analysis: As contractor will be U.S. based, AID/W will have cognizant audit responsibilities and AID/W audit procedures will be followed. Project officers will monitor on-going activities and end results of training. Contractor performance will be included as a key element of the overall performance evaluation.*
  - *Local Technical Services for Program Management:*
    - a. *Type of Contract: A.I.D. Personal Services Contract (PSC)*
    - b. *Brief Description of Services: Technical services of local hire technical advisor to assist with the development, management and evaluation of specified project*

activities.

- c. *Estimated Dates: Starting in FY 94 and ending in September 1999. Two year contracts with possibility of extension.*
- d. *Estimated Cost: \$0.27 million*
- e. *Potential for Minority Involvement: Local contract, not applicable*
- f. *Need for Waiver: Moroccan source and origin is anticipated.*
- g. *Contracting Office: Regional Contracting Officer*
- h. *AID Method of Financing: Direct Payment*
- i. *Audit/Evaluation Analysis: Specialized procurement with A.I.D. as paying office. Employee will be subject to regular performance evaluation as prescribed for FSN employees.*

*Procurement of Commodities:*

*Commodities procurement will fall into five major categories: vehicles (\$5.0 million), clinic equipment and supplies (\$3.5 million) and clinic and office materials and furniture (\$1.2 million), automation equipment (\$0.75 million), IEC/Training audio visual equipment and materials (\$0.75 million), and contraceptive commodities (\$8.0 million). Refinement in this list may result in minor shifts or substitutions from one commodity to another but the estimated \$ 20.0 million programmed (including commodity, freight, fee) for commodity procurement will remain relatively unchanged. Precise details and specifications, for local procurement will be developed by the MOPH, USAID and the contractor during the implementation of the project.*

- *U.S. Purchase of Vehicles:*

- a. *Type of Contract: Subcontract through institutional contractor or A.I.D. contract with Automotive Company*
- b. *Brief Description of Goods: Approximately 200 vehicles with spare parts including: all terrain utility vehicles or crew-cab type trucks for rural outreach; vehicles for program management, training, and supervision at the regional and central levels; specially equipped IEC mobile units for regional IEC teams; and two semi-type delivery trucks for contraceptive transport. Prior to procurement a complete assessment of need for vehicles will be conducted, including use and maintenance of current vehicles, maintenance records and problems, maintenance capabilities and resources available for fuel purchase. The MOPH, with assistance from contractor, will provide a detailed justification and specifications for vehicles will be provided.*
- c. *Estimated Delivery Dates: Order date beginning o/a June 1, 1994, with delivery*

*starting as soon thereafter.*

- d. *Estimated Cost: \$ 5.0 million*
  - e. *Potential for Minority Involvement: Not applicable*
  - f. *Need for Waiver: U.S. source and origin is planned*
  - g. *Contracting Office: Regional Contracting Officer if through the Institutional Contract, A.I.D. Office of Procurement if Direct Procurement.*
  - h. *A.I.D. Method of Financing: Direct Payment*
  - i. *Audit/Evaluation Analysis: The MOPH will be required to submit of list of distribution points and will be required to maintain an inventory of location and status of vehicles. USAID, with the assistance of the contractor, will verify receipt and monitor end-use status by periodical and random site visits and regular reporting. Vehicle performance will be tracked and reported to USAID by the MOPH with assistance of the contractor. Appropriate use of vehicles will be reviewed at time of management reviews and audits.*
- *U.S. Purchase of Clinic and Office Equipment and Supplies:*
    - a. *Type of Contract: Subcontract through institutional contractor or A.I.D. direct contract with vendor*
    - b. *Brief Description of Goods: Basic equipment kits and expendable supplies for fixed facility and outreach family planning, CDD, safe motherhood or other child survival programs in identified provinces; medical and clinical equipment to upgrade or equipment for new public and private sector voluntary surgical contraception, family planning and maternity services. In addition, furniture and materials for selected service sites and offices involved in project activities will be provided.*
    - c. *Estimated Delivery Dates: Order dates beginning June 1, 1994 with delivery date commencing accordingly*
    - d. *Estimated Cost: \$ 4.75 million: \$3.5 million for clinic equipment and supplies, and \$1.25 million for clinic and office equipment and furniture. Prior to procurement, a complete assessment of need for clinical equipment will be conducted, including use and maintenance of current equipment, maintenance records and problems, maintenance capabilities. The MOPH, with assistance from the institutional contractor, will provide a detailed justification and specifications for clinical equipment and supplies to be provided.*
    - e. *Potential for Minority Involvement: Priority will be given to minority vendors.*
    - f. *Need for Waiver: U.S. source and origin is anticipated for equipment, some*

host country source origin is anticipated for some furniture and supplies available locally.

- g. *Contracting Office: Regional Contracting Officer If through institutional contractor or AID/W Office of Procurement depending on final contract mechanism*
  - h. *A.I.D. Method of Financing: Direct Payment*
  - i. *Audit/Evaluation Analysis: The MOPH will be required to submit a list of distribution points and will be required to maintain an inventory of location and status of non-expendable clinic and office equipment. USAID, with the assistance of the contractor, will verify receipt and monitor end-use status by periodic random site visits and regular reporting. Appropriate use of equipment will be reviewed at time of management reviews and audits.*
- *U.S. Purchase of Automation Equipment and Supplies:*
    - a. *Type of Contract: Subcontract through institutional contractor or A.I.D. direct contract with vendor*
    - b. *Brief Description of Goods: Approximately 200 computers, and appropriate software, accessories and furniture for provinces, regional and central level; and necessary servers and back-up equipment to establish link to central level and regions/provinces, at an estimated 10 units.*
    - c. *Estimated Delivery Dates: Beginning June 1, 1994 - September 30, 1999.*
    - d. *Estimated Cost: \$ 0.75 million*
    - e. *Potential for Minority Involvement: Priority will be given to minority vendors.*
    - f. *Need for Waiver: U.S. source and origin is anticipated for automation equipment and supplies.*
    - g. *Contracting Office: Regional Contracting Officer if through the institutional contractor, AID/W Office of Procurement if direct contract with vendor.*
    - h. *A.I.D. Method of Financing: Direct Payment*
    - i. *Audit/Evaluation Analysis: The MOPH will be required to submit a list of distribution points and will be required to maintain an inventory of location and status of computer equipment. A.I.D., with the assistance of the contractor, will verify receipt and monitor end-use status by periodical and random site visits and regular reporting. Appropriate use of equipment will be reviewed at time of management reviews and audits. Prior to procurement, a complete assessment of need will be conducted, including location, use and maintenance of current automation equipment, maintenance records and*

problems, maintenance capabilities. The MOPH will provide a detailed justification and specifications, based on nationally applied standards, for automation equipment and supplies to be provided. A.I.D. will request IRM technical review of proposed equipment prior to initiating purchases.

- U.S. Purchase of Audio-visual Equipment and Supplies:

- a. *Type of Contract: Subcontract through institutional contractor or A.I.D. direct contract with vendor*
- b. *Brief Description of Goods: Audio visual equipment for including television sets, video players, slide projectors, bull horns, movie projectors, recorders, overhead projectors for identified IEC regional and provincial sites and for regional training centers; high-tech audio visual equipment for the central level studios for filming, materials development, reproduction. Prior to procurement, a complete assessment of need of audio-visual equipment will be conducted, including location, use and maintenance of current audio-visual equipment, maintenance records and problems, maintenance capabilities. The MOPH, with assistance from the contractor, will provide a detailed justification and specifications for required audio-visual equipment and supplies.*
- c. *Estimated Delivery Dates: Orders beginning in June 1994 with delivery to follow accordingly*
- d. *Estimated Cost: \$ 0.75 million*
- e. *Potential for Minority Involvement: Priority will be given to minority vendors.*
- f. *Need for Waiver: U.S. source and origin is anticipated for most equipment. Some audio-visual equipment may require a waiver, which will be obtained prior to purchase.*
- g. *Contracting Office: Regional Contracting Officer if through the institutional contractor, AID/W Office of Procurement if direct contract with vendor.*
- h. *A.I.D. Method of Financing: Direct Payment*
- i. *Audit/Evaluation Analysis: The MOPH will be required to submit a list of distribution points and will be required to maintain an inventory of location and status of audio visual equipment. USAID, with the assistance of the contractor, will verify receipt and monitor end-use status by periodical and random site visits and regular reporting. Appropriate use of equipment will be reviewed at time of management reviews and audits.*

- U.S. Procurement of Contraceptive Commodities:

- a. *Type of Contract: USAID operating year budget (OYB) transfer for incrementally funding RD/POP's central procurement contract for contraceptives.*

- b. *Brief Description of Goods: Contraceptive supplies, materials and equipment. (Given that some contraceptive supplies (eg. Depro-provera) will require syringes a special effort will be made to assure that all GOM procedures for their safe disposal will be followed).*
- c. *Estimated Delivery Dates: Continuous, throughout life of project. Last order date will be 1998.*
- d. *Estimated Cost: \$8.2 million*
- e. *Potential for Minority Involvement: Not applicable*
- f. *Need for Waiver: U.S. source/origin is anticipated.*
- g. *Contracting Office: AID/W Office of Procurement*
- h. *A.I.D. Method of Financing: Direct Payment*
- i. *Audit/Evaluation Analysis: As contractor will be U.S. based, AID/W will have cognizant audit responsibilities and AID/W audit procedures will be followed. USAID will utilize the AID/W logistic management contract to periodically assess the commodity logistic system and to provide technical assistance, if necessary for corrective action. The institutional contractor and MOPH will maintain commodity distribution reports and will maintain an inventory record of contraceptive distribution. Through site visits, USAID will monitor procurement, storage and distribution and re-ordering of contraceptive supplies. The contraceptive logistics management systems will be thoroughly reviewed during the internal management reviews and during performance evaluation.*

*In addition to the above official contract procurement, a small number of items such as expendable supplies, basic equipment, special services (courier services, translations, printing/xeroxing, small purchases, etc.) will be purchased for program support. These items will be procured by purchase order or other approved procurement mechanism as established by the USAID Executive Officer or Regional Contracting Officer. These items will not exceed \$250,000 over the life-of-project. In addition, the contingency of \$2.84 million will be used for the procurement of goods and services not yet specified as needed. These procurement will be made in accordance with A.I.D. procurement policies and regulations.*

#### **IV. COST ESTIMATES AND FINANCIAL PLAN**

*The Family Planning and Maternal Child Health V project will be implemented over a period of six and a half years. It will be jointly funded by A.I.D. and the Government of Morocco. A.I.D.'s contribution will be \$52.0 million with the host country contribution amounting to approximately \$108.4 million. The GOM contribution is the sum of the projected Phase IV contribution (\$15.0 million and the Phase V contribution (\$93.4 million). The total life of project funding will be \$160.4 million.*

## A. HOST COUNTRY CONTRIBUTION

*Table IV.1 summarizes the project budget by major inputs and details the host country contribution. The GOM will contribute approximately 68% of the total cost of implementing the project. The GOM contribution will take the form of support for staff salaries and allowances, purchases of contraceptives, other commodities, supplies and equipment, and payment of travel and training-associated costs. Furthermore, the GOM will provide support to technical assistance and contractors and other personnel, such as office space, clerical help and transport.*

*The project budget is structured to reflect a phased reduction in USAID subsidies for local and recurrent costs. During the Phase III and the initial four years of Phase IV implementation, USAID has gradually phased-out financing for indemnity for field personnel and gas coupons, and the GOM has assumed responsibility for these costs. During Phase V, USAID will gradually reduce financing for local costs associated with staff training and supervision, special studies and research, IEC and MIS support and expendable supplies, with the GOM assuming responsibility for these costs.*

*During Phase V, USAID will also phase-down financing support for dollar purchases of contraceptive commodities, with the GOM financing approximately 75% of dollar contraceptive purchases by the PACD. Table IV.2 provides a breakout of USAID-financed local costs for the years 1994-1999 (note that this table includes local cost support for construction and mobility to be financed under phase IV 1994-1996). Table IV.3 describes the planned phased transfer of responsibility for local costs and contraceptive commodities envisioned under Phase V. Table IV.3b predicts the GOM contribution for local costs and commodities over the LOP. Table IV.3c breaks out the total GOM LOP contribution attributable to the phase IV (608-0198) and Phase V (608-0223) projects.*

*The Project Financial Analysis, Annex H, contains a detailed description of contraceptive commodity requirements, and associated costs, through FY 99. The figures in Table IV.3 assume that USAID will progressively decrease its share of the budget required to purchase contraceptives, and that the GOM will gradually increase its contribution. These figures also assume that the GOM will be able to purchase contraceptives at the same price A.I.D. pays for products purchased through a consolidated central contract. Annex H also contains current price estimates for contraceptives, including current A.I.D. prices. Finally, the contraceptive commodity projections were calculated to include 5% annual inflation and increased contraceptive prevalence. A.I.D.-financed contraceptives are purchased and called forward with a 1.5 - 2 year lead time. A final call forward in FY 1998 will provide A.I.D.-financed contraceptives up to the 1st quarter FY 2000 PACD.*

## B. A.I.D. CONTRIBUTION

*The projected rate of expenditures of A.I.D. funds under this project has been carefully analyzed and compared with the proposed obligation schedule. Table IV.4 lays out both the expected expenditures and obligations of USAID funds. The initial obligation*

for the project will be made in the fourth quarter of FY 93. The initial obligation for the amended project will allow USAID to plan and fund start up activities as soon as the Conditions Precedent are met. Funding remaining under the Phase IV project will be reprogrammed to support the initial design and implementation of key interventions, including development and implementation of a policy agenda, broad-based program evaluation and the private sector component. The Phase V obligation schedule has been structured to limit excessive pipelines. No obligations are anticipated during the final two years of implementation.

USAID will contribute \$52.0 million to this activity. This comprises approximately 32% of the total cost of the project. The majority of USAID assistance will finance technical assistance, commodities and local costs. Table IV.5 describes the allocation of dollar-financed project costs by category, employing the standard A.I.D. expenditure categories of technical assistance, commodities, training, local costs, evaluation and contingency. An additional category, project management, has been included to reflect USAID and institutional contractor management-related costs.

Technical Assistance (\$6,982,500) includes the cost of long- and short-term technical assistance provided by the institutional contractor, 50% of the total cost of planned buy-ins, and 50% of the funding budgeted for establishing linkages with U.S.-based academic, professional or research organizations. The institutional contractor will provide approximately 186 person-months of long-term and long-term intermittent technical assistance, and an additional 80 months of short-term technical assistance. Approximately another 80 months of short-term technical assistance will be provided through buy-ins to centrally-managed projects offering unique, specialized technical services. An additional 16 months of short-term technical assistance will be provided through institutional linkages with professional, academic or research organizations.

Training (\$940,000) has been budgeted to support U.S.-based short-term training, invitational travel and specialized study tours. The project will finance approximately 32 U.S.-based, short-term specialized training programs supporting project objectives, for Moroccan counterparts. For this training the MOPH will provide the cost of the airfare to the training site. \$640,000 has been reserved for conferences, study tours, and invitational travel. Approximately \$10,000 per year has been budgeted to support the costs of English-language training for counterparts. In-country training programs represent another large budget component, but represent local currency expenditures and are, therefore, included in the local cost budget category.

Commodities (\$19,439,000) represent the single largest project cost category. Included in this total are contraceptives (\$8,189,000), vehicles (\$5,000,000), automation equipment (\$750,000), clinical supplies and equipment (\$3,500,000), furnishings and materials (\$1,250,000) and audio visual equipment and supplies (\$750,000).

The project will finance procurement of vehicles with spare parts to increase fieldworker mobility, improve supervision, and facilitate decentralized delivery of services and IEC. Although specifications for vehicles have not yet been finalized, the MOPH and USAID agree that vehicle purchases will fall into three categories: utility

vehicles or crew cab-type trucks with covered bed, to transport health and supervisory workers, and equipment (estimated at \$16,000 - \$20,000 per vehicle); large, specially equipped trucks that will operate regionally in support of IEC activities (estimated at \$50,000 per vehicle); and two semi-type delivery vehicles for contraceptive transport. Although the total numbers and mix of vehicles has not yet been determined, the total funding budgeted would purchase approximately 200 utility vehicles plus 10 specially-equipped IEC vehicles and 10 specially-equipped mobile clinic units.

Automation equipment purchases will include micro-computers, communications hardware, and a range of specialized software. Automation equipment purchases will support the project evaluation component (\$50,000 for approximately 10 specially-equipped stations), MOPH counterpart managers (\$70,000 for approximately 20 stations) and the national management information system (\$630,000 for approximately 180 stations, 3 per province). Audio-visual equipment, including video cassette recorders and monitors, projectors, overheads and specialized production equipment purchases are budgeted at \$750,000.

Clinical supplies and equipment purchases will be financed to equip both public and private sector service providers. For budgeting purposes, the cost of a clinical and supplies includes basic equipment and expendable supplies for family planning, safe motherhood and CDD and other child survival programs; and equipment package for new VSC. family planning, and maternity services for service sites. An additional \$6,250 per provider or service delivery point has been budgeted for furnishings and materials (examining tables, special supplies, syringes, etc.) and office equipment and supplies for the project.

These estimates will be elaborated and refined in consultation with clinical services, IEC, training and automation specialists prior to the purchase of commodities. A needs assessment will be conducted for each major purchase, and detailed specifications developed.

Local Costs (\$14,677,500) include funds programmed in support of Morocco-based activities -- training, IEC, research, training, supervision, MIS and private sector support -- as well as 50% of the funding designated for buy-ins and linkages with academic, professional and research organizations. \$1,500,000 has been budgeted for special studies and research based on an average of \$10,000 each for 75 applied operations research or other diagnostic studies, and 20 specialized studies averaging \$37,500 each. In country training costs are estimated at \$40 per trainee per day. The \$3,000,000 budgeted for in-country training will support approximately 75,000 trainee days. Under phases III and IV, USAID financed approximately 42,000 trainee days over a six year period. Local cost support for training under phase V has been increased to reflect an increased emphasis on training.

Local cost support for IEC will include financing for materials production, development and dissemination/airing of radio and television spots and print materials conveying key family planning and maternal child health messages, and support for training materials development and training of trainers and supervision of IEC field workers; and development, production and dissemination of educational materials to assist

providers in patient education and counselling. Past experience with materials and message development indicates that developing, packaging and delivering health messages requires significant initial investment. Approximately \$1.5 million of the IEC budget will be reserved for designing, testing and producing key messages for family planning, safe motherhood and CDD and other child survival interventions. Once these messages have been developed, an additional \$2.5 million will finance the production of materials and training for IEC and other information agents in their use, including the production of a stock of materials for future use. Another \$1.0 million will support the development of provincial or regional health education units over the course of the project.

Service delivery support, budgeted at \$1.0 million over the life-of-project, will finance the development and production of supervision and clinical protocols (\$500,000) the training of staff in their application (\$400,000 assuming 5 training days for each of 2000 field staff), and direct, limited support for supervision (\$100,000).

Private sector support, budgeted at \$500,000 per year for the initial three years of the project, will finance the development of materials and information directed to private sector providers, the production of these materials, and training programs and seminars for private sector providers, cost-related to the experiments of social marketing,

Project Management (\$6,483,000) includes the range of project management-related costs. These are AID management personnel (TAACS and PSC technical advisors/project managers), funds included in the institutional contract for local personnel and office rental and operational expenses, overhead to the institutional contractor for processing trainees and travelers, managing the linkage sub-contract, and managing the local cost budget, as well as the fees associated with dollar commodity purchases.

Evaluation/Contingency (\$3,178,000) is the sum of funds budgeted for periodic evaluations and audits (\$640,000) plus a combined contingency/inflation line of \$2,838,000, or approximately 7% of total project funding.

Table IV.6 shows the projected rate of expenditures of USAID funds over the life-of-project. Peak expenditures will be reached in years two, three and four of the project, corresponding to the period of highest activity for the technical assistance contract and commodity purchases, and complete of Phase IV activities. Expenditures in years 1998 and 1999 will be less as the project will be in a phase-down mode.

A detailed project budget by fiscal year and input is shown in Table IV.7. All items with asterisks will be financed under the institutional contract. The institutional contractor will be responsible for managing and supervising Morocco-based activities, facilitating Moroccan participation in U.S.-based conferences and seminars, and organizing study tours for Moroccan colleagues. Finally, the technical assistance contractor will directly manage a linkage sub-contract with a U.S. academic or research institution. Table IV.8 provides an illustrative budget for the proposed technical assistance contract. The proposed technical assistance contract is budgeted at approximately

*\$23.6 million. This includes the cost of maintaining a team leader and other technical assistance staff in Morocco, contractor home office support, financing for Morocco-based activities (the institutional contractor will serve as a pass-through for local cost support), and support for U.S.-Moroccan linkages.*

*The remaining items will be managed directly by USAID, including U.S.-based short-term training. The project will fund professional staff members based at USAID and responsible for various aspects of project management. One of these, a Technical Advisor in AIDS and Child Survival will be responsible for managing clinical and services-related project components, and will advise USAID on AIDS and other child survival interventions. The salary and benefits for this position have been estimated based on current AID/W guidelines. In addition, the project will fund an FSN contract position, for technical and programmatic monitoring. This position will be graded at the appropriate level under the applicable local personnel classification standards, and the salary will be budgeted in conformance with current FSN pay scale. Based on funding and ceiling levels, additional TAACS or PSCs to assist mission management may be considered.*

*USAID will be responsible for contracting directly for audits and evaluations. Three evaluations are planned: an in-house evaluation in 1995, and two external evaluations in 1997 and 1999. Funding for the in-house evaluation is intended to cover in-country travel, report production costs and other associated costs of the study. The external evaluations will be conducted under short-term contracts which will be funded for approximately one month. Audits/financial reviews are planned for 1995 and 1999 and will be used primarily to review contractor performance and primarily local cost expenditures for the institutional contractor.*

*USAID will also execute buy-ins to centrally managed projects implemented by Cooperating Agencies under the auspices of RD/POP and RD/H. Buy-ins to date under the Phase IV project have totalled approximately \$8 million, and under the Phase V project will total approximately \$3.2 million. This reduction reflects the transfer of many implementation management responsibilities to the institutional contractor, as described in Section III, Implementation Plan.*

### **C. COST FACTORS**

*All costs used to develop the project financial plan are based on Mission experience with current projects and local conditions. Inflation has been factored at 5% per year. The following is a list of major cost factors used to develop the budget:*

<b>Budget Item</b>	<b>Unit Cost</b>
<i>U.S. Team Leader</i>	<i>\$275,000 per year</i>
<i>IEC Specialist</i>	<i>\$188,000 per year</i>
<i>Management/Quality Specialist</i>	<i>\$188,000 per year</i>
<i>Technical Specialist</i>	<i>\$192,000 per year</i>
<i>Private Sector Specialist</i>	<i>\$192,000 per year</i>
<i>Long Term Training</i>	<i>\$ 40,000 per year</i>

<i>Short Term Training</i>	\$ 7,500 per course
<i>U.S. Conference</i>	\$ 3,000 per attendee
<i>U.S. Study Tour</i>	\$ 7,000 per traveler
<i>In-Country Training</i>	\$ 40,000 per trainee day
<i>FSN PSC at FSN 12</i>	\$ 45,000 per year
<i>FSN PSC at FSN 10</i>	\$ 30,000 per year
<i>FSN PSC at FSN 8</i>	\$ 22,000 per year
<i>TAACS Advisor</i>	\$140,000 per year
<i>Office rental/utilities</i>	\$ 35,000 per year
<i>Short Term Technical Assistance</i>	\$ 20,000 per month

#### **D. METHODS OF IMPLEMENTATION AND FINANCING**

*The methods of implementation and financing selected for this project are in accordance with A.I.D. policy and regulations. The major portion of the project will be implemented through a institutional contractor. This contract will be a USAID direct contract and will be funded through normal A.I.D./direct payment methods. Commodity procurement will be accomplished with a direct contract through the institutional contractor or via a funded PIO/C through the Office of Procurement. Buy-ins to centrally-managed contracts with the Office of Population or Health cooperating agencies will be executed to obtain unique technical services in select areas. Contraceptives will be purchased through an OYB transfer to the Office of Population, for a direct contract through the central contraceptive procurement system. U.S.-based training will be through a funded PIO/C to the Office of International Training for inclusion in the worldwide training contract. No host country contracting is anticipated. The Mission will not employ Bank Letters of Commitment for any procurement. Table VI.9 summarizes the methods of implementation and financing.*

TABLE IV.1  
FAMILY PLANNING AND MATERNAL CHILD HEALTH V

PROJECT EXPENDITURES BY BUDGET COMPONENT

SOURCE	A.I.D.	GOM	TOTAL PROJECT
USES:			
TECHNICAL ASSISTANCE/PERSONNEL	6982	66494	73476
TRAINING	940	0	940
COMMODITIES	11250	0	11250
LOCAL COSTS	14678	35326	50004
PROJECT MANAGEMENT	6483	0	6483
EVAL/AUDIT/IMPACT STUDIES	640	0	640
CONTINGENCY/INFLATION	2838	0	2838
CONTRACEPTIVE COMMODITIES	8189	6651	14840
TOTAL	52000	108471	160471
% of Total Project Funding	32%	68%	100%

## EXPLANATORY NOTE FOR BUDGET BREAKDOWNS IN TABLES IV.1 AND IV.5

**Technical Assistance (\$6982.5):**

Technical assistance line	5055
50% of buy-in line	1607.5
50% of linkages line	<u>320</u>
	6982.5

**Training (\$940):**

Training line	1036
minus overhead	<u>- 96</u>
	940

**Commodities (\$19439):**

Commodity line minus overhead	11250
Contraceptives	<u>8189</u>
	19439

**Project Management (\$6843):**

Contractor + AID management	3713
Overhead on local costs	1275
Overhead on training	96
Overhead on commodities	1125
Overhead on linkages	<u>274</u>
	6843

**Evaluation/Aud/Cont (\$3478):**

Evaluation/audit line items	640
Contingency/Inflation	<u>2838</u>
	3478

**Local Costs (\$14678):**

Local Costs line minus overhead	12750
50% of buy-in line	1607.5
50% of linkages line	<u>320</u>
	14678

**TABLE IV.2**  
**FAMILY PLANNING AND MATERNAL CHILD HEALTH PHASE V**  
**BREAKOUT OF USAID-FINANCED LOCAL COSTS**

CATEGORY	1994	1995	1996	1997	1998	1999	TOTAL
A. Special Studies/Research	150	300	300	300	300	150	1500
B. Training and Seminars	500	500	500	500	500	500	3000
C. IEC Support	500	1000	1000	1000	1000	500	5000
D. Service Delivery Support	100	200	200	200	200	100	1000
E. MIS Support	150	150	150	150	75	75	750
F. Mobility Support	70	0	0	0	0	0	70
<b>SUBTOTAL</b>	<b>1470</b>	<b>2150</b>	<b>2150</b>	<b>2150</b>	<b>2075</b>	<b>1325</b>	<b>11320</b>
G. Private Sector Support	500	500	500	0	0	0	1500
H. Construction & Equipment	1329	1300	800	0	0	0	3429
I. 10% Overhead A-E, G	190	265	265	215	208	133	1276
<b>TOTAL</b>	<b>3489</b>	<b>4215</b>	<b>3715</b>	<b>2365</b>	<b>2283</b>	<b>1458</b>	<b>17525</b>

Note: Mobility Support and Construction lines are funded under Phase IV

FAMILY PLANNING AND MATERNAL CHILD HEALTH V  
TABLE IV.3

PHASED TRANSFER OF FINANCING RESPONSIBILITY

BUDGET CATEGORY	YEAR								TOTAL
	1993	1994	1995	1996	1997	1998	1999	2000	
<b>Local Costs:</b>									
A.I.D.	0	3489	4215	3715	2365	2283	1458	0	17525
GOM	1040	4798	5038	5290	5554	5832	6124	1650	35326
Subtotal	1040	8287	9253	9005	7919	8115	7582	1650	52851
<b>Contraceptives:</b>									
A.I.D.	**	1890	1987	1898	1414	1000	**	**	8189
GOM	**	0	221	633	1414	2076	2307	**	6651
Subtotal	**	1890	2208	2531	2828	3076	**	**	12533
A.I.D. Grand Total	0	5379	6202	5613	3779	3283	1458	0	25714
GOM Grand Total	1040	4798	5259	5923	6968	7908	8431	1650	41977

Explanatory Budgetary Notes on Following Page

**Explanatory Budget Notes**  
**Table IV.3 a**

**LOCAL COSTS:**

AID local cost support under Phase V is budgeted FY 1994 - FY 1999 only. Local cost support for the FY 1993 fourth quarter will be financed under Phase IV. Local cost support for the 1st quarter of FY 2000 will be programmed, as required, from available funds.

MOPH local cost support is based on 1993 local cost contribution estimates, with a 5% annual increase through the PACD. Although these estimates are substantially lower than the projections contained in the host country contribution section of the Financial Analysis, the total MOPH contribution to this project significantly exceeds the AID requirement. MOPH personnel support costs, currently estimated at \$10.3 million per year, are not reflected in Table IV.3. Host country contribution projections, excluding personnel support, are contained in the table on the following page.

**CONTRACEPTIVES:**

AID-financed contraceptive purchases are estimated, programmed and called forward with a 1.5 - 2 year lead time. Contraceptives for FY 1993 have been financed under Phase IV and are in the current pipeline. Contraceptives budgeted in FY 1998, the final year of AID financing for contraceptives, will fill the pipeline through the 1st quarter FY 2000 PACD.

