

MOROCCO OPTIONS ANALYSIS:

SELECTION OF INTERVENTIONS
FOR EXPANDED USAID SUPPORT
IN FAMILY PLANNING/CHILD SURVIVAL

Report to USAID/Morocco on the
Contribution of the External Consultant Team

Team Preparation: January 12-15, 1993
Team Field Work: February 1 - March 5, 1993
Team Leader Follow-up: March 8 - April 19, 1993

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The enclosed report is a description of one part of a lengthy analytical process in which the USAID/Morocco mission has been engaged for over a year, and which will conclude with the approval of a follow-on project in Family Planning/Child Survival. The segment of that process which is the subject of this report involved an external consultant team which, with USAID staff and Moroccan counterparts, conducted a series of structured analyses and made recommendations for consideration in the follow-on project.

Individual team members left detailed reports with USAID in their subject matter areas. This report is an effort by the team leader to describe the contribution of the external team; to provide their perspective on the CONTEXT in which they approached their joint analysis in early 1993; and to describe the CONCLUSIONS that were drawn at the end of this particular phase of the overall mission decision-making process. Those who participated during this period have had little opportunity to comment on the accuracy of this report, and the author therefore accepts responsibility for factual errors.

SUMMARY

During the early part of 1993, USAID/Morocco conducted a structured Options Analysis exercise, consisting of a systematic and comprehensive review and selection of interventions to be included in expanded assistance to Morocco's FP/MCH program to the end of the century. The exercise was preceded by a year-long process of USAID strategic planning and continuous needs assessments of selected FP/MCH program areas; and it is currently being followed by development of a follow-on project.

For purposes of this report, the Options Analysis exercise is defined by the period mid-January to mid-April of 1993 in which an external team of consultants and the team leader were employed by USAID to participate in a decision-making process that provided the basis for expanding USAID support to Morocco in FP/MCH.

I. BACKGROUND AND SCOPE OF WORK

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 \$31 million through 1996. It was the mission's intention that the project constitute the last significant USAID contribution to Morocco's public sector FP/MCH

program, including AID procurement of contraceptives.

Since late 1991, USAID/MOROCCO has been assessing family planning and child survival needs for the express purpose of modifying and expanding USAID support to these services. The assessment began in the winter and spring of 1991-92 during preparation of the mission strategic plan, which took the form of a Program Objective Tree developed with assistance under the PRISM contract. One of the four strategic objectives selected was improved health of children under five and women of child bearing age. To monitor progress of the mission's strategic plan a program performance monitoring and evaluation plan was designed later in the year (October and November 1992).

In April and May of 1992, following preparation of the mission strategic plan, a program management review team drew on the outputs and sub-outputs of the FP/MCH segments of the plan to prepare an Implementation Plan for USAID assistance in FP/MCH. In September 1992, the mission reviewed and approved the Implementation Plan with revisions, and indicated several areas that required further evaluation and analysis. In the context of this review, the mission formalized the decision to execute a project amendment which would provide for some mid-course corrections and make a number of programmatic changes in response to changing conditions. Chief among the mission's concerns was that the 1996 timeline for USAID phaseout might be premature, and that increased funding might be essential for a strong, self-sufficient FP/MCH program by the year 2000.

Throughout 1992 and into January 1993, needs assessments, studies, and proposed service strategies were commissioned by USAID to provide guidance for reprogramming and increasing project assistance. Supplementing these informational efforts were the analysis of 1992 DHS results which furnished recent indicators of progress in FP/MCH; data from the MOPH including national strategies for priority service areas, internal organizational reviews, and health care reform agendas; and data from assessments of other donor agencies.

Finally, between January and April 1993, an options analysis exercise was undertaken by the mission to identify concrete interventions for the project amendment, which would be most effective and feasible in achieving FP/MCH objectives over the next few years. A team of external consultants was asked to participate in developing the options analysis process and in field work in February and March, and its findings and recommendations were used in March and April as the basis for follow-up meetings with the mission and MOPH and a draft project paper amendment. A decision was subsequently made by the Mission to wind down Phase IV and prepare a totally new Phase V project, expanding on the proposed amendment.

The purpose of the options analysis exercise was to review all program actions which had already been planned or which had recently been proposed for project assistance; identify those aspects about which decisions needed to be made before they could be translated into project interventions; gather any needed additional information; and propose concrete activities which could be financed under expanded USAID support.

II. METHODOLOGY

It is important to note that the analysis of available options involved the mission, SEATS resident staff, the MOPH and other key parties, as well as the external consultant team; and that the process extended beyond the field work phase in which the consultants participated. The role of the members of the external consultant team was to assist in developing the framework for the exercise prior to their arrival in-country; facilitate analysis and discussion in their assigned program areas during the field work phase; and prior to their departure to make recommendations for project interventions based on their findings and conclusions from a synthesis of documentary information and interviews.

Furthermore, it is important to note that some key MOPH officials had only recently assumed their responsibilities in FP/MCH. While knowledgeable about the issues from their previous positions, they had not been involved in the Implementation Plan development in 1992 and were thus particularly interested in a thorough examination of options.

A. January 12-15: Development Phase Carried Out by External Consultant Team

The external consultant team met in Washington, D.C. for a four-day period prior to departure for Morocco. The team conducted a series of information-gathering activities including a review of extensive documentation, and face-to-face and telephone meetings with AID staff and consultants who have recent experience with Morocco.

1. Delineation of Framework and Tasks for Conducting Exercise

- CURRENT PROJECT: review on-going and planned activities under the current project to determine whether there are indications that some may not be appropriate as originally envisioned, and may need to be modified, reduced, expanded, or eliminated.

- OVERALL USAID/MOROCCO GOAL: take into account mission strategic plan, Program Performance Monitoring and Evaluation Plan, Implementation Plan, and mission Action Memorandum; review and select options presented within the broad

strategies proposed in the Implementation Plan AS APPROVED BY THE MISSION, and recommend project interventions, inputs, and outputs consistent with the mission's strategic objectives, and most particularly with the performance indicators.

- NEEDS OF SELECTED FP/MCH PROGRAM AREAS: take into account special assessments and analyses of selected program areas, particularly those undertaken in the previous 12-month period including quality of services in five provinces, procurement, control of diarrheal diseases, potential for an expanded private sector role in FP/MCH, and IEC; as well as information generated by such special efforts as the target cost model and project-wide budget analysis; review and determine whether the options analysis team's findings support conclusions of these assessments, what concrete project interventions would be needed to implement any recommendations that resulted, and what implications the analyses have for project interventions.