**PAST TREND AND FORECAST FOR LOCAL CONTRIBUTION  
INCLUDING CONTRACEPTIVES**

Table IV.3b

Year	Actual/Budgeted	Predicted	Contraceptives	Total budget
1990	\$2,201,578			\$2,201,578
1991	\$2,891,279			\$2,891,279
1992	\$3,644,291			\$3,644,291
1993 *	\$4,164,378	\$1,041,095		\$5,205,473
1994	\$4,797,935	\$4,797,935		\$4,797,935
1995		\$5,037,832	\$221,000	\$5,258,832
1996		\$5,289,723	\$633,000	\$5,922,723
1997		\$5,554,210	\$1,414,000	\$6,968,210
1998		\$5,831,920	\$2,076,000	\$7,907,920
1999		\$6,123,516	\$2,307,000	\$8,430,516
2000 **		\$1,650,000		\$1,650,000
<b>TOTAL L.O.P</b>	<b>\$4,797,935</b>	<b>\$35,326,230</b>	<b>\$6,651,000</b>	<b>\$41,977,230</b>

\* Last trimester of 1993

\*\* First trimester of 2000

**FORECAST FOR TOTAL G.O.M CONTRIBUTION TO PROGRAM**

1993 - 2000

Table IV.3c

Year	Local costs	Contraceptives	Personnel	Total budget
1993*	\$1,041,095		\$2,557,474	\$3,598,569
1994	\$4,797,935		\$10,229,896	\$15,027,831
1995	\$5,037,832	\$221,000	\$10,229,896	\$15,488,728
1996	\$5,289,723	\$633,000	\$10,229,896	\$16,152,619
1997	\$5,554,210	\$1,414,000	\$10,229,896	\$17,198,106
1998	\$5,831,920	\$2,076,000	\$10,229,896	\$18,137,816
1999	\$6,123,516	\$2,307,000	\$10,229,896	\$18,660,412
2000**	\$1,650,000		\$2,557,474	\$4,207,474
<b>TOTAL</b>	<b>\$35,326,231</b>	<b>\$6,651,000</b>	<b>\$66,494,324</b>	<b>\$108,471,555</b>

\* Last trimester of 1993

\*\* First trimester of 2000

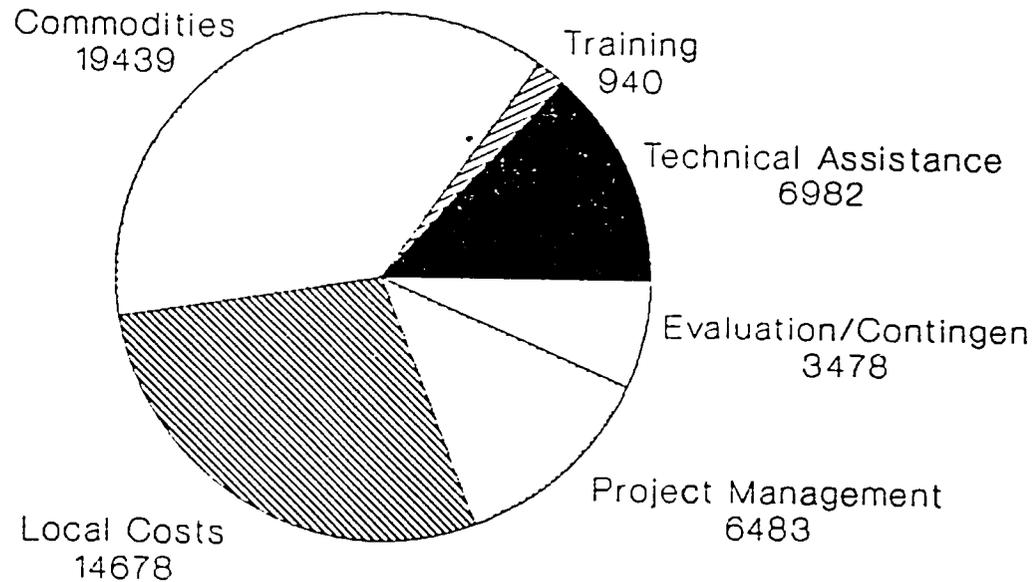
**TABLE IV.4**  
**FAMILY PLANNING AND MATERNAL CHILD HEALTH PHASE V**  
**CASH FLOW ANALYSIS**

(\$000s)

AID FUNDS	1993	1994	1995	1996	1997	1998	1999	TOTAL
OBLIGATION	8000	8000	10000	8000	8000	6000	4000	52000
EXPENDITURES	0	7114	13306	12617	8144	6736	4083	52000
BALANCE	8000	8886	5580	963	819	83	0	0

# TABLE IV.5

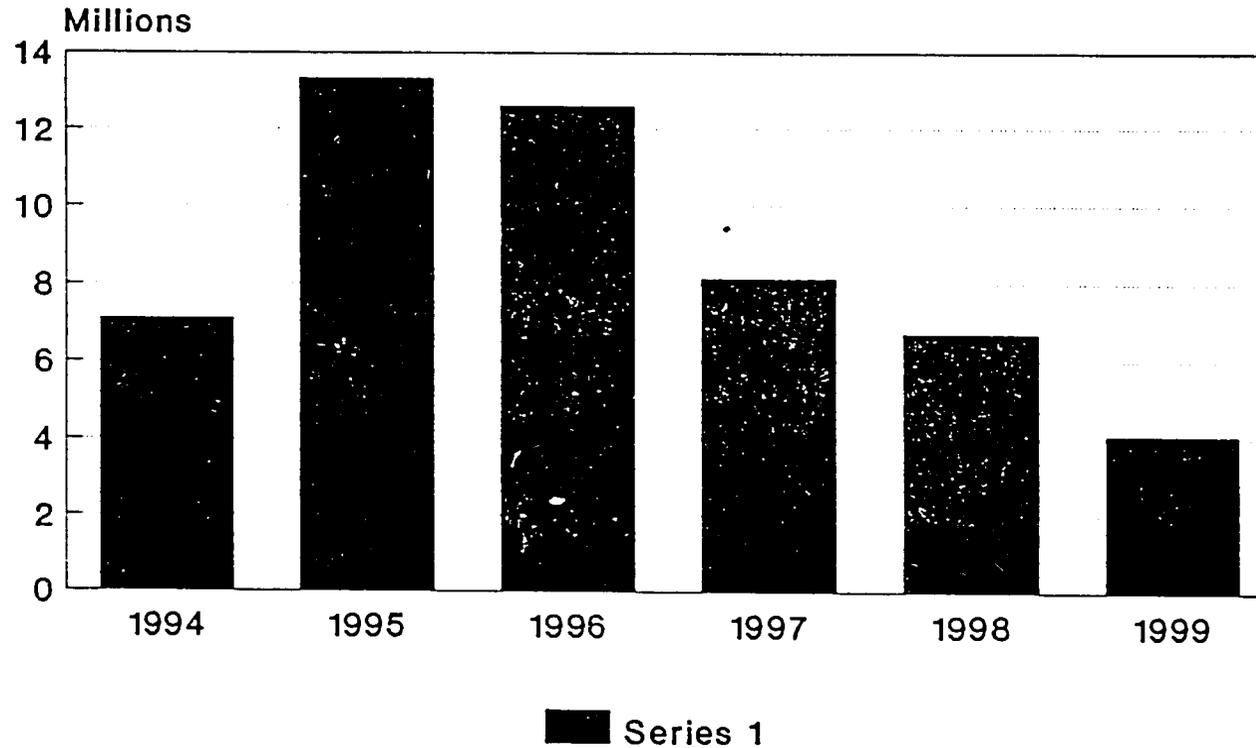
## ALLOCATION OF PROJECT COSTS



FAMILY PLANNING AND MCH PHASE V

# TABLE IV.6

## RATE OF EXPENDITURES



FAMILY PLANNING AND MCH PHASE V

TABLE IV.7  
 FAMILY PLANNING AND MATERNAL CHILD HEALTH PHASE V  
 SUMMARY OF COSTS BY BUDGET CATEGORY AND FISCAL YEAR

<b>1. TECHNICAL ASSISTANCE</b>							
<b>LONG TERM (RESIDENT/INTERMITTENT)</b>							
A. Team Leader-Salary*	80	80	80	80	80	40	440
Benefits & Overhead*	120	120	120	120	120	60	660
Support Costs*	100	100	100	100	100	50	550
B. IEC Specialist*	25	50	50	25	13	12	175
Benefits & Overhead*	38	75	75	38	20	18	264
Support Costs*	31	63	63	31	17	14	219
C. Management/Quality Specialist*	25	50	50	25	13	12	175
Benefits & Overhead*	38	75	75	38	20	18	264
Support Costs*	31	63	63	31	17	14	219
<b>INTERMITTENT (NON-RESIDENT)</b>							
D. Technical Specialist (4pm/yr)*	17	17	17	17	9	0	77
Benefits & Overhead*	26	26	26	26	14	0	118
Support Costs*	21	21	21	21	18	0	102
E. Private Sector Specialist (4pm/yr)*	17	17	17	0	0	0	51
Benefits & Overhead*	26	26	26	0	0	0	78
Support Costs*	21	21	21	0	0	0	63
<b>SHORT TERM:</b>							
E. Short-Term TA (80 months)*	120	360	360	360	260	140	1600
Subtotal TA	736	1164	1164	912	701	378	5055
<b>2. TRAINING</b>							
A. U.S. Short-Term Training	30	45	45	45	45	30	240
B. U.S. Cont/Study Tour/Inv Travel*	80	120	120	120	120	80	640
C. English Language Training	10	10	10	10	10	10	60
D. 10% Overhead Item C*	12	18	18	18	18	12	96
Subtotal Training	132	193	193	193	193	132	1036
<b>3. COMMODITIES FOR INSTITUTIONS</b>							
A. Vehicles*	0	2500	2500	0	0	0	5000
B. Automation Equipment*	250	500	0	0	0	0	750
C. Clinical Supplies and Equipment*	500	750	750	750	500	250	3500
D. Furnishings & Materials*	250	500	250	250	0	0	1250
E. Audio-Visual Equip. & Materials*	250	250	250	0	0	0	750

TABLE IV.7  
 FAMILY PLANNING AND MATERNAL CHILD HEALTH PHASE V  
 SUMMARY OF COSTS BY BUDGET CATEGORY AND FISCAL YEAR

F. 10% Overhead Items A-E*	125	450	375	100	50	25	1125
Subtotal Commodities	1375	4950	4125	1100	550	275	12375
<b>4. LOCAL COSTS</b>							
A. Special Studies/Research*	150	300	300	300	300	150	1500
B. Training and Seminars*	500	500	500	500	500	500	3000
C. IEC Support*	500	1000	1000	1000	1000	500	5000
D. Service Delivery Support*	100	200	200	200	200	100	1000
E. Private Sector Support*	500	500	500	0	0	0	1500
F. MIS Support*	150	150	150	150	75	75	750
G. 10% Overhead Items A-F*	190	265	265	215	208	133	1275
Subtotal Local Costs	2090	2915	2915	2365	2283	1458	14025
<b>5. U.S.-MOROCCAN LINKAGES</b>							
A. Professional Associations*	25	50	50	50	50	25	250
B. Data Sources*	15	15	15	15	15	15	90
C. One University Linkage*	0	75	75	75	50	25	300
D. 30% Overhead Items A-C*	17	60	60	60	49	28	274
Subtotal Linkages	57	200	200	200	164	93	914
<b>6. PROJECT MANAGEMENT</b>							
<b>AID</b>							
A. TAACS	0	0	250	250	250	250	1000
B. One PSC Project Manager (FSN-12)	45	45	45	45	45	45	270
<b>CONTRACTOR</b>							
C. Home Office Support*	30	40	40	30	30	10	180
D. One Local Professional (FSN-12)*	30	45	45	45	45	45	255
E. Two Local Professionals (FSN-10)*	40	60	60	60	60	60	340
F. Two Administrative Staff (FSN-3)*	32	44	44	44	44	44	252
G. Office Lease, Utils & Maint*	30	35	35	35	35	35	205
H. Operational Expenses-Local Office*	30	35	35	35	35	35	205
I. 70% Overhead on Items C-H*	134	181	181	174	174	160	1006
Subtotal Project Management	371	485	735	718	718	684	3713

TABLE IV.8  
FAMILY PLANNING AND MATERNAL CHILD HEALTH V  
PROPOSED TECHNICAL ASSISTANCE CONTRACT

Fiscal Year	1994	1995	1996	1997	1998	1999	TOTAL
<b>1. TECHNICAL ASSISTANCE</b>							
<b>LONG TERM (RESIDENT/INTERMITTENT)</b>							
A. Team Leader – Salary	80	80	80	80	80	40	440
Benefits & Overhead	120	120	120	120	120	60	660
Support Costs	100	100	100	100	100	50	550
B. IEC Specialist	25	50	50	25	13	12	175
Benefits & Overhead	38	75	75	38	20	18	264
Support Costs	31	63	63	31	17	14	219
C. Management/Quality Specialist	25	50	50	25	13	12	175
Benefits & Overhead	38	75	75	38	20	18	264
Support Costs	31	63	63	31	17	14	219
<b>INTERMITTENT (NON-RESIDENT)</b>							
D. Technical Specialist (4pm/yr)	17	17	17	17	9	0	77
Benefits & Overhead	26	26	26	26	14	0	118
Support Costs	21	21	21	21	18	0	102
E. Private Sector Specialist (4pm/yr)*	17	17	17	0	0	0	51
Benefits & Overhead	26	26	26	0	0	0	78
Support Costs	21	21	21	0	0	0	63
<b>SHORT TERM:</b>							
F. Short-Term TA (80 months)	120	360	360	360	260	140	1600
Subtotal TA	736	1164	1164	912	701	378	5055
<b>2. TRAINING</b>							
A. 10% Overhead Conf/Study Tours	12	18	18	18	18	12	96
<b>3. COMMODITIES FOR INSTITUTIONS</b>							
A. PSA Services Commodities (@10%)	125	450	375	100	50	25	1125
<b>4. LOCAL COSTS</b>							
A. Special Studies/Research	150	300	300	300	300	150	1500
B. Training and Seminars	500	500	500	500	500	500	3000
C. IEC Support	500	1000	1000	1000	1000	500	5000
D. Service Delivery Support	100	200	200	200	200	100	1000
E. Private Sector Support	500	500	500	0	0	0	1500
F. MIS Support	150	150	150	150	75	75	750

TABLE IV.8  
FAMILY PLANNING AND MATERNAL CHILD HEALTH V  
PROPOSED TECHNICAL ASSISTANCE CONTRACT

Fiscal Year	1994	1995	1996	1997	1998	1999	TOTAL
G. 10% Overhead Items A-F	190	265	265	215	208	133	1275
Subtotal Local Costs	2090	2915	2915	2365	2283	1458	14025
<b>5. U.S.-MOROCCAN LINKAGES</b>							
A. Professional Associations	25	50	50	50	50	25	250
B. Data Sources	15	15	15	15	15	15	90
C. One University Linkage	0	75	75	75	50	25	300
D. 30% Overhead Items A-C	17	60	60	60	49	28	274 ?
Subtotal Linkages	57	200	200	200	164	93	914
<b>CONTRACTOR</b>							
A. Home Office Support	30	40	40	30	30	10	180
B. One Local Professional (FSN-12)	30	45	45	45	45	45	255
C. Two Local Professionals (FSN-10)	40	60	60	60	60	60	340
D. Two Administrative Staff (FSN-8)	32	44	44	44	44	44	252
E. Office Lease, Utils & Maintenance	30	35	35	35	35	35	205
F. Operational Expenses-Local Office	30	35	35	35	35	35	205
G. 70% Overhead Items A-F	134	181	181	174	174	160	1006
Subtotal Project Management	326	440	440	423	423	389	2443
<b>CONTRACT GRAND TOTAL</b>	<b>3346</b>	<b>5187</b>	<b>5112</b>	<b>4018</b>	<b>3639</b>	<b>2355</b>	<b>23658</b>
Percent of Total Expenditures	14%	22%	22%	17%	15%	10%	100%

Table IV. 9

## METHODS OF IMPLEMENTATION AND FINANCING

METHOD OF IMPLEMENTATION	METHOD OF FINANCING	VALUE (000's)
<b>TECHNICAL ASSISTANCE</b>		
Institutional Contractor Buy-Ins	Direct Reimbursement Direct Reimbursement	\$23650 \$ 1927
<b>COMMODITIES</b>		
AID procurement Institutional Contractor/PSA	Direct Payment Direct Reimbursement	\$ 5000 \$14439
<b>TRAINING</b>		
AID procurement	Direct Payment	\$ 2236
<b>EVALUATION/AUDIT</b>		
AID procurement	Direct Payment	\$ 640
<b>PSC/TAACS</b>		
AID procurement Buy-in	Direct Payment Direct Reimbursement	\$ 1000 \$ 270
<b>CONTINGENCY</b>		
	Direct Reimbursement	<u>\$ 2838</u>
	<b>Total:</b>	<b>\$52000</b>

## V. MONITORING AND EVALUATION PLAN

### A. PERFORMANCE MONITORING AND EVALUATION

*Continuous performance and evaluation of project-financed activities form integral elements of this project. A broad range of techniques will be employed for this purpose, including applied operations research, special studies, analysis of services and sales data, surveys and spot checks, model and pilot implementation sites and periodic implementation reviews. Monitoring will serve to assure implementation progress and follow family planning and maternal/child health status trends. The evaluation component will determine the impact and effectiveness of project-financed activities. The Institutional Contractor will have primary responsibility for ongoing data collection and for maintaining fiscal accountability for all project activities.*

#### 1. Implementation Progress

*The responsibility for monitoring project progress rests with USAID project managers in the Office of Population and Human Resources, in collaboration with the MOPH Project Management Unit, Institutional contractor staff, and technical advisors financed under the project. This core project management team will be advised and assisted by the USAID Controller and Program Officer, and the Regional Contracting Officer and Legal Advisor, as appropriate.*

*Soon after the project is executed, USAID managers and members of the MOPH Project Advisory and Coordination Committee will meet to review the overall project plan and methods of implementation. A second meeting with the PMU will focus on development of a workplan and financial plan for the initial year of project implementation. Regular monitoring of the project will consist of semi-annual joint work planning sessions between the MOPH Project Advisory and Coordination Committee, USAID managers, and institutional contractor staff. Prior to these work planning sessions, the MOPH Project Coordination Committee will review project progress to define policy and implementation guidelines for workplan development. The Project Advisory and Coordination Committee will provide crucial information on implementation successes or shortcomings, emerging or special needs and targets of opportunity. The results of these meetings, coupled with findings from any special studies, will provide the basis for project status reports and workplan submissions to USAID by the MOPH and Institutional Contractor. These reports will be reviewed and discussed with the USAID Director and senior staff during the semi-annual Project Implementation Reviews, and corrective steps will be taken as needed.*

#### 2. Program Effectiveness

*This is a second generation project, corresponding to the evolution of Morocco's health and family planning indicators. Given that services are presently available to well over 80% of the population, continued improvement in health status indicators will increasingly rely on improved access to quality services, and less on services expansion, per se. The program monitoring and evaluation activities planned in*

conjunction with this project are designed to reflect this transition, and to provide the performance feedback necessary for periodic program implementation modifications. The project aims to assist the MOPH in developing sustainable methods of monitoring and evaluation which may then be incorporated into future projects. While some of the methods are specific to A.I.D. policies and procedures, others are designed to be administered by the MOPH. The elements of the project monitoring and evaluation plan are described below.

- *The Program Performance, Monitoring, Evaluation and Reporting Matrix, a USAID assessment strategy developed in conjunction with the PRISM Project, forms the cornerstone for project monitoring and evaluation. This matrix (included as Annex B along with the project logframe) employs a combination of annual services data and statistics, social marketing program sales data, information from national or spot surveys, and proxy indicators that will be used to measure program performance through 1997. The logframe has extrapolated select indicators to the year 2000 for end of project status indicators. Performance data will be collected from MOPH, the institutional contractor and other GOM sources. USAID staff will compile the final report on program progress and trends.*
- *Model quality sites will be financed under this project to measure and evaluate the impact of the full range of management and services interventions described in the project narrative. Based on the evaluation, successful interventions will then be expanded to additional sites. The outreach program successfully employed this model prior to its expansion nationwide.*
- *Through a buy-in to the centrally-managed Evaluation Project, the project will obtain expertise in the design and development of evaluation systems for the health and family planning sector. Technical assistance under this project will be directed to the design of on-the-ground evaluation systems and the establishment of a program evaluation unit within the MOPH.*
- *The 1997 Demographic and Health Survey financed by the project will provide the information critical to measuring program progress and impact. DHS central program managers have agreed to work with the MOPH and USAID to design a mini-survey questionnaire that will be administered annually to a sub-set of the original DHS survey respondents, permitting more frequent updates of data on contraceptive prevalence and mortality.*
- *To assure continuity of monitoring and evaluation initiatives, the project will support the development of research capabilities of two of the MOPH institutions: INAS and Service de l'Etude de l'Information Statistique. These institutions will then be responsible for collecting and analyzing data for future projects. In addition, the project will train key personnel in monitoring and evaluation techniques. In this way, the institutional capacity for evaluation will be developed and continuation of the activities assured.*

### 3. Family Planning and Maternal Child Health Status Trends

*The project has set specific targets for contraceptive prevalence, fertility rate, infant and child mortality, the proportion of women using prenatal care, proportion of diarrheal disease cases provided ORS, and private sector share of services delivery. These indicators will be monitored via a number of sources including the 1997 DHS, special studies and the MOPH's management information system.*

#### **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.

## VI. CONDITIONS PRECEDENT AND COVENANTS

The following conditions precedent and covenants will read in the Project Grant Agreement as follows:

### A. CONDITIONS PRECEDENT

#### 1. Conditions Precedent to First Disbursement

Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to the two Parties:

- A statement of the name of the person acting on behalf of the Grantee specified in Section 8.2, of the name of the Project Director, and of any additional representatives, together with a specimen signature of each person specified in such statement; and
- Evidence that the Grantee has planned for adequate space and allocated sufficient staff to the Project Management Unit to carry out project administrative, programming, monitoring, and evaluation functions. This evidence will include a document which delineates the Project Management Unit configuration and provides corresponding job descriptions.
- Evidence that A.I.D. and the Grantee have identified and agreed on areas of a policy agenda to be pursued during the life-of-Project.

#### 2. Conditions Precedent to Disbursement of Funds for Local Costs

Except as A.I.D. may otherwise agree in writing, prior to annual disbursement of local costs under the Grant, the Grantee will furnish to A.I.D., in form and substance satisfactory to both Parties:

- An Annual Workplan, collaboratively developed by A.I.D and the Grantee, delineating major implementation actions and schedules along with financial plans, reflecting both Parties' contributions, for the workplan period.
- Evidence that the Grantee contributes a gradually increasing share of local costs, as described in Table III in the Financial Plan of the Project Grant Agreement, and, as required by annual Workplans.

### B. COVENANTS

The Grantee agrees that, over the life-of-project, the Ministry of Public Health will further develop, refine and implement, as appropriate:

- *the policy agenda, to include efforts facilitating the Involvement of the Moroccan private sector in the delivery of preventive FP/MCH services*
- *the decentralization of public sector health care services and systems through regional and provincial structures.*

*The Grantee agrees that, over the life-of-project, the Ministry of Public Health and the Ministry of Finance will budget sufficient funds, on an annual basis:*

- *for contraceptives in line with targets established in Table IV.3 of the Financial Plan.*
- *for the maintenance, repair, fuel; and, spare parts not furnished by A.I.D., necessary for the vehicles provided by the project.*
- *for the maintenance, repair, replacement parts and operating supplies necessary for the materials and equipment provided by the project.*
- *for indemnities and other expenses necessary for project activities and not covered by the Grant.*

*The Grantee agrees that the above budget allocations, over the life-of-project, will not have an adverse budgetary impact on other preventive health care activities.*

### **C. TERMINAL DATES FOR CONDITIONS PRECEDENT**

*If all of the conditions specified in Section 4.1 have not been met within ninety days (90) from the date of this Agreement, or such later date as A.I.D. may agree to in writing, A.I.D., at its option, may terminate this Agreement by written notice to the Grantee.*

*If the condition specified in Section 4.2 is not met on an annual basis throughout the life-of-Project, or such later date as A.I.D. may agree to in writing. A.I.D., at its option, may cancel the then undisbursed balance of the Grant to the extent not irrevocably committed to third Parties, and may terminate this Agreement by written notice to the Grantee.*

### **D. PROJECT EVALUATION**

*The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one point thereafter: (a) evaluation of progress toward attainment of the objectives of the Project; (b) identification and evaluation of problem areas or constraints which may inhibit such attainment; (c) assessment of how such information may be used to help overcome such problems; and, (d) evaluation, to the degree feasible, of the overall development impact of the Project.*

## 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, may be considered by the team 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 are devoted of primary 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 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 ("IDs, 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.

**ANNEX A.**

**- PID APPROVAL CABLE**

**- RESPONSE TO AID/W PID CONCERNS**

UNCLAS

AIDAC

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608-022

ACTION: AID-1  
INFO: ECON-0

DISTRIBUTION: AID  
CHARGE: AID

VZCZCTRO077RAO592  
PP RUFHRA  
DE RUEHC #9763/01 1460756  
ZNR UUUUU ZZH  
P 260754Z MAY 93  
FM SECSTATE WASHDC  
TO AMEMBASSY RABAT PRIORITY 5955  
BT  
UNCLAS SECTION 01 OF 03 STATE 159763

ACTION: PHR  
DUE DATE: 05/28  
INFO: Dir. Proc.  
CHRON.

AIDAC  
E.O. 12356: N/A  
TAGS:

SUBJECT: NEDAC REVIEW OF MOROCCO FAMILY PLANNING AND  
MATERNAL AND CHILD HEALTH PHASE V, PROJECT 608-0223

1. SUMMARY. ON MAY 13, 1993, THE NEAR EAST DEVELOPMENT  
ADVISORY COMMITTEE (NEDAC) MET TO REVIEW AND DISCUSS THE  
PROJECT IMPLEMENTATION DOCUMENT (PID) FOR THE MOROCCO  
FAMILY PLANNING AND MATERNAL AND CHILD HEALTH PROJECT,  
PHASE V. THE NEDAC DISCUSSED ISSUES AS FOLLOWS: 1) THE  
FEASIBILITY OF A COMPLETE PHASE-OUT OF PUBLIC SECTOR  
SUPPORT FOR FAMILY PLANNING/MATERNAL AND CHILD HEALTH  
SERVICES BY 1999; 2) THE PROBLEM OF UNDER-UTILIZATION OF  
CURRENTLY AVAILABLE SERVICES; 3) THE LACK OF OFFICIAL  
PROJECT EVALUATION OF THE PHASE IV PROJECT; 4) NEED FOR  
DECISION ON WHETHER THE PROGRAM STRATEGIC AND PROJECT GOAL  
SHOULD INCLUDE THE POPULATION OBJECTIVES OF FAMILY  
PLANNING; 5) THE NEED FOR A STRONG JUSTIFICATION AND  
PROCUREMENT PLAN FOR THE PURCHASE OF THE VEHICLES; AND 6)  
AGENCY ENVIRONMENTAL GUIDANCE ON SAFE AND PROPER DISPOSAL  
OF PROJECT-FUNDED SYRINGES. THE NEDAC INVITED THE  
RESEARCH AND DEVELOPMENT BUREAU (R&D) OFFICES OF  
POPULATION AND HEALTH TO PARTICIPATE IN THE FINANCIAL  
PLANNING FOR THE PROGRAM IN MOROCCO BY INDICATING THEIR

CONTRIBUTION, AND THE NEDAC ENCOURAGED THE MISSION TO SEEK  
CLOSE DONOR COORDINATION.

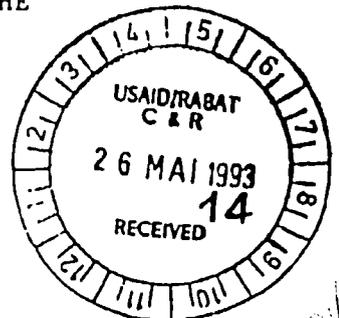
BASED ON THE REVIEW AND DISCUSSION, THE NEDAC APPROVED THE  
SUBJECT PID AND THE ACTING ASSISTANT ADMINISTRATOR FOR THE  
NEAR EAST (AA/NE) DELEGATED AUTHORITY TO THE MISSION  
DIRECTOR FOR THE PROJECT PAPER APPROVAL AND PROJECT  
AUTHORIZATION SUBJECT TO THE CONDITIONS OUTLINED IN THE  
FOLLOWING CABLE TEXT. END OF SUMMARY.

1. THE BUREAU NEDAC, CHAIRED BY THE ACTING AA/NE DENNIS

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CHANDLER, MET MAY 13, 1993 TO REVIEW AND DISCUSS THE PID FOR THE MOROCCO FAMILY PLANNING AND MATERNAL AND CHILD HEALTH PROJECT, PHASE V. THE MISSION WAS REPRESENTED BY THE MISSION DIRECTOR MARTIN DAGATA AND HPN CHIEF JOYCE HOLFELD. NEAR EAST BUREAU STAFF ATTENDED AS WELL AS REPRESENTATIVES FROM GENERAL COUNSEL, RESEARCH AND DEVELOPMENT BUREAU OFFICES OF POPULATION AND HEALTH. BELOW IS A BRIEF DESCRIPTION OF THE PROJECT, AS WELL AS ISSUES DISCUSSED AND CONCLUSIONS REACHED AT THE NEDAC MEETING.

3. PROJECT DESCRIPTION. THE FAMILY PLANNING AND MATERNAL CHILD HEALTH, PHASE V WILL BE A SEVEN-YEAR, \$52 MILLION PROJECT. THE GOAL OF THE PROJECT IS TO IMPROVE HEALTH OF CHILDREN UNDER FIVE YEARS OF AGE AND WOMEN OF CHILDBEARING AGE. THE PURPOSE OF THE PROJECT IS TO INCREASE THE EFFECTIVE USE OF FAMILY PLANNING AND SELECTED CHILD SURVIVAL SERVICES AND TO INCREASE SUSTAINABILITY OF THOSE SERVICES. THE SUCCESSFUL ACHIEVEMENT OF THE PROJECT GOAL DEPENDS ON THE POPULATION'S WILLINGNESS TO USE 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 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. MAJOR INPUTS TO THE PROJECT INCLUDE TECHNICAL ASSISTANCE, TRAINING, VEHICLES, CONTRACEPTIVES AND OTHER COMMODITIES, AND LOCAL SUPPORT COSTS FOR INFORMATION/EDUCATION, TRAINING AND RESEARCH ACTIVITIES. THE PROJECT IS EXPECTED TO INVOLVE SUBSTANTIALLY MORE PROCUREMENT OF U.S. COMMODITIES THAN PREVIOUS PROJECTS. THE PROJECT WILL BE IMPLEMENTED UNDER THE GENERAL SPONSORSHIP OF THE MINISTRY OF PUBLIC HEALTH (MOPH). A U.S. INSTITUTIONAL CONTRACTOR, WITH A LONG-TERM RESIDENT STAFF, WILL MANAGE MOST PROJECT INPUTS, INCLUDING PROVISION OF TECHNICAL ASSISTANCE AND TRAINING, AND DISBURSEMENTS OF LOCAL SUPPORT COSTS. SELECT BUY-INS TO CENTRALLY-FUNDED PROJECTS WILL BE MADE FOR SPECIALIZED EXPERTISE.

4. ISSUES. THE FOLLOWING ISSUES WERE DISCUSSED AND THE FOLLOWING CONCLUSIONS WERE REACHED AT THE MEETING.

A) IS IT REALLY FEASIBLE TO CONSIDER A COMPLETE PHASE-OUT OF PUBLIC SECTOR SUPPORT FOR FAMILY PLANNING/MATERNAL AND CHILD HEALTH SERVICES BY 1999?

THE MISSION INDICATED THAT IT PLANS TO SEEK A SYSTEMATIC

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PHASE OVER TO THE GOM OF LOCAL AND RECURRENT COSTS, BASED ON PROJECT AGREEMENT AND ANNUAL NEGOTIATIONS WITH THE MINISTRY OF PUBLIC HEALTH AND THE MINISTRY OF FINANCE.  
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HOWEVER, THE MISSION IS UNCERTAIN WHETHER IT IS REALISTIC AND NECESSARY TO PURSUE A COMPLETE PHASE-OUT OF PUBLIC SECTOR SUPPORT, PARTICULARLY FOR CONTRACEPTIVES, BY THE YEAR 1999. THE NEDAC NOTED THAT THE MISSION AND THE GOM ARE COMMITTED TO GRADUAL ASSUMPTION OF LOCAL AND RECURRENT COSTS BY THE GOM AND THAT PURSUANCE OF A PHASE-DOWN (BUT NOT NECESSARILY PHASE-OUT) IS NEEDED FOR LONG-TERM SUSTAINABILITY. THE NEDAC AGREED THE MISSION SHOULD, IN THE PP, ESTABLISH TARGETS FOR WITHDRAWAL AND DEVELOP A MEANS FOR SYSTEMATIC REVIEW OF THE PHASE-OVER PROCESS. AS PART OF THE ON-GOING POLICY ANALYSIS AND DIALOGUE, THE NEDAC INDICATED THAT THE MISSION COULD DECIDE IF SPECIFIC CONDITIONALITY AND/OR COVENANTS ARE NECESSARY. FINALLY, THE NEDAC STATED THAT A SUCCESSFUL PHASE-DOWN WOULD REQUIRE CLOSE COORDINATION WITH OTHER DONORS AS WELL AS AN ACCURATE READING ON THE RESOURCES AVAILABLE TO MOROCCO THROUGH AID CENTRAL FUNDING.

) GIVEN THE UNDER-UTILIZATION OF CURRENTLY AVAILABLE SERVICES, IS IT APPROPRIATE TO CONSIDER INCREASED FUNDING AT THIS TIME?

THE NEDAC AGREED WITH THE MISSION THAT THE PROJECT IS DESIGNED TO IMPROVE EFFICIENCY IN THE CURRENT SYSTEM AND TO CORRECT THE PROBLEMS OF UNDER-UTILIZATION, BOTH OF WHICH ARE NECESSARY TO MEET THE FUTURE DEMAND FOR SERVICES. THE NEDAC REQUESTED THAT THE PP CLEARLY DESCRIBE THE PROBLEM OF UNDER-UTILIZATION OF PUBLIC SECTOR SERVICES AND TO STATE EXACTLY HOW THE PROJECT WILL EFFECT UTILIZATION OF SERVICES.

C) HAS THE PHASE IV PROJECT BEEN EVALUATED?

THE NEDAC AGREED THAT THE 24 STUDIES AND THE DEMOGRAPHIC AND HEALTH SURVEY CONDUCTED OVER THE PAST YEAR ON POPULATION AND CHILD SURVIVAL ACTIVITIES IN MOROCCO ARE

SUFFICIENT AND OBTAIN THE NEED FOR A SPECIFIC EVALUATION. THE NEDAC REQUESTED THAT THE MISSION PREPARE A REPORT WHICH CONSOLIDATES FINDINGS OF THE VARIOUS STUDIES, INDICATES LESSONS LEARNED, AND DEMONSTRATES THE IMPACT OF THE PREVIOUS USAID EFFORTS.

D) SHOULD THE STRATEGIC PROGRAM AND PROJECT GOAL INCLUDE

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## THE POPULATION OBJECTIVES OF FAMILY PLANNING?

DURING THE PRISM EXERCISES AT THE MISSION, IT WAS DECIDED TO KEEP THE STRATEGIC OBJECTIVE FOR THE SECTOR SIMPLE AND FOCUSED, HENCE THE STRATEGIC OBJECTIVE, "IMPROVE HEALTH OF WOMEN OF CHILDBEARING AGE AND CHILDREN UNDER FIVE YEARS OF AGE." GIVEN THE PROJECT WILL HAVE A VERY CLEAR DEMOGRAPHIC IMPACT, THE MISSION ASKED GUIDANCE AS TO WHETHER THE PROJECT GOAL OR PURPOSE SHOULD BE ADJUSTED TO REFLECT POPULATION OBJECTIVES OF FAMILY PLANNING. THE NEDAC DECIDED THAT, AT THE PROJECT LEVEL, IT IS NOT NECESSARY TO REVISE THE CURRENT PURPOSE AS DEMOGRAPHIC IMPACT IS INHERENT IN "INCREASED USE OF FAMILY PLANNING," BUT THE MISSION IS NOT PRECLUDED FROM SO DOING. THE NEDAC AGREED THAT IT IS APPROPRIATE, IN THE PP, FOR THE MISSION TO MAKE THE CONNECTION BETWEEN FAMILY PLANNING AND DEMOGRAPHIC OBJECTIVES, TO IDENTIFY INDICATORS THAT DEMONSTRATE DEMOGRAPHIC IMPACT (E.G., CONTRACEPTIVE PREVALENCE, MEETING OF UNMET NEED, FERTILITY REDUCTION, ETC.), AND TO DEVELOP A MECHANISM TO SYSTEMATICALLY MONITOR THE VARIABLES. AT THE STRATEGIC PROGRAM LEVEL, THE NEDAC INDICATED THAT THE MISSION SHOULD MODIFY THE STRATEGIC OBJECTIVE OF "IMPROVED HEALTH OF CHILDREN UNDER 5 AND WOMEN OF CHILD BEARING AGE " TO REFLECT MORE VIBLY THE LARGE FAMILY PLANNING EMPHASIS OF THE PROGRAM.

E) IS THERE AN ADEQUATE JUSTIFICATION OF NEED AND A SOUND PROCUREMENT PLAN FOR THE PURCHASE OF THE VEHICLES?

GIVEN THE ACCOUNTABILITY ASPECTS INVOLVED WITH VEHICLES, THE NEDAC REQUESTED THAT THE PP CONTAIN A JUSTIFICATION FOR THE VEHICLES, A CLEAR EXPLANATION OF THEIR PLANNED USE, AND A DETAILED PROCUREMENT PLAN FOR VEHICLE PURCHASE.

F) IS THERE AGENCY ENVIRONMENTAL GUIDANCE ON THE SAFE AND PROPER DISPOSAL OF PROJECT-FUNDED SYRINGES?

GIVEN THAT THE MISSION PLANS TO USE PROJECT FUNDS TO PURCHASE SYRINGES FOR THE INTRODUCTION OF INJECTABLES, THE MISSION ASKED FOR AGENCY GUIDANCE ON THE ISSUE. THERE ARE ENVIRONMENTAL REQUIREMENTS FOR PROPER AND SAFE DISPOSAL OF A.I.D.-PROCURED SYRINGES UNDER 22 CFR 216, BUT NO SPECIFIC AGENCY GUIDANCE FOR SYRINGE DISPOSAL. THE NEDAC REQUESTED

THAT THE MISSION INCLUDE IN THE PP THE PLAN THAT WOULD  
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FOLLOWED TO ENSURE THE PROPER AND SAFE DISPOSAL OF A  
PROCURED-SYRINGES. ALSO, THE NEDAC ASKED THE NE  
ENVIRONMENTAL COORDINATOR TO REVIEW THE ISSUE AND TO  
ASSIST IN THE PREPARATION OF THE IEE WHICH WILL COVER

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SYRINGE DISPOSAL ISSUE. THE NEDAC ALSO REQUESTED TH R&D/POPULATION AND R&D/HEALTH PREPARE, FOR THE MISSI USE, TECHNICAL GUIDANCE ON COSTS AND OTHER ASPECTS 0 SYRINGE USE AND DISPOSAL BASED ON AGENCY'S EXTENSIVE EXPERIENCE WITH INOCULATION PROGRAMS.

5. THE NEDAC AGREED THAT THE PROJECT PAPER SHOULD SPECIFY IN THE PROJECT DESCRIPTION AND BUDGET THE CONTRIBUTIONS FROM R&D/POP AND R&D/HEALTH AS WELL AS BILATERAL FUNDS. THIS IS IN KEEPING WITH AGENCY EFFORTS TO DEFINE CLEARLY THE FULL AMOUNT OF AID RESOURCES BENEFITING EACH COUNTRY AND SECTOR. THE ACTING AA/NE REQUESTED THAT THE PP BUDGET ALSO INCLUDE INDICATION OF SUCH OTHER AGENCY INPUTS AND OTHER DONOR INPUTS.

6. IN ADDITION TO THE SPECIFIC GUIDANCE INDICATED ABOVE THE NEDAC REQUESTED THAT THE PP:

A) BE SPECIFIC ABOUT THE POSITIVE SYNERGISM BETWEEN IMPROVED QUALITY AND INCREASED SUSTAINABILITY (PG. 11 AND

PREPARING THE PRIVATE SECTOR FOR ITS KEY ROLE IN MAKING CONSUMER FUNDED SERVICE DELIVERY MORE WIDELY UTILIZED.

B) TO ADDRESS THE PUBLIC-PRIVATE SECTOR MIX FOR THE DELIVERY OF MCH SERVICES AND THE SUSTAINABILITY OF PUBLICLY-PROVIDED SERVICES, DESCRIBE HOW MECHANISMS SUCH AS ASSESSMENTS OF HEALTH CARE CONSUMPTION PATTERNS CAN HELP POLICY-MAKERS PLAN MORE ACCURATELY CONCERNING THE SEGMENTATION OF HEALTH CARE CONSUMERS AND THE EXPRESSION OF CHOICE BETWEEN A VARIETY OF HEALTH CARE PROVIDERS. THESE MECHANISMS SHOULD ASSIST THE PROCESS OF DEFINING AND ACHIEVING THE OPTIMAL MIX OF PUBLICLY AND PRIVATELY PROVIDED MCH SERVICES.

C) CLASSIFY THE WORLD BANK AS A LENDER NOT A DONOR (PG. 8). SPELL-OUT MORE SPECIFICALLY THE KEY ROLE OF WHO.

D) CLARIFY THE KEY ROLE OF DECENTRALIZATION IN ACHIEVING SUSTAINABILITY. INCLUDE THE USE OF RAPID-TYPE PRESENTATIONS TO GARNER LOCAL SUPPORT FOR EXPANDED FAMILY PLANNING.

E) INCLUDE LANGUAGE THAT WOULD FACILITATE THE UTILIZATION OF A GRAY AMENDMENT ENTITY AS THE POSSIBLE PRIME

INSTITUTIONAL CONTRACTOR, OR AT LEAST SPECIFY THAT 1 PERCENT OF THE PROCUREMENT BE THROUGH GRAY AMENDMENT ENTITIES (PG. 19) AND INDICATE THAT AT LEAST 10 PERC FUNDS SUB-CONTRACTED WITH U.S. INSTITUTIONS FOR RESE AND TRAINING ACTIVITIES WILL BE WITH HISTORICALLY B

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LLEGES AND UNIVERSITIES.

7. BASED ON THE COMMITTEE'S DISCUSSION, THE NEDAC

APPROVED THE SUBJECT PID AND THE ACTING ASSISTANT ADMINISTRATOR FOR THE NEAR EAST DELEGATED AUTHORITY TO THE MISSION DIRECTOR FOR THE PROJECT PAPER APPROVAL AND PROJECT AUTHORIZATION SUBJECT TO THE CONDITIONS OUTLINED ABOVE.

8. THE BUREAU JUST LEARNED THAT THE ALLOCATIONS OF FY'94 POPULATION FUNDS TO THE REGIONAL BUREAU WILL PROBABLY BE CONSIDERABLY LESS THAN ENVISIONED AND THAT MOST OF THE AGENCY'S POPULATION FUNDS WILL BE ALLOCATED TO R&D/POP FOR PROGRAMMING. THE CURRENT PLANNING LEVEL FOR THE BUREAU IN FY'94 DROPPED FROM \$17 MILLION TO \$10.5 MILLION. AS A RESULT, THE AMOUNT OF POPULATION FUNDS AVAILABLE FOR MOROCCO IN FY'94 MAY ONLY TOTAL \$4.2 MILLION. THE MISSION

SHOULD CONSIDER POPULATION FUNDING AVAILABILITY IN FUTURE YEARS AS A FACTOR IN PROJECT DESIGN AND IT ALSO MAY WANT TO DISCUSS WITH THE NEAR EAST BUREAU AND R AND D/POP NEW POSSIBILITIES FOR R AND D COLLABORATIVE FUNDING WHEN DEVELOPING THE PP.

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**RESPONSE TO AID/WASHINGTON PROJECT REVIEW COMMITTEE CONCERNS  
AND DESIGN GUIDELINES**

**III. Issues:**

- 1. Is a complete phase-over of public sector support for FP/MCH services feasible by 1999?**

*Both the Mission and the GOM are committed to a gradual assumption of local and recurrent costs by the GOM and that pursuance of a targeted phase-over is needed for long term sustainability.*

*In support of sustainability this project will incorporate a rational plan to phase-down AID public sector health support and increase concomitantly GOM capacity for assessing and meeting contraceptive and commodity needs. AID and the GOM will meet on an annual basis in order to determine requirements for program phase-down. [For specifics, please refer to description given in section II, Contraceptive Logistics and Supplies Management of the Detailed Project Description; the Host Country Contribution in section, Cost Estimate and Financial Plan; and the Financial Analysis in Annex I.]*

- 2. Describe the problem of under-utilization of public sector services and how the project will rectify this problem.**

*Progress has been made in extending FP/MCH services throughout Morocco, but many potential clients are still not using them, especially in rural areas. For example, the infant mortality rate is 44 per 1000 live births in urban areas and 65 in rural areas. 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, under-utilization of prenatal and postpartum services, and continued high mortality due to childhood diarrheal diseases (CDD). For example, even though 73% of married women want no more children or want to postpone another child for at least two years, and most of them know of at least one modern method. Of these women, 80% are relying on the pill. Although the maternal mortality rate is suspected to be very high, in 1992 only 31% of deliveries were attended by medical practitioners, and only 32% of pregnant women received modern prenatal care. Diarrheal diseases are the leading cause of infant and early childhood deaths at 28% in 1992, yet only 16% of DHS respondents whose children recently had diarrhea used oral rehydration therapy. [For further details on under-utilization see description given in Section I, Project II, Project Rationale Increase the effective use of FP/MCH services.]*

*The project is devoted to increasing use of services by identifying and resolving service problems, supporting MOPH efforts to improve quality, and addressing past weaknesses of IEC efforts. The intention and design of the project is to correct the problems of under-utilization, [see description given in section. Component One: **Increased Effective Use of FP/MCH Services.**]*

**3. Has the Phase IV Project been evaluated?**

*USAID will prepare a summary of all recent studies and analyses by the end of the calendar year, 1993.*

**4. Is there an adequate justification of need and a sound procurement plan for the purchase of the vehicles?**

*The project will finance procurement of vehicles to increase field-worker mobility, improve supervision, and facilitate decentralized delivery of services and IEC. Before purchase of vehicles, a full assessment will be conducted of maintenance need and capabilities, purchases will then be made accordingly. [For details see, PROCUREMENT PLAN: Commodities.]*

**5. Should the project goal or purpose be adjusted to reflect population objectives of family planning?**

*The Mission agrees that at the project level, it is not necessary to revise the current goal or purpose as demographic impact is inherent in increased use of family planning. Indicators of fertility rate and contraceptive prevalence, will be followed closely.*

**6. Is there Agency environmental guidance on the safe disposal of project-funded syringes?**

*Syringe disposal will not pose a significant environmental risk, consequently, a negative Environmental Determination has been made. The Mission will submit an IEE for Bureau Environmental Officer review prior to PP approval.*

**IV. Suggested Clarifications**

**1. Specificity of synergy between quality and sustainability.**

*The synergy, between quality and sustainability has been made throughout the document.*

**2. Clarify the key role of decentralization in achieving sustainability. Include the use of RAPID-type presentations to garner support for expanded family planning.**

*Improving the health status of a growing population requires dynamic decentralized leadership and direction from MOPH. The project will assist the MOPH to fully institutionalize regional structures as well as improve provincial level planning and management capabilities to systematically services. [For details see description under Reinforced Decentralized Institutional Capacity, subsection, Management Systems Reinforcement.]*

**3.&4. Include language that would facilitate the utilization of a Gray Amendment entity as the possible prime institutional contractor, or at least specify that 10% of the procurement be through Gray Amendment entities and indicate that at least**

**10% of funds sub-contracted with U.S. institutions for research and training activities will be with historically black colleges and universities.**

*It has been a long standing policy of USAID/Morocco to make use of the skills and services offered by the Gray Amendment firms in all of its projects. This project will require that a minimum of 10% of funds for the U.S. institutional contractor be allocated to qualifying Gray Amendment firms. In addition, efforts will be made to utilize historically black universities in research and training activities to the maximum extent possible.*

- 5. For comprehensive financial planning of the Pop/Health sector program in Morocco, the AA/NE invited the offices of R&D to indicate their contribution for the program in Morocco.**

*The Mission will work closely with the offices of R&D to determine their contributions to Mission programs additive to the project. The Mission will submit on an annual basis its expected buy-ins and request for core support activities not covered by the project. The Mission has worked successfully with the offices of R&D Pop. and Health over the years and for sees no problem in this area.*

- 6. Describe how mechanisms such as assessments of health care consumption patterns can help policy-makers plan more accurately concerning the segmentation of health care consumers and the expression of choice between a variety of health care providers.**

*Part of the private sector strategy is to conduct studies on market segmentation. 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 project sector participation, and testing of effective strategies for expanding FP/MCH services through social marketing, the work-place, and private group practice. [For details see description under Diversified Resource Base/Private Sector Participation, subsection, Private Sector Development.]*

- 7. Classify the World Bank as a lender not a donor.**

*The World Bank has been noted as a lender.*

- 8. Spell-out more specifically the key role of WHO.**

*The World Health Organization provides assistance in terms of financing, contributing approximately \$4 million for 1990-91. Its technical assistance in AIDS control, public health training, communicable diseases and epidemiology is a most useful complement to the efforts of the other agencies. In addition, WHO finances a technical advisor to the National Health Training Institute, INAS.*

**ATTACHMENT A**

**GOM/USAID 1994-1998 Estimated Contraceptive Requirements and Cost**

TABLE 1

CONTRACEPTIVE CONSUMPTION ESTIMATES 1992-1998

PRODUCT	92	93	94	95	96	97	98
CONDOMS	5700	6000	7000	8000	8000	8000	8000
LO-FEMENAL	6500	6800	7000	7500	8000	8500	8500
OVRETTE	345	400	500	600	650	650	650
DEPO- PROVERA	0	15	20	40	75	100	150
NORPLANT	0	5	3	4	6	7	8
COPPER T	67	80	85	90	100	110	120

THIS TABLE STARTS WITH ACTUAL DISPENSED TO CLIENTS DATA FOR 1992. THIS INFORMATION CAME FROM THE MOH FROM THEIR ANNUAL TOTAL " QUANTITE DES CONTRACEPTIFS UTILISES " FOR 1992. THAT REPORT DID NOT INCLUDE INFORMATION FOR DEPO-PROVERA AND NORPLANT, NEITHER OF WHICH WERE USED IN MOPH CLINICS AT THAT TIME.

CONSUMPTION FOR 1993-1999 IS BASED ON ESTIMATES OF CHANGES IN METHOD MIX, WITH DEPO-PROVERA AND NORPLANT USED FOR CLIENTS WHO MIGHT OTHERWISE HAVE SELECTED ORAL CONTRACEPTIVES. BUT USE OF ORAL CONTRACEPTIVES WILL INCREASE BECAUSE OF PROGRAM GROWTH. FOR PRACTICAL PURPOSES NEITHER DEPO NOR NORPLANT WILL BE AVAILABLE IN 1993.

TABLE 2

CONTRACEPTIVE PRICE ESTIMATES, 1994-1998

**A. CONDOMS**

	94	95	96	97	98	TOTAL
QUANTITY (1,000s)	7000	8000	8000	8000	8000	39000
PRICE PER UNIT	0.053500	0.056175	0.058984	0.061933	0.065030	
COST	374500	449400	471870	495464	520237	
FREIGHT (6%)	22470	26964	28312	29728	31214	
TOTAL COST	396970	476364	500182	525191	551451	2450158

TABLE 2 (CONTINUED)

**B. LO-FEMMAL**

	94	95	96	97	98	TOTAL
QUANTITY (1000s)	7000	7500	8000	8500	8500	39500
PRICE PER CYCLE	0.165000	0.173250	0.181913	0.191008	0.200559	
COST	1155000	1299375	1455300	1623569	1704748	
FREIGHT (6%)	69300	77963	87318	97414	102285	
TOTAL COST	1224300	1377338	1542618	1720983	1807032	7672271

**C. OVRETTE**

	94	95	96	97	98	TOTAL
QUANTITY (1000s)	500	600	650	650	650	3050
PRICE PER CYCLE	0.165000	0.173250	0.181913	0.191008	0.200559	
COST	82500	103950	118243	124155	130363	
FREIGHT (6%)	4950	6237	7095	7449	7822	
TOTAL COST	87450	110187	125338	131605	138185	592764

**D. DEPO-PROVERA**

	94	95	96	97	98	TOTAL
QUANTITY (1000S)	20	40	75	100	150	385
PRICE PER DOSE	1.000000	1.050000	1.102500	1.157625	1.215506	
COST	20000	42000	82688	115763	182326	
FREIGHT (6%)	1200	2520	4961	6946	10940	
TOTAL COST	21200	44520	87649	122708	193265	469342

TABLE 2 (CONTINUED)

**E. MORPLANT**

	94	95	96	97	98	TOTAL
QUANTITY (1000s)	3	4	6	7	8	28
PRICE PER UNIT	23.00000	24.15000	25.35750	26.62538	27.95664	
COST	69000	96600	152145	186378	223653	
FREIGHT (6%)	4140	5796	9129	11183	13419	
TOTAL COST	73140	102396	161274	197560	237072	771442

**F. COPPER T**

	94	95	96	97	98	TOTAL
QUANTITY (1000s)	85	90	100	110	120	505
PRICE PER UNIT	0.965000	1.013250	1.063913	1.117108	1.172964	
COST	82025	91193	106391	122882	140756	
FREIGHT (6%)	4922	5472	6383	7373	8445	
TOTAL COST	86947	96664	112775	130255	149201	575841

TABLE 3

TOTAL CONTRACEPTIVE COST, 1994-1998

PRODUCT	94	95	96	97	98	TOTAL
CONDOMS	396970	476364	500182	525191	551451	2450158
LO-FEMENAL	1224300	1377338	1542618	1720983	1807032	7672271
OVRETTE	87450	110187	125338	131605	138185	592764
DEPO- PROVERA	21200	44520	87649	122708	193265	469342
MORPLANT	73140	102396	161274	197560	237072	771442
COPPER T	86947	96664	112775	130255	149201	575841
TOTAL	1890007	2207469	2529835	2828302	3076207	12531819

TABLE 4

SHARED CONTRACEPTIVE COST, USAID AND GOM, 1994 - 98

	AID 100%	AID 90%	AID 75%	AID 50%	AID 25%	TOTAL
	94	95	96	97	98	
AID	1890007	1986722	1897376	1414151	769052	7957307
GOM	0	220747	632459	1414151	2307155	4574512
TOTAL	1890007	2207469	2529835	2828302	3076207	12531819

THE FIGURES IN TABLE 4 ASSUME THAT USAID WILL PROGRESSIVELY DECREASE ITS SHARE OF THE BUDGET NEEDED TO PURCHASE CONTRACEPTIVES, AND THAT GOM WILL GRADUALLY INCREASE ITS CONTRIBUTION. THE FIGURES ALSO ASSUME THAT GOM WILL BE ABLE TO PURCHASE CONTRACEPTIVES AT THE SAME PRICE USAID PAYS FOR PRODUCTS PURCHASED THROUGH A CONSOLIDATED CENTRAL CONTRACT.

## **A N N E X B.**

### **LOGICAL FRAMEWORK**

**Logical Framework**

**Performance Monitoring Plan for Mission  
Strategic Objectives**

## LOGICAL FRAMEWORK

Life of Project: 2000  
 Total U.S. Funding: \$52,000,000  
 Date Prepared: May 19, 1993

Project Title & Number: Family Planning & Maternal/Child Health V (FP/MCH), Project 608-0223

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>Program Goal:</b></p> <p>Improved health of children under five years of age, and women of childbearing age</p>	<p><b>Measures of Goal Achievement:</b></p> <p>Reduced infant and child mortality rates (From respective 1992 rates of 57 and 20/1000)</p> <p>Reduced maternal mortality (From estimated 1992 rate of 300-400/100,000)</p> <p>Reduced total fertility rate (From 1992 rate of 4.1)</p>	<p>Demographic and Health Survey</p> <p>Census and demographic surveys</p> <p>UNICEF State of the World's Children</p> <p>National Standard of Living Survey</p>	<p>GOM proceeds with social sector development</p> <p>GOM implements planned health sector reforms</p> <p>Socio-political environment remains favorable towards family planning/child survival</p> <p>Economic conditions continue to improve</p> <p>There are no major epidemics or natural disasters</p>

<u>Project Purpose:</u>	<u>End of Project Status (EOPS).</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTIONS</u>
<p>To increase the effective use of family planning and select child survival services and to increase sustainability of those services</p>	<p><u>EFFECTIVE USE</u></p> <ol style="list-style-type: none"> <li>1. Contraceptive prevalence increased to: overall:54% urban:60% Long term:12% rural:48% Short term:35%</li> <li>2. More women receive prenatal care (from 30% to 50%)</li> <li>3. More cases of CDD treated with ORS, (from 14% to 25%)and ORT (from 15% to 30%)</li> </ol> <p><u>SUSTAINABILITY</u></p> <ol style="list-style-type: none"> <li>4. Favorable policy climate for rapid expansion of FP/MCH services.</li> <li>5. Increased institutional capacity at national, regional and provincial levels</li> <li>6. Diversified funding base for FP/MCH services</li> <li>7. Increased market share of contraceptives obtained through the private sector (from 36% to 50%)</li> <li>8. FP/MCH service expand with increased public resources/policy support as donor assistance is scaled</li> </ol>	<p>Census and demographic Surveys</p> <p>Demographic health survey</p> <p>Service statistics</p> <p>Government budget</p> <p>Pharmaceutical industry and private sector data</p> <p>Special MOPH and private studies</p>	<p>Effective officials in place, and turnover low</p> <p>Government will continue to support private sector provision of services</p> <p>GOM continues to make greater investment in primary health care and preventive health services.</p> <p>GOM assumes greater share of local and contraceptive costs.</p>

<u>PROJECT OUTPUTS:</u>	<u>MAGNITUDE OF OUTPUTS:</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTIONS</u>
<p>Component 1:</p> <p>Effective Use of FP/MCH Services</p> <p><u>Increased Access</u></p> <ol style="list-style-type: none"> <li>1. Better organized and wider range of FP, CDD and the safe motherhood services</li> <li>2. Fully integrated FP/MCH structures and services</li> <li>3. Alternative health care service delivery strategies tested</li> </ol>	<ol style="list-style-type: none"> <li>1. 10 diagnostic/special studies to ascertain access problems</li> <li>2. Long-term method including, Norplant, injectables, minilap and postpartum family planning available.</li> <li>3. Improved contraceptive method mix (currently 80% are contraceptives)</li> <li>4. Improved client flow between FP/MCH services; integrated client record and MIS system; referral mechanisms and supervision systems in place</li> <li>5. Outreach and Intersectorial referrals into MOPH service system (e.g. agricultural, NGOs and community agents)</li> </ol>	<p>DHS studies</p> <p>UN and other donor reports</p> <p>GOM service statistics pharmaceutical sector sales data</p> <p>Evaluation reports</p> <p>Contractor reports</p> <p>MOPH statistical or special reports</p> <p>Copies of service protocols</p> <p>Training curricula</p> <p>Training evaluation reports</p> <p>Supervision records</p> <p>Copies of IEC materials produced</p> <p>Consultant trip reports</p>	<p>Providers and clients accept broader range of contraceptives as well as CDD and safe motherhood services</p> <p>MOPH successful in its strategy to fully integrate services and avoid vertical programming</p> <p>MOPH implements plan to obtain intersectorial support for service delivery</p>

<u>PROJECT OUTPUTS</u>	<u>MAGNITUDE OF OUTPUTS</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTION</u>
<p><u>Improved Quality</u></p> <ol style="list-style-type: none"> <li>Standards of Practice on FP and CS widely disseminated</li> <li>Pre and In-service curriculum development and training undertaken</li> <li>Improved supervision system</li> <li>Improved clinic/service environment</li> </ol>	<ol style="list-style-type: none"> <li>4 FP/MCH protocols available nationwide</li> <li>At least 4 needs assessments and training plans developed</li> <li>curriculum for FP/MCH revised at nursing and medical schools</li> <li>Services providers trained in in-service courses for technical and counselling skills development</li> <li>Tested FM/MCH supervision systems operational and supervisors trained</li> <li>Physical environments of clinic setting improved</li> </ol>	<p>DHS studies</p> <p>UN and other donor reports</p> <p>GOM service statistics pharmaceutical sector sales data</p> <p>Evaluation and reports</p> <p>Contractor reports</p> <p>MOPH statistics or special reports</p>	<p>MOPH continues to focus on improving quality</p> <p>MOPH continues to provide indemnities for supervision, training and outreach</p>
<p><u>Improved Quality IEC</u></p> <ol style="list-style-type: none"> <li>Increased capacity of MOPH to develop, pretest and disseminate health information</li> <li>Decentralized, integrated IEC programs in place</li> </ol>	<ol style="list-style-type: none"> <li>National and at least 5 provincial IEC needs assessments and action plans developed and implemented</li> <li>Messages developed and disseminated for FP, CDD and safe motherhood programs.</li> <li>Materials produced/ disseminated/eg.slide sets, flip charts, Brochures-posters and radio/TV spots</li> <li>Mass media materials developed + disseminate (eg. radio/TV spots)</li> <li>IEC personnel trained from 5 provinces, private sector and intersectorial agencies.</li> </ol>	<p>Copies of service protocols, training curricula</p> <p>Supervision records</p> <p>Copies of IEC materials developed</p> <p>Training evaluations reports</p> <p>Consultant trip reports</p>	<p>MOPH successfully integrates IEC with technical offices</p>

<u>PROJECT OUTPUTS</u>	<u>MAGNITUDE OF OUTPUTS</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTION</u>
<p>Project Component 2: Sustainability</p> <p><u>Favorable Policy Environment</u></p> <p>1. Favorable policies for the expansion of FP/MCH services particularly in the private sector.</p> <p><u>Improved Institutional Capacity</u></p> <p>1. Functioning decentralized MOPH structure 2. Improved managerial expertise of both public and private sector providers 3. Strategy planning framework developed for gradual assumption by GOM of contraceptive and local costs</p>	<p>1. Policy agenda developed &amp; implemented</p> <p>2. Alternative policies developed and wide support mobilized.</p> <p>1. Formalized regional structure established and provincial structures reinforced</p> <p>2. Managers trained in programming, planning evaluations, operations research, MIS system, and logistics supply.</p> <p>3. Targets for financial phase-down established and evaluated annually.</p>	<p>Policy agenda statements</p> <p>Records of major changes in policies and regulations, particularly effecting private sector</p> <p>Regional records and MIS reports</p> <p>Planning documents</p> <p>Evaluation reports</p> <p>Research study results/reports</p> <p>Line item for contraceptive/local cost in national budget</p> <p>Consultant reports</p>	<p>GOM willing to adapt and aggressively pursue health sector reform</p> <p>No major reorganization of the MOPH (including decentralization) disrupts services</p> <p>GOM continues to support public sector expansion of FP/CS services, particularly decentralization</p> <p>GOM gives sufficient support to private sector initiatives</p> <p>Private sector is willing to participate in nation FP/MCH</p> <p>GOM increases MOPH budget lines for recurrent costs</p>

<u>PROJECT OUTPUTS</u>	<u>MAGNITUDE OF OUTPUTS</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTION</u>
<p><u>Diversified Resource Base/Private Sector</u></p> <ol style="list-style-type: none"> <li>1. Increased knowledge and information of potential role of private sector in FM/MCH</li> <li>2. Feasibility of social marketing of long term methods and linkages with private sector providers determined</li> <li>3. Workplace services and referral mechanisms piloted</li> <li>4. Private sector health providers trained in FP/MCH</li> </ol>	<ol style="list-style-type: none"> <li>1. Social marketing programs expanded for oral contraceptives, ORS, Condoms)</li> <li>2. Strategies developed for new approaches to private sector</li> <li>3. workplace strategies piloted in at least 10 workplace sites.</li> <li>4. At least 100 private providers trained in special techniques of FP (minilap or laparoscopy), special maternity</li> </ol>	<p>Service statistics from private providers</p> <p>Training records/reports</p> <p>Special studies, marketing surveys</p> <p>Consultant reports</p>	<p>Private Sector interested and willing to provide preventive health services</p> <p>Moroccans will seek preventive health services and through the private sector</p> <p>Employers see advantages and are willing to provide services in their place of business</p> <p>Social marketing will continue to be an acceptable strategy</p>

<u>Project Inputs:</u>	<u>Magnitude of Inputs</u> <u>(\$000):</u>		<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTION</u>
SOURCE	A.I.D.	GOM		
TECHNICAL ASSISTANCE/PERSONNEL	6962	66494	Grantee contracts and reports	AID funds will become available on a timely basis
TRAINING	940	0	Shipping documents and reports on commodities	The GOM can effectively absorb and utilize AID provided resources
COMMODITIES	11250	0	Site visit reports	
LOCAL COSTS	14678	35326	Project financial reports	The GOM will assume cost of personnel, training, local costs and contraceptives.
PROJECT MANAGEMENT	6483	0	Host country contribution tracking system	Moroccans will pay for FP/MCH services
EVAL/AUDIT/IMPACT STUDIES	640	0		
CONTINGENCY/INFLATION	2838	0		
CONTRACEPTIVE COMMODITIES	8189	6651		French speaking technical consultants are available for short-term TA
<b>T O T A L</b>	<b>52000</b>	<b>108,471</b>		
<b>GRAND TOTAL</b>		<b>160,471</b>		

TABLE 1 PERFORMANCE MONITORING PLAN FOR SO3

Strategic Objective No.3: Improved health of Children under five and women of child bearing age

PERFORMANCE INDICATOR	PRECISE DEFINITION OF INDICATOR UNIT OF MEASUREMENT	DATA SOURCE/SET DATA QUALITY	EVAL METHOD/ APPROACH	TIMING AND FREQUENCY OF DATA COLLECTION	FUTURE COST OF COLLECTING INFORMATION AND SOURCE OF FUNDS	RESPONSIBLE PERSON/ OFFICE
1. Total Fertility Rate	The average number of children that would be born alive to a woman during her lifetime if she were to pass through all her childbearing years conforming to the age-specific fertility rates of a given year	Demographic and Health Surveys 1992 and 1997; 1992 data were of high quality, but the DHS does have a substantial margin of error. However, no better and more timely source exists.	This is a proxy indicator for maternal health, since it is difficult to determine maternal mortality in any survey conducted less comprehensively and more frequently than a population census.	baseline in 1992; end of strategy period in 1997 (data represent annual averages for the previous five years)	Cost: \$500,000 in 1992; cost will be higher in 1997. This covers the cost of data collection and analysis for several indicators. Source: buy-in	Population and Human Resources
2. Infant Mortality Rate	Annual number of deaths of infants under the age of one per thousand live births	DHS (as above)	standard indicator along with child mortality rate for measuring improvements in the health of children under five	as above	Cost: as above Source:	Population and Human Resources
3. Child Mortality Rate	Annual number of deaths of children aged one through four years per total population of the same age	DHS (as above)	as above	as above	Cost: as above Source:	as above

Table 1.a PERFORMANCE MONITORING PLAN FOR PROGRAM OUTCOME

Strategic Objective No. 3: Improved Health of Children Under Five and Women of Child Bearing Age  
 Program Outcome 3.1 : Increased Use of Effective MCH/FP Services

PROGRAM INDICATOR	PRECISE DEFINITION OF INDICATOR UNIT OF MEASUREMENT	DATA SOURCE/SET DATA QUALITY	EVAL METHOD/ APPROACH	TIMING AND FREQUENCY OF DATA COLLECTION	FUTURE COST OF COLLECTING INFORMATION AND SOURCE OF FUNDS	RESPONSIBLE PERSON/ OFFICE
1 Contraceptive Prevalence Rate (Long-term/short-term)	Percent of married women of child-bearing age (15-49) currently using contraceptives, desegregated by long-term/short-term methods.	DHS - data quality good in Morocco; processed data available	Standard measure for increased use of family planning services	1992, 1997 available the same year	Cost: 1992 \$500,000, cost will be higher in 1997	Population and Human Resources -
Proxy 1.1 Couple Years of Protection Provided by the Public Sector	Measured using MOPH service statistics, converting long-term/short-term products distributed to CYP: sterilization= 10 CYP; 1 Norplant= 3.5 CYP; 1 IUD= 3.5 CYP; 15 cycles of pills+1 CYP; 150 condoms= 1 CYP	MOPH service statistics - MIS of Sante Maternale Infantile/Planification Familiale Data quality reasonably good (USAID has invested in improving this MIS over the past several years), calculation of CYP will need to be made.	This is a proxy indicator for CPR, since CPR data will only be available in 1992 and 1997. If CYP is increasing, more women should be practicing family planning and/or they are selecting longer-term methods. This captures public sector data only. This indicator needs to be analyzed in conjunction with the indicator recording private sector distribution of short-term methods below.	Annual, by calendar year	Cost: 2 days of staff time to collect data and make calculations	as above