- MOROCCO HEALTH AND POLICY CONTEXT: take into account additional information such as the DHS survey, and GOM and MOPH strategies, that help to assess the conceptual soundness of the overall project design, determine whether the design is consistent with the most recent MOPH national service strategies, and determine whether other options are therefore indicated.

2. Definition of Terms: "Options Analysis"

It became increasingly apparent during the team's efforts to develop a framework and tasks, that the term "options" needed to be very broadly defined to encompass many types of decision points in expanding USAID assistance to the FP/MCH program. The program areas covered a wide spectrum of subject matter, and within each of them the range of choices available and the level at which decisions needed to be made varied significantly. In some areas, major decisions needed to be made regarding the future direction of USAID support, e.g., expansion of the private sector role, scope of increased support for child survival and maternal health services. In other areas where direction had already been decided, unanswered questions related to refining a chosen strategy, e.g. development and use of family planning reference centers.

The nature of an "option" to be selected depended upon the stage of evolution or the amount of experience with a particular program area. At one end of the continuum the most viable options consisted of data-gathering interventions such as feasibility studies in the private sector or operations research in services delivery. At the other end of the continuum, the options consisted of direct support for expanding program operations, such as vehicles and equipment.

3. Organization of Team Efforts

The external consultant team assigned responsibilities to each member using the following broad program areas:

- Demand Generation/IEC
- Strengthening of Public Sector Services Delivery
- Strengthening Strategic Planning for Sustainability
- Expansion of Contraceptive Method Choice
- Private Sector Promotion

Each team member identified areas within the member's responsibility for which input would be needed from others, and identified specific individuals on the team and in Morocco with whom the team member would need to work. An in-country schedule and workplan was developed showing the evolution of weekly activities that would be required to complete the task, and individual needs for appointments and field travel were identified. Finally, the team developed a process for data-gathering and synthesizing their findings, as well as a table of contents for a final report on the options analysis. The team leader developed a report outline for her final task of drafting a project paper.

The results of the team's preliminary work were forwarded to the mission, the U.S. institutional contractor (SEATS), and the MOPH.

B. February 1 - March 5: Field Work of Expanded Team

Once in-country the options analysis team was enlarged to include staff of the mission, SEATS, the MOPH, and representatives of key organizations and agencies. SEATS resident staff also provided administrative and logistical support during the field work phase. The MOPH organized the activities of the larger team around six basic themes on the basis of the preliminary work provided by the external consultant team staff, as follows:

- Family Planning Program Management/Implementation
- Construction/Renovation of MOPH FP Facilities
- Strengthening the MOPH Child Survival Program
- Strengthening IEC Capacity in Public and Private Sector
- Support for Strategic Planning and Policy Evolution/Reform
- Defining USAID Program of Assistance for Private Sector Family Planning Service Provision

A seventh theme, Program Support for AIDS and MST, was subsequently integrated into the other groups.

The themes were used as a basis for making appointments with public and private sector officials and organizations. They were also used by the MOPH to schedule two day-long meetings of all team members, one each in week two and week three, at the office of the Red Crescent in Mehdiya. The purpose of the meetings was to provide a forum in which the enlarged team could participate in the options analysis exercise in a consolidated fashion, ensuring that overlapping program areas would be discussed in a more comprehensive manner. In view of the recent arrival on the job of certain key officials, it also ensured a more exhaustive review of recent history and identification of the most pertinent issues.

The goal of the first Mehdiya meeting was to review the current FP/MCH situation with respect to each theme, identify constraints and problems, and outline solutions for the medium term. Specific objectives for each theme were provided in advance to participants. The goal of the second Mehdiya meeting was to synthesize the findings of the first meeting and propose concrete interventions which would ensure coordination among major FP/MCH service components, and which USAID - as well as other donors - could support.

During this period, the Minister of Health personally conducted a two-day, multisectorial meeting in Mohammedia which he had convened for the purpose of broadening the base of support for delivering family planning services. External consultant team members were invited to observe the proceedings, in which many Moroccan counterparts were heavily involved. The meeting thus provided a timely opportunity for input from a wide array of public and private sector individuals and organizations into the options

analysis exercise.

The team of five outside consultants worked in-country between February 1 and March 5 for time periods ranging from one and a half to five weeks, as follows:

Week	1	2	3	4	5
Jewell 1/31-----3/5 (Team Leader/policy)					
Wolffe 1/31-----2/11 (Mgt./Quality)					
Chandler 1/31-----2/20 (policy/soc.mark)					
Parlato (IEC)		2/7-----2/27			
Harris (Private Sector)		2/7-----2/24			

The field activities of the expanded team proceeded as follows:

Week one: organizational meeting of all parties and individual meetings according to topic

Week Two: continued individual meetings, one day-long meeting of all parties mid-week, individual follow-up meetings, preparation of reports synthesizing the day-long meeting in order to provide a departure point for the second day-long meeting, development by team members of very preliminary reports of options for discussion with mission and MOPH counterparts; and attendance at a special two-day seminar called by the minister of public health to encourage intersectorial collaboration in family planning

Week Three: continued individual meetings; second day-long meeting of all parties mid-week to develop more specific priorities for interventions financed by donors; preparation by team members of preliminary conclusions regarding options

Week Four: preparation of team conclusions regarding options analysis; meetings with MOPH and the mission to obtain feed-back on preliminary conclusions

Week Five: preliminary draft of rationale and project description

for the project paper

Prior to departure, each team member prepared a report of findings and recommendations in the subject matter which had been assigned to each member.

C. March 24 - April 19: Follow-up and Completion of Draft Project Paper

Once the external consultant team completed its contribution, the staff of the mission and MOPH worked with the team leader to review recommendations and to narrow the options still further, and the team leader prepared a first draft of a project paper. The team leader's role was that of facilitator and synthesizer, and the mission excluded the team leader from any discussions regarding specific funding levels. Activities during this phase included meetings with the MOPH as well as USAID project review committee meetings to provide guidance on project development.

D. Summary of Options Analysis Exercise

1. Organization of Information Generated

The results of the options analysis are presented under the following headings:

Project design: duration, type of assistance, and funding level; implementation strategy; priority services

Program Services:

- access: specific problems related to expanded prenatal and postpartum services; use of family planning reference centers, range of contraceptive methods available, integration of health care, informational needs about other barriers to access;
- outreach and service distribution channels;
- quality of services;
- IEC

Institutional Development: procurement; decentralization; planning and evaluation capacity including strategic planning tools, operations research, and MIS; management skills; training capability; material resources and construction and renovation

Policy Reform: including policy agenda and policy dialogue

Diverse Resource Base for Future FP/MCH Program: including availability and allocation of public resources and role of collectivités locales

Private Sector Role in FP/MCH

2. Context

The nature of the analysis conducted for each option was shaped by the context in which the option or its underlying issue was situated on February 1, 1993 when the exercise was initiated. Thus the sections of this report describing the context conveys the assumptions and understanding of the external team when it first set out on its task. This historical perspective - although difficult to reconstruct in the best of circumstances - provides a reasonably accurate rationale for later recommendations.