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PROGRAM INDICATOR	PRECISE DEFINITION OF INDICATOR AND UNIT OF MEASUREMENT	DATA SOURCE/SET DATA QUALITY	EVAL METHOD/ APPROCH	TIMING AND FREQUENCY OF DATA COLLECTION	FUTURE COSTS OF COLLECTING INFORMATION AND SOURCE OF FUNDS	RESPONSIBLE PERSON/ OFFICE
Proxy 1.2 Couple Years of Protection Provided by the Private Sector	Measured as in 1.1 for pills and condoms only, sold by wholesalers, using sales statistics (International Marketing Services Data available through SOMARC)	IMS through SOMARC, because data count wholesaler sales, losses at the retailer level cannot be calculated. Data are accurate for wholesaler sales to retailers. processed data available.	This is a proxy indicator for CPR, since CPR data will only be available in 1992 and 1997. This captures private sector data for short-term methods. If CYP goes up more rapidly in the private sector, this might be a sign that the private sector is beginning to assume a larger share of the service delivery burden.	annual, by calendar year	SOMARC purchase and provides at no cost	Population and Human Resources -
2 Contraceptive Use Effectiveness Rate	One minus the probability that a woman would get pregnant while using contraceptives	DHS - data of good quality. Processed data available.	Standard measure of whether methods are being used properly - If use effectiveness improves, then more effective methods are being selected and/or women are using methods appropriately.	1992 and 1997	see CPR	as above
3 Percentage of Pregnant Women Receiving Qualified Prenatal Care	Percentage of pregnant women seeing an MD, nurse or midwife at least once for prenatal care and receiving one tetanus toxoid injection	DHS - data of good quality. processed data available.	An indicator that measures increased use of effective MCH services.	1992 and 1997	see CPR	Population and Human Resources
4 Percent of Diarrheal Disease Cases Provided with ORS	Percent of all children under five who had diarrhea in the previous two weeks and who were treated with ORS sachet or home solution	DHS - data of good quality	ibid. -	1992 and 1997	see CPR	as above

PROGRAM INDICATOR	PRECISE DEFINITION OF INDICATOR UNIT OF MEASUREMENT	DATA SOURCE/SET DATA QUALITY	EVAL METHOD/ APPROACH	TIMING AND FREQUENCY OF DATA COLLECTION	FUTURE COST OF COLLECTING INFORMATION AND SOURCE OF FUNDS	RESPONSIBLE PERSON/ OFFICE
Proxy 4.1 Number of New Diarrhea Cases Provided with Rehydration Therapy at MOPH Facility	MOPH service statistics defining number of new diarrheal disease cases provided with ORS	MOPH service statistics – MIS of Sante Maternale Infantile/Planification Familiale	This is a proxy indicator for the above indicator, so that data can be collected annually	Annual, by calendar year	Cost: half day of staff time p.a. to collect and analyse data	as above

Table 1.b PERFORMANCE MONITORING PLAN FOR PROGRAM OUTCOME

Strategic Objective: Improved Health of Children Under Five and Women of Child Bearing Age  
 Program Outcome : Increased Sustainability of MCH/FP Services

PROGRAM INDICATOR	PRECISE DEFINITION OF INDICATOR UNIT OF MEASUREMENT	DATA SOURCE/SET DATA QUALITY	EVAL METHOD/ APPROACH	TIMING AND FREQUENCY OF DATA COLLECTION	FUTURE COST OF COLLECTING INFORMATION AND SOURCE OF FUNDS	RESPONSIBLE PERSON/ OFFICE
1 Number of MCH/FP visits pr donor dollar	Number of MCH/FP visits to MOPH facilities for pregnancy and delivery, FP, diarrheal disease, nutrition surveillance, and immunization services - divided by the number of major donor dollars (USAID, UNFPA, UNICEF, EEC). Donor dollars per annum will be calculated by averaging - taking the grant divided by the number of years of each grant.	Major donor records of grants; MOPH service statistics - data of reasonably good quality.	The Ministry does not organize its budget by program so it is not possible to track the MCH/FP budget or portions thereof to determine if the MOPH is replacing donor funds being shifted from recurrent costs to other interventions. It is possible to count the number of MCH/FP visits, which should increase, and divide this by donor dollars, to express the efficiency in use of donor funding. This assumes that donor funding remains relatively stable.	Annual, but donor funding will be calculated according to annual averages.	Cost: No \$ cost but 2 days p.a. of staff time to collect information from donors and MOPH and make calculation	Population and Human Resources
2 Percentage of FP users getting contraceptives in the private sector	FP users getting contraceptives in the private market as a percentage of total FP users.	DHS - data of good quality	One way to increase sustainability is to have the private sector pick up a larger share of service provision.	1992 and 1997	Cost: 1992 - \$500,000; more in 1997 Source: buy-in	Population and Human Resources -

PROGRAM INDICATOR	PRECISE DEFINITION OF INDICATOR AND UNIT OF MEASUREMENT	DATA SOURCE/SET DATA QUALITY	EVAL METHOD/ APPROCH	TIMING AND FREQUENCY OF DATA COLLECTION	FUTURE COSTS OF COLLECTING INFORMATION AND SOURCE OF FUNDS	RESPONSIBLE PERSON/ OFFICE
Proxy 2.1 Private Sector share of the condom and oral contraceptives market	Ratio of commercially distributed pills and condoms to MOPH-provided pills and condoms, translated into CYP	IMS data through SOMARC, MOPH service statistic.	This is a proxy for the indicator above because data can be collected annually. The DHS can be expected to provide a more accurate picture of the private sector share.	annual, by calendar year	SOMARC purchase and provides at no cost	Population and Human Resources
3 Percentage of target population completely vaccinated by MOPH	Percentage of target population completely vaccinated with 3 DPT, 1 measles, 1 Polio, 1 BCG	MOPH service statistics - of reasonably good quality; DHS for two years. The two sources differ so MOPH data will be collected each year and DHS data will be used to confirm Ministry data. Discrepancies will be analyzed.	Donor support is being withdraw from immunization, and the MOPH is being assisted to develop a vaccine capitalization fund in order to buy vaccines from their own resources. If current high levels of vaccination are maintained, this is a sign that the Ministry has sustained its vaccination program.	Ministry service statistics are annual, reported on a calendar year basis; DHS done in 1992 and 1997	Cost: DHS \$500,000 in 1992; more in 1997.	Population and Human Resources
Comments/Notes:						

TABLE 2

## Baseline and Performance Targets

STRATEGIC OBJECTIVE, PROGRAM OUTCOMES/SPECIFIC RESULTS	PRECISE DEFINITION OF INDICATOR & UNIT OF MEASUREMENT	BASELINE YEAR & VALUE	PERFORMANCE TARGETS					CRITICAL ASSUMPTIONS
			1993	1994	1995	1996	1997	
<p>Strategic Objective N. : Improved Health of Children Under Five and Women of Child Bearing Age Indicators:</p> <p>1. Total Fertility Rate</p> <p>2. Infant Mortality Rate</p> <p>3. Child Mortality Rate</p>	<p>1 The average number of children that would be born alive to a woman during her lifetime if she were to pass through all her childbearing years conforming to the age-specific fertility rates of a given year</p> <p>2 Annual number of deaths of Infants under the age of one per thousand live births</p> <p>3. Annual number of deaths of children aged one through four years per total population of the same age</p>	<p>1992 = 4.2</p> <p>1992 = 57</p> <p>1992 = 20</p>					<p>3.7</p> <p>50</p> <p>17</p>	<p>Socio-political environment remains favorable toward family planning.</p> <p>There are no major epidemics or natural disasters.</p> <p>Economic conditions continue to improve.</p>

TABLE 2a

STRATEGIC OBJECTIVE, PROGRAM OUTCOMES/SPECIFIC RESULTS	PRECISE DEFINITION OF INDICATOR & UNIT OF MEASUREMENT	BASELINE YEAR & VALUE	PERFORMANCE TARGETS					CRITICAL ASSUMPTIONS
			1993	1994	1995	1996	1997	
Program Outcome No. : Increased Use of Effective MCH/FP Services								No major reorganizations of the MOPH, disrupting services.
1. Contraceptive Prevalence Rate	1 Percent of married women of child-bearing age (15-49) currently using contraceptives, desegregated by long- term/short-term methods.	1992 = 42 LT = 6 ST = 30					49 LT = 11 ST = 31	
1.1. Couple Years of Protection- Public Sector	1.1 Measured using MOPH service statistics, converting long-term/short-term products distributed to CYP: sterilization=10 CYP; 1 Norplant = 3.5 CYP; 1 IUD=3.5 CYP; 15 cycles of pills=1 CYP; 150 condoms=1 CYP	1991 = LT = 207,396  ST = 733,357	LT = 222,622  ST = 736,792	LT = 265,576  ST = 738,510	LT = 287,054  ST = 740,228	LT = 308,531  ST = 741,945	LT = 330,008  ST = 743,663	
1.2 Couple Years of Protection- Private Sector	1.2 Measured as in 1.1 for pills and condoms only, sold by wholesalers to retailers, using sales statistics	1991 = 263,000	289,901	303,352	316,803	330,253	343,704	
2. Contraceptive Use Effectiveness Rate	2 One minus the probability that a woman would get pregnant while using contraceptives	available 1993	TBD					
3. Percentage of pregnant women receiving qualified pre- natal care	3 Percentage of women seeing and MD, nurse or midwife at least once for pre-natal care and receiving one tetanus toxoid injection	1992 = 32					54	
4. Percent of diarrheal disease cases provided with ORS	4 Percent of children under five who had diarrhea in the previous two weeks and who were treated with ORS sachet or home solution	1992 = 15					TBD	
4.1 Number of new diarrhea cases provided with rehydration therapy at MOPH facility	4.1 MOPH service statistics defining number of new diarrheal disease cases provided with	To be obtained	TBD					

TABLE 2b

STRATEGIC OBJECTIVE, PROGRAM OUTCOMES/SPECIFIC RESULTS	PRECISE DEFINITION OF INDICATOR & UNIT OF MEASUREMENT	BASELINE YEAR & VALUE	PERFORMANCE TARGETS					CRITICAL ASSUMPTIONS
			1993	1994	1995	1996	1997	
<p>Program Outcome No. : Increased Sustainability of MCH/FP Services</p> <p>Indicators:</p> <p>1 Number of MCH/FP visit per donor dollar</p> <p>2. Percentage of FP users getting contraceptives in the private sector</p> <p>2.1 Ratio of commercially distributed pills and condoms to MOPH-provided pills and condoms, translated to CYP</p> <p>3. Percentage of target population completely vaccinated by MOPH</p>	<p>1 Number of MCH/FP visits to MOPH facilities for pregnancy and delivery, FP, diarrheal disease, nutrition surveillance, and immunization services - divided by the number of major donor dollars (USAID, EEC). Donor dollars per annum will be calculated by averaging - taking the grant divided by the number of years of each grant.</p> <p>2. FP users getting contraceptive in the private market as a percentage of total FP users.</p> <p>2.1 Ratio of commercially distributed pills and condoms to MOPH-provided pills and condoms, translated into CYP</p> <p>3 Percentage of target population completely vaccinated with 3 DPT, 1 measles, 1 Polio, 1 BCH</p>	<p>To be obtained</p> <p>1992 = 37</p> <p>1991 = 26</p> <p>1992 = 76</p>						<p>Government will continue to support private sector provision of services.</p> <p>Government continues to buy vaccines.</p>
			28	29	30	31	32	
			76	76	76	76	76	

NB: DHS baseline data for 1992 represent an annual average for the period 1987 to 1992

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**ATTACHMENT B**

**1991 International Contraceptive Price Estimates and Range**

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**A N N E X C.**

**GOM REQUEST FOR ASSISTANCE**

MONSIEUR ROLAND W. ROSKENS  
ADMINISTRATEUR DE L'USAID

WASHINGTON

Etats-Unis d'Amérique

OBJET : PROG

DATE : 08/15

INFO : DIR DIR

HR OFI - CHRON - RF

OBJET / Demande de financement par l'USAID d'un Programme de  
Prévention sanitaire.-

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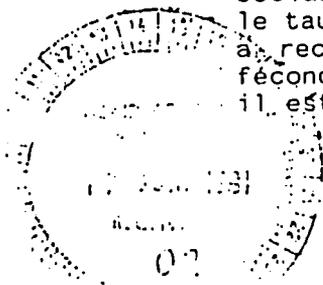
Monsieur l'Administrateur,

Au nom du Gouvernement de S. M. le ROI, je vous présente mes remerciements pour la visite que vous venez d'effectuer dans notre pays. Cette visite m'a offert l'occasion et le plaisir de vous rencontrer et d'échanger avec vous des points de vue sur des problèmes d'intérêt commun, comme elle vous a permis de prendre connaissance sur le terrain de nos succès et de nos problèmes en matière de développement économique et social.

En effet, M. l'Administrateur, depuis son accession à l'indépendance le Maroc a accompli des progrès considérables dans le domaine du développement social.

La politique économique menée par le Gouvernement a eu des effets redistributifs importants destinés à répondre mieux aux besoins du pays dans le domaine social.

L'amélioration progressive du niveau des prestations sociales, au cours de ces 20 dernières années, qui a résulté, elle-même, d'une croissance économique de plus en plus soutenue a permis une nette amélioration des principaux indicateurs sociaux. Ainsi, l'espérance de vie est passée de 49 à 62 ans et le taux de mortalité de 18 à 8 pour mille ; la mortalité infantile a reculé de 145 à 73 pour mille et l'indice synthétique de fécondité de 6 à 4,6. Quand au taux d'alphabétisation des femmes il est passé de 10 % en 1970 à 22 % en 1985.



ACTION TAKEN

No Action Necessary

Replied by:

*[Handwritten signature]*

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Ces progrès auraient été encore plus importants si la croissance de la population, qui a doublé de 1960 à 1987 en passant de 11,6 à 22,3 millions d'habitants, n'avait pas été aussi forte.

Malgré ces résultats, plusieurs indicateurs sociaux demeurant défavorables. La mortalité juvénile reste très élevée (32 pour mille) et la mortalité maternelle et infantile reste relativement forte.

Cette situation sanitaire se manifeste avec beaucoup plus d'acuité dans le milieu rural.

Le Maroc, qui se trouve à 14 km. de l'Europe, a une population jeune qui souffre encore de maladies considérées actuellement comme historiques, telles que les maladies infectieuses, les maladies ophtalmologiques et les MST qui se manifestent notamment dans les milieux scolaires et universitaires. On recense actuellement quelque 5 millions de jeunes sanitaires mal encadrés.

Dans le cadre de ses efforts en matière de santé, le Gouvernement de S. M. le ROI a décidé d'orienter son action vers un programme intégré pour la promotion de la santé de base avec pour composantes principales :

- la lutte contre les maladies transmissibles ;
- le contrôle des sources d'infection ;
- le planning familial ;
- la thérapie de réhydratation orale ;
- la vaccination ;
- la lutte contre la malnutrition ;
- l'éducation sanitaire notamment en milieu rural ;
- le renforcement de l'hygiène scolaire ;
- la vulgarisation de techniques sanitaires simples et appropriées ;
- le renforcement de l'encadrement par une formation adéquate.

Cette tâche de grande envergure ne peut se réaliser que par la conjugaison des efforts de tous. En effet l'amélioration du niveau de santé implique une collaboration dans divers domaines visant à renforcer l'éducation de base, les réseaux d'assainissement et l'accès à l'eau potable, l'hygiène personnelle, les conditions de logement et l'éducation sanitaire.

En vue d'augmenter les moyens de financement du secteur de la santé, le Gouvernement a décidé de faire participer au développement de ce secteur les collectivités locales, les organisations non-gouvernementales nationales ainsi que les autres secteurs publics et parapublics qui peuvent contribuer directement ou indirectement à cet effort d'intérêt national.

Par ailleurs, un certain nombre d'actions sont en cours de réalisation ou de préparation pour motiver et encourager le secteur médical privé à se développer pour qu'il puisse contribuer valablement à la satisfaction des besoins de la population.

Le Gouvernement multipliera également ses efforts pour mobiliser les ressources nécessaires au développement du secteur de la santé auprès des pays amis et des organisations multilatérales susceptibles d'aider le Maroc dans ce domaine.

A cet égard, le Gouvernement de S.M. le ROI souhaite que l'USAID apporte une contribution significative à la réalisation du programme de prévention sanitaire dont les grands axes sont résumés ci-dessus. Nous espérons que cette contribution soit au même niveau que celle qui était accordée au Maroc dans le cadre du Programme Alimentaire compensatoire qui s'est achevé en Septembre 1990, soit 20 millions de dollars par an sur une durée de cinq ans.

Veillez agréer, Monsieur l'Administrateur, l'assurance de ma haute considération.

Le Premier Ministre

Signé : Ur Azeddine LARAKI



**LE MINISTRE**

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01 JUIN 1993

**MONSIEUR LE DIRECTEUR DE L'AID**

**Monsieur le Directeur,**

Dans le cadre de notre coopération commune et compte tenu de l'intérêt porté par notre département au développement des programmes de planification familiale et de santé maternelle et infantile, j'ai l'honneur de vous demander de bien vouloir examiner la possibilité de négocier un nouveau projet visant le renforcement de ces programmes qui sera exécuté à partir de l'année 1993.

Lors des récentes réunions de travail entre la Direction de la Prévention et de l'Encadrement Sanitaire et l'AID, nous avons discuté les grandes lignes des objectifs à atteindre et des actions à envisager. Nous avons conclu qu'un programme d'action visant en priorité les populations rurales et celles du milieu peri-urbain est à mettre en oeuvre; les actions d'Information, d'Education et de Communication doivent bénéficier d'un support beaucoup plus important que par le passé; une stratégie d'action visant le renforcement du rôle des différents partenaires en particulier du secteur privé est le seul garant d'une viabilité à long terme de nos programmes de Planification Familiale et de Santé maternelle et infantile; Enfin, un renforcement de l'effort de décentralisation soutenu par un développement des ressources humaines au niveau périphérique est la meilleure garantie d'une gestion efficace des moyens disponibles et d'une qualité optimale des prestations offertes par les structures de santé.

En espérant que vous puissiez donner une suite favorable à cette demande et en vous remerciant pour toute l'assistance que l'AID apporte à nos programmes, je vous prie de croire, Monsieur le Directeur, à ma parfaite considération.

Le Ministre de la Santé  
Publique

Signé : Pr. Abdelahim H. Z. H.

**ATTACHMENT C**

**Contraceptive Procurement Cycle**

## 1991 Contraceptive Price Estimates

<u>Contraceptive</u>	<u>Estimated Unit Price Range (USD)</u>
Condom (ea)	0.016 - 0.070
IUD (ea)	
Copper T 380A	0.70 - 0.95
Copper T 200B	0.50 - 0.65
Multiload	1.50 - 3.00
Oral Contraceptive (cycle)	
Low dose combined	0.15 - 0.20
Triphasic	0.19 - 0.28
Progestin only	0.15 - 0.35
Vaginal Foaming Tablet (ea)	0.07 - 0.10
Injectable (dose)	0.70 - 0.90

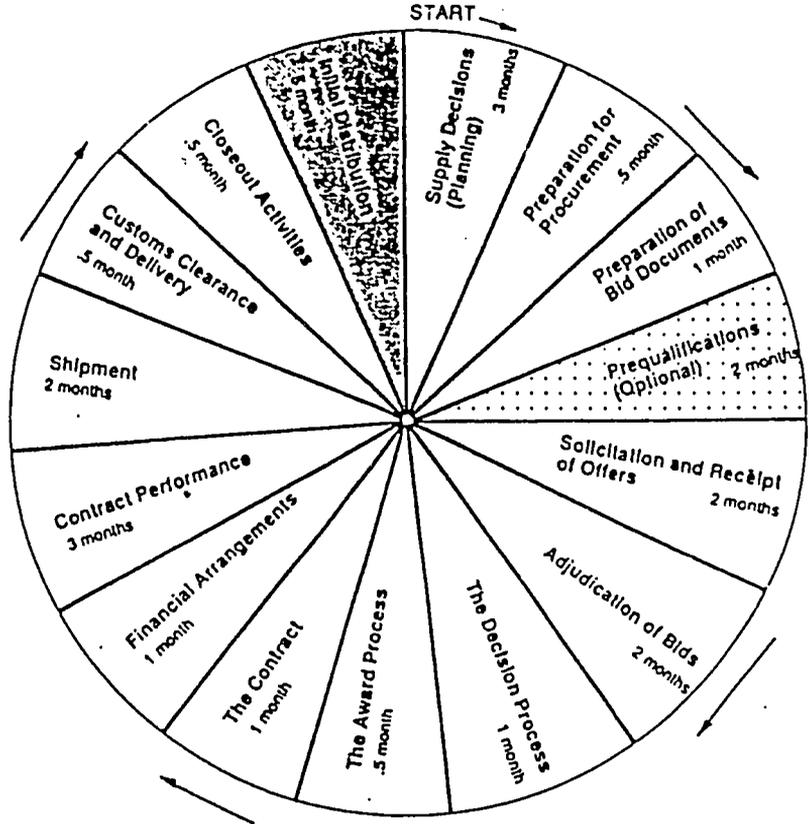
All price estimates are per unit prices, U.S. dollars, FOB country of origin, and packaged per manufacturer's standard packaging practice. Actual costs for contraceptives will depend on such factors as the quantity ordered, transportation costs, delivery date requested, and packaging and labelling requirements requested.

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# The Contraceptive Procurement Cycle

In order to give a fair representation of the sequence needed to accomplish a procurement, several related Planning and Distribution activities from "The Logistics Cycle" have been incorporated into a secondary chart shown below as "The Contraceptive Procurement Cycle:"



- Program Management Activities
- Logistics Activities
- Procurement Activities
- Optional Activities

D R A F T

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**ANNEX D.**

**DONOR CONTRIBUTION**

## 5 - 1 - LA COOPERATION AVEC LES ORGANISATIONS INTERNATIONALES

Les diverses formes de l'aide multilatérale en faveur du Secteur de la Santé marquent bon nombre de convergences, mais également des divergences notables dans la façon d'appréhender le problème. Ainsi, par exemple, l'action de l'Organisation Mondiale de la Santé (OMS) privilégie l'assistance technique, l'expertise et le conseil ; par contre, le Fonds des Nations Unies pour l'Enfance (UNICEF) s'oriente davantage vers l'aide directe.

Le Ministère de la Santé Publique a cherché à bénéficier au mieux de ces différents modes d'intervention en assurant leur complémentarité avec ses ressources propres. Les principaux partenaires multilatéraux du Ministère restent les agences et les organes du système des Nations Unies, suivis par quelques organisations, non gouvernementales internationales.

### A - L'ORGANISATION MONDIALE DE LA SANTÉ (OMS)

L'OMS intervient dans les différents pays à travers des bureaux régionaux (au nombre de cinq) et rarement directement depuis son siège.

Le Maroc, qui a fait partie du bureau régional de l'Europe, jusqu'en 1985, bénéficiait d'un apport qui ne dépassait pas 500 000 \$ par biennium.

Le passage à la région OMS de la Méditerranée Orientale s'est accompagné d'une part d'un accroissement significatif des fonds qui lui sont accordés (2.500.000 \$ par biennium, et, d'autre part, d'une diversification des projets dont le nombre atteint 44 actuellement.

L'ouverture en 1988 d'une représentation de l'OMS au Maroc a contribué sensiblement à l'amélioration du taux d'exécution des projets bénéficiant de la contribution de cette Organisation (40 projets sur les 44 du biennium 1990-1991 ont été exécutés à 100%) ; elle a permis la mobilisation d'importants Fonds extrabudgétaires (1.500.000 \$ pour le biennium 1990-1991) pour l'appui d'activités prioritaires telles que la formation continue et la lutte contre le SIDA,...

### B - LE FONDS DES NATIONS UNIES POUR LES ACTIVITÉS DE POPULATION (FNUAP)

Le FNUAP concentre, conformément à son mandat, sa collaboration avec le Ministère de la Santé Publique sur la Santé materno-infantile et la planification familiale en complémentarité avec d'autres partenaires extérieurs notamment l'USAID. Les programmes du FNUAP portent sur des quinquennats, le dernier s'étant achevé en 1991 ; il a connu la mise en

œuvre de cinq projets portant sur la santé materno-infantile, la formation en gestion, le système d'information sanitaire, la planification des ressources humaines et, enfin, l'amélioration des conditions d'accueil dans les formations sanitaires.

Le quinquennat 1992-1996 est marqué par un grand engagement de cet organisme qui a approuvé au profit du Ministère de la Santé Publique une enveloppe de 8.000.000 \$ (soit 47% de l'enveloppe accordée au Maroc pour la période indiquée contre 4.700.000 \$ pour la période 1987-1991 : soit, une augmentation de 70%).

### C - LE FONDS DES NATIONS UNIES POUR L'ENFANCE (UNICEF)

C'est un organisme dont les plans cadre d'opération sont également quinquennaux, le dernier s'est achevé en 1991 et a connu la réalisation de sept projets portant sur la santé de l'enfant (vaccinations, malnutrition et maladies de carence, maladies diarrhéiques, mortalité infantile et maternelle et morinatalité, soins de santé de base, éducation pour la santé et, enfin, l'eau potable et assainissement). En plus, un soutien a été apporté en fin de quinquennat au laboratoire d'immunologie pour le doter des moyens et capacités nécessaires au suivi et à l'évaluation de l'impact du programme national d'immunisation et aux essais sur les nouveaux vaccins.

Le Ministère de la Santé Publique et l'UNICEF envisagent ensemble la poursuite d'objectifs communs à savoir :

- promouvoir la survie, le développement et la protection des femmes mères et enfants.
- placer et maintenir l'inscription de la santé de l'enfant au premier plan des priorités.
- réduire les taux de mortalité et morbidité infantiles et juvéniles, ainsi que le taux de mortalité maternelle.

Une enveloppe globale de 12.780.000 \$ est prévue pour la période 1992-1996 contre 3.275.000 \$, initialement alloués pour 1987-1991 (soit une multiplication par 3,9).

La coopération avec l'UNICEF, datant de l'indépendance, a connu une évolution positive ces dernières années en se concentrant sur des domaines spécifiques, comme en témoignent les journées nationales de vaccinations, devenues depuis 1990 maghrébines.

L'initiative d'indépendance vaccinale est également une action exemplaire en matière de coopération internationale ; elle permettra au Maroc d'assurer le maintien du taux de couverture vaccinale atteint ces dernières années.

### C - LE PROGRAMME DES NATIONS UNIES POUR LE DÉVELOPPEMENT (PNUD)

Durant le quinquennat de programmation 1987-1991, le PNUD a contribué à deux projets dans le Secteur de la Santé : le premier concerne la maintenance des équipements hospitaliers et le second consiste à renforcer la capacité de gestion du programme national de lutte contre le SIDA. La contribution globale du PNUD s'est élevée à 1.112.000 \$.

Pour le quinquennat 1992-1996, cet organisme continuera à collaborer pour les deux projets sus-cités, en plus de trois autres projets nouveaux dans les domaines de l'amélioration de l'hygiène du milieu au niveau provincial et de la gestion hospitalière, avec une enveloppe globale de 3.655.000 \$, soit une multiplication par 3,3 environ.

### D - LA COMMUNAUTÉ ECONOMIQUE EUROPÉENNE (CEE)

La coopération avec la CEE porte sur neuf projets, dont certains sont en cours de finalisation. Ces projets portent sur des domaines variés tels les laboratoires, la production de vaccins, le contrôle des sérums et vaccins, la planification familiales, la lutte contre l'usage des drogues et la lutte contre le SIDA.

### E - L'AGENCE INTERNATIONALE POUR L'ENERGIE ATOMIQUE (AIEA)

La collaboration entre cette agence et le service national de radioprotection, notamment en matière d'expertise, s'est développée ces dernières années en vue de doter ce service des capacités de contrôle et de prévention des risques liés au développement des activités radioactives.

### F - LA BANQUE INTERNATIONALE POUR LA RECONSTRUCTION ET LE DÉVELOPPEMENT (BIRD)

L'intervention de cette institution dans le domaine de la santé remonte à l'année 1985 quand elle a accordé le premier prêt au secteur sanitaire (d'un montant de 28.400.000 \$).

Le projet, d'une durée de six ans et d'un montant total de 47.600.000 \$, visait d'une part à renforcer les capacités du Ministère de la Santé Publique en matière d'élaboration des politiques d'organisation, de planification et de gestion, et d'autre part à améliorer et étendre le système de soins de santé de base dans trois provinces (Agadir, Settat et Taroudant).

Un second prêt a été accordé par cette banque en 1989 pour financer le Projet d'Investissement dans le Secteur de la Santé (PRISS) d'un montant de 104.000.000 \$ ; le coût total du projet est de 171.000.000 \$ pour une durée de six ans et ses objectifs peuvent se résumer comme suit :

- rétablissement, sur l'ensemble du territoire national, des programmes de santé viables et accroissement de la productivité des investissements d'infrastructure effectués dans le passé,

- renforcement de l'Administration et de la gestion des services afin d'en accroître l'efficacité, de contenir les coûts, de faciliter l'application des réformes administratives,

- introduction des réformes dans le financement du secteur.

La banque est également agence d'exécution d'un projet d'alimentation et de nutrition, financé sur un don Japonais et ayant pour objectif la réalisation, de diverses études en matière d'alimentation et de nutrition, au profit de plusieurs départements ministériels dont celui de la santé.

Le Ministère de la Santé Publique ; est également partie prenante (choix des méthodes et surveillance sanitaire) au projet de réutilisation des eaux usées épurées pour l'irrigation que la Banque mène avec le Ministère de l'Intérieur dans les provinces de Ouarzazate, Khouribga, Agadir, Marrakech et Rabat.

Une coopération non financière avec la Banque Mondiale s'est développée ces dernières années consistant en une réflexion conjointe sur des questions d'intérêt commun, tels que l'insertion des défavorisés dans la vie économique et le développement d'alternatives nouvelles pour le financement du secteur de la santé.

### G - LA BANQUE AFRICAINE POUR LE DÉVELOPPEMENT (BAD)

La première intervention de cette institution financière est en cours de finalisation ; elle démarrera au cours du second semestre de l'année 1992 et durera cinq ans. Il s'agit d'un vaste projet portant sur quatre volets à savoir :

- l'extension du réseau d'établissements de soins de santé de base, y compris les études, la construction, l'équipement et la fourniture de matériel, véhicules et médicaments essentiels

- l'appui à six programmes sanitaires qui sont : l'hygiène scolaire et universitaire, la lutte contre les MST et le SIDA, la lutte contre les infections respiratoires aiguës, la lutte contre la leishmaniose, la lutte contre la carence en iode et la SMI/PF,

- le renforcement de dix unités provinciales de maintenance des infrastructures et équipements hospitaliers,

- l'appui à la cellule d'exécution du projet.

Le coût total du projet hors taxe est évalué à 615 millions DH. T.T.C., dont 70% et 25% vont aux deux premiers volets. Le coût total du projet sera financé à hauteur de 86% par un prêt du groupe de la Banque Africaine (BAD et FAD).

Pour ce qui est de la coopération avec les ONG, elle a connu également une certaine dynamisation et plusieurs d'entre elles interviennent dans des domaines jusqu'à présent non couverts tels que la lèpre, la réhabilitation des

handicapés physiques, la lutte contre la cécité, l'assainissement et l'hygiène du milieu, ...

Par leur action, quoique relativement réduite, les ONG apportent un appui très appréciable, eu égard à la souplesse qui caractérise leur intervention. Les possibilités qu'offre ce segment de la coopération internationale restent à explorer pour en tirer un meilleur profit.

## 5 - 2 - LA COOPERATION BILATERALE

La Coopération Bilatérale diffère dans ses formes et son ampleur selon les pays. La Coopération avec l'ensemble de l'Amérique du Nord est plutôt à sens unique ; elle porte sur l'appui financier à titre de don mais également sur la formation des cadres et le conseil, de plus en plus rarement sur les soins.

Ainsi, avec les USA, la coopération est assurée par l'USAID qui veille sur le programme "Population et Survie de l'Enfant" et confie l'appui aux activités de Nutrition au Catholic Relief Service (CRS).

Le projet de soutien aux activités démographiques et à la planification familiale est conçu, depuis son démarrage en 1971, comme un vaste programme coiffant de nombreuses activités et apportant ainsi la souplesse nécessaire dans le contexte marocain.

Le projet est actuellement à la phase IV, portant sur la période septennale 1990-1996, avec une contribution Américaine de 31.000.000 \$ sur un budget total de 115.000.000 \$. Trois grands volets composent ce projet à savoir l'élargissement de l'accès aux services de planification familiale et de santé materno-infantile ; l'augmentation de l'efficacité du programme, et le financement du Secteur de la Santé.

Dans le Cadre du Programme Alimentaire Compensatoire, la coopération avec les USA, à travers l'USAID) avec comme agence d'exécution le C.R.S., comporte deux parties : la première porte sur l'échange du don en lait reçu de ce pays contre la farine (Actamine) en vertu d'une convention avec SEPO. L'Actamine est distribuée dans le cadre du projet de lutte contre la Malnutrition. La seconde partie concerne la monétisation des dons en nature pour développer trois principales activités : l'éducation nutritionnelle et notamment l'allaitement maternel, la formation en matière de lutte contre les maladies de carence et l'amélioration des conditions de stockage de l'Actamine.

Avec le Canada, la coopération porte essentiellement sur la formation des cadres supérieurs, notamment en matière de gestion, dans les Universités Canadiennes et l'appui accordé à l'Institut National d'Administration Sanitaire.

La coopération avec la France est traditionnelle et couvre un éventail assez large d'activités telles que la formation, la fourniture d'équipements hospitaliers et de laboratoires, l'information, l'appui à l'Institut Pasteur du Maroc, l'expertise, etc. Cette coopération revêt généralement la forme d'aide non remboursable et exceptionnellement (cas de fourniture d'équipements au C.H.U. Ibn Sina par exemple) la forme de prêt dans le cadre des protocoles financiers Maroc-Français.

La coopération Maroc-Espagnole a été relancée en 1990, après une période de stagnation, ce qui a permis de reprogrammer un certain nombre de projets portant sur la fourniture de matériels et la formation essentiellement dans les domaines de l'administration sanitaire, de la maintenance des équipements biomédicaux et du personnel para-médical.

Avec le partenaire Italien également, la coopération a connu une certaine stagnation. Depuis la fin de l'année 1991, on relève une volonté de reprendre cette coopération sur la base des activités programmées en 1988 mais également en intégrant quelque nouvelles activités. Ainsi le programme de coopération portera, pour les quatre années à venir, sur : transfusion sanguine, l'appui à l'Institut Pasteur du Maroc et à l'Institut d'Hygiène, la cardiologie infantile et l'appui à la pharmacie centrale.

La coopération Maroc-Allemande dans le domaine de la santé est moins intense en égard aux priorités du partenaire Allemand. Malgré cela un projet a été financé en 1990 dans le cadre de la coopération technique et un prêt a été consenti dans le cadre du protocole financier Maroc-Allemand pour l'acquisition d'équipements hospitaliers.

La partie Allemande a offert également sa garantie, par le biais d'une assurance à l'exportation, pour un prêt de 100 Millions de Deutsch-Marks pour financer partiellement la construction d'hôpitaux régionaux.

La coopération avec les pays d'Europe Centrale concerne essentiellement la Pologne et la Tchécoslovaquie avec lesquelles des conventions dans le domaine de la santé ont été signées et prévoient la prise en charge des soins à titre gratuit dans les formations étatiques, au profit des ressortissants d'un pays, vivant sur le territoire de l'autre, et vice versa.

Avec la Pologne, la Coopération couvre un volet commercial portant sur

l'importation du médicament alors que l'assistance technique polonaise pratiquement pris fin.

Pour ce qui est de *la coopération maghrébine*, depuis la création de l'UMA, le domaine de la santé a été l'un des secteurs qui ont réussi à concrétiser un certain nombre d'actions ayant profité aux cinq pays de l'Union.

Ainsi, les taux de couverture vaccinale ont atteint des niveaux records dans les cinq pays grâce à l'organisation des journées maghrébines de vaccination. Cette expérience sera étendue à la lutte contre la Diarrhée et à l'hygiène scolaire et universitaire. L'achat en commun des médicaments constitue également une réussite incontestable, puisque cette opération a permis de réduire les prix d'achat d'environ 50% par rapport aux achats individuels.

La coopération sanitaire maghrébine avance avec beaucoup de réalisme et le conseil des Ministres sectoriels veille à la sélection des activités de coopération, qui présentent un intérêt certain pour toutes les parties, ce qui imprime à ses décisions un caractère de crédibilité certaine.

Une étroite coordination est assurée dans ce cadre au sein des instances régionales ou internationales. Ainsi, à partir de 1991, le Conseil a décidé de s'adresser à l'Assemblée Générale Annuelle de l'OMS par un discours unique de l'UMA et a pris la résolution lors de sa 5ème session (Marrakech, Octobre 1991) de jeter les bases d'une coopération UMA/OMS.

Quant à *la coopération Arabe*, elle s'exerce essentiellement à travers le Conseil des Ministres Arabes de la Santé, exception faite des Emirats Arabes Unis qui financent la réalisation de deux formations hospitalières : l'hôpital de Zone de Guercif et l'hôpital Cheikh Zayed à Rabat.

Ce dernier est en cours de réalisation depuis la pose de la première pierre par S.M. le Roi Hassan II et Son Altesse Cheikh Zayed Ibn Soltane Al Nanhian le 3 août 1991. Cet hôpital de 220 lits regroupera la quasi totalité des spécialités et sera doté d'un plateau technique faisant appel aux plus récentes technologies d'investigation et d'intervention. Le Conseil des Ministres Arabes de la Santé, instance institutionnelle de la Ligue des Etats Arabes, a connu ces cinq dernières années une intense activité à laquelle le Maroc a énormément contribué à travers le Conseil Exécutif dont il assure la présidence. Parmi les réalisations importantes, on peut citer la clarification de la situation financière du Fonds Arabe pour le Développement Sanitaire, l'aide apportée aux pays-membres victimes de catastrophes ou ayant des difficultés, l'inauguration d'une collaboration

fructueuse avec le bureau régional l'OMS pour la Méditerranée orientale et l'action menée au sein des instances internationales en faveur de l'amélioration de la situation sanitaire dans les territoires arabes occupés, et plus particulièrement la Palestine.

*La coopération avec le Japon* connaît un développement très significatif, puisque le projet de réaménagement du CHU Ibn Sina a reçu un accord de principe. Ce projet dotera cet établissement Hospitalo-Universitaire des équipements nécessaires à la rénovation et la modernisation du plateau technique de la majorité des services des différentes formations hospitalières et, ce, en complémentarité avec les équipements fournis par d'autres coopérations notamment, Française et Allemande.

Parallèlement à cela, plusieurs dons ponctuels ont été accordés pour l'acquisition d'équipements à travers des associations nationales.

La coopération maroco-japonaise permet également l'utilisation des services de volontaires Japonais dans les domaines de l'informatique et de l'édition notamment.

*Avec la Chine*, la coopération est assez ancienne et porte essentiellement sur la mise à la disposition du Ministère de la Santé Publique, par la partie Chinoise, d'équipes médicales spécialisées. Des résultats remarquables ont été enregistrés par ces équipes sur le plan des techniques médicales de pointe ce qui permet au personnel marocain de se perfectionner en travaillant en étroite collaboration avec les équipes en question.

*Avec les pays Africains*, la coopération reste non institutionnalisée et porte généralement sur la formation, la prise en charge de malades dans nos formations hospitalo-universitaires, l'échange de quelques rares documents et sporadiquement, l'envoi d'experts marocains pour développer des programmes sanitaires pour promouvoir la coopération avec l'Afrique.

Une mission marocaine s'est rendue en 1990 au Niger pour appréhender les possibilités de renforcement de coopération avec ce pays. Le Tchad a également émis le vœu en 1990 de coopérer avec le Maroc dans les domaines de fabrication de médicaments et de formation de cadres médicaux et paramédicaux Tchadiens. D'autres pays africains, francophones essentiellement, manifestent leur désir de coopérer avec le Maroc dans le secteur sanitaire et il s'agira à l'avenir de mettre en place une stratégie à même d'éclairer notre action et de dégager les moyens nécessaires.

**ANNEX E.**

**TECHNICAL ANALYSIS**

## TECHNICAL ANALYSIS

### Background

*In the interim since the Population and Child Survival Project (608-0198, "Phase IV") was signed in August 1989, a number of external and internal factors have surfaced which dictate a need for a follow-on project.*

*Changes are required as a result of inflation or underbudgeting of certain line items in 608-0198; cancellation of the development of a health care financing project pursuant to AID/Washington review of the 1992-97 Action Plan prepared by USAID Morocco; and exchanges in budget lines between Phase IV and Phase III (608-0171).*

*Furthermore, increased funding is required to expand on-going efforts and to undertake new activities which will greatly enhance project effectiveness and sustainability of FP/MCH in Morocco. The opportunities and the needs which merit increased assistance were identified during USAID's internal project management review and in the case of IEC, were also requested by the Prime Minister and the Minister of Public Health.*

*The design for the follow-on project evolved from a series of analyses and studies, beginning in the winter and spring of 1991-2 with the mission's own strategic planning process through a PRISM review. Based on health and population outputs identified during the review, an Implementation Plan was developed in April and May of 1992 containing strategies for achieving the mission's goals. Subsequently, several needs assessments, studies, and proposed service strategies were commissioned by USAID to provide further guidance for reprogramming and increasing project assistance. Supplementing this information are the 1992 DHS results, which furnish recent data on progress in the FP/MCH effort and reveal the greater demand for services; and MOPH national strategies for priority service areas, internal organizational reviews, and health care reform agendas.*

*Finally, a team of consultants worked with the Mission and the MOPH in February 1993 to synthesize findings and conclusions from the efforts of the previous year and a half, and made recommendations which provided the basis for a draft project paper. A bibliography of key documents is contained in Annex J and are on file at USAID.*

*The need for expanded USAID assistance is great. The project is feasible because it is tailored to the needs and conditions in the country, and reflects thorough and extensive analysis of all available options. 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 environment is positive.*

### Need for increased USAID support

*The GOM faces many challenges which this project will address.*

## E2

- *Underutilization of available services and failure to adopt health practices are of serious concern. Only half of women expressing a need for family planning are using modern methods; many maternities are vastly underutilized; few respondents in a recent survey used oral rehydration therapy for a child who had a recent episode of diarrhea*
- *A greater effort is required to reach the rural population. Statistics reflect persistent, significant urban-rural differences in health status and pattern of service utilization. Despite the expanded catchment area of the health service infrastructure in which 80% of the population resides, estimates of rural population covered is as low as 50%.*
- *The service delivery capacity must be substantially increased to attain future goals. Merely sustaining the current rates of contraceptive prevalence and FP/MCH service utilization translates into several million more clients by the year 2000, because the population is growing at over 2.4% a year. Achieving year 2000 fertility and health targets requires serving a larger proportion of this growing target population. Yet there are already proportionately fewer personnel for the recently expanded outreach delivery system.*
- *There is no assurance of continued public sector support from USAID and other donors beyond 2000; yet the GOM depends heavily on donors for day support such as contraceptives.*
- *The primary burden for providing FP/MCH services for the vast majority of the population rests with the MOPH, even though many clients are able to pay for services. To date the GOM has been unwilling to institute fees for service in the public sector, and the private sector generally does not play a significant role in provision of preventive services.*

### Government Response to Needs

*The Government recognizes the need for providing a sustainable, quality health care system, and has targetted health as one of four major areas of social development. The MOPH has made family planning, diarrheal disease control, and safe motherhood very 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 GOM has moved on many fronts to convey the themes of decentralization and democratization as a means of enabling communities to identify and help resolve their own problems. As part of this effort, the MOPH is committed to equipping managers at all levels of the delivery system to plan and manage services, increasing the likelihood that they will be more accessible and of higher quality in response to local needs.*

The GOM also recognizes the urgency of expanding the resource base of health care services and is encouraging the private sector to play a bigger role. The MOPH is actively seeking to identify and reform potential legal and regulatory barriers to greater participation of the private sector in delivering FP/MCH services. To further expand the base of support, the MOPH has initiated collaborative activities with other government agencies who have expressed willingness to use their delivery systems to refer or provide FP/MCH services to underserved populations. To maximize its own resources the MOPH has undertaken reorganization, and has been reviewing the impact of reorganization on effectiveness of its management systems. This internal assessment has created a positive environment in which to analyze and meet institutional needs that are critical to a successful FP/MCH program, such as planning and evaluation and a management information system. The MOPH has also begun to plan for replacement of donor assistance, and will include a budget line item for contraceptive procurement beginning in 1994.

### Project Design

In its PRISM exercise the Mission chose to focus its assistance on the goal of improving the health of children under five and women in childbearing age. The successful achievement of this goal depends upon Morocco's ability to provide services - and the population's willingness to use them - that reduce major preventable causes of child mortality, improve conditions of pregnancy and delivery, and ensure fewer, healthier pregnancies. To reach this goal the Mission has therefore decided that the purpose of future USAID assistance must be to increase the effective use of FP/MCH services and increase future program sustainability. The services given highest priority are those with the greatest potential for addressing multiple health needs and are most supportive of MOPH priorities: family planning, diarrheal disease control, and safe motherhood including breastfeeding.

- *Use of Services*

*Interventions to increase the effective use of services are feasible because they take into account the advanced stage of development of the Moroccan FP/MCH program:*

- *Contraceptive prevalence in Morocco has increased from approximately 20% in 1979 to 42% in 1992,*
- *Total fertility has declined from 5.9 in 1979 to 4.2 in 1992,*
- *Vaccination coverage has increased from 40-50% in 1985 to over 70% in 1989 (fully documented),*
- *Mortality of children age 1-4 has decreased from an estimated 77 per 1000 in the early 1970s to 20 in 1992,*
- *Infant mortality has declined from an estimated 122 per 1000 live births in the early 1970s to 57 in 1992, and*

- From 1986-1992 there have been only 121 reported cases of AIDS.

*Project interventions that were selected to achieve these objectives are designed for a "second-generation" program such as the one found in Morocco. The proposed activities are supported by conclusions from Mission and MOPH assessments and analyses related to the following: the Implementation Plan; the on-going quality assessment in five provinces; the proposal for USAID assistance to the diarrheal disease control program and to an IEC initiative; and national MOPH strategies for family planning, safe motherhood, breastfeeding, and diarrheal disease control.*

*Interventions also reflect the characteristics necessary to increase use of services, particularly by rural and other underserved populations: services must be readily accessible when a health care need arises; the level of quality must be high enough to attract and retain clients and promote improved health practices; and the population must be sufficiently informed and motivated to use them appropriately.*

*Access can be increased through a number of practical actions which the project will support. The high level of knowledge of permanent and long term methods which are not even widely available in Morocco, and the current heavy reliance on oral contraceptives, points to the need for expansion of contraceptive choice. MOPH strategies for FP/MCH programs describe the failure of the current service delivery structure to provide holistic preventive care for women and children who come in for a particular health problem. Thus the closer integration of services and stronger referral linkages are a high priority of these programs. Problems of underutilization of existing services are not well understood, and operations research is essential to identifying and resolving other access barriers. Additional channels for delivering services are especially required in rural areas where other government services and some private organizations have resources they are willing offer in an effort to expand services or referral.*

*Improved quality of services is a priority for the MOPH. Project assistance support continued efforts by the MOPH to systematically introduce standards of practice, strengthen technical competence through improved and regionalized training, and strengthen routine supervision of health workers.*

*The project interventions to expand and improve IEC are feasible because they are directed at acknowledged weakness in past IEC efforts by building on existing structures and capabilities. Needs assessments in Morocco and lessons learned from other countries show that a strong interpersonal communications component to IEC is key to behavioral change: counseling clients in clinics and outreach facilities is indispensable to the kind of individualized information clients require to make informed decisions. The mass media can and should spread information quickly, attract attention, and provide strong motivational messages to reinforce personal contact between health worker and client.*

*In Morocco, health workers do provide some education to clients, and an interpersonal communications skills training module has been developed. Project interventions will*

address weaknesses identified in needs assessments showing that these skills are generally weak, training has not been systematically introduced, opportunities for counselling are often not available, and IEC activities in the field are not well planned and organized.

The broadcast media infrastructure is highly developed in Morocco. State and private radio and television cover the entire country. Regional stations allow for the production of local programming aimed at specific audiences. Penetration of radio is high in both urban and rural areas, and the reach of television is high in the urban areas while reaching a third in rural areas.

Project interventions will develop the full potential of broadcast media has not been exploited with creative, informative programming aimed at specific target audiences. Much of the current programming consists of panel discussions or interviews with health specialists who have not necessarily mastered the art of conveying health information in easy-to-understand language. Other types of programs use messages that often come across as unfocused and impersonal, and lack strong motivational arguments or call-to-action messages.

Needs assessments reveal that the IEC activities do not take place within the context of a planned, national program adapted to local needs and conditions. With project assistance the MOPH will strengthen the technical expertise and management skills of the division of health education (DES), and provincial capabilities for tailoring IEC to local needs and for delivery of IEC services. This approach is expected to ensure a coherent national IEC program based on sound message development; and a coordinated, focused channeling of messages using interpersonal communications reinforced by national and regional mass media programming.

Project interventions to increase use of services are wide ranging and complex. Nevertheless, they are feasible and necessary to achieve a significant increase in results from a mature program which has experienced a steady and impressive gain in health status and contraceptive prevalence over the past decade. Actions required to move Morocco to another level of performance must be of far greater depth than those supporting an undeveloped delivery system. However ambitious and complex the project may be, it has been designed on the basis of extensive research and analyses, and the concept is sound.

- Program Sustainability

The project interventions to ensure future program sustainability are practical because they take into account certain factors which jeopardize the gains in health status and program development efforts of the past twenty years:

- o The Moroccan population continues to increase currently at the rate of 2.45 per year. Forty percent of the population is under the age of 15. The urban population is 47.5% of the total population and increasing at an annual rate of 3.6%. The

*demand for family planning and child survival services is growing and will continue to grow.*

*o Due to the impact on the health budget during the 1980's, the MOPH is serving a smaller percentage of the population that might otherwise have been served, particularly in the rural and some urban areas. In addition, the large proportion of resources directed to curative and hospital-based services severely limits the ability of the public sector to expand preventive services to meet future demand.*

*o There is no assurance that USAID's support for FP/MCH activities in the public sector - currently at \$6 million per year - will be continued after 1999. Other donors have also indicated the intention of reducing and eliminating their support for specific preventive care services. A public sector that is hard pressed to meet existing demand and faces increased demand for services, will face serious difficulty in assuming greater responsibility for preventive services when donor assistance is discontinued.*

*The project interventions are also practical because they reflect essential characteristics of the effort needed to ensure program sustainability in the long term. There will have to be very widespread support for FP/MCH. In view of strong GOM and MOPH thrusts toward decentralization and democratization, it is important that this support be developed at the national and local levels. Furthermore, the MOPH will need to reinforce its institutional capacity to expand the health delivery system and reach underserved populations. Finally, the financial, material, and human resources required for service delivery must be as broad-based as possible. The more diverse the resources the more likely that a sufficient amount can be mobilized to reach a larger number of women and children.*

*The primary burden for providing FP/MCH services for the vast majority of the population rests with the MOPH, even though analysis shows that many clients are able to pay for services. To date the GOM has been unwilling to institute fees for service in the public sector, and the MOPH will therefore have to compete for additional public resources with other compelling health and human service needs.*

*The private sector has not played a significant role in provision of preventive services, currently providing only 36% of contraceptives. Limited experience with the private sector will have to be expanded and new strategies tested for vastly increasing the private sector as source for FP/MCH services.*

*Finally, the feasibility of project interventions is confirmed by the extensive studies and assessments carried out during 1992 and into early 1993. Conclusions from these analyses point to specific project interventions that would be most likely to succeed given the existing situation in Morocco, including a range of practical options from which the mission and MOPH could choose as the project generated additional experience on which to build. The conclusions were drawn from information related to the following: the Implementation Plan; the assistance provided by the Family Planning Logistics*

*Management (FPLM) to the MOPH in assessing and planning for procurement responsibilities; reviews of the MOPH management information system, MOPH reorganization, and health financing initiatives; the IEC strategy for policy dialogue; the training and technical assistance activities for program managers in quality management and problem-solving; evaluation of social marketing activities; and assessments of a larger private sector role in FP/MCH.*

*It was thus determined that future sustainability could be achieved with project assistance aimed at identifying and pursuing a policy reform agenda; strengthening the institutional capacity of the MOPH for planning, management and evaluation; improving the ability to accurately project needs and advocate for public resources; and expanding the role of the private sector in services provision.*

*Thus the project design reflects the larger policy context in which FP/MCH operates including the history of family planning policy in Morocco; current MOPH institutional issues; the health share of the GOM budget and the role of donor assistance; and the readiness of the private sector to play a larger role in meeting FP/MCH needs.*

*To date, the policy environment for family planning has been positive, and has evolved since the early 1960s when the results of the 1960 census led to recognition of the relationship between population growth and economic development. In subsequent years, His Majesty King Hassan II became outspoken in his support by signing-in 1966 the United Nations Declaration on Population, creating national and provincial population commissions, and abrogating the law prohibiting the promotion of contraception and liberalizing the practice of therapeutic abortion.*

*By the mid-1970s population growth had become a priority in the government's five-year development plans and a division of population was created in the Ministry of Public Health to focus on family planning. External assistance for family planning began at this time, and USAID has been the major donor, with UNFPA a distant second in terms of funding. Since the mid-1970s, USAID has contributed over \$50 million to population activities, focusing its support on the VDMS program, associated training of personnel, contraceptive commodities, IEC, and large-scale demographic and health surveys (WFS, DHS I and II). UNFPA has provided major support for censuses, population education (both formal and non-formal), and policy-relevant activities (e.g., World Population Day activities) and has also contributed directly to family planning training and IEC. It was also during the 1970s that the IPPF affiliate AMPF began adding its family planning clinics, outreach, and IEC to the efforts of mentioned above, although on much smaller scale.*

*Now that both family planning and other MCH services have achieved significant gains in contraceptive prevalence and health indicators, and an extended health delivery system is in place, assistance can be effectively used to identify, monitor, and take action on policy implications of moving the program into an even more advanced stage. Policy issues that will become more important in the future include the effect on MOPH authorizing legislation and personnel practices of organizational changes required for increasing access and improving quality; the regulatory framework which governs private*

*sector involvement in FP/MCH services; medical practices related to client eligibility for and access to various long term and permanent contraceptives; and the reaction to a more vigorous and visible IEC effort by opponents of family planning who may have been previously unaware of the dimension of the program.*

*Strengthening the institutional capacity of the MOPH includes reinforcing the decentralization approach to management already adopted by the MOPH. The MOPH is committed to reinforcing systems at the central level while providing strong managerial skills to service providers at all levels of service delivery. Areas of institutional strengthening that the MOPH has already begun addressing include the regionalization of training, the ability to plan and manage a nation-wide IEC program, the ability to make effective use of the management information system, and skills training in quality management. The MOPH is also planning to assume responsibility for procurement, advocate for appropriate adjustments in its share of the GOM budget, and identify policy implications of its intersectorial goals; it will therefore need strategic planning tools to support these key interventions.*

*Diversification of the resource base for FP/MCH services into both the public and private sectors, protects the delivery system against the vulnerability of a single public source, and the instability of external assistance. Interventions to maximize public resources allocation for FP/MCH services take into account the health share of the GOM budget and the role of donor assistance.\* During the 1980's, the budget of the MOPH declined slightly as a percentage of the national budget and dramatically in real terms (an estimated 23% from 1980-1986). In the same period, both current and capital expenditures for health also fell as a percentage of total government expenditures. In addition MOPH expenditures for health became hospital and urban intensive. The MOPH has recently moved to reverse these trends by increasing the health sector budget and initiating outreach activities to unserved and underserved areas, although the effects may not be seen in the short term.*

*While the MOPH has concentrated resources on curative health care in the urban sector, USAID and other donors have continually focussed on provision of primary and preventive health services, principally family planning and immunization, to rural as well as urban residents. Thus, although relatively modest in terms of total resources in the health sector, the donor assistance has contributed significantly to improving the health status of the population.*

*The GOM is now focusing on the fact that USAID funding of family planning - which has dominated donor contributions - will be diminished significantly and possibly terminated by the end of the next decade. The primary financial responsibility for the public family planning and maternal and child health program, including contraceptives, will be transferred to the GOM. While other donor support for FP/MCH interventions is likely to continue over the decade, this support is relatively minor compared to that of USAID. In sum, it is unlikely that other external funding will replace AID's large contribution to the family planning program.*

*Procurement of contraceptives will be a major additional burden on public resources. Contraceptive purchases represent the single largest category of financial support from AID at \$2 million per year. The public sector accounts for nearly 75% of the contraceptive market in the country, and virtually all of it is supported by donors - most by AID - and provided free of charge by the MOPH.*

*In a recent report of a visit to Morocco by the Family Planning Logistics Management project it was pointed out that demographic indicators signal a major increase in contraceptive use for all regions of the world over the next decade. In addition to family planning AIDS awareness has increased the demand for condoms, which was unanticipated five years ago. It will be an enormous challenge for the MOPH to keep pace with this growing demand. It will be essential to employ a strategic planning approach by focusing on the key determinants of contraceptive method use in the public sector, for which the MOPH will be responsible. These determinants include the pattern of contraceptive use in the public and private sector, as well as demographic growth.*

*USAID anticipated the phase out of procurement of contraceptives by 1994. However, project management review and a subsequent Mission Review Committee recommended that USAID seek additional funding for procurement through 1977. This will allow time for a comprehensive phase-out plan to be developed and implemented, which will prepare the Ministry of Public Health to assume responsibility for contraceptive procurement.*

*With respect to other implications for public resources, MOPH current efforts in reorganization and improvements in quality and access of services will promote the efficient use of existing resources. However, additional resources will clearly be needed. Therefore, advocacy and policy dialogue activities will become increasingly important for securing support from decision-makers and opinion leaders at all levels of the decentralized system.*

*GOM decision-makers must be convinced that fertility reduction and improved maternal and child health status merits significantly increased support from its own treasury. The level of commitment needed by the government to implement a nationwide family planning program financed from its own resources is much higher than the level of commitment needed when those services are overwhelmingly supported by foreign donors. FP/MCH services will be forced to compete with other high-priority programs for scarce government funds. As it stands now, all government spending on public health represents only 3% of the GOM's annual budget. Even with a shift of some of the burden to the private sector and possible savings due to new measures aimed at cost recovery for hospital services or program effectiveness, government leaders and those who influence them (including the media) will have to become convinced that a significantly larger investment in family planning is in the country's best interests.*

*Along with decentralization comes decision-making authority over resources, including material and human resources as well as finances. Thus opinion leaders and decision-makers at the local level must also be convinced of the merits of FP/MCH services if they*

are to be adequately supported with local resources. Little is known about the potential of *collectivités locales* in this regard, but the MOPH is very interested in studying the feasibility of a greater role for them.

*Project Interventions will strengthen the ability of the MOPH to accurately project budget needs, and to advocate forcefully for a fair share of both the GOM budget and local resources.*

*Involvement of the private sector is critical to diversifying the resource base of the FP/MCH program. Activities to expand the private sector role through social marketing, the workplace, and private practitioners are feasible and practical. By broadening the financial base for FP/CS through increasing private sector investment, the burden of program support may be considerably alleviated. In addition, movement toward a public-private sector partnership to share the costs of health care provision for the entire country may lead to greater access to public sector services by those least able to pay.*

*Despite the growth in the private health sector in the past few years, the public sector remains a major player in the Moroccan health care market. It was estimated that in 1987 the public and quasi-public sector provided about two-thirds of the hospital care and nearly half of the outpatient care in the country, and roughly 60% of the value of hospital and ambulatory care combined. It was also estimated that the growth of private ambulatory care for the three preceding years was about equal for the two systems (public and private), though the fastest growth overall was in private hospitals/clinics.*

*A study of conditions in the private sector revealed that interviewees believe the decreasing GOM health resources in the 1980's resulted in notable declines in both the quality of care in public health facilities, and the working conditions of health practitioners assigned to these facilities. As a result, an increasing number of people have been seeking care from the private and quasi-public sectors. Indeed, the fastest growing segment of the health market has been private practitioners.*

*A wide range of health providers operate in the private sector in Morocco. These include general practitioners (GPs), and specialist physicians in individual practice, group practices, private clinics with inpatient facilities, dentists, paramedical personnel, laboratories, and pharmacies. The geographic distribution and total numbers of physicians involved in group practice are not known. The study reported signs, however, of a growing tendency toward the formation of group practices in recent years, particularly among specialist physicians. The interviews indicated that doctors chose group practices for two main reasons: to share equipment costs and to benefit from close working relationships with other physicians. Most of the group practices interviewed involved partnerships of specialists of the same type (for example, radiologists), since it is this type of partnership that can best take advantage of shared equipment costs. Clinics owned by groups of physicians may group together a variety of specialties - for example, Clinique El Hakim in Casablanca.*

*The provision and financing of health services by employers in Morocco currently consists*

of a complicated mix of legal obligations, contractual agreements, and social assistance given to improve employee relations. The study reported that while many employers are obligated by law to provide insurance for work-related accidents, only some enter into contractual agreements to provide overall medical insurance (usually splitting the premiums with employees). Some enterprises hire a physician to supervise work-related medicine ("medecine du travail", such as overseeing safety). Several interviewees pointed out providing curative care (other than for work-related injuries) at the workplace was forbidden by law, presumably because such arrangements run counter to the code of medical ethics, which stipulate that there must be a direct payment relationship between physician and patient.

The overwhelming majority of pharmacists operate in the private sector - a total of 1,546 in 1989 (see Table 10), and 65% of these are located in the Center and Northwest regions.

The Caisse Nationale des Oeuvres de Prevoyances Sociale (CNOPS) is an umbrella organization of mutual insurance companies providing medical coverage for 80% of public servants. In 1987, 2.1 million beneficiaries (9% of the total population) were covered by CNOPS mutuels (694,077 members and 1.4 million dependents). In addition to reimbursing beneficiaries for a fixed percentage of medical expenditures, a number of mutuels operate clinics to provide services to their beneficiaries. Membership in CNOPS is concentrated in the Northeast (38%) and Center (32%) regions.

The Caisse Nationale de la Securite Sociale (CNSS) is the national social protection program for private sector employees. Its funds are obtained from a 10% levy on the wages of private sector employees. Benefits include family benefits, indemnity benefits, and retirement pensions. From 1979 to 1988, CNSS used a portion of its funds to build a network of 13 polyclinics: four in Casablanca and one each in Mohammadia, El Jadida, Marrakech, Tanger, Agadir, Kenitra, Oujda, and Settat. Over half the beds in this system are in the four clinics in Casablanca.

The study identified certain perceptions of obstacles and means of removing them, that would draw more of the private sector into health services. It is toward these perceptions that project interventions in the private sector are directed:

**Perceived Obstacles**

Confusion in the interpretation rules and regulations concerning practices

The requirements for opening new service delivery sites is burdensome

**Action to Remove Obstacle**

Demonstration and support of efficient group practice group settings, especially in desirable (underserved) areas

Streamlined requirements and availability of information and technical and financial support for desirable practice models.