3. Conclusions

The conclusions described below are the basis for recommendations made by external team members in their individual reports and during debriefing meetings with the mission. They also incorporate the combined thinking of external consultants, USAID staff, the MOPH, and other parties who participated in various phases of the structured options analysis exercise. Since the exercise formally drew to a close with the departure of the team leader April 19th, the conclusions reflect the situation on that date, differing somewhat from what existed at the time the other team members departed in late February and early March. Furthermore, as development of a follow-on project moves ahead, additional information continues to lead to even more changes.

III. THEMES EMERGING DURING OPTIONS ANALYSIS EXERCISE

Certain themes ran through the options analysis exercise and influenced both the methodology and the final outcome, and are not immediately apparent in the presentation of the issues as organized below.

- The Morocco family planning effort was frequently referred to as "second generation."

Morocco has a mature family planning program in which services are generally available throughout the country through an organized health delivery system. Therefore, future efforts need to focus on strengthening what exists so it is more closely tailored to remaining unmet needs; and ensuring future sustainability free from heavy donor input. Thus, interventions must focus on operations research, closer integration of family planning with other services, technical competence of staff, stronger supervision, and a vigorous IEC effort to inform the population. They must also focus on institutionalization through decentralization, training, and technical assistance in areas currently dependent on donors.

- The decision by USAID to invest heavily in efforts designed to test more effective service delivery approaches, brings with it a risk of burdensome future recurrent expenses for the GOM once pilot projects and research are translated into routine operations, at a time when donors are attempting to phase out.

To provide for the most reasonable phasing out of donor contributions, interventions are planned so as not to precipitously reduce or eliminate particular items without developing a capability for replacing it (e.g. procurement); and heavy investments will also be made in items of a more permanent nature such as management training, hardware, and vehicles.

- Concerns were often expressed that there is a danger of hitting a plateau at the current contraceptive prevalence rate of 42% for all methods.

The family planning program to date has been successful in meeting needs of those who are easiest to reach. Interventions must be designed to increase access for the hard-to-reach. Interventions must therefore include alternative channels of distribution and broader geographic coverage, a vastly expanded role for the private sector, and greater integration of family planning with closely related services such as safe motherhood and child survival.

- Improved quality and access in the public health delivery system which provides services free of charge, could hamper progress toward the goal of expanding the private for-profit sector role in FP/MCH.

It is too early to determine the extent to which competition from free public health services will affect the ability of the private sector to attract fee-paying clients. The evolution of the private sector role needs to be monitored regularly; and operations research and pilot projects could assess the feasibility of means tests or other efforts to reserve public sector resources for those unable to pay.

I. RESULTS OF OPTIONS ANALYSIS

A. Project Design

Issue: Duration, Type of Assistance, Funding Level

Context

- Current (Phase IV) Project - The current family planning/child survival project was signed in August 1989 for \$31 million and has a project completion date of September 1996. There is no explicitly stated project goal of ending public sector support after that date. However, such action has been discussed with the MOPH; termination of AID procurement has been planned for 1994; and recurrent expenditures and local costs have been progressively reduced or eliminated, including gasoline for vehicles and some salary costs of the outreach program.
- Intervening Factors Since Project Initiated - In the interim since the project was signed a number of factors have influenced the direction of future USAID assistance:
 - the DHS survey findings of 1992 became available, which along with other recent health indicators indicate significant progress in contraceptive prevalence and reduced infant and child mortality, but continued gaps between availability and use of FP/MCH services, particularly in rural areas;
 - the MOPH developed national FP/MCH strategies in preparation for Morocco's 1993-97 Five Year Development Plan, emphasizing quality and access, as well as greater intersectorial collaboration;
 - the mission completed a strategic planning exercise in the winter of 1991-92, and the health care financing component was subsequently cancelled;
 - a program management review was conducted in April-May 1992 culminating in a proposed Implementation Plan for future USAID assistance;
 - the Plan was approved by the mission with some revisions in September 1992, at which time the decision was made to amend and extend the current (Phase IV) project through July 1999 with additional funding, both to maintain the momentum reflected in the DHS survey, and to strengthen the ability of the GOM to assume responsibility for a growing FP/MCH program as external support is progressively phased out.

- Type of Assistance - Final decisions on specific project interventions under an amendment were to await the outcome of a project evaluation scheduled for early 1993, which ultimately gave way as an options analysis. However, areas which were strongly indicated for increased assistance at the outset of the options analysis exercise were selected child survival services, Information, Education, and Communications (IEC), expansion of long term contraceptive method choice and postpartum family planning, targeted interventions to improve quality, institution-building in the public health delivery system, and development of the private sector role.
- Funding Level - Although the management review team had recommended \$15 million for IEC alone under a project extension, the mission ultimately decided not to commit to specific amounts to any one component until after a project-wide budget analysis. However, a figure of an additional \$20 million was provided as a tentative target for the options analysis exercise.

Conclusions

- The project should be extended through 1999. Rather than establish an unequivocal goal of terminating subsequent public sector support, it should be made clear to all parties that future support is uncertain, and that the most sensible strategy for the project extension is to reduce project support in a phased manner through 1999, keeping recurrent and local costs to a minimum.
- Decisions regarding type of assistance were corroborated and more finely detailed, and in addition, greater emphasis was recommended for a policy reform agenda and for a heavy investment in vehicles, equipment, and other commodities as part of institution-building.
- The external consultant team did not recommend specific funding levels, but rather provided the mission with a basis for arriving at a final budget in recommending detailed project interventions. The team also recommended the kinds of local costs that should be given priority for funding, such as training of trainers, specialized training, pilot projects, and one-time purchases of vehicles and equipment.

Issue: Implementation Strategy

Context

- GOM Role - The primary recipient of project support is the Ministry of Public Health, and the Directorate of Prevention and Health Training (DPES) has responsibility for implementation. The lead division for the project within the

DPES has been the Population Unit, since the primary emphasis for project support has been in family planning.