## E12

*Interventions in the private sector are also designed to respond positively to key questions about whether they are feasible and will result in achieving the desired goals of the MOPH to shift some of its health delivery burden and increase access.*

*- Will the recommended activity actually lead to a reduction in the government's burden vis a vis services and their distribution and in terms of both geography and market segmentation?*

*- Is the activity relatively simple in its technical, managerial, and political aspects, such that its implementation can be carried out with a minimum of complication from any of these sources?*

*- Will the activity make services more accessible to those who otherwise would not have access, or will it enhance the public sector's ability to provide services to the indigent?.*

*The project design for achieving future sustainability contains multiple and wide-ranging actions that will require a high level of commitment from both the MOPH and the private sector. This design is necessary in view of the GOM commitment to reaching underserved populations and improving health status by 2000; and in view of the planned reduction of external assistance. The design is also feasible because the GOM and MOPH have created a favorable environment for strengthening their institutions and encouraging private sector participation, and project interventions have been designed after careful and extensive research and analysis.*

**ANNEX F.**

**INSTITUTIONAL/ADMINISTRATIVE ANALYSIS**

## INSTITUTIONAL/ADMINISTRATIVE ANALYSIS

*The Ministry of Public Health (MOPH) is the institution which will receive project inputs for public sector activities, and the Directorate of Prevention Services and Health Training (DPES) will be responsible for implementing project activities as the lead office within the MOPH for FP/MCH services. Private sector partners are responsible for social marketing activities, and additional partners will be identified for expanded private sector activities.*

*USAID has recently put into place an institutional contractor to assist with the planning, development, and implementation of project activities. It is anticipated that an institutional contractor will also be used for the follow-on project. Development and implementation of the private sector activities will be carried out with technical assistance from RD/POP and Health and the institutional contractor. A separate contractor will be engaged for construction activities. USAID will request a continuation of the Technical Advisor for Child Survival, and the mission plans to add an FSN professional to the health/population office. USAID therefore anticipates that there will be no problem programming funds.*

*The project interventions are feasible and additional funding can be efficiently utilized by both the public and private sectors. Family planning and child survival is a priority for the MOPH, and the 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 that occurred between the late winter of 1991 and February 1993, and which led to the project design. The institutional capacity exists to absorb and use USAID inputs to meet identified needs, and outputs will be translated into a more effective FP/MCH program.*

*Project interventions are also designed to strengthen the institutional capacity of the MOPH where vulnerabilities exist, further assuring the overall feasibility of the project. Assistance will be provided to reinforce management support systems within a decentralized structure, and to expand technical and managerial expertise at all staff levels through skills training and technical assistance.*

*Private sector experience to date has been very encouraging. Social marketing activities have generally exceeded expectations, and the condom sales component is nearing complete self-sufficiency. The GOM and MOPH are committed to an expanded private sector role, and to addressing regulatory and policy barriers to such expansion. In February 1993 the minister of public health personally conducted a two-day intersectorial seminar for the purpose of engaging the non-health public sector and the private sector in actively delivering or referring for FP/MCH services.*

*The following narrative describes institutional capacity as well as project interventions designed to further strengthen that capacity.*

- *Institutional Context of FP/MCH*

*Morocco has a sophisticated and multifaceted FP/MCH program which involves several organizational units within the Ministry of Public Health at the provincial and central levels, other public institutions, and private sector groups. Within the central ministry these include the DPES and its technical divisions in family planning (SCPF), maternal and child health (SMI), and health education (DES); a division of information and statistics planning (DPIS), with a unit (SEIS) responsible for data collection and analysis of the national health information system, and another unit (SETI) generally responsible for MOPH information services and computer capability; and other central offices responsible for in-service training, personnel policies, and other services which affect FP/MCH. FP/MCH training is carried out under central office supervision in nine regions, using facilities and staff of the province in which the training is carried out.*

*Other key public institutions that support FP/MCH services delivery are the National Institute of Health Administration (INAS), and the National Training Center for Reproductive Health (CNFSR) which is affiliated with one of the two university teaching hospitals (CHUs).*

*At the decentralized ministry level there are 61 provincial and prefectural health delivery systems headed by delegates (délégés); the health care delivery system is divided into hospital services, headed by medical chiefs (médecin chef), and ambulatory care services (SIAAP), also headed by medical chiefs. FP/MCH services fall under the SIAAP unit. FP/MCH services are delivered through the public health delivery system consisting of hospitals, 2200 health centers, dispensaries and health posts, and 3000 outreach points. The Ministry of Public Health (MSP) employs over 2,600 physicians and 22,000 paramedical staff. The level of services ranges from basic primary health care through sophisticated tertiary care to the two university teaching hospitals (Centres Hospitaliers Universitaires, or CHUs) in Rabat and Casablanca.*

*Prior to 1987 the ministry 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 ministry 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 few resources and capabilities above the level of individual technical divisions. Authority and responsibility for critical support functions such as planning, evaluation, training, personnel deployment, and 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 a considerable burden on the DPES to seek cooperation from multiple offices throughout the MOPH, and to seek consensus and coordination among its technical divisions. However, 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 61. Reorganization has not yet addressed this issue. Where activities such as FP/MCH training are regionalized, they continue to be centrally funded and rely on the cooperation of provincial staff in which regional activities are located. The MOPH has recently taken under consideration a proposal for a regional structure for FP/MCH services, as well as for the division of information and statistics planning (DPIS).*

*It was estimated that in 1987 the public and quasi-public sector provided about two-thirds of the hospital care and nearly half of the outpatient care in the country, and roughly 60% of the value of hospital and ambulatory care combined. Health service clinics are also operated by the umbrella organization of mutual insurance companies (CNOPS) which provide medical coverage for 80% of civil servants; and the national social protection program for private sector employees (CNSS). Despite growth in private sector ambulatory care in the past few years, the private sector accounts for little more than a third of health care, including 36% of contraceptive services. Private sector entities important to FP/MCH services include the IPPF affiliate (AMPF) which provides about 6% of family planning services, professional associations in the fields of medicine and pharmacy, and commercial firms and manufacturers .*

- Planning and Evaluation

*For project interventions to successfully promote FP/MCH goals, the MOPH central level must provide strong direction and support to managers at the service delivery level. It is equally critical that these managers have sufficient information, resources and authority to assess and meet needs at the provincial and local level.*

*At the central level, the DPES has the mandate to direct a national FP/MCH effort, but it has no structure to house planning and evaluation functions for an integrated FP/MCH program, or such related support services as operations research and data analysis. These functions are carried out with the combined support of the technical divisions within the DPES, the MOPH national health information system, and INAS, none of which has a mandate to plan or evaluate a national FP/MCH program. Planning in coordination with the provincial level takes place through annual action plans.*

*At the provincial level, under the MOPH decentralization strategy, there should be considerable management authority and resources. However, the FP/MCH program is still highly centralized. A major obstacle to decentralizing management is the absence of a middle level of authority between the central level and 61 provinces and prefectures. Development of a regional organizational structure would greatly facilitate decentralized programming activities; and the regionalized FP/MCH training could become a*

*transitional step toward giving the provinces In each of the regions decision-making authority over use of training resources to meet their own needs.*

*The project will provide support to the DPES, to the regional level if instituted, and to the provincial level, to strengthen DPES 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 DPIS 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.*

- *Management Information System*

*Information services and Computer capability at the provincial level have become increasingly important to the process of decentralization, and hence to the FP/MCH program: decentralized information management will allow for better local access and use of data, reduce the burden on the central management for data processing and analysis, and eliminate delays in data processing and analysis that limit local level decision making. Currently, information is not effectively used to plan and manage FP/MCH services.*

*In the past 10 years the MOPH has developed a strong central MIS and data analysis capability through the national health information system which is under the responsibility of the DPIS. Health and demographic data are collected from all levels of service delivery points and sent on a monthly basis to the health information and studies unit (SEIS) of the DPIS, which then compiles the data sent from all the provinces into one comprehensive report. The reports are to be used by health care managers at all levels for decision-making and program design. A duplicate of FP/MCH data is sent to be analyzed separately by the family planning office (SCPF) within DPES, since to date the MIS has been unable to provide more direct and timely information services.*

*SEIS is also responsible for contributing relevant subject material for health planning, and for undertaking studies to analyze and evaluate the health sector. Furthermore, the information services unit (SETI) of the DPIS, is responsible for Ministry-wide selection of equipment, choice of networks, and the types of computer applications and technical assistance required by the MOPH. A recent masterplan for MOPH information management and automation was recently completed under the auspices of SETI. Both units continue efforts to more effectively integrate FP/MCH components into the MIS, promote better use information at the peripheral level, and develop provincial level data processing and analysis capability. However, problems continue to limit the effectiveness of the MIS system, including:*

- *poor articulation between SEIS and technical service offices;*
- *duplicative, parallel channels of information;*
- *a high level of centralization of information resources, i.e. provincial and peripheral levels do not have the computer capability, training, resources, or responsibility to use the information that passes through*

*UNFPA is providing financial assistance for short term technical assistance, the purchase of some provincial level computers, computer systems for SEIS, and vehicles. The project will support strengthening components of the national MIS which are essential to a strong FP/MCH program, in coordination with the UNFPA, without committing a disproportionate amount of inputs to the entire MIS.*

- *Human Resources Development*

*The DPES has a responsibility to assess the human resources needs in FP/MCH in the areas of training, staffing pattern, personnel deployment, job functions, and material support; and for drawing on available resources in an effort to meet those needs. Human resource issues are wide-ranging and include the availability of specialized professionals such as OB/Gyns required for the VSC program and midwives required for safe motherhood services; adaptation of personnel policies when more effective FP/MCH service delivery necessitates changes in job descriptions and work conditions; expansion of FP/MCH modules in pre-service training to ensure a certain level of expertise to the public health system.*

*The key entities which the DPES can draw on for support include the MOPH office of continuing education, which is responsible for in-service clinical training; INAS, which provides training in health delivery management, the CNFSR, which provides training in clinical contraceptive services; the university teaching hospitals; and paramedical training schools.*

*The continuing education office has developed a national strategy for decentralizing continuing education for public health professionals, with a four pronged approach. 1) Creation of provincial expertise in continuing education by placing 1-4 animaters for continuing education in each province. This small cellule of expertise is responsible for assisting in the development of training programs in the province. 2) Expansion of expertise in training by improving the skills of the provincial health leadership in communications and training. 3) Development of a provincial training plan. 4) Informing and encouraging chiefs of the central ministry and provinces to use the training services of the continuing education unit when developing training programs. Recently a commission headed by the director of continuing education has been formed to study the national in-service training strategy, develop a national training schedule, evaluate training needs and results and propose changes to the current plan.*

*Although the regional strategy of the continuing education office is consistent with the needs of the FP/MCH program, in practice training programs of most MOPH divisions and provinces are carried out without their assistance. Separately from this strategy, nine regional training capabilities have been developed in FP/MCH, still funded from the central level. This approach brings training courses closer to the field, and health officials and service providers in the area surrounding the training centers are developing expertise.*

*There is as yet no decentralized capacity to assess and meet human resource needs,*

particularly as concerns clinical skills. The precise role of central and provincial managers needs to be defined with respect to training as well as other HRD activities, including needs assessments, specialized and basic training, staffing pattern, job descriptions, and posting.

Project interventions will strengthen the capacity of the DPES to build linkages among the various offices within the MOPH which will help the DPES to meet human resource needs of the FP/MCH program. This may include selected, targeted assistance to certain organizational units if necessary. At the provincial level, support will be provided to move forward with the MOPH decentralized training strategy. Selected support will also be given to INAS to strengthen its training role.

- *Managerial Skills and Tools*

Program managers at the provincial and peripheral levels have received training abroad and in-country from INAS and other sources in management, the WHO "problem-solving" technique, operations research, and other technical support areas. However, management is still highly centralized, and technical assistance and training are envisioned during the course of the project. Quality management, strategic planning, and other managerial tools will be provided through training, technical assistance, and institutional linkages at the central and provincial levels.

Quality management will have a particular focus in the project, because it transfers managerial skills at the same time that it involves service providers in the practical experience of resolving problems identified through quality assessments. Assistance will include support for INAS to strengthen its capacity to provide training and technical assistance in quality management. Since it is not possible to use USAID resources to provide quality management expertise in all 61 provinces and prefectures at once, models and pilot projects will be developed within selected provinces and replicated as expeditiously as possible.

- *Contraceptive Procurement*

Virtually all of the contraceptives in the Moroccan family planning and HIV/STD program are provided by donors, and most are furnished by AID. The project will fund contraceptives through 1997, which, because of the two year time lag between ordering and receiving commodities, will ensure sufficient contraceptives to the end of the project period. However, USAID does not intend to support procurement after 1997. Therefore the MOH will need to develop the ability to gain access to a stable flow of needed contraceptive supplies on a reliable basis, maintaining as much continuity as possible in type of contraceptive to avoid disruption in use among clients, and using resources over which they have effective control.

The MOPH has already signalled its intention of including a budget line item for contraceptives after 1994, although funding for this line item is as yet uncertain.

*The process of phase-out of AID support for contraceptives and development of self-reliance is a long-term proposition, and will require the coordination, resources, and technical assistance of many Individuals and organizations. There is little previous experience with this process, so a number of innovative interventions rather than one single approach will necessary. The project will support this process by providing technical assistance in the following areas:*

- *Development of Goals and Objectives for phasing into contraceptive procurement:* these are necessary to ensure that efforts over the next several years are directed toward the same ends, that there is common understanding of language such as "self-reliance"; and that guidance is provided for detailed annual action plans. A senior staff member will be delegated responsibility for overseeing the successful transfer of responsibility and monitoring progress toward the goals; and will facilitate technical and policy issues arising within the context of the goals and objectives.
- *Strategic Planning for Procurement:* The MOPH will develop a capacity for maintaining accurate projections of such key determinants of contraceptive needs as population growth and distribution, contraceptive prices, contraceptive prevalence, client method mix, progress of the AIDS awareness program and impact on condom use, GOM and MOPH budgets, share of each type of service and product provided by private sector, and any change in MOPH cost recovery policies.
- *Select Source and Financing of Contraceptives:* The MOPH will have to make decisions - to be reviewed and revised as conditions change - regarding purchase of imported and locally produced contraceptives, issues affecting local production (taxes on raw materials, quality assurance, economic feasibility), reliance on other donors for certain contraceptives, donor financing (including World Bank loans), bulk purchasing, impact of source and financing on brand name and chemical formulation and the consequences for consumer preference, development of a budget line item, potential for a revolving fund similar to that set up for the immunization program, client fees for services or products, the ability of Collectivites Locales to participate either in financing or in managing self-replenishing local pharmacies or depots.
- *Encouragement and Monitoring of Private Sector Roles:* the GOM needs to encourage the private sector to play a greater role, sharing its goals and objectives as well as long term policies and programmatic intentions, so the private sector can plan; progress needs to be closely tracked for its impact on procurement in the public sector; policy and other determinants of private sector success need to be analyzed and modified (e.g., price of products as affected by wholesaler and pharmacist profit margins, as well as by duties on imports) to affordability, quality and continuity of chemical formulation (especially for the low-dose pills).
- *Logistics Management:* The MOPH logistics management system is well

developed. However assistance is needed to refine and strengthen the system as the MOPH assumes full responsibility for procurement, e.g. the projection of needs and distribution of contraceptive on a timely basis to regional and local distribution points, the logistics management information system, quality assurance

- *Information, Education, Communication*

*The Health Education Division (DES) is a technical division within the DPES with a mandate to provide the IEC services of the MOPH. Although it has a sizeable permanent staff and is well-equipped it seldom is given its own budget for major FP/MCH programs. Instead, the vertical health programs use funds available to them from various donors to develop their own communication programs, rarely relying on input from the DES.*

*Needs assessments show that IEC activities are not part of a systematic development process with quantifiable objectives or messages and audience selection based on formative research. There is little pre-testing of messages and materials, and little impact evaluation. Provinces are equipped with a health education agent (animateur) and assessments show that many have a solid infrastructure and innovative programs. However, there is little substantive support from the central level for their efforts. Monitoring visits by DES staff to provide technical assistance, encouragement, and IEC materials are infrequent. By a number of accounts, visual and teaching aids are inadequate or in insufficient quantity.*

*The DES seldom plans with the broadcast media to create a variety of well-sequenced health and family planning programs and spots which might be aired at regular times year-round. Although competent private advertising and marketing firms have often taken on the production of IEC materials, they usually do not conduct the research and pre-testing critical to the effective promotion of health behaviors. While the technical quality of materials is often high, they are not necessarily suited to a particular target audience's needs.*

*The MOPH is committed to strengthening the DES as a means of developing a coherent IEC program at the national and provincial levels, and ensuring that the MOPH has a specialized IEC unit with technical expertise. In view of the capability which already exists within the DES, it will be an efficient use of resources to expand the skills of the core staff so they are able to plan and evaluate a national program, design and carry out research, pretest messages and materials, prepare strategic plans, and creatively develop and produce media for a variety of different subjects. A stronger DES will be able to develop working partnerships with the DPES technical divisions which provide the medical, clinical, and programmatic context for educational programs. The model of an IEC division which provides message, theme, and media has been effective in many countries.*

*The DES would thus be able to revitalize the provincial health IEC program; provide needed technical assistance to IEC programs generated by the technical FP/MCH divisions of the DPES; improve and expand current training in IEC, providing more information to trainees on the socio-cultural context into which new ideas are introduced,*

*and on the techniques of communication most appropriate for different populations; and develop a national IEC program with complementary media and interpersonal elements, ensuring that accurate technical information is most relevant to each target audience and that the most effective communication media and techniques are used. 4/26/93 file "PPTECH"*

**ANNEX G.**

**ECONOMIC ANALYSIS**

## ECONOMIC ANALYSIS

As indicated in the Project Identification Paper, the economic analysis will be limited to a re-examination of analysis contained in the last Project Paper, as well as an analysis of the potential for transferring users from the public to the private sector.

### Benefit-Cost Analysis

The Project Paper (Annex B) for Family Planning and Child Survival IV (608-0198) reported on an earlier benefit-cost analysis of family planning, which concluded that the benefits to the Government of Morocco (GOM) from investing in family planning were high in relation to the costs. Specifically, this earlier analysis found that the cumulative benefits net of costs over a twenty year period amounted to over 2 billion Dirham. This stream of benefits and costs corresponded to an internal rate of return of 175 percent.

At the time the reported benefit-cost analysis was done (1987), there was almost no reliable data on family planning costs in Morocco. Crude estimates were developed based on a recently completed survey of costs in the MOPH outreach program (V.D.M.S.). Since then, there have been two careful analyses of family planning costs in Morocco: one, a comprehensive time use and cost survey of the ambulatory health system; and the other, a more narrowly focused study of voluntary sterilization costs.<sup>1</sup> Table 1 presents a comparison of the cost estimates used in the original study with the more recent and reliable estimates.

Table 1

A Comparison of Cost per User Estimates from Two Different Sources  
(current Dirham)

	Oral Contraceptives	IUD	Female Sterilization	Condoms
1987 estimates	Dh 109	58*	250*	337
1989 estimates	Dh 98	187*	1130*	176

\* Estimates for the IUD and Female Sterilization refer to cost per acceptor.

<sup>1</sup> Ministère de la Santé Publique. 1993. *Evaluation du coût des services de planification familiale et des soins primaires au Maroc*. Programme National de Planification Familiale; and Association for Voluntary Sterilization,.....

**Source:** 1987 estimates: *Project Paper (608-0198), Annex B*  
 1989 estimates: James C. Knowles and Laurie Emrlich. 1991. "The Estimation of Family Planning and Primary Health Service Costs in Morocco." Draft: March 30, 1991. The Futures Group, Chapel Hill, NC.

*Although the earlier estimates appear to have been quite wide of the mark, the fact that the estimates for oral contraceptives, which account for the bulk of contraceptive use in Morocco, are reasonably close means that the use of the more recent and reliable estimates do not alter significantly the conclusions of the earlier benefit-cost analysis. In the case of projections for 1992, for example, the earlier projected total cost of the MOPH FP program was Dh. 107,119,210; with the more refined estimates, the corresponding estimate is Dh 100,712,111--a difference of only 6 percent. As the authors of the original analysis noted, "The benefit-cost ratio is greater than one after only two years....Even a doubling of the estimated family planning costs per user does not significantly alter the qualitative conclusions reached by the analysis (the benefit-cost ratio would still be above one by 1992)" (Project Paper, Annex B).*

*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. More recently completed projections of future program trends assume that the method mix will shift toward relatively cost-effective longer-term methods (particularly the IUD) and that the MOPH share of family planning costs will decline steadily as the commercial sector expands its role as a provider of oral contraceptives.<sup>2</sup> 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.<sup>3</sup>*

*The results of the 1990 OPTIONS/MOPH time use and cost survey suggest an even more compelling (although admittedly crude) analysis of the benefits and costs from investing in family planning. These data can be used to show that the savings due to family planning within the ambulatory system alone are almost as large as the costs incurred to provide family planning services. According to this survey, the 17 facilities for which*

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<sup>2</sup> In this regard, it is important to point out that both of these favorable developments from the standpoint of future costs to MOPH would be much less likely to occur in the absence of the current project.

<sup>3</sup> James C. Knowles and Anne E. Wagman. 1991. The Relationship between Family Planning Costs and Contraceptive Prevalence: Will FP Costs per User Decline Over Time?" Paper presented at Annual Meetings of the Population Association of America. Washington, D.C. (March, 1990).

service statistics and cost data were collected provided 12,915 couple-years of protection (CYPs) through their FP program activities.<sup>4</sup> Assuming one birth averted per four CYPs (a commonly made crude assumption), approximately 3,229 births were averted in 1989 due to the FP activities of these 17 clinics. According to standard assumptions made by MOPH, the surveyed facilities served a theoretical population of 465,000. Assuming that the birth rate was approximately 30 per thousand, 13,950 births occurred to this population during 1989; and assuming the proportion of children under 15 in the population was 40 percent, there were 186,000 children served by these facilities. Estimates derived from the survey data imply that FP services accounted for approximately 12 Dirham of every 100 Dirham of costs in these surveyed facilities, with pre- and post-natal care accounting for another 4 Dirham and services consumed by children, another 37 Dirham. The health services savings from FP, per 12 Dirham in FP costs, include a once only saving in pre- and post-natal care costs ( $3,229/13,950 = 0.23 * 4 \text{ Dh} = 0.92 \text{ Dh}$ ) and annual savings extending over 15 years from treating fewer children ( $3,229/186,000 = 0.0174 * 15 * 37 \text{ Dh} = 9.6 \text{ Dh}$ )--10.52 Dh in total savings within the ambulatory system itself for each 12 Dh expended on family planning.<sup>5</sup> 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 economic analysis of the previous Project Paper reported on some preliminary cost-effectiveness analysis carried out under the OPTIONS project. This analysis concluded that: (1) the cost of FP services was higher in rural areas than in urban areas (due to lower rates of service utilization in rural areas); (2) the cost of 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). The results of this analysis provided some justification for the MOPH's shift of emphasis toward greater reliance on mobile teams and fixed service points (points du contact) in its outreach program (strategie mobile) under the FP and CS IV project (608-0198). The estimates on which these conclusions were based, however,

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<sup>4</sup> Tables 5 and 6, in James C. Knowles and Laurie Emrich. 1991. "The Estimation of Family Planning and Primary Health Service Costs in Morocco." Draft: March 30, 1991. The Futures Group, Chapel Hill, NC.

<sup>5</sup> The discounted present value of these savings is 5.7 Dh, assuming a discount rate of 10 percent.

were prepared with the very limited data which existed at the time. More recent and reliable cost estimates support some of these conclusions, but not all. Table 2 provides the earlier estimates as well as the more recently available corresponding estimates.

Table 2  
Comparison of Cost-Effectiveness Estimates  
Annual Cost per CYP (\$)

	1987 Estimates	1989 Estimates
<b>URBAN</b>		
Health Center	\$11.29	\$10.23
Dispensary	\$ 7.53	\$15.35
FP Reference Center	\$34.71	\$20.70
Urban VDMS	\$35.18	.*
<b>RURAL</b>		
Health Center	\$30.82	\$13.37
Dispensary	\$25.18	\$13.60
Basic Rural Dispensary	-	\$15.23
Rural VDMS	\$27.65	\$5.00
Mobile Teams	\$10.59	\$1.74

\* Urban VDMS was discontinued in 1988.

Source: 1987 estimates: Project Paper (608-0198), Annex B  
1989 estimates: A.I.D. Center for Development Information and Evaluation,  
; "Evaluation of A.I.D. Child Survival Programs: Morocco Case Study," p. 15.

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.

The 1989 cost estimates presented in Table 1 are also interesting for cost-effectiveness analysis. The comparable dollar estimate of cost per CYP for the IUD is \$6.21, compared to \$11.28 for oral contraceptives and \$20.50 for condoms.<sup>6</sup> The IUD is clearly cost-effective in Morocco. It also has the added feature of being economical in terms of commodity costs. Sterilization's cost per CYP of \$13.14, on the other hand, is not particularly favorable, especially when one considers the fact that the average age of sterilization users is relatively old in Morocco (i.e., 40.7 years of age, according to the 1992 DHS, compared to 32 years, for users of oral contraceptives).

#### *Potential for Transferring Users from the Public to the Private Sector*

Based on international trends and experience, the greatest potential for transferring users from the public to the private sector exists with respect to supply methods (i.e., orals and condoms).<sup>7</sup> Since oral contraceptive users presently account for approximately 80 percent of all public sector users (and an even higher percentage of the public sector contraceptive bill), a strategy designed to encourage their transfer to the commercial sector can yield a potentially high pay-off to GOM. It should also be mentioned that, under the existing tax structure, GOM benefits additionally from the fact that it not only saves contraceptive and related MOPH costs for each user transferred to the private sector, but it also gains in tax and import duty revenue collected from the commercial sale of contraceptives to each transferred user.

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, i.e., the lower the cost to the consumer, the greater the number of users who are likely to transfer out of the public sector. Skilled promotion should also be important. 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. In a market which is as large as Morocco's current commercial market for oral contraceptives (approximately 4 million cycles sold annually), transfers from other commercial brands alone may support a large sales volume.

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 percent of the private market and 20.5 percent of the total market). By 1997, SOMARC forecasts that the commercial sector will account for 45.4 percent of the total oral contraceptive market, as compared to 36 percent in 1992 (DHS). According to this scenario, the size of the total market will grow at a rate of 2.9 percent annually between 1993 and 1997, with the public distribution of oral contraceptives actually declining at a rate of -0.4 percent per annum.

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<sup>6</sup> The following exchange rates and conversion factors were used: \$1 = 8.6 Dirham; 1 IUD insertion = 3.5 CYPs; 1 sterilization = 10 CYPs; 15 pill cycles = 1 CYP; and 150 condoms = 1 CYP.

<sup>7</sup> Service delivery costs loom large in the case of clinical methods, with the result that private sector prices are often prohibitively high.

## Conclusions

*The preceding discussion leads to the following conclusions. First, family planning continues to be an excellent investment for the public sector in Morocco, whether viewed from the narrow perspective of the health sector or from the broader perspective of the entire social services sector. Second, family planning services can be provided cost-effectively to the rural population, whether through fixed facilities or through outreach. Third, expanding the availability of the IUD 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. Maintaining a competitive price for the socially marketed project will be key to the success of this effort.*

## **ANNEX H.**

### **FINANCIAL ANALYSIS**

- H1. Morocco Strategy for USAID Contraceptive Phase-Down**
- H2. Target Cost Analysis**
- H3. Estimate of Private Sector Contribution**
- H4. Host Country Contribution**

*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 Phase-Down contains precise estimates of public sector contraceptive requirements through 1999, based on current and past consumption, and taking into account projected changes in method mix and increased contraceptive prevalence.*

*The Target Cost Model for Morocco, a computer modeling program, has been updated to reflect shifts in method mix toward long-term methods and a gradual increase in private sector provision of contraceptives. From this model, the Estimate of Private Sector Contribution to Contraceptive Purchase in Morocco have been generated.*

*The Host Contribution section estimates the magnitude of current host country contributions to the program, projects the host country contribution for the LOP, and describes the sources and methods to be employed for annual reporting of the host country contribution.*

*H1*

**MOROCCO  
STRATEGY FOR USAID  
CONTRACEPTIVE  
PHASE-DOWN**

**MAY 1993**

## **GOAL**

The goal of this contraceptive phase-down strategy is to increase the Government of Morocco's (GOM) capacity to institutionalize the management and procurement of contraceptives as A.I.D. gradually decreases its contraceptive donations. Consequently, this strategy places strong emphasis on developing GOM expertise and knowledge for managing contraceptive procurement.

## **OBJECTIVES**

By the completion of this family planning project, the GOM will have the institutional capacity to:

- \* Accurately forecast contraceptive needs
- \* Determine the financial costs for the needed contraceptives and secure the funds as a line item in the Ministry of Public Health (MOPH) budget
- \* Procure needed contraceptives
- \* Manage the distribution and storage of contraceptives
- \* Manage the contraceptive logistics management information system (LMIS)

## **I. INTRODUCTION AND BACKGROUND**

### **A. SELF-RELIANCE**

Population studies point to major increases in contraceptive demand for all regions of the world over the next decade. In addition to the contraceptive needs for family planning, AIDS awareness has further increased the demand for condoms. Present levels of donor funding will be unable to keep pace with this growing demand. Assuring the availability of contraceptives by fostering contraceptive self-reliance is vitally necessary for the

sustainability of public sector family planning and AIDS programs.

Contraceptive self-reliance is the ability of a country to gain access to needed contraceptive supplies on a continued reliable basis, using resources over which they have control. Effective control refers to locally available purchasing capacity or arrangements with multinationals or other entities. Control explicitly excludes continued total dependency on donated contraceptives.

There is no roadmap or blue print to contraceptive self-reliance. A number of innovative interventions rather than one single approach will be necessary. The ability of individuals and organizations to be creative and adaptable will facilitate this arduous task and increase the chances of success and sustainability. While there are a number of countries in the developing world that have become self-reliant, each country's approach to self-reliance has been unique due to diverse political, economic and cultural environments. However, a common thread has been the political will and firm commitment towards achieving self-reliance. Although there are a number of technical documents that reflect the combined experience of these countries, the GOM will need to develop a strategy appropriate to its own needs.

For Morocco, the gradual phase-down by USAID will decrease dependence on a single donor and initiate a process of increased control and self-reliance for the GOM. Success of this phase-down should be measured by the reduction of donor dependency and the shifting and sharing of costs to other entities for the funding of contraceptives. Strategy success will also be dependent on the firm commitment and political will - at the highest levels - of the GOM, USAID and other donors.

## B. FAMILY PLANNING IN MOROCCO

Presently, all contraceptives available in Morocco are imported, with the vast majority in the public sector donated by A.I.D. Based on the 1992 Moroccan Demographic and Health Survey (MDHS), it is estimated that the private sector accounts for approximately 36 percent and the public sector for 64 percent of the source of contraceptive supply.

Under the current Family Planning and Child Survival Project, USAID has financed the bulk of contraceptives for the GOM's public sector and social marketing programs through 1994, at a cost of approximately U.S. \$2 million per year. The current project places considerable emphasis on the development of program sustainability; this phase-down is compatible with those objectives. USAID is currently developing a follow-on project which will continue to provide contraceptives in gradually reduced amounts while the GOM prepares to assume responsibility for contraceptive procurement.

### C. CONTRACEPTIVE LOGISTICS SYSTEM

The logistics management system in Morocco is a comprehensive multi-level system which provides contraceptives to an infrastructure of over 2,200 fixed facilities and a nationwide out-reach program serving an estimated 80 percent of the population. Donated contraceptives provided to the public sector arrive at the port in Casablanca where they are cleared through customs and transported to the MOPH central contraceptive warehouse in Casablanca. From Casablanca they are either issued by allocation or distributed upon request to the provincial level. Subsequently, they are distributed through the districts (Moroccan circonscriptions) and outlets for client consumption.

To date, the family planning program in Morocco has a strong record of accomplishments which have been made possible by the effectiveness of its logistics management system. USAID family planning logistics technical assistance has focused on contraceptive storage, logistics management information systems (LMIS) and forecasting. Whereas in the past port clearance and storage were problematic, the MOPH has made considerable improvements in the conditions in which contraceptives are stored and the time required in customs clearance.

An apparent lack of uniformity in recording and under-reporting of client usage data to the central level has impeded the accurate forecasting of national needs. Future USAID logistics technical assistance will focus on refining the LMIS, forecasting, training local personnel in logistics management and contraceptive procurement.

## II. A STRATEGY FOR CONTRACEPTIVE PHASE-DOWN

In order to increase the Government of Morocco's (GOM) capacity to institutionalize the management and procurement of contraceptives, USAID will need to provide long-term technical assistance over a period of five years to ensure that there is a smooth transition of responsibility without program disruption and that clients will continue to have access to high quality contraceptives on demand. Although this strategy envisions intensive technical assistance, all activities undertaken will strive to involve MOPH staff so as to transfer the necessary skills and knowledge which will enable the process to be sustainable and institutionalized.

The strategy to ensure successful GOM management and procurement of contraceptives has divided responsibility between GOM and USAID. This strategy has multiple components that are dependent on the technical skills and coordination of many individuals and organizations. Therefore, it is essential that both USAID and the MCH/FP services assign senior level persons to implement this strategy. Most of the activities in this strategy are in fact long-term interventions. As such, it is essential that the individuals selected are committed for the long-term.

USAID will be responsible for the following components:

- (A) Provision of contraceptive supplies in decreasing amounts.
- (B) Provision of short term technical assistance in logistics system development, logistics management training and contraceptive procurement.
- (C) Provision of a logistics specialist to assist the GOM during the phase-down period and transfer technical expertise in the area of logistics management and procurement.

The MOPH will be responsible for the following components:

- (D) Contraceptive logistics management including: storage, distribution, monitoring and data collection.

- (E) Strategic planning for contraceptive self-reliance including: review of technical documents and reports from countries with experience in contraceptive self-reliance issues, and; review of procurement issues, such as product selection, forecasting, preparing cost estimates, and obtaining necessary funding approvals.
- (F) Procurement of contraceptives including product specifications and formulations, packaging and labeling, quality assurance standards and testing, regulatory and customs requirements and procurement options.
- (G) Identification of a Senior Contraceptive Coordinator to oversee all aspects of this phase-down strategy.

Below is a detailed description of the components listed above.

A. USAID will continue to provide contraceptive supplies in decreasing amounts through 1998. The phase-down assumes that the GOM will procure increasing amounts of contraceptives beginning in 1995. This would be the earliest reasonable point for GOM procurement to be in place due to budgeting and procurement action lead-times. A typical contraceptive procurement cycle, involving international competitive bidding, will cover a period of 18 to 20 months. Family planning programs are especially vulnerable to disruptions in the supply chain. The credibility of the family planning program can be severely compromised by stockouts and unreliable supply.