- USAID Role - In May of 1992 the Mission contracted a buy-in from the SEATS project to implement many of the project activities through July 1994, thereby reducing the management burden of the mission. Other activities continue to be implemented by the mission, and by centrally funded projects including AVSC, JHPIEGO, the Options Project, FPLM, PSI, Future Group/Somarc, the Evaluation Project.

Conclusions

- The MOPH should continue to be the primary recipient of assistance. Recommended activities will significantly expand the project, implicate several public and private sector organizations at the national and peripheral levels, and increase the emphasis on child survival efforts. However, the ministry's FP/MCH program is at a very advanced stage of development, it is delivered through an established infrastructure, and it has a professionally sophisticated staff. The Program staff are experienced in coordinating with multiple partners, making use of private sector expertise, and translating donor assistance into operational activities.
- The implementation role of the DPES should be strengthened. Recent changes in DPES staffing have brought increased field experience and other areas of expertise to the program, reinforcing ability to implement activities. In view of the expansion of support beyond family planning, the Project should further develop the DPES capacity to ensure closely integrated efforts of its technical divisions.
- Experience has demonstrated that the use of multiple buy-ins creates an unwieldy management structure for both USAID and the MOPH, and the range and volume of activity recommended will place greater demands on the mission. Therefore the majority of technical assistance and support for local currency expenditures should be through a single institutional contractor, with limited use of buy-ins from centrally funded projects.

Issue: Priority Services

Context

- Achievements to Date - USAID has supported health and family planning services in Morocco since 1971. The gains have been encouraging, and are reflected in expanded health coverage, increased rates of contraceptive prevalence, vaccination coverage, and reduced infant and child mortality and morbidity. The centerpiece of USAID support has been family

planning, and the steady progression in contraceptive prevalence over the past two decades was reaffirmed in the 1992 DHS survey.

- Remaining Challenges - The 1992 DHS survey revealed the continued and disturbing gap between the desire for family planning and knowledge of methods on the one hand, and the use of contraception on the other; a serious underutilization of prenatal services; the low use of trained health professionals for childbirth; and the low use of oral rehydration therapy for infants with episodes of diarrhea. Furthermore, maternal mortality is estimated to be as high as 400 per 100,000 in some areas; over half of infant deaths occur in the first month of life, due primarily to pregnancy, childbirth, and postpartum conditions which could be prevented or reduced; and the leading cause of infant deaths is diarrheal disease infection, the impact of which can be largely prevented through oral rehydration therapy.

Conclusions

- Future USAID assistance should increase support for Safe Motherhood, Breastfeeding, and Control of Diarrheal Diseases in view of the low cost and relative ease with which these services can be expanded, their close relationship to family planning services, and the significant impact they can have on maternal and child mortality rates. Improved child survival rates can also reasonably be expected to lead to increased use of family planning services to space or limit pregnancies.
- Support should be provided for other child survival and related services in the areas of IEC, training, and supervision, where they can be easily included in efforts designed to improve priority services. These secondary services include HIV/AIDS prevention, detection and treatment of STDs, acute respiratory disease prevention and treatment, and vaccination. An attempt to expand full support to these services would involve considerable resources for other directorates and divisions within the MOPH, and risks diluting attention to priority services.

B. Program Services

Issue: Access to Services

Context

- Prenatal, Childbirth, and Postpartum Services - The 1992 DHS survey showed that only 31% of pregnant women used prenatal services and 32% used trained health professionals in childbirth; postpartum family planning services are not

generally available. The DPES is currently revising its strategy to vastly improve the quality of maternity services it believes is needed if they are to be effectively used. The European Economic Community (EEC) has targeted support for 12 of the largest maternities, where feasibility studies on postpartum family planning services will be conducted.

- Family Planning Reference Centers - Several provinces now have a family planning reference center, many of which are significantly underutilized. These reference centers were originally designed to provide back-up for house to house distribution of oral contraceptives and condoms under the VDMS project, and provide IUD insertion and screening of women for sterilization, services generally not available in most facilities. However, health facilities are becoming increasingly capable of meeting family planning needs, including insertion of IUDs.
- Range of Contraceptive Methods Available - The 1992 DHS shows that knowledge of long term and permanent methods is far greater than actual use or availability. Family planning clients are heavily dependent upon the pill (80% of modern contraceptive use); training in sterilization is primarily confined to laparoscopy and is largely intended for public sector physicians; 34 sites are equipped to provide laparoscopy, and only 6,000 are performed annually, although recent liberalization of eligibility criteria for clients may lead to increased use; injectables are not yet available in the public system, although an introductory study is planned; Norplant is currently being introduced through a trial with 400 users; and postpartum family planning is not routinely offered, nor is it routinely counseled during prenatal care. The potential for increased IUD use is more promising: training in IUD insertion has been expanded to include nurses, and a decentralized program has trained 900 providers to date, with an additional 400 scheduled to be trained. No plans have been developed to extend long term and permanent methods to the private sector through support for physicians and nurses who leave the public sector for private practice.
- Integration of Health Care - While all FP/MCH services are offered in the public health system and are therefore integrated in a general sense, at the point of delivery in fixed and outreach facilities clients are not routinely referred for related care when they seek out a particular service, follow-up is not systematically conducted, health workers are not polyvalent in that they are not similarly trained and supervised to deliver all aspects of services, and no mechanisms exist to facilitate referral and follow-up. Thus entry into a system of complete FP/MCH care is not necessarily assured when a client comes in for a particular problem or need.

- Information About Barriers to Access - MOPH national strategies for FP/MCH services have all identified needs for additional information regarding attitudes and practices which may inhibit use of available services.

Conclusions

- To expand the availability of prenatal and postpartum services, multiple services should be offered in specialized facilities. An examination of family planning reference centers should be conducted to redefine their role, including provision of prenatal services, and an action plan for implementation should be financed by the project. Funds should be allocated to conduct studies of use of maternity services to complement the efforts funded under the EEC grant; and to expand postpartum family planning services once results are available from the EEC feasibility studies.
- Project funds should be allocated to activities which expand and speed up the introductory trials of new methods and which encourage greater availability of other methods. Thus ample support should be provided for training in counseling as well as provision of method, equipping of sites, expendable materials, design of introductory trials, medical supervision, technical oversight, evaluation of progress, analysis of client acceptability, dissemination of findings among providers and decision-makers, development of IEC materials, and expansion into the private sector by supporting trained providers who move into private practice.
- Project activities should be undertaken to ensure that FP/MCH services are more closely integrated so that the range of services are more easily accessed by clients who come into the system to meet a particular need. Activities would include development and training in the use of referral and follow-up mechanisms linking outreach and fixed facilities, and linking services at the same facility. Training should be designed to produce polyvalent health workers. Institutional support to the DPES is required to ensure support for these activities from the vertical programs within the technical divisions of the DPES.
- Operations research should be programmed and financed on the basis of a prioritized list of informational needs about barriers to access, most of which have already been identified by DPES technical divisions. Funding should be allocated for implementation of action plans which emerge from research findings, including for such activities as publication and dissemination of findings, promulgation of changes in clinic policies, equipment and materials, seminars, training, and supervision.

Issue: Outreach and Service Distribution Channels

Context

- The health delivery structure in Morocco has been vastly expanded since 1984, doubling the proportion of population that resides within it, from 40% to 80%. An extensive outreach component includes approximately 3,000 points of contact, house-to-house visits (VDMS), and mobile clinics. Nonetheless, serious rural-urban disparities persist in health status, as well as in use and availability of services. Estimates of rural population within reach of health services are as low as 50% (UNICEF). There is also evidence of pockets of underserved urban populations. Furthermore, there are proportionately fewer personnel serving the outreach system as it has expanded over the past few years.
- Little is known about the potential role of Collectivités Locales in outreach or services distribution, and the MOPH is greatly interested in exploring the issue further. Other public and private sectors have varying degrees of experience in rural outreach, including the agricultural extension program and the Moroccan private family planning association (AMPF). A February 1993 seminar conducted by the minister of public health has resulted in a collaborative process among these public and private providers in delivering FP/MCH services.

Conclusions

- Increased assistance should be provided to strengthen the existing outreach system including evaluation and resources for local program managers to adapt the system to local needs; and materials, equipment, and vehicles to improve and expand points of contact and mobile clinics.
- Resources should be made available to encourage and support current collaborative efforts to expand channels of service delivery including: provision of materials and training to agricultural extension workers and other personnel who can provide or refer for FP/MCH services; evaluation and dissemination of findings regarding AMPF experience with community agents; and specific support for activities and study tours of the national committee on intersectorial collaboration which emerged from the February 1993 seminar.
- Funds should be made available to conduct feasibility studies on the role of Collectivités Locales in referral or delivery of FP/MCH services.

Issue: Quality of Services

Context

- Much of the assistance provided under the current project contributes to MOPH efforts to improve the quality of services, including the decentralized IUD training program, development of a counselling skills training modules, development and dissemination of service protocols, decentralized management training in problem-solving, and the quality assessment carried initiated in five provinces.
- The mission strategic planning exercise identified improved quality as one of six strategies required to increase the use of services, and the Implementation Plan contained several options to carry out the strategy, subsequently endorsed by the mission: establish model quality sites and conduct district team problem-solving training with available funds, and seek additional funding to undertake other selected activities to promote quality in response to the findings of the planned quality assessment.
- A quality assessment was undertaken in five provinces in the latter part of 1992 and early 1993, and preliminary findings were compiled during the options analysis exercise.
- The assessment is not intended to capture information reflective of the country as a whole, but it is intended as a methodological test of the approach to improving quality which can be replicated throughout the national FP/MCH program.
 - The assessment is designed to furnish specific information to service providers in the provinces where it is carried out. In the second phase, just initiated when the options analysis exercise drew to a close, service providers identify and resolve quality problems using Total Quality Management (TQM) and Continuous Quality Improvement (CQI) methodologies.
 - Central and provincial MOPH officials are integrally involved in this methodological testing along with program managers and health workers at all levels. The approach is viewed as a means of decentralizing the responsibility and the capability for improving quality, and incorporating it as an ongoing function of program management and service delivery.

Conclusions

- The project should expand assistance to improve quality by developing and incorporating protocols into FP/MCH services; upgrading technical competence of all providers in the use of service protocols - incorporating into their training the

revised approaches to service delivery to make them more accessible, as described previously; and developing a systematic, routine supervision system.

- The quality improvement approach currently being tested in the five provinces is essential if Morocco is to successfully reduce dependence on the central level to initiate actions and provide resources for sustaining quality services. The approach will broaden the base of responsibility in all 61 provinces and prefectures, for identifying and resolving problems more pertinent to their areas.
- The project should increase support for institutionalizing total quality management (TQM) and continuous quality improvement (CQI) tools, including the costs of training, field work, and evaluation to follow up the initial quality assessment and refine the model for replication in other provinces; and support for INAS to develop its capability for offering TQM and CQI training and technical assistance.

Issue: Information, Education, Communications (IEC)

Context

- IEC is viewed by high level Moroccan officials as essential for the growth of FP/MCH services, and within the past year and a half the prime minister and the former and current ministers of public health have requested additional USAID assistance for a stronger IEC effort.
- IEC emerged as a critical need in the mission strategic planning exercise, and the Implementation Plan provided a broad framework within which a vastly stronger IEC effort could be undertaken. The mission approved pre-design activity for IEC in September 1992, specifying that two major features of IEC should be policy communications and institutional strengthening for the MOPH health education division (DES).
- The mission specifically requested that the options analysis exercise be used as an opportunity to corroborate the decision to conduct a strong IEC effort.
- The pre-design IEC activity moved forward and culminated in a January 1993 report which proposed a comprehensive IEC strategy based on the following situational analysis:
 - Strengthen the DES with training, technical assistance and expansion of technical resources: The DES is a well-equipped technical division with a sizeable staff located within the DPES. It has a mandate to provide the IEC services of the MOPH but is seldom given its own budget

for major FP/MCH programs. Vertical health programs use funds available to them from various donors to develop their own communication programs, using the DES and commercial firms at their own discretion. Therefore, IEC activities are generally not part of a systematic development process with quantifiable objectives, or with messages and audience selection based on formative research. There is little pre-testing of messages and materials, and little impact evaluation.

- Strengthen province-level IEC capability with training and resources, and pilot test the development of IEC "units" that invests provincial IEC staff with greater responsibility for directing IEC activities of vertical programs: Provinces are equipped with a health education agent (animateur) and many have a solid infrastructure and innovative programs, but they have no authority over vertical program activities, there is little substantive support from the central level, visual and teaching aids are few or nonexistent, and there is little systematic integration of other sectors into IEC activities.

- Tap into the potential of the extensive public and private broadcast media, and make appropriate use of IEC technical expertise available in the private sector: 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.

- Develop a policy communications component: Based on experience in other countries which have made significant gains in contraceptive prevalence and health status, Morocco faces a serious risk stalling at its present level of indicators in the absence of a major investment in service expansion through all possible channels. Such an investment will require a greater share of future public and private resources which will not be possible without widespread support and commitment to FP/MCH among decision-makers and opinion leaders at all levels.