It should be pointed out that a phase-down plan that splits the responsibility for procurement presents logistical problems if brands other than those currently supplied are used. In addition, the GOM may not be able to get scale discounts if the volume is too low in the early years.

The following is the bilateral Phase-down plan which includes the percentage of contraceptive quantities for the GOM and USAID.

**Bilateral Phase-down Plan,  
Based on Calendar Year**

	USAID	GOM
1994	100%	0%
1995	90%	10%
1996	75%	25%
1997	50%	50%
1998	25%	75%

Attachment A provides a detailed summary by method of the total quantities and costs for USAID and the GOM from 1994 - 1998. The estimated quantity is based on the 1993 Contraceptive Procurement Tables (CPTs) prepared by Centers for Disease Control (CDC) consultant Neal Ewen in conjunction with MCH/FP officials. The costs are based on current USAID prices with an inflation factor plus six percent for shipping.

The CPTs calculate contraceptive need (the quantity of contraceptives to be procured or ordered) by taking into account stock-on-hand, historical consumption, transfer, loss and disposal, estimated consumption, expected shipments, lead time, and maximum and minimum stocks. The primary source of data used for this forecast were inventory records and issues data from the MOPH Central Stores in Casablanca.

Issues data alone are insufficient to prepare these forecasts; a number of other factors were taken into consideration. It is necessary to observe the program and solicit the insights and thoughts of staff at all levels. Through discussions at the central level with program

management, field visits to service providers and storage facilities, the following factors were taken into consideration:

- Current contraceptive method mix and future method mix trends
- Contraceptive preferences of service providers and clients
- Present and future program plans and direction
- Field stocks on hand, stock movement and storage capacity
- The accuracy of recording and reporting data
- General logistics management problems and concerns

These forecasts will need to be reviewed and updated each year since, the further into the future estimates are made, the less reliable they are.

Current USAID contraceptive prices were used in preparing these tables. However, the GOM should recognize that due to the large quantities purchased by USAID, USAID often pays less than other buyers. In other cases, such as with condoms, USAID typically pays somewhat higher prices due to U.S. Government regulations requiring that all purchases be sourced in the U.S., regardless of cost. Attachment B is a list of estimated contraceptive unit price ranges for the international market. This list should be carefully reviewed by GOM officials in determining their contraceptive cost budget.

B. USAID will continue to provide technical assistance in logistics system development, logistics management training and contraceptive procurement so that the GOM will develop the institutional capacity to manage these activities and ensure clients will have access to sufficient quantities of high quality contraceptives. In order to procure contraceptives, a program must have a well-functioning logistics system since the component activities are highly interrelated. Typically, if a problem is identified in one activity, it is likely to affect other activities as all activities are dependent on one another. For example, insufficient data will affect the accuracy of forecasts and quantities ordered.

1. USAID will conduct a comprehensive review of the logistics management system. The general purpose of this review is to identify areas for improvement of the logistics system and target the technical assistance to strengthen areas found deficient. This review will look at forecasting, MIS, storage, transport, procurement, staffing and training. Based on this review a detailed action plan will be developed which will include areas of technical assistance, training needs and a time frame which will provide a smooth transition to GOM procurement responsibility and its institutionalization.

2. USAID will provide technical assistance in training in the areas of logistics management, procurement and training-of-trainers based on the above review. A generic logistics management curriculum developed by CDC/FPLM will be adapted for Morocco.

3. USAID will provide technical assistance and training in public sector procurement. A review of the procurement system will be prepared and areas for needed improvement will be identified and technical assistance and/or training provided.

C. USAID will provide a full-time Logistics Specialist to assist the GOM during the phase-down period. This person will help transfer technical expertise to MOPH personnel in the area of logistics management and procurement. This person will assist the MOPH with the:

- \* Estimation of future contraceptive needs
- \* Preparation of contraceptive procurement budget
- \* Development of procurement documentation
- \* Clearance of contraceptives from the port and customs
- \* Development of logistics management procedures
- \* Improvement of reliable transportation
- \* Improvement of an efficient warehousing system

- Development and implementation of logistics management training strategies
- Aggregation and analysis of logistics management data
- Preparation of logistics reports and documentation

This person will be housed at the MOPH and report to the Senior Contraceptive Coordinator.

D. The GOM will be responsible for strengthening contraceptive logistics management activities. A contraceptive logistics system, in the broadest sense, encompasses all the activities that occur between the manufacturer and the point at which contraceptives are dispensed to clients. The logistics system includes:

- \* Selection of contraceptives
- \* Inventory control
- \* Forecasting
- \* Procurement
- \* Storage
- \* Transport
- \* Managing data

All the logistics components listed above are an integral part of the logistics cycle and cannot function without other essential logistics management activities. For example, in the area of inventory control, inaccurate, out-of-date or missing information may lead to overstocking (which may result in expired products) or understocking (which may cause a disruption of service to clients).

E. The GOM will be responsible for the strategic planning for contraceptive procurement. The first step in planning includes a review of technical documents on topics such as procurement, local production, recurrent costs, user fees, and reports from countries that have experience with contraceptive self-reliance (upon request USAID will provide these documents for GOM review).

The second step is specific to procurement and includes: a review of the local public and private sector procurement infrastructure, product selection, forecasting, preparing cost estimates, and obtaining necessary funding approvals.

It is unclear what impact (if any) a change in brands will have for the program and client behavior. Careful review of brand loyalty from the perspectives of both the consumer and service provider should be undertaken before any changes in brands are implemented.

Another example of the importance of planning, forecasts must accurately anticipate quantities up to two years before contraceptives are actually needed by clients. Therefore a well-managed logistics system is essential to the procurement process. Disruption in the supply of contraceptives can jeopardize the credibility of the program. In addition, shortages or lack of contraceptives is a contributing factor to client discontinuation. Again, strategic planning is an essential first step in the procurement process.

Planning is a time-consuming process due to the number of government agencies and other organizations involved. Meetings, correspondence and approvals are also labor intensive and require additional personnel. Procedures for international banking, duties, international shipping, insurance, taxes, tariffs, and customs all require specialized technical expertise. In addition, bid documents, contracts, and financial arrangements require access to legal expertise.

F. The MOPH will be responsible for the procurement of contraceptives in gradually increased amounts. This requires specific knowledge of product specifications and formulations, packaging and labeling, quality assurance standards and testing, regulatory and customs requirements and various procurement options. In addition, the GOM will need to ensure that hard currency is available as all three procurement options require the importation of contraceptives.

## TARGET-COST ANALYSIS

*The purpose of this section is to present the results of an application of the Target-Cost Model and discuss the significance of the findings and their implications for the future of the Moroccan family planning program.*

*The Target-Cost Model is a computerized model which allows program managers and planners to project the resources required to attain specified changes in fertility or specified changes in contraceptive use. It was developed to enable policymakers to understand the implications of demographic objectives specified in population policies or development plans and their significance in terms of numbers of clients the family planning program must serve and resources the program will require. It is also used by program managers to project the number of acceptors and users, by method and service delivery mode, needed to attain program objectives and the resources required to provide services for these clients. The assumptions used in this application of the Target-Cost model are based upon the objectives set forth in the design of this project, information collected in the 1992 DHS, as well as assumptions developed with experts familiar with the program at both the Ministry of Health and USAID.*

### *Methodology*

*The methodology used by the Target-Cost model is based on that developed by Bongarts and Stover for the Target model. It can be used to project either the change in contraceptive use required to attain a specified decrease in fertility or the change in fertility which will result from a specified change in contraceptive use.*

*The data required by the model are of four types. The first include the proximate determinants which determine the fertility of the population. Among the proximate determinants are: the number of women of reproductive age, 15 - 49 years of age, for each year of the projection; the percent of these women who are married; the incidence of sterility among this population; breastfeeding practices; and contraceptive use. The second type of data includes information about each of the contraceptive methods. This includes the method mix used by the population, the effectiveness of each of the methods, and data concerning the discontinuation rates of acceptors who begin contracepting but do not continue use for an entire year of protection. The third type of data includes information about the source for each of these methods. This includes estimates of the percent of users who obtain their methods from the public sector and the percent who use private sector services. In addition, within each of these categories additional information can be included such as estimates of public sector users who use different service delivery modes such as clinic based services or outreach services. Similarly in the private sector, additional information can be included such as estimates of the percent of users who obtain their services from pharmacies, private physicians, or social marketing programs. The final type of data included in the model is cost data. This includes costs for each of the alternative service delivery modes - consultation costs as well as commodity costs. In service delivery modes where fees are charged, the fee for the service can be input in order to project the revenues which can be generated by the program.*

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to project the revenues which can be generated by the program.

*These data are input for the base year of the analysis and target estimates are input for the target year. Analyses can be conducted to project resource needs for the next 5 or 10 years of the program. Since data are input for each year of the projection, the expected impact of specific program interventions can be factored into the analysis. Target-Cost allows program managers to understand the implications of various policies regarding future program operations. For example, a scenario can be developed which introduces a new method, such as Norplant, to the range of methods provided by the program. Estimates of the impact the availability of this new method will have on the demand for existing methods enables planners to forecast the impact of changes in demand on service utilization and resource needs. Target-Cost is a powerful planning tool which enables managers to project the impact of various decisions on service utilization and to plan strategically in order to use program resources as efficiently as possible.*

### *Target-Cost Analysis of the Moroccan Family Planning Program*

*The Moroccan family planning program must face new challenges of providing quality services for a growing population, generating demand for family planning amongst targeted populations, increasing access to family planning services, improving the quality of services and mobilizing additional resources to support all of these efforts. Progress in each of these areas will enable the program to become more sustainable and move towards self sufficiency.*

*The program has identified efforts to strengthen each of these areas and has developed goals and objectives to be obtained in the next 10 years. These objectives have been included in this application of the Target-Cost Model. The program plans to increase contraceptive prevalence from 41.5% indicated by the 1992 DHS to 54% prevalence in 1999. In addition, the program is undertaking efforts to shift contraceptive use from its current reliance on the pill (67.7% of prevalence) to increased use of long-term methods such as the IUD and sterilization. Training of physicians as well as improvements in counseling will promote this shift. In addition, Norplant will be introduced into the program. Finally, efforts will be made to increase the role of the private sector in the provision of family planning. The private sector is already an important provider of family planning - currently providing 40% of supply methods and 18% of clinic based methods. Increasing this participation to 54% of total prevalence by 1999 is an objective which the program plans to achieve. Efforts to identify and reform laws and regulations which impede the private sector provision of family planning as well as implement additional policies which promote private sector involvement will be undertaken to achieve this goal. With careful planning and effective implementation of each of these efforts, the program will be able to reach these stated objectives. The Target-Cost Model provides insight into the number of acceptors and users the program must serve and the resources which will be required in order to achieve each of these objectives.*

### *Target Population of the Moroccan Family Planning Program*

*The Moroccan family planning program must serve the needs of a growing population. In 1990 the Moroccan population was estimated to be 25.1 million and was growing at a rate of 2.6% a year. In 1992, there were estimated to be 6,430,000 women in the reproductive ages of 15 - 49. Approximately 55.3% of these women, 3,555,790, were in union and consequently at risk of becoming pregnant. In 1994 there will be 3,768,614 married women of reproductive age. In 1999, this number will increase to 4,332,293, an increase of 15% due to population growth alone. This has tremendous significance for the family planning program. Maintaining quality services for a population growing at this rate will require significant effort. Increasing prevalence amongst this population will require even greater effort.*

*At a contraceptive prevalence rate of 41.6% there were 1,479,209 women using family planning in Morocco in 1992. In 1994 this number will reach 1,582,818. Of these women, 64% rely upon 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 their family planning needs. This is a 30% increase over a 5 year period of the number of women who are projected to use public sector services. Table 1 summarizes the number of users and acceptors of family planning required to achieve this increase in prevalence. The program must take steps to ensure that resources are available to meet the needs of these women and that the program objectives are met.*

Table 1

*Projected Users and Acceptors of Family Planning*

Year	Prevalence	Users 000s	Acceptors 000's
1992	42%	1479	670
1993	44%	1604	683
1994	46%	1726	697
1995	48%	1852	709
1996	49%	1981	697
1997	51%	2091	728
1998	53%	2233	738
1999	54%	2378	745

Method Mix

Table 2

*Method Mix*

Method	1992	1999
Condom	2.2 %	5 %
Female Ster.	7.2 %	10 %
Injectable	0.2 %	1 %
IUD	7.7 %	20 %
Male Ster.	0 %	0.5 %
Norplant	0 %	3 %
Orals	67.7 %	50 %
Traditional	14.5 %	10 %
Vaginal Barrier	0.5 %	0.5 %

Source: 1992 Demographic and Health Survey

*In addition to increasing overall prevalence, the program is planning to promote the*

use of long-term methods. Table 2 indicates the assumptions of changes in method mix which were incorporated into this application of the Target-Cost model. The target method mix for 1999 was developed with input from experts on the Moroccan program at both the Population Division of the Ministry of Health and USAID. It is used here for illustrative purposes only.

This shift in method mix reflects the anticipated impact of several program interventions. These include training of physicians in IUD insertion and sterilization techniques, introduction of Norplant into the range of methods currently provided by the program, improved counseling to encourage women to consider long-term methods and to perceive them as more appropriate to meet their fertility and health needs. And, finally, improved access to services which will result in a reduction of the use of traditional methods for women who want to space their births.

Table 3

Projected Users and Acceptors by Method  
Thousands

Method	1992 Users	1999 Users	1992 Acceptors	1999 Acceptors
Condom	32.5	98.9	20.7	53.9
Female Ster.	106.5	198.3	19.3	30.5
Injectable	3	18.1	2.2	6.9
IUD	113.9	387.9	56.1	140.5
Male Ster.	0	8.3	0.8	2.2
Norplant	0	49.9	4.8	21.8
Oral	1001.4	1315.3	440.4	335.3
Trad.	214.5	269.9	123.6	148.2
V. Barrier	7.4	11.9	2337.6	3245.8

Table 3 indicates the numbers of users and acceptors by method in 1992 and 1999 needed to achieve the specified changes in overall prevalence and method mix. These people will be obtaining services from both public and private sector providers. Table 4 provides illustrative figures of users and acceptors obtaining services from the public sector, the private sector and other sources such as the IPPF affiliate in Morocco.

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Table 4

*Projected Users by Method and Source  
Thousands*

<i>Method</i>	<i>1992 Public User</i>	<i>1992 Private User</i>	<i>1992 Other User</i>	<i>1999 Public User</i>	<i>1999 Private User</i>	<i>1999 Other User</i>
<i>Condom</i>	12.0	19.1	1.4	35.22	34.73	28.9
<i>F.Ster.</i>	88.1	17.7	.7	145.6	71.8	.5
<i>Inj.</i>	.5	2.4	0	3.3	14.8	0
<i>IUD</i>	91.0	14.6	8.32	234.1	123.5	30.2
<i>M.Ster.</i>	0	0	0	4.2	4.2	0
<i>Nor.</i>	0	0	0	34.9	10.5	4.5
<i>Oral</i>	599.9	362.5	39.1	531.0	741.3	43.0
<i>V. Bar.</i>	1.2	0	6.2	0	11.9	0

*The objectives established for the 1999 provision of family planning services will ensure a more sustainable delivery of family planning services. Increasing the use of long term methods such as sterilization, Norplant and particularly the IUD will increase the cost effectiveness of the program. These interventions require up front costs for training and equipment, however, they require little in terms of recurrent costs. The IUD in particular has been found to be quite cost effective in Morocco. Reducing the dependence on supply methods will reduce the recurrent expenditure requirements of the program freeing up financial resources to be directed towards other needs. In addition, plans to promote the private sector provision of family planning services will increase the sustainability of the program. The Somarc project has proven quite effective in increasing the provision of pills and condoms through pharmacies. Moroccans are becoming accustomed to purchasing these products from the private sector and continued social marketing efforts will strengthen this trend. Shifting this burden of the provision of family planning services towards the private sector will free public sector resources for efforts to target hard to reach populations, increase prevalence and provide family planning to those populations which require subsidized services.*

### H3

#### *Estimates of Private Sector Contribution to Contraceptive Purchases in Morocco*

##### *Dollars Spent for Contraceptives*

	<i>A.I.D.</i>	<i>GOM</i>	<i>Private Sector</i>
<i>1994</i>	<i>1890</i>	<i>0</i>	<i>1081</i>
<i>1995</i>	<i>1987</i>	<i>221</i>	<i>1394</i>
<i>1996</i>	<i>1898</i>	<i>633</i>	<i>1769</i>
<i>1997</i>	<i>1414</i>	<i>1414</i>	<i>2132</i>
<i>1998</i>	<i>769</i>	<i>2307</i>	<i>2556</i>
<i>1999</i>		<i>2891</i>	<i>3035</i>

*The estimates in this table are derived in Table 1. They are based upon projections of the increase in users driven by the growth of the population as well as an increase in contraceptive use. These projections reflect contraceptive prevalence increasing from 42% in 1994 to 54% in 1999 and use of traditional methods declining from 14.5% in 1994 to 10.5% in 1999. They also reflect growing involvement of the private sector with the private sector share of the market increasing from 36% in 1994 to 47% in 1999. Costs for private sector procurement of commodities are based upon estimates of the price of contraceptives on the international market. They include the cost of the contraceptives themselves as well as shipping costs.*

There are three basic procurement options available to the GOM:

1. Competitive procurement generally means that sealed bids are solicited from suppliers based on product specifications and performance expectations. Competitive procurement is used to purchase large volumes and requires up to 18 months lead-time.

2. Intermediate Agencies may carry out procurement on behalf of the program. UNFPA and IPPF provide this service for a fee which ranges from 2 to 5 percent, depending on the dollar value and volume of the order. There are generally no volume requirements and the timeline for procurement ranges from 7 to 9 months.

3. Single-source procurement is an alternative that has been used during the transition period from donor supply. In addition to a shortened procurement time and a reduced level of procurement expertise, single-source procurement from an existing supplier also offers the advantage of continued use of a product with which the local market is familiar. However, negotiation of favorable prices can be problematic.

The procurement cycle (see attachment C) including international competitive bidding will cover a period of 18 to 20 months. The portion of time allocated to actual procurement functions may range from 14 to 16 months depending upon the procedures adopted and the length of time needed by the supplier to produce and ship the goods. In the case of orals, Morocco will require up to 7 million cycles per year. As this amount is generally not kept in stock by manufacturers, the GOM would need to contract with a supplier well in advance to ensure that this quantity could be provided when needed.

Quality assurance is an important aspect of the procurement process. Independent testing by the GOM is required both during the invitation to bid and prior to delivery to determine that the contraceptives are of the highest quality before they are put in the logistics supply system. During the invitation to bid, bidders should include a statement guaranteeing use of Good Manufacturing Practices with applicable audit authority.

For a comprehensive understanding of procurement issues a useful reference manual is the "Competitive Procurement of Public Sector Contraceptive Commodities". This manual is designed to be an easy-to-use guide on how to obtain contraceptive commodities through competitive procurement. This manual describes widely accepted procedures for competitive

tendering; however, there are many acceptable variations. Therefore, the guidance provided must be adapted by the GOM to take into account its particular needs and unique circumstances, especially with regard to specific local legal and economic systems and administrative structures.

G. The MOPH will provide a Senior Contraceptive Coordinator to oversee all aspects of this phase-down strategy. This person will be charged with assuring the smooth transition of donor-supplied contraceptives to contraceptives provided by the GOM. The following is a list of tasks that this person will be responsible for overseeing and/or coordinating:

- \* Estimation of future contraceptive needs
- \* Establishment of a budget for contraceptive procurement
- \* Procurement of contraceptive supplies
- \* Clearance of contraceptives from port and customs
- \* Development and implementation of the logistics management training
- \* Development of logistics management procedures
- \* Ensuring reliable transportation
- \* Development of an efficient warehousing system
- \* Supervision of the USAID Logistics Specialist
- \* Monitoring and developing logistics management information and reports

Since continuity and institutional memory is essential, this position should be established as a permanent one.

### III. OTHER ISSUES

The following are various issues and activities for USAID and GOM consideration:

#### A. Revolving Fund

Recurrent costs for financing contraceptives is an important issue. One possibility is the establishment of a revolving fund for the procurement of contraceptives. The Moroccan National Immunization Program is in the process of establishing a revolving fund for the procurement of vaccines. The GOM will provide an adequate amount of local currency and UNICEF/Rabat will furnish the foreign currency and procure the vaccines through the UNICEF system. The local currency will be used by UNICEF/Rabat for local expenditures. An initial deposit in foreign exchange was supplied by USAID.

There are three essential and critical elements if the family planning program is going to replicate this fund:

- \* Agreement by the GOM to furnish an adequate budget on an on-going basis for the procurement of contraceptives
- \* An initial foreign exchange deposit to start the fund
- \* An organization that can furnish foreign exchange and utilize the local currency supplied by the GOM

The above assumes local currency is not convertible; if regulations change, then the need for foreign exchange will no longer be an issue. It should also be noted that the establishment of the Immunization Program's revolving fund was a protracted process which needed the coordination of many individuals and organizations. In addition, this arrangement does not create the institutional capacity for procurement as UNICEF is responsible for the procurement and provision of the hard currency.

## B. Local Production

The local production of contraceptives is a complex issue demanding a comprehensive assessment. It would be advisable to undertake a study to ascertain the viability of manufacturing contraceptives locally. Although population and market size might quickly determine feasibility, there are numerous other issues to take into account, such as exportation, local packaging of imported products, new technology, regional demand and more productive uses of investment capital. Due to economies of scale in local production, the public sector would typically have to guarantee that they would procure all it's contraceptives from a local producer, even though local prices might be higher than those on the international market. Most importantly, any feasibility study should determine the economic viability of local production.

Establishing local production is a long-term process. Therefore, the capacity to procure externally is presently the only viable alternative to ensuring an uninterrupted supply of contraceptives.

## C. Financial Sustainability

The USAID Implementation Plan for USAID Assistance in Population and Health 1992 - 1996 is designed to promote financial sustainability over the next five years. The focus will be on the following two objectives:

- \* Shifting contraceptive users (particularly of supply methods) from the public to the private sector.
- \* Strengthening MOPH capacity and commitment to assume the burden of financing and procuring contraceptives for the public program.

With the phase-down of USAID contraceptive support, increasing responsibility will fall to the GOM for the financing and procurement of contraceptives. Therefore, senior level decision makers and planners need to be creative in securing funding for contraceptive procurement. The following is a list of options available to finance the procurement of

## contraceptives:

- \* Increase the financial resources available in the MOPH budget for the procurement of publicly supplied contraceptives
- \* Introduce cost recovery by the collection of user fees
- \* Increase the share of clients served by the private sector
- \* Explore various external options for financing, e.g. World Bank or other donors

The World Bank has offered low interest loans for the procurement of contraceptives for public sector programs in various countries. This financing option has the disadvantage of transferring the costs of contraceptive procurement to the future when loans come due. USAID's centrally funded PROFIT project may provide funding opportunities for a private sector initiative.

It should be emphasized that for the foreseeable future the public sector will continue to be the primary source of contraceptives for the vast majority of Moroccans. There will also be a substantial proportion of the population who will consistently be unable to afford contraceptives and others who do not see the need for preventive health care. Clear, consistent policies and guidelines need to be established for these clients. The issue of "equity" will necessitate close and careful consideration.

### D. Contraceptive Phase-down Conference

USAID will fund a two-day conference that will provide a forum for the contraceptive phase-down strategy for members of the public and private sector, donor community, international health experts and technical experts. The purpose of this forum is to:

- \* Initiate dialogue on contraceptive phase-down strategy
- \* Build consensus on actions to be taken

- \* Formulate a plan to address the issues relating to contraceptive procurement and the USAID phase-down strategy

The Conference will address technical, programmatic, political and policy issues. The first half of the conference will deal with:

- \* Global lessons and knowledge learned on contraceptive self-reliance
- \* Demographic trends and contraceptive demand
- \* Budget projections
- \* Local production of contraceptives
- \* Private sector importation of contraceptives
- \* Logistics management issues including: public sector, procurement, logistics management information systems (LMIS), distribution and contraceptive quality assurance
- \* GOM articulation of policy and budget plans and any impediments to phase-down strategy
- \* USAID articulation of the phase-down strategy

In the second half of the conference participants will be divided into three groups - policy, procurement and financing - and asked to review their topics and develop an action plan that will be presented to the larger group for clarification, comments and/or additions. Based on each group's presentation, a comprehensive action plan will be developed detailing persons responsible, tasks and a timeline for future activities. In addition to assigning discrete tasks for phase-down activities, this conference will focus attention on and promote the phase-down strategy for a cross section of organizations and disciplines.

### E. Committee Meeting

There is currently a structure in the family planning program of various technical committees. Since the procurement of contraceptives demands various technical expertise, it is recommended that the committee/s facilitate dialogue with donors, private sector pharmaceutical agents, social marketing experts, procurement specialists, logistics experts and other pertinent experts to share their knowledge on these important topics.

More specifically, the committee's agenda should focus on monitoring the Strategy Action Plan (see below) and resolving outstanding issues and impediments to the phase-down. The Logistics Specialist and the Senior Logistics Coordinator should be active committee participants.

### E. HIV/AIDS

Presently all condoms for the National AIDS Prevention Program are provided and funded by USAID. In 1992, approximately 1.75 million condoms were given to the program. For 1993 program officials have requested 3 million. Similar increases will have a major impact on condom estimates and the overall contraceptive budget. There are many examples of countries where annual condom demand has increased over 100 percent in one year.

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#### IV. STRATEGY ACTION PLAN

The Action Plan is a collection of general statements which are in fact often complex tasks and need to be addressed in a comprehensive manner. Many of these tasks will require the technical skills and coordination of many individuals and organizations and often long-term interventions. As much as possible the steps are listed in chronological order; many of the steps will occur simultaneously.

#### ACTION PLAN

ACTIVITY	PERSONS &/or ORGANIZATIONS RESPONSIBLE	DATE
<b><u>Planning</u></b>		
Comprehensive Review of Technical Documents, etc.	SCC(1)/ LS(2)	Jun93
FP Technical Committees Discuss Phase-down Issues	SCC/ LS	Aug93 On-going
Phase-Down Conference	SCC/ FPLM	Nov/93
Forecasting Needs	FP/MCH/ FPLM	Annually
Contraceptive Specifications	SCC/ LS	Jan94
Budget Estimates	SCC/ LS	Feb94
Official Procurement Approvals	SCC/	Mar94

ACTIVITY (cont.)	PERSONS &/or ORGANIZATIONS RESPONSIBLE	DATE
<u>Personnel</u>		
Recruitment of Senior Contraceptive Coordinator (SCC)	FP/MCH	Jul93
Recruitment of Logistics Specialist (LS)	USAID	Jul93
	LS	
<u>Procurement</u>		
Preparation of Bidding Documents	SCC/ LS	Jun94
Advertising Bids	SCC/ LS	Aug94
Adjudication of Bids	SCC/ LS	Nov94
Awarding of Contract	SCC/ LS	Nov94
Inspection and Testing	SCC/ LS	Dec94
Letter of Credit	SCC/ LS	Dec94
Shipping	SCC/ LS	Mar94
Port Clearance and Reception	SCC/ LS	Jun94
Initial Distribution	SCC/ LS	Jul94

ACTIVITY (cont.)	PERSONS &/or ORGANIZATIONS RESPONSIBLE	DATE
<b><u>USAID Technical Assistance</u></b>		
Forecasting	FPLM	Oct93 Oct94
Logistics Management Information System (LMIS)	FPLM	Oct93 Oct94
Procurement	FPLM	Dec93
Training	FPLM	TBE (3)
<b><u>Special Studies (4)</u></b>		
Local Production	TBE	TBE
Program Sustainability and Self Reliance	TBE	TBE
Revolving Fund	TBE	TBE
Income Generation	TBE	TBE
Brand Acceptability Studies	TBE	TBE
Consumer Price Elasticity Study	TBE	TBE
Contraceptive Quality Assurance	TBE	TBE

1. SCC = Senior Contraceptive Coordinator

2. LS = Logistics Specialist

3. TBE = To Be Established

4. Special Studies refer to activities that may need more in-depth review and/or technical assistance. Requests for these activities will be determined by the Senior Contraceptive Coordinator and/or the Family Planning Committee.

## HOST COUNTRY CONTRIBUTION

*The purpose of this section is to (1) estimate the magnitude of the host country contribution to this project, in terms of personnel, local costs and commodities; (2) project future levels of these contributions to serve as targets; and (3) describe the sources and methods to be used in updating these estimates for annual reporting purposes.*

### Personnel Costs

#### *Base-year Estimate*

*It is difficult to estimate the personnel costs of preventive health care programs carried out by the Ministry of Public Health (MOPH) because: (1) the programs are carried out within an integrated primary health care system (SIAAP), which provides a wide range of curative and preventive services; and (2) the salaries paid to health personnel are administered by the Ministry of Finance and are not listed in the annual MOPH budgets. Fortunately, a recent time use and cost survey of SIAAP facilities provides a basis for making such estimates. This survey was carried out in 1990 by staff of the A.I.D.-funded OPTIONS project, MOPH and a local consulting firm (ICONE) and included 18 SIAAP facilities in three provinces (Kenitra, Ben Slimane and Agadir). One each of the following types of facilities was surveyed in each province over a one-week period: Urban Health Center (CSU), Urban Dispensary (DU), Family Planning Reference Center (CRPF), Rural Health Center (CSR), Rural Dispensary (DR) and Basic Rural Dispensary (DRB). The time use survey utilized observers who recorded the activities of all health workers in fixed facilities during the week, supplemented by self-administered time sheets covering the activities of health personnel conducted outside the facilities (e.g., outreach services). In addition, detailed cost and service statistics data were collected for the facilities surveyed, and cost data were collected as well as for the provincial health offices in the three provinces. The procedures used in the survey, as well as its findings, have been described in several reports.<sup>1</sup>*

*Data from the OPTIONS/MOPH cost survey provide estimates of the proportion of time spent by each surveyed health worker in various programs, including the four programs most directly involved in the current project, i.e., family planning (PF), pre- and post-natal care (PSGA), diarrheal disease control (PLMD) and health education (ES). Data on the salaries actually paid to these health workers (including benefits) were obtained at the time of the survey from the Ministry of*

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<sup>1</sup> Ministère de la Santé Publique. 1993. *Evaluation du Côté des Services de Planification Familiale et des Soins Primaires au Maroc*. Programme National de Planification Familiale. Rabat, Morocco. Some additional tables are provided in James C. Knowles and Laurie Emrich. 1991. "The Estimation of Family Planning and Primary Health Service Costs in Morocco." Draft (March 30, 1991). The Futures Group, 1526 E. Franklin Street, Chapel Hill, NC 27514.

Finance and were used, in combination with the time use survey, to obtain estimates of annual direct personnel costs, by program, in each type of facility for 1989.<sup>2</sup> These estimates are reported below.

Table 1  
Direct Personnel Cost per Facility for Selected Programs, 1989 (Dirham\*)

	CSU	DU	CRPF	CSR	DR	DRB
PF	8,549	7,001	11,507	13,637	3,544	638
PSGA	2,399	8,201	81	11,359	1,513	434
PLMD	761	1,101	0	1,919	606	32
ES	726	760	1,135	1,646	391	0

Source: 1990 OPTIONS/MOPH Cost Survey

\* One U.S. Dollar = 8.6 Dirham at the time of the survey.

To the above estimates of direct personnel costs (i.e., costs of time spent working directly on program-specific activities) must be added a pro-rata share of facility-level indirect personnel costs (e.g., reception, administration, supervision, communication, reports, training, absences and leave), as well as provincial-level administrative personnel costs. These indirect personnel costs were allocated to programs in proportion to their share of total direct personnel costs. The resulting estimates of total program-specific personnel costs are presented below.

Table 2  
Total Personnel Cost per Facility for Selected Programs, 1989 (Dirham)

	CSU	DU	CRPF	CSR	DR	DRB
PF	34,621	41,836	127,400	57,066	24,474	4,440
PSGA	9,717	49,006	897	47,533	10,445	3,015
PLMD	3,082	6,581	0	8,029	4,187	225
ES	2,939	4,542	12,561	6,889	2,698	0

Source: 1990 OPTIONS/MOPH Cost Survey

<sup>2</sup> The procedures used to produce annual estimates from the survey data are described in the various reports cited above.

Data on the number of primary health facilities of each type are available for 1991 (Table 3) and are used to obtain estimates of total personnel cost at the national level (Table 4) by multiplying the per facility estimates in Table 2 by the number of facilities of each type.