- A member of the IEC external consultant team which developed the proposed IEC strategy was also a member of the options analysis external consultant team, thus providing continuity of in the continued development of IEC in the context of the larger FP/MCH project.

Conclusions

- The need for a strong IEC program and additional funds was corroborated. Specific components of the proposed IEC strategy should move forward as quickly as possible with support from existing funds, based on the following justification:
 - Strengthening DES: It is essential to a coherent and quality national IEC effort that strong leadership and direction as well as technical expertise be available within the MOPH. 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, creatively develop and produce media for a variety of different subjects, and contract out and competently supervise private sector technical IEC services. A stronger DES can direct and support provincial programs and 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.
 - Strong province-level capability: For IEC activities to be effective they need to be shaped and delivered by those closest to the community, including MOPH service providers and other key individuals and organizations; and they need to be backed up by a quality, accessible service system. In view of the provincial IEC capability already provided by IEC animateurs, the most efficient use of resources is to increase training and technical support to provinces from a strengthened DES, including use of appropriate communications techniques, and modules adaptable to the local level such as complementary media-interpersonal communication campaigns. Furthermore, an organizational mechanism needs to be tested and established at the provincial level which can integrate the IEC and service activities of vertical programs, thereby ensuring that accurate technical information is most relevant to each target audience, that the most effective communication media and techniques are used, and that services are accessible to the population once they have been motivated to use them. Finally, training and resources are necessary for service providers to secure intersectorial collaboration at the provincial and local levels.
- The situational analysis regarding policy communications was

very well described, and the need is clear. However, rather than establish an IEC goal of policy communications, the project should establish the goal of developing and updating a policy agenda based on identified needs for reform. (See section on policy below). The agenda should be a function of pertinent policy issues which are identified and analyzed in the context of strategies for achieving project goals and objectives. IEC activities should be mobilized to support policy dialogue efforts designed to modify and reform laws, regulations, policies and practices as determined by the agenda.

C. Institutional Development

Issue: Procurement of Contraceptives

Context

- The current project provides for financing contraceptives through 1994, which would ensure a supply through 1996. The mission agreed with the Implementation Plan recommendation that period of financing should extend through 1997, ensuring a supply through 1999, and that an action plan should be developed for shifting procurement responsibility to the GOM.
- A target-cost model was developed which could be used by the GOM as a strategic planning tool, both for projecting future contraceptive needs and for establishing practical family planning objectives in the public and private sectors. The success of the private sector in expanding its role as a provider of different kinds of contraceptives, will determine how much it will cost the GOM to assume procurement responsibility for public health clinics.
- An assessment of procurement issues was conducted by the FPLM in January 1993 which identified several steps that need to be taken by the GOM with project support, including: establishment of goals and objectives for procurement, strategic planning, selection of source and financing, monitoring the progress of the private sector as a contraceptive sources, and logistics management.
- The MOPH and the mission were left with several options, including: whether to seek a donor to replace AID procurement, whether to begin procuring injectables even though it would increase the procurement costs which the GOM would have to assume, whether to treat all contraceptive methods in the same fashion with respect to AID termination of support, and whether condoms used by the AIDS prevention project should be treated in the same fashion as those used by family planning programs.

Conclusions

- The project should finance all contraceptive methods - whether used for the family planning or the AIDS prevention program - through 1997.
- The GOM/MOPH needs an action plan for assuming a greater share of the financing of contraceptives as well as increasing responsibility for procurement in general, as outlined by the FPLM. Support will be provided by the project to develop the plan and for institutional development in those areas essential to assuming increasing responsibility for procurement, e.g. strategic planning, specifying targets, identifying the private sector role, searching for international offerors, selecting and ordering in the international market, and instituting quality control.
- The MOPH should be supported in its decision - communicated during the options analysis exercise - to finance contraceptives at some future date, and to include a line item for contraceptives in their budget proposal beginning in 1994.

Issue: Decentralization

Context

- The MOPH decentralization policy is an integral part of an overall GOM strategy of democratization and decentralization intended to place more responsibility and resources at the local level for meeting needs of the population.
- The MOPH policy toward decentralization has progressed to delegating authority and responsibility to the provincial level over some aspects of the provincial budget, including such basic operational costs as electricity and telephone, as well as such program costs as medical supplies and gasoline. While total resources may not have been increased, provincial MOPH offices have an increased degree of flexibility over how they will be allocated.
- A difficulty facing the MOPH decentralization strategy is that there is no intermediary level of authority in the organizational structure between the central level and 61 provinces and prefectures. There is a strong possibility that the MOPH will be formally regionalized, and some MOPH divisions (e.g. Division de la Planification de la Statistique et de l'Informatique) have apparently already decided to place central personnel in regional offices. IUD training has been "regionalized", even though it is still operated from the central level. Training is located in several cities where needs of multiple provinces can be met, and where facilities and personnel from numerous provinces can be equipped to

provide training services.

- Decision-making in deliver of FP/MCH services continues to be highly centralized. Although resources are increasingly oriented toward program managers at all levels, such as regional delivery of IUD training, and skills training for service providers in operations research and problem-solving techniques, authority to plan and allocate resources rests at the central level.

Conclusions

- Project assistance earmarked for institutional development should be designed to ensure stronger capabilities at all levels of the MOPH. A clear role delineation within a decentralized structure should guide all project interventions aimed at reinforcing management functions such as planning, evaluation, training, and service delivery, so that the needed leadership and direction from the central level can be assured while at the same time service providers and program managers are equipped to provide effective and efficient management of quality services.
- The project should take advantage of any opportunity to support regionalization of the MOPH should it come to fruition, including infrastructure development and management training.

Issue: Planning and Evaluation Capability

Context

- Task Assigned to Options Analysis Team - The Implementation Plan signalled the need for strengthening institutional capabilities. The plan and subsequent mission discussion particularly stressed the need for research and evaluation capabilities, but attention centered primarily on the narrower functions of data analysis. The options analysis was to examine the extent to which INAS could meet the institutional need in this area, and identify the kind of support the project should provide. However, it became increasingly clear during the options analysis that the proposed project expansion would require a far broader institutional capability in planning and evaluation than had been examined previously, for DPES to provide direction and leadership to an integrated, national FP/MCH effort, and to periodically evaluate program performance.
- Institutional Background - The DPES has no formal planning and evaluation unit or full time staff engaged in this and related functions, such as operations research and operation of a

management information system. Technical divisions, most particularly the population unit, have developed varying degrees of planning and evaluation capabilities in their specific program area.

- Current Program Planning and Evaluation Activities - National strategies have been developed in each of family planning, safe motherhood, breastfeeding, control of diarrheal disease, and IEC. Provincial level planning in FP/MCH takes place primarily through action plans, periodic meetings with provincial officials, and other mechanisms used by the DPES to implement national strategies. The DPES has formal, routine communication with the other six directorates whose support is necessary for the realization of FP/MCH goals and objectives. Routine and periodic information is available to the DPES in the form of the MOPH health information system, the DHS, and various studies and evaluations financed by the ministry and donors, usually within a technical division of the DPES for a particular program.
- Strategic Planning Tools - In contrast to system-wide, routine program planning to guide on-going operations and service delivery, "strategic" planning is employed to ensure that critical, priority issues are identified in a timely fashion and that resources and policy needs for addressing them are anticipated and reasonably provided for; or to ensure that scarce resources are allocated to the most promising and highest priority activities. The target cost model for projecting contraceptive costs has been developed for use by the MOPH as one means of dealing with the critical issue of phasing over procurement responsibility from AID to the MOPH.
- Operations Research - There have been many important FP/MCH operations research and related data-gathering efforts undertaken to date. However, with the exception of the recent quality assessments, they have not generally been tied together as part of any coherent strategy aimed at achieving planned objectives. They have more frequently been undertaken at the initiative of vertical programs within the technical divisions of the DPES, or by INAS in collaboration with the programs, to meet a particular need identified by a program when resources have become available. Methodological content varies depending on the sources used to carry out the work, which have included INAS as well as private sector research agencies.
- Management Information system - The MOPH health information system has been developed over the past ten years, and now incorporates FP/MCH service information. Authority over the system lies with a division that reports directly to the secretary general, and its technical services are responsible

for communications with MOPH units that feed data into the system. Two problems have been identified with the MIS. First, the system does not adequately meet the informational, analytical, and timing needs of the FP/MCH program. Second, program managers do not yet make effective use of information currently available to them.

Conclusions

- An institutional assessment, already planned for the area of research and evaluation, should be broad enough to assess the status and needs of DEPS for its planning and evaluation functions, including strategic planning, OR, and MIS.
- Project assistance should be guided by results of the assessment and should be directed toward strengthening the DPES role in planning and evaluation, not only of the FP/MCH program in general, but of specific areas such as IEC and training.
- The DPES arguably has a mandate but no capability for prioritizing, planning, or providing technical oversight to a planned, integrated OR effort. INAS has a training mandate to ensure skilled program managers within the MOPH and could provide assistance in that capacity to DPES; but its mission and position within the organizational structure are not appropriate to assuming any responsibility for directing OR efforts except as delegated to it by the DPES. Support should be provided to INAS if the assessment concludes that it can play a larger role in supporting evaluation and operations research. Funds should also be allocated for contracting with private sector research agencies to provide evaluation and research services under DPES and INAS direction.
- As the expanded project moves forward, the implications of phasing out donor assistance and the policy implications of many project interventions, will emerge as critical issues to be addressed for which strategic planning tools will be valuable. Provision should therefore be made in the budget to assist in creating and using strategic planning tools in the context of phasing over procurement responsibilities, and in the context of a developing a policy reform agenda and related strategies for gaining the support of opinion leaders and decision-makers.
- To improve the use of available data for management decisions, the project should support training, technical assistance, and pilot projects involving program managers; and provide equipment and other support so that MOPH units responsible for the MIS can be more supportive in analyzing and disseminating FP/MCH service information. Support to the MIS must be very specifically targeted to avoid diverting FP/MCH resources

toward an overhaul of the MOPH-wide MIS.

Issue: Management Skills

Context

- The original project budgeted support for strengthening decentralized management including training and technical assistance for program managers in use of data and incorporation of effective management tools such as the WHO "problem solving" methodology and TQM/CQI methodologies. The options analysis was to include a review of proposed funding and determine whether the level should be increased.

Conclusion

- The importance of decentralized management capabilities was corroborated during the options analysis. Program sustainability will depend greatly on the existence of broad-based responsibility for assessing and meeting FP/MCH needs as opposed to a continued dependence upon the central level for identifying problems and supplying resources to resolve them. Where possible the project should expand current efforts in total quality management stemming from the quality assessment carried out in five provinces. Assistance would include resources for INAS to become proficient in conducting TQM training and follow-up services in the field; and replication to other provinces as quickly as resources can be absorbed.

Issue: Training Capability

Context

- There is as yet no decentralized, in-service FP/MCH training capability. Such training is offered by the central level, generally at the impetus of one of the technical divisions and without assistance from the MOPH training office. Provincial and service provider input has been obtained in such efforts as the IUD regional training, and in the context of pilot projects such as the quality assessment.
- The MOPH training office developed a national strategy for decentralizing continuing education for public health professionals, which includes creation of a provincial core of trainers and expertise, provincial training plans, and technical assistance from the central training office. A commission headed up by the training director and including staff from DPES and other directorates has been studying the potential for implementing the strategy.

Conclusion

- The project should support the implementation of the national decentralized training strategy in the area of FP/MCH, perhaps on a pilot basis to identify the most feasible approach.
- An assessment of a broader human resource development capability in FP/MCH should be supported, to ensure that a decentralized in-service training function operates in a larger context of national pre-service and in-service training needs assessments, standardized curriculum, personnel deployment, and other human resource issues.

Issue: Material Resources and Construction/Renovation

Context

- Under the current project, financing was approved for renovation of facilities and for construction of family planning reference centers, according to a set of selected criteria. Financing was also approved for other material resources, including vehicles.

Conclusions

- The external consultant team was not significantly involved in this issue, other than to confirm the need for an assessment of remaining sites where family planning reference centers were programmed (see section on "access", above). At the time the team leader had departed, the mission had tentatively identified the need for a significant increase in support for material resources, including vehicles, as a means of furthering the institutionalization of services.

D. Policy Reform

Issue: Policy Agenda and Policy Dialogue

Context

- Considerable policy analysis had already been conducted with USAID assistance in the context of Morocco's health care financing reform. USAID support for health care financing was eliminated in 1992 and funds freed up to be programmed elsewhere. However, the policy analysis provided an informative, broad perspective on health care delivery in the public and private sector.
- Within the context of the IEC strategy of January 1993, further analysis was conducted and a policy communications intervention was proposed as a means of securing broad support of opinion leaders and decision-makers.
- Certain policy issues were highlighted in the Implementation

Plan as potential barriers within the context of specific project interventions, such as postpartum sterilization and IUD insertion. The mission requested that the centrally-funded Options Project conduct an analysis in April 1993 to further explore these and other issues, now planned for later in 1993.