Table 3  
Number of Primary Health Facilities, 1991

	CSU	DU	CRPF	CSR	DR	DRB
N of Facilities	250	166	32	182	581	432

Source: MOPH

Table 4  
Total Personnel Cost at the National Level, 1991

	Annual Cost (Dirham)	Annual Cost (\$)	Percent of Total
PF	Dh 46,200,459	\$ 5,372,146	10.25
PSGA	26,615,221	3,094,793	5.90
PLMD	5,854,458	680,751	1.30
ES	4,712,084	547,917	1.05
Subtotal: (Project-related Programs)	Dh 83,382,222	\$ 9,695,607	18.50
Total Personnel Cost	Dh 450,838,154	\$52,423,041	100.00

Source: see text

According to Table 4, the total personnel cost of these four programs in 1991 is estimated to be \$9,695,607. This estimate includes a pro-rata share of all indirect and provincial administrative personnel costs, but it does not include the personnel costs of the central administrative offices of these programs. An estimate of these costs was obtained using data provided from MOPH on the number of personnel by salary grade working in various divisions/services of the Direction de la Prévention et Encadrement Sanitaire (DPES), which includes all four programs, as well as estimates of the average monthly salary for each grade. The resulting estimates for each program are provided in Table 5, which include an additional pro-rata share of the personnel costs of supervisory staff (i.e., the Director and his support staff), which were allocated to the various divisions in proportion to their numbers of staff (excluding the motor pool).

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2Table 5  
Central Administrative Personnel Costs, 1993

PF	Dh 1,331,301
PSGA	539,515
PLMD	563,515
ES	2,160,556
Total (Dirham)	Dh 4,594,887
Total (\$)2	\$534,289

The estimates in Tables 4 and 5 need to be added together to obtain an estimate of the total personnel cost involved in the four programs. The problem is that the estimates in Table 4 refer to 1991 while those in Table 5 refer to 1993. The preferred approach would be to obtain a 1993 estimate of the total personnel cost of SIAAP and to multiply it by the estimated percentage of these costs which are attributable to the four programs (18.5 percent, from Table 4) to obtain an updated estimate of the four program's SIAPP costs for 1993. Alternatively, if information on SIAAP personnel costs is not readily available, 1993 data on numbers of facilities by type (similar to the 1991 data reported in Table 3) can be used to obtain an estimate for 1993. Finally, if these are not available, there is probably not much error resulting from simply adding the two estimates together to obtain an estimate for 1993 (i.e., \$9,695,607 + \$534,289 = \$10,229,896).

Moreover, the resulting estimate (however obtained) is a very conservative estimate of host country contribution in the form of personnel costs because it excludes the following additional personnel costs related to the project: (1) all hospital- and maternity-based costs, including those of sterilization (PF) and delivery (PSGA) facilities; (2) costs of training facilities (e.g., INAS); and (3) costs of research (e.g., SEIS, INAS). One reason these items are not included is that there is no survey available to provide estimates of the relevant program's share of these costs. Although it would be possible to collect data from these facilities for the baseline, the added cost and effort needed to update them on an annual basis is not considered to be worth the effort. The additional costs would be expected to be relatively minor compared to those already included.

Projected Levels

It is proposed that the base-year estimates of total personnel costs be straight-lined over the life of the project, for the following reasons. First, there is clearly a lot of under utilized personnel time in the existing primary health system. The OPTIONS/MOPH time use survey, for example, found that 25 percent of labor costs in all facilities surveyed were consumed in waiting for the next patient to arrive, with another 16.7 percent consumed by unexcused leave. Second, while the total volume of family planning services is expected to increase very rapidly from 1993 to 1999 (by 49 percent, according to the base scenario in the Target-Cost Model), the

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Increase in public sector users is projected to be less (only 19.5 percent). Growth in other MCH users, while substantial, is expected to be less rapid than in the past, due to continually declining levels of fertility. In a recent simulation exercise, for example, in which FP/MCH services were assumed to increase by 22.3 percent between 1993-99 without any reallocation of personnel between under utilized and more heavily utilized facilities, FP/MCH personnel costs increased by only 6.7 percent.<sup>3</sup>

### Annual Reporting

The estimates of personnel costs for 1991 reported in Table 4 indicate that the four programs involved consume 18.5 percent of the total personnel costs of SIAAP at the national level. The actual estimate of SIAAP personnel costs absorbed by the four programs in 1993 can be obtained by multiplying the total estimated personnel cost of SIAAP in 1993 by 18.5 percent. The estimate can then be updated each year by applying the same percentage to the current SIAAP personnel costs in each year. A much less satisfactory procedure would involve carrying forward the same procedure used to obtain the baseline estimates reported in Table 4, i.e., obtaining data on the number of facilities by type in each year (cf Table 3) and multiplying these by the estimates provided in Table 2. The problem with this procedure is that it would not be sensitive to any under-staffing problems which might arise during the life of the project.

The personnel costs of the central administrative divisions and services can be updated in the same way they were estimated for 1993, i.e., from a table of the number of DPES personnel by division/service and salary grade, together with estimates of average salary for each grade.

### Local Costs

The host country contribution in the form of local costs is budgeted as operating costs of the project-related units of MOPH (i.e., FP/MCH and Health Education). These are split between the MOPH recurrent and investment budgets.<sup>4</sup> Tables 6

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<sup>3</sup> James C. Knowles and Anne E. Wagman. 1991. The Relationship between Family Planning Costs and Contraceptive Prevalence: Will FP Costs per User Decline Over Time?" Paper presented at Annual Meetings of the Population Association of America. Washington, D.C. (March, 1990).

<sup>4</sup> The annual operating budget for preventive health services has been split between the recurrent and investment budgets for several years. A variety of explanations have been offered for this unusual practice. One is that most of these costs were once financed by a World Bank loan and were included in the investment budget for that reason. Another is that MOPH convinced the Ministries of Plan and Finance that expenditures in FP/MCH activities were partially investments and should be budgeted accordingly. In any case, the consensus is that this

and 7 summarize the recent evolution of the recurrent and investment budgets for the activities covered by the project (i.e., FP/MCH services and Health Education) by line item during the period, 1990-93.

Table 6  
Recurrent Budgets (FP/MCH and Health Education), 1990-93

	1990	1991	1992	1993
<i>Furniture, Supplies and Office Equipment</i>	<i>Dh 205,000</i>	<i>Dh 205,000</i>	<i>Dh 550,900</i>	<i>Dh 595,450</i>
<i>Technical Equipment</i>	<i>90,000</i>	<i>90,000</i>	<i>140,000</i>	<i>290,000</i>
<i>Transportation and Mobility</i>	<i>3,550,000</i>	<i>3,550,000</i>	<i>3,650,000</i>	<i>3,700,000</i>
<b>TOTAL (DH)</b>	<b>3,845,000</b>	<b>3,845,000</b>	<b>4,340,900</b>	<b>4,585,450</b>
<b>TOTAL (\$)</b>	<b>\$447,093</b>	<b>\$447,093</b>	<b>\$504,756</b>	<b>\$533,192</b>

Source: MOPH (\$1 = 8.6 Dh)

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treatment makes it possible for FP/MCH to receive higher levels of funding than would otherwise be the case.

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Table 7  
Investment Budgets (FP/MCH and Health Education), 1990-93

	1990	1991	1992	1993
Vaccine and Medications	7,422,950	8,501,990	15,600,000	15,000,000
Supplies	1,188,870	2,255,000	1,810,000	2,190,000
Furniture and Equipment	2,205,000	3,940,000	4,100,000	5,400,000
Purchase of Vehicles	1,013,500	300,000	390,000	450,000
Transportation and Mobility	3,052,050	4,828,010	4,870,000	5,930,000
IEC Materials and Media		731,000		1,678,200
Maintenance		70,000	130,000	230,000
Temporary Personnel	19,200	50,000	100,000	150,000
Miscellaneous	187,000	344,000		200,000
TOTAL (Dh)	15,088,570	21,020,000	27,000,000	31,228,200
TOTAL (\$)	\$1,754,485	\$2,444,186	\$3,139,535	\$3,631,756

Source: MOPH (\$1 = 8.6 Dh)

#### Base-year Estimate

A base-year (1993) estimate of the operating budgets for the project-related units of MOPH can be obtained by adding totals from the recurrent budget (Table 6) to those of the investment budget (Table 7). The 1993 estimate of the operating budget of \$4,164,948. It should be noted that this estimate includes approximately \$713,953 in budgeted amounts for equipment and vehicles. However, it should be pointed out that a significant portion of these funds is intended for use in maintaining previously donated equipment. Moreover, the estimate derived from Tables 6 and 7 does not include any estimate of operating costs incurred at the provincial level in connection with the ordinary operation of the facilities providing FP/MCH services (e.g., utilities, telephone, cleaning and office supplies) and is therefore conservative.

#### Projected Levels

Table 8 (column 2) reports the actual operating budgets of the MOPH project-related units from 1990-93 (obtained from Tables 6 and 7), as well as a provisional

estimate of the operating budget for 1994. These data are extrapolated forward in time, using linear regression analysis, to provide forecasts of the operating budget for the years 1994-99 (column 3).

Table 8  
Past Trends and Forecast of Local Contribution

Year	Actual/Budgeted	Predicted	Contraceptives	Total budget
1990	\$2,201,578			\$2,201,578
1991	\$2,891,279			\$2,891,279
1992	\$3,644,291			\$3,644,291
1993 <sup>5</sup>	\$4,164,378	\$1,041,095		\$5,205,473
1994	\$4,797,935 <sup>6</sup>	\$4,797,935		\$4,797,935
1995		\$5,037,832	\$221,000	\$5,258,832
1996		\$5,289,723	\$633,000	\$5,922,723
1997		\$5,554,210	\$1,414,000	\$6,968,210
1998		\$5,831,920	\$2,076,000	\$7,907,920
1999		\$6,123,516	\$2,307,000	\$8,430,516
2000 <sup>7</sup>		\$1,650,000		\$1,650,000
<b>TOTAL L.O.P</b>	<b>\$4,797,935</b>	<b>\$35,326,230</b>	<b>\$6,651,000</b>	<b>\$41,977,230</b>

Source: Col. 1: MOPH  
Col. 2: Predicted values

The data in Table 8 indicate that the MOPH operating budgets for FP/MCH and Health Education can be expected to double approximately between 1994 and 1999. In fact, the expected growth in the MOPH operating budget for these project-related units over the life of the project (1994-99) exceeds the average level of A.I.D.-funded local costs under the project (\$3.23 million in projected budget growth versus \$2.93 million average project-funded local costs). Given that some of the project-funded local costs are not expected to be sustained at their average level beyond the life of the project, the MOPH should be able to absorb the project's local costs in its ordinary operating budgets without great difficulty.

<sup>5</sup> Last trimester of 1993

<sup>6</sup> Provisional budget

<sup>7</sup> First trimester of 2000

## *Annual Reporting*

*The MOPH can report the operating budgets for the project-related units (i.e., FP/MCH and Health Education) by extracting the relevant information directly from the annual recurrent and investment budgets.*

## *Contraceptive Commodities*

*MOPH assumption of the cost of contraceptive commodities is an important feature of the project. These are estimated to be approximately \$2.3 million by the end of the project. MOPH does not currently spend any funds on contraceptive procurement, but it has reportedly added such a line item to its 1995 operating budget. According to the projections reported above (Table 8), the anticipated cost of contraceptives to be procured by MOPH would amount to approximately 28 percent of the operating cost budgets of the project-related MOPH units at the end of the project. Although this is indeed a significant burden for MOPH to assume, it is not without precedent. MOPH expenditures on vaccines, for example, rose from 1.78 million Dirham (\$207,000) in 1989 to 11.2 million Dirham (\$1.3 million) in 1992.*

*Annual reporting of budgets on contraceptive commodities can be easily accomplished by MOPH, by extracting the information directly from annual recurrent and investment budgets. These budgets are prepared two years in advance.*

**ANNEX I.**

**INITIAL ENVIRONMENTAL EVALUATION**

ENVIRONMENTAL CONSIDERATIONS

THRESHOLD DECISION BASED ON INITIAL ENVIRONMENTAL EXAMINATION

Project Location: Morocco  
Project Title/I.D.: Family Planning Maternal and Child Health Phase V (608-0223)

Funding (Fiscal Year and Amount): First FY '93: \$8,012,000  
LOP \$52,000,000

IEE Prepared by: Joyce Holtfeld *JMH* Date: June 3, 1993

Environmental Action Recommended: Negative Determination

Therefore, no further Environmental Assessment is required

Mission Decision:

Approval/Disapproval of Environmental Action Recommended in the IEE:

Approved: \_\_\_\_\_

*Martin V. Dagata*  
Martin V. Dagata  
Mission Director

Disapproved: \_\_\_\_\_

Date: \_\_\_\_\_

Clearances:

Mission Environmental Officer: Rick Scott  
Date: \_\_\_\_\_

*Rick Scott*  
\_\_\_\_\_ 6/3/93

Concurrence:

Bureau Environmental Officer:

Approved: \_\_\_\_\_

Disapproved: \_\_\_\_\_

Date: \_\_\_\_\_

*Hibat S. Jaber*  
\_\_\_\_\_ 6/27/93

I.2

INITIAL ENVIRONMENTAL EXAMINATION

1. Project Location: Morocco
2. Project Title/ID: Family Planning Maternal and Child Health Phase V
3. Funding (Fiscal Year and Amount): First FY '93: \$8,012,000  
LOP \$52,000,000
4. IEE Prepared By: Joyce Holfeld Date: June 3, 1993
5. Action Recommended: Negative Environmental Determination. Therefore, no further environmental assessment is required.

6. Discussion of major environmental relationships of project relevant to attached Impact Identification and Evaluation Form:

This Initial Environmental Examination deals with activities which will be financed through a new project, Family Planning Maternal and Child Health, a new project. The LOP funding for this major effort in family planning and mother and child health care is \$52,000,000. During the seven year life-of-project period, the project will focus on increasing access to health care facilities and services, improving their quality, and determining potential diversified funding sources for future health care programs implemented by the Ministry of Public Health. Project objectives will be completed through the provision of technical assistance, training, information services, and commodities. These activities will not have a direct effect on the natural or physical environment. The project may spend approximately .0007 percent of LOP funds (\$350,000) on an injectable program which may require the purchase of syringes from the United States. Although used syringes pose a potential risk to the environment, there are no anticipated significant effects from this activity because the amount of waste generated will be small and used syringes will be disposed of according to GOM guidelines. During the course of the LOP, the disposal of syringes will be monitored.

I.3

ENVIRONMENTAL IMPACT IDENTIFICATION AND EVALUATION FORM

ENVIRONMENTAL IMPACT INDICATOR AREAS/ENVIRONMENT CONSIDERATIONS

A. Land Use:

- 1. Changing the character of the land through:
  - a. Land Clearing N
  - b. Construction (roads, buildings, piping) N
  - c. Extraction of minerals/natural resources N
  - d. Creation of deposits of unwanted materials (waste spoils) N
- 2. Alteration of natural barriers (dunes, marshes): N
- 3. Foreclosing important future uses: N
- 4. Potential for endangering populated areas: N
- 5. Other factors: N

(Notes):

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B. Surface and Groundwater:

- 1. Effects on quality:
  - a. Introduction of industrial pollutants: N
  - b. Introduction of agricultural pollutants: N
  - c. Introduction of urban/sewage wastes: N
  - d. Introduction of biomedical wastes: N
  - e. Potential for transnational impacts: N
- 2. Effects on quantity:
  - a. Changes in water flow rates: N
  - b. Increasing probability of floods: N
  - c. Potential for changing demand/supply relation: N
  - d. Potential for transnational impacts: N
  - e. Potential for evaporation losses: N

C. Air:

- a. Potential for increased NO<sub>x</sub>, SO<sub>x</sub>, HC, CO<sub>2</sub>/CO emissions: N
- b. Potential for increased particulate emissions: N
- c. Potential for increase of noxious odors, vapors, pathogens: N
- d. Noise pollution: N
- e. Other factors: N

D. Energy:

- a. Potential for increased energy demand:   N
- b. Use of renewable energy source:   N
- c. Plans for energy efficiency/conservation:   N
- d. Other factors:

E. Coastal and Marine Resources:

- a. Introduction of biological/chemical pollutants:   N
- b. Introduction of agricultural runoff:   N
- c. Mineral extractions:   N
- d. Impacts on fish/shellfish harvests:   N
- e. Potential for algal blooms:   N
- f. Potential for erosion (wind, sand, water):   N

F. Biota:

- a. Introduction of exotic/pathogenic organisms:   N
- b. Destruction/alteration of critical habitat:   N
- c. Potential for impact to endangered species:   N

G. Antiquities Protection:

- a. Potential to harm historic sites:   N
- b. Increased access/use of historic sites:   N

H. Pesticide Use: (required by 22 CFR 216)

- 1. Will be pesticides be used?   NO
- a. Are they USEPA registered?
- b. Are they "restricted use?"
- c. Are they canceled?
- d. Are they under "special review"?
- e. Are complete plans in place to train and fully protect applicators?
- f. Impact to wildlife and aquatic organisms:   N

I. Other possible impacts (not listed above)

Prepared by:   Rick Scott   Date:   5/3/93    
 Project location:   Morocco    
 Project Title/ID:   Family Planning Maternal and Child Health Phase V (608-0223)  

N - no perceived environmental impact      H - High environmental impact  
 L - little environmental impact            U - unknown environmental impact  
 M - moderate environmental impact

**ANNEX J.**

**BIBLIOGRAPHY**

**BIBLIOGRAPHY**

*Andrien, Michel and Najia Hajji: Analyses Causale relative à l'allaitement maternel et à la surveillance de la croissance et Plan d'Action de l'allaitement maternel. 1990*

*Benamar, M. and Fakhreddine, A.: Analyse des données sur la surveillance de la grossesse et de l'accouchement, Enquete nationale sur la planification familiale, la fécondité et la santé de la population. 1990*

*Brachmi A: Chapitre: Communication et éducation en matière de population. July 1981*

*Belouali, R.: Collaboration Intersectorielle. 1992*

*Chiavaroli, Eugene, & A. Angle, S. Clark & P. Gibson: Evaluation of AID Child Survival Programs: Morocco Case Study. 1991*

*Consultative Group on Morocco: Government of Morocco Investment Program in 1987. 1987*

*Day, Lawrence, adn A. Percy, L. Jaidi, M. Lahbabi, M. Lahlou of John Snow, inc. and ICONE: Morocco Private Health Sector Study: Findings and Project Design Recommendations. 1991*

*Experdata: Quality of Family Planning & Safe Motherhood Services Study. 1993.*

*Fikri, Ben Brahim: Cooperation sanitaire internationale. 1992*

*Fishman, Claudia: Nutrition Communication Project, Reconnaissance Visit. 1988*

*Garenne, Michel: National Survey on Causes and Circumstances of Infant and Child Death: An Infant Mortality Study in Morocco. 1989*

*Gilmore, Judith, and C. Adelman, A. Meyer and M. Thorne: Morocco: Food Aid and Nutrition Education, Project Impact Evaluation. 1980*

*Groupelement ICONE/SEDES--Akebi, Najib, Director: Enquete auprès des entreprises sur leurs dépenses de santé en 1987. 1989*

*Hakkou, Farid: Médicaments information, sécurité et recherche. 1992*

*Halpert: Contraceptive Self-Reliance Morocco Trip Report, Family Planning Logistics Management Project, 1993.*

*Halpert, Carl Hawkins: Strategy for USAID Contraceptive Phase-Down. 1993.*

*Harway, Michele: Assessing the Social Factors Affecting the Delivery of Family Planning and Mother and Child Health Services, 1981*

*HEALTHCOM: Assessment of Communication and Social Marketing in the Moroccan Health and Population Sectors, 1992.*

*Institut Nationale de L'Administration Sanitaire: Etude de mortalité maternelle a travers l'analyse des Interventions obstetricales au Maroc (1989). 1992*

*Institute for Resource Development: Special Supplementary Analyses of the 1992 DHS, 1992.*

*Jaidi, Larbi: Observations from Private Sector Interviews. 1991?*

*Lecomte, Jean and Tafforeau, Jean: Secteur: Santé maternelle et infantile et planification familiale. 1990*

*Leighton, Charlotte, and Moncef M. Bouhafa, Miriam Labbok, Charles Tilquin, William Trayfors: Mid-Term Evaluation of the Population and Family Planning Support Project, Phase II (608-0171), Morocco. 1988*

*Maddy-Weitzman, Maddy: "Report on Population Growth and Family Planning in Morocco. 1992*

*Ministère de la Santé Publique: Guide d'utilisation du sous système national d'information sanitaire SMI/PF. 1991*

*Ministère de la Santé Publique, Direction des Affaires Techniques, Division de la Population, Service Central de la Planification Familiale: Cout de la logistique des produits contraceptifs, Rapports préliminaire, 1ère partie. 1992*

*Ministère de la Santé Publique, Direction des Affaires Techniques: Le Programme de visites a domicile de motivation systématique (VDMS). 1988*

*Ministère de la Santé Publique, Direction de la prévention et de l'encadrement sanitaire/Division de la population/Service central de planification familiale: Etude sur la mauvaise information et les rumeurs négatives en planification familiale/Synthèse des rapports "focus group" provinciaux (AlHoceima, Agadir, Béni-Mellal, Fès) 1991*

*Ministère de l'Emploi, de l'Artisanat et des Affaires Sociales: Plan d'action national. 1992*

*Ministère de la Santé Publique: Rapport Général. 1991*

*Ministère de la Santé Publique, Direction de la prévention et de l'encadrement sanitaire, division de S.M.I.: Service de protection de la santé de la mère, Evolution des Activités, 1974-1991.*

*Ministère de la Santé Publique, Direction de la prévention et de l'encadrement sanitaire, Division de la S.M.I., Service de Protection de la santé de la mère: Extraits du rapport final de la conférence Maghrebine, "Maternité Sans Risque", 1991.*

*Ministère de la Santé publique, Direction de la prévention et de L'encadrement sanitaire/Division de la population/Service central de la planification familiale: Séminaire de relance des activités DIU and LT. 1991*

*Ministère de la Santé Publique, Direction des ressources humaines: Les ressources humaines, bilan et perspectives. 1992*

*Ministère de la Santé Publique: Abstracts. 1992*

*Ministère de la Santé Publique, Direction des Affaires Techniques, Division de la Population, Service Central de la Planification Familiale: Cout de la logistique des produits contraceptifs, Rapport préliminaire, 1ère partie. 1992*

*Ministère de la Santé Publique, Direction des Affaires Techniques: Etude sur la gestion des stocks des produits et matériels, Rapport N. 2. 1987*

*Macro International and MOPH: Demographic and Health Surveys 1992 Preliminary Report, 1992.*

*Moroccan National Health Administration Institute: Experience In Developing Research on Peripheral Health Care Systems, 1992.*

*MOPH: Moroccan Ministry of Public Health 1993-1995 Action Plan for Childhood Diarrheal Disease, 1993.*

*MOPH: Moroccan National Strategy for Reducing Maternal and Perinatal Mortality Through Safe Motherhood Programs, 1992.*

*MOPH: National Study on the Causes and Circumstances of Infant and Child Death, 1991.*

*MOPH: Plan for Breastfeeding Promotion in Morocco, 1991.*

*Naima Lamdouar Bouazzaoui: Correlation Entre L'Etat Nutritionnel de la Mère et le Poids de l'Enfant à la Naissance au Maroc. 1987*

*Population Reference Bureau, Inc.: Options Briefing Packet: Morocco. 1992*

*Price Waterhouse/Casablanca: Evaluation des capacités contractuelles du Ministère de la Santé Publique au Maroc. 1991*

*RD/POP: Summary of A.I.D. Experience in Contraceptive Phase-Out, RD/POP, 1993.*

*Saulniers: Annotated Bibliography of Moroccan Family Planning and Child Survival Documents, 1993.*

*Société Moussahama: Enquete nationale sur la planification familiale, la fécondité et la santé de la population au Maroc, Synthèse des résultats. 1987*

*Société Moussahama: Planification Familiale Plan de Développement Socio-Economique: 1988-1992.*

*Snow, John, Inc.: Possibilities to expand the Private Health Sector in Morocco. 1991*

*Snow, John, Inc.: Project Recommendations for USAID on Health Insurance and Managed Care in Morocco. 1992*

*Scholfield, Ken: Executive Summary of IBRID Report: "Morocco Reaching the disadvantaged: Social Expenditure Priorities in the 1990's". 1990*

*Target-Cost Model (Contraceptive Mix and Cost Projections) for Morocco, 1992.*

*The Futures Group: Maroc: Relations entre les facteurs démographiques et le développement. 1987?*

*Tomaro, RD/H: Private Sector Health Care Initiatives Options, 1993.*

*UNDP: UNFPA Proposed Projects and Programmes: Recommendation by the Executive Director Assistance to the Government of Morocco Support for a comprehensive Population Programme, 1992-1996. 1991*

*UNFPA: Extension and Strengthening of the National Health Information System, 1991.*

*UNICEF: Review of Breastfeeding Practices in Moroccan Maternities, 1992.*

*UNICEF/Morocco: Saving 30,000 Children by 1994 -- Accelerating Diarrheal Disease Control in Morocco, 1992.*

*USAID Management Review Team: Implementation Plan for USAID Assistance in Population and Health 1992-1996, 1992.*

*USAID/Morocco consultant team: Strategic Plan for USAID/Morocco in IEC, 1992.*

*USAID/Morocco: Family Planning and Child Survival IV Project Paper and Project Authorization. 1989*

*USAID/Morocco: Morocco Implementation Plan for USAID Assistance in Population and Health 1992-1996.*

*USAID/Morocco: Project Assistance Completion Report.*

*USAID/Morocco: Support Documentation: Background, Issues, and Concerns Regarding Health Care Financing in Morocco. 1989*

*USAID/Morocco Consultant Report: Analysis of Options for USAID/Morocco in Family Planning and Child Survival, 1993*

*USAID/Morocco: Contraceptive Procurement Tables, 1992.*

*USAID/Morocco and PRISM staff: USAID/Morocco Program Performance Monitoring Plan, 1992.*

*USAID/Morocco: Health Care Financing Briefing Book. 1990*

*World Bank: Morocco: Economic Growth and Social Welfare Social Sector Strategy (in two volumes). 1989*

*World Bank: Morocco: Reaching the Disadvantaged: Social Expenditure Priorities in the 1990's. 1990*

*Weisman, Julie: Strategy for the Reform of Food and Nutrition Programs in Morocco. 1990*

*Wylie, Victoria Hammer: UNICEF/Government of Morocco Plan of Operations: Maternal Health Care, 1992-1996. 1991*

*World Bank: Population and Human Resources Division, Country Department II, Europe, Middle East and North Africa Region: Report N. 8108-MOR.*

*World Bank: Population and Human Resources, Maghreb, Europe, Middle East and North Africa: La Croissance Demographique au Maghreb (Maroc, Algerie, Tunisie): Un Defi a la Poursuite du Developpement Economique, 1990*

*Waters, PRITECH: Recommendations to USAID/Morocco for Interventions in CDD, 1993.*

*WHO: Joint Focussed Program Review for CDD, 1992.*

## **A N N E X K.**

### **STATUTORY CHECKLIST**

- Country Checklist**
- Statutory Project Checklist**

**SC(1) - COUNTRY CHECKLIST**

**MOROCCO**

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

**A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE**

**1. Narcotics Certification**

(FAA Sec. 490): (This provision applies to assistance provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance relating to international narcotics control, disaster and refugee relief assistance, narcotics related assistance, or the provision of food (including the monetization of food) or medicine, and the provision of non-agricultural commodities under P.L. 480. This provision also does not apply to assistance for child survival and AIDS programs which can, under section 542 of the FY 1993 Appropriations Act, be made available notwithstanding any provision of law that restricts assistance to foreign countries.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct

source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) has the President in the April 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 calendar days, of a resolution disapproving such a certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals and objectives established by the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, or that (b) the vital national interests of the United States require the provision of such assistance?

Yes

(2) with regard to a major illicit drug producing or drug-transit country for which the President has not certified on April 1, has the President determined and certified to Congress on any other date (with enactment by Congress of a resolution approving such certification) that the vital national interests of the United States require the provision of assistance, and has also certified that (a) the country has undergone a fundamental change in government, or (b) there has been a fundamental change in the conditions that were the reason why the President had not made a "fully cooperating" certification.

N/A

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

No .

3. **Seizure of U.S. Property** (FAA Sec. 620(e)(1)): If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

No

4. **Communist countries** (FAA Secs. 620(a), 620(f), 620D; FY 1993 Appropriations Act Secs. 512, 543): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by

No

the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

5. Mob Action (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? N/A

6. OPIC Investment Guaranty (FAA Sec. 620(l)): Has the country failed to enter into an investment guaranty agreement with OPIC? No

7. Seizure of U.S. Fishing Vessels (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? No

8. Loan Default (FAA Sec. 620(q); FY 1993 Appropriations Act Sec. 518 (Brooke Amendment)): (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds? No

9. **Military Equipment (FAA Sec. 620(s)):** If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

Yes

10. **Diplomatic Relations with U.S. (FAA Sec. 620(t)):** Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No

11. **U.N. Obligations (FAA Sec. 620(u)):** What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

Payments up to date

12. **International Terrorism**

a. **Sanctuary and support (FY 1993 Appropriations Act Sec. 554; FAA Sec. 620A):** Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

No

b. Airport Security (ISDCA of 1985 Sec. 552(b)). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No

13. Discrimination (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

No

14. Nuclear Technology (FAA Secs. 669, 670): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

No

15. Algiers Meeting (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)

A. Yes

B. Yes, taken into account

16. Military Coup (FY 1993 Appropriations Act Sec. 513): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance? No

17. Refugee Cooperation (FY 1993 Appropriations Act Sec. 538): Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin? Yes

18. Exploitation of Children (FAA Sec. 116(b)): Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services? No

**COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")**

1. Human Rights Violations (FAA Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? No

2. Abortions (FY 1993 Appropriations Act Sec. 534): Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary No

sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

C. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO ECONOMIC SUPPORT FUNDS ("ESF")

Human Rights Violations (FAA Sec. 502B): Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

4. Indigenous Needs and Resources (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

4. Project design has paid significant attention to the needs, desires and capacities of Moroccan people as discerned through various surveys, and evaluations conducted over a period of years. (see bibliography in the annex for further details) Project interventions will increase participation of local government in basic health service delivery.

5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

5. Yes

6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

6. The project will improve the sustainability of the GOM's health programs by increasing their efficiency, by increasing cost recovery in public facilities and by stimulating greater financing and provision of health services by the private sector. The project will contribute to the improvement of women's health status through birth spacing, birth monitoring, and the provision of related basic health services

7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed country)?

7. The GOM will provide at least 25% of the costs of the program

**S T A T U T O R Y   P R O J E C T**  
**C H E C K L I S T**

**CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY**

1. Agricultural Exports (Bumpers Amendment) (FY 1993 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

N/A

2. Tied Aid Credits (FY 1993 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

No

3. Appropriate Technology (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

No

8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? **8. Yes**

9. Abortions (FAA Sec. 104(f); FY 1993 Appropriations Act, Title II, under heading "Population, DA," and Sec. 534):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? **9. a. No**

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? **b. No**

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? **c. No**

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? **d. Yes**

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? **e. No**

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to

methods of, or the performance of, abortions or involuntary sterilization as means of family planning?

f. No

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?

g. No

10. Contract Awards (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

10. Yes

11. Disadvantaged Enterprises (FY 1993 Appropriations Act Sec. 563): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 0 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

11. The general training and technical assistance contract envisioned under the project will require a broad range of proven competency to limit the prime contractor to minority firms. However, sub-contracting opportunities will be encouraged for both TA and commodity procurement, TA for evaluations be provided by 8(a) firms and HBCU's will be considered for placement of participants.

12. Biological Diversity (FAA Sec. 119(g)): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

12. The nature of this project does not lead itself to activities in support of bio-diversity.

13. Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):

a. A.I.D. Regulation 16: Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

13. a. assistance complies w/reg. 16

b. Conservation: Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation,

b. The nature of the project does not lend itself to activities promoting tropical forest

and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. Forest degradation: Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

c. N/A

d. Sustainable forestry: If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

d. N/A

e. Environmental impact statements: Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

e. N/A

14. Energy (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

14. N/A

15. Debt-for-Nature Exchange (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

15. N/A

16. Deobligation/Reobligation (FY 1993 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as

16. If dob/reob authority is used, authorized procedures will be followed.

originally obligated, and have the House and Senate Appropriations Committees been properly notified?

17. Loans

17. N/A

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

18. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical

18. The project will improve the sustainability of the GOM's health programs by increasing their efficiency, by increasing cost recovery in public facilities and by stimulating greater financing and provision of health services by the private sector. The project will contribute to the improvement of women's health status through birth spacing, birth monitoring, and the provision of related basic health services

assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

19. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A): 19. N/A

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the

poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

20. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach. 20. Project purpose is to provide for low-cost, integrated FP/MCH services for mothers and young children.

21. Education and Human Resources Development (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities. 21. N/A

22. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is: 22. N/A

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of

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research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

23. Capital Projects (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): 23. N/A  
If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?