Conclusions

- The proposed interventions for expanded project support, which have grown out of the options analysis exercise, have many policy implications which must be analyzed and followed up to ensure successful achievement of project goals. Chief among the interventions with serious policy implications are the expanded private sector role, increased access to long term and permanent contraceptive methods, and an invigorated IEC effort that will markedly raise the awareness about FP/MCH issues among both supporters and opponents.
- The project should provide resources to develop and periodically update a policy agenda. The agenda should guide efforts to remove barriers and fill vacuums in law, regulation, policy, and practice, which are necessary to achieve project objectives.
- The planned policy analysis by the Options Project would lay the groundwork for developing a policy agenda, and would include an assessment of the impact of laws, regulations, policies, and practices on current and future FP/MCH activities, the necessity for change, the ease or difficulty of reform, and the potential benefits if successful.
- A description of the policy implications of proposed project interventions was prepared in a separate section of the draft project paper, and will facilitate the task of the Options Project.
- Policy dialogue would be among the strategies used to secure support of opinion leaders and decision makers for specific project objectives and activities. Such strategies would be identified and elaborated in the policy agenda, and would include mobilizing IEC resources in support of policy dialogue.

E. Diverse Resource Base for Future FP/MCH Program

Issue: Availability and Allocation of Public Resources

Context

- Four options for future financial sustainability were

identified in the Implementation Plan: increased share of the MOPH budget; cost recovery, i.e. fees or cross-subsidies; more efficient use of existing resources; increased share of services financed by the private sector. The Plan points out that the bulk of ambulatory health care resources are absorbed by low-cost, high-volume curative care; thus, even a small charge per visit for these services would generate ample resources for preventive care.

Conclusions

- The project should support development of a capability to project financial needs and to advocate for a fair share of public resources. In view of the decentralization strategy, this capability needs to be directed at securing adequate allocations from the GOM/MOPH budget, as well as soliciting financial and other resources at the local level. The capability should include accurate projections of need as well as effective demonstrations of the cost-effectiveness-benefit of FP/MCH.
- There is as yet no interest on the part of the MOPH in charging fees for FP/MCH services. The options analysis exercise did not pursue the issue of charging small fees for the high volume curative services. Project financing should allow for supporting any opportunity to study the feasibility of this or similar strategies should the MOPH be willing to explore them.
- The idea of public sector social marketing was mentioned by the MOPH but was not fully explored during the options analysis exercise; the project should support feasibility studies of this or any possible means for reducing public expenditures.
- The role of Collectivités Locales in co-financing some health services should be part of any feasibility studies of its potential for supporting FP/MCH.
- In general the project promotes efficient use of resources by improving quality and thereby lower discontinuation rates; and reinforcing such efficient strategies as points of contact over house-to-house visits and decentralized in-service training.
- The project should also support purposeful use of management tools to lower costs, such as the target-cost model which can demonstrate how shifting certain contraceptives to the private sector will lower costs of procurement in the public sector.
- The options analysis exercise did not explore the idea of permanent fund to finance contraceptive procurement, similar

to that developed for vaccinations; the project should support feasibility studies of this and similar strategies.

- The most promising means of ensuring sufficient public resources for those least able to pay for FP/MCH services is to shift clients to the private sector who are able to pay. The proportion of clients willing to move into the private sector will depend on the degree to which a quality, free public FP/MCH program is a more desirable provider. The project should ensure that all social marketing and private sector activities carefully track the movement of clients from the public sector; or movement of clients from one part of the private sector to another, e.g. movement of brand name pill clients to socially marketed, cheaper pills.

F. Private Sector

Issue: Expanded Private Sector Role in FP/MCH

Context

- Prior to the mission's strategic planning exercise and program management review, the social marketing of condoms had been launched, and very extensive assessments had been made of the potential for increased private sector FP/MCH services.
- The Implementation Plan proposed that the private sector role in FP/MCH be vastly expanded for multiple reasons: to shift clients from the public health system who can afford to pay for services, thereby freeing up resources to reach more of the underserved populations and possibly shifting more expensive contraceptives away from the MOPH as it assumes responsibility for procurement; to provide greater access to services by offering a wider array of delivery channels; to speed up the expanded availability of long-term and permanent contraceptive methods; and to ensure future program sustainability by broadening the resource base on which services delivery is built.
- The proposals in the Implementation Plan for expanding the private sector role were highly generalized, except for a recommendation to add products to the social marketing effort. The Plan highlighted many of the unanswered questions about private practitioners, employers, economic incentives, private sector ability to reach low income populations, viability of using existing health insurance networks, the regulatory environment, and use of NGOs in introductory trials of new contraceptives.
- The mission initially decided to proceed with the design of a private sector health care initiative for start-up in 1994,

and to limit any expansion of private sector activities under the current project to preparatory activities.

- In early 1993 a report was prepared which summarized more succinctly the potential for an expanded private sector role.
- The mission subsequently decided to move the separately funded initiative until 1995 and expand funding for private sector activities under the project amendment as a means of laying a more solid foundation for the future investment
- The options analysis team was requested to synthesize the vast amount of information generated from all assessments carried out to date, identify in concrete terms the realistic options for an expanded private sector role in Morocco over the long term, and recommend the most promising private sector activities for USAID support in the immediate and medium term consistent with those options.
- By the time the options analysis exercise was initiated, social marketing of contraceptive pills was launched in late 1992, and the effort to social market oral rehydration salts continued to be developed.

Conclusions

- On the whole, experience with the private sector is very limited, beyond the encouraging results of the social marketing activities. Additional funding should be provided under the follow-on project for the next year and a half for the purpose of generating more experience and information about the private sector, on the basis of which a significantly greater investment could be made to expand the role of this sector.
- Existing products should be expanded through other channels where possible, and the social marketing experience should be assessed to extract lessons learned.
- Feasibility studies for new products should be undertaken over the next year and a half. (By the time the team leader departed April 19, a tentative decision has been made that no funding should be included in an amended project for launching new products; but rather that results of feasibility studies should provide the basis for additional funding in the context of the separate private sector initiative.)
- The project should develop private sector FP/MCH projects with the greatest potential for producing results in the next eighteen months on which significantly greater activity can be built. The project should also conduct feasibility studies

and undertake other information-generation activities in lesser known areas of private sector activity, as a means of identifying other areas which would benefit from a significant investment of resources. Finally, the project should support MOPH efforts designed to promote the role of the private sector among decision-makers.