

Country Activity Plan

Morocco 1998-99

July 6, 1998



Partnerships
for Health
Reform

PHR

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Partnerships
for Health
Reform

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *better informed and more participatory policy processes in health sector reform; more equitable and sustainable health financing;*
- ▲ *improved incentives within health systems to encourage agents to use and deliver efficient and quality health service; and*
- ▲ *improved organization and management of health systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and informs and guides the exchange of knowledge on critical health reform issues.

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Acronyms

ANE	Asia Near East
CA	Cooperating Agency
CAP	Country Activity Plan
EPI	Expanded Program on Immunization
FP/MCH	Family Planning/Maternal and Child Health Care
FP	Family Planning
GOM	Government of Morocco
JSI	John Snow, Inc.
LTA	Long Term Advisor
ORS	Oral Rehydration Salts
PHN	Population Health and Nutrition
PHR	Partnerships for Health Reform
SOMARC	Social Marketing Project
TRG	Training Resources Group
USAID	United States Agency for International Development

Executive Summary

Over the last 25 years, USAID has become the Government of Morocco's (GOM) principal external partner in family planning and maternal child health (FP/MCH). This FP/MCH collaboration has become one of the most successful of such programs in the Arab world, including strong results in contraceptive prevalence (rising from 42% to 50% in just the last three years) and a similarly rapid decline in total fertility (down 25% between 1987 and 1995). The total fertility rate in Morocco's urban areas is, in fact, now approaching replacement levels.

In April 1996, PHR began to help USAID plan its transition out of the FP/MCH sector, in cooperation with the POLICY Project, USAID's Office of Health and Nutrition, local counterparts from various ministries, USAID's bilateral FP/MCH project, and NGOs. The transition team worked to identify the principal policies that need revision or development to enhance the impact and sustainability of the USAID-assisted FP/MCH programs and to generate Moroccan policy dialogue on these issues. In addition, PHR began to identify key stakeholders involved in the provision of FP/MCH services to support the transition process and policy dialogue. Since the transition period is short, these policy efforts are focused on ensuring sustainability in areas where USAID has allocated substantial resources and efforts, most notably in family planning.

The overall goal of PHR activities in Morocco is to provide technical assistance and training to increase the government financial resources for family planning/maternal and child health, and help improve the policy environment supporting these services. All of the activities are in support of USAID/Morocco's transition plan and contribute to ensuring sustainability of FP/MCH programs in Morocco. Specifically, PHR contributes to the R4 Strategic Objective 1; Intermediate Result 1.2: Improved policy environment supporting FP/MCH services.

The PHR activity for Morocco is designed to achieve three objectives: (1) Maintain high levels of contraceptive prevalence as USAID funding for operating expenses for the FP program is phased out; (2) reduce the unnecessary and often substantial costs of taxes and other administrative costs associated with the purchase of imported essential FP and MCH commodities. Decrease the total cost of locally (GOM) purchased imported contraceptives and vaccines; (3) improve the population's access to affordable, appropriate, high quality FP/MCH service providers; (4) maintain high EPI coverage rates independent of outside donor support; and (5) assure financial sustainability of FP/MCH services after USAID bilateral assistance ends in 1999. The Country Activity Plan (CAP) covers the 11 month period from July 1998 to June 1999 and has an estimated budget of \$400,000 in field support and additional support of \$445,500 from the Global Bureau's Child Survival and ANE Bureau. The PHR Deputy Director for Operations, Cheri Rassas, will be the Officer in Charge and will have overall responsibilities for PHR's activities in Morocco. Jean-Jacques Frere, the PHR ANE Coordinator, will be responsible for the technical quality control of all PHR activities. The Program Officer for Morocco, Phara Georges, will carry out the day-to-day management of the project from the US, and the local coordinator will serve as our liaison and contact in Rabat.

01. Introduction and Methodology

Since 1980, fertility and infant mortality have declined significantly in Morocco while contraceptive prevalence and immunization coverage have increased dramatically. Despite this impressive progress, important challenges remain: sustaining the existing levels of performance as USAID and other donors phase out support; ensuring that overall gains are shared equitably throughout Moroccan society; and increasing the capacities of all sectors (public, for-profit private, NGOs) to resolve current and future programmatic challenges in a sustainable manner.

PHR has been assisting USAID's transition out of the family planning/maternal and child health (FP/MCH) sector since April 1996, when a joint PHR, POLICY Project, USAID/G/PHN team visited Morocco to work on transition planning with USAID Mission staff and local counterparts from various ministries, USAID's bilateral FP/MCH project, and NGOs. PHR's assistance is designed to assist USAID and the government of Morocco in achieving the intermediate result of *"improved policy environment supporting expansion of family planning and maternal and child health services"* under the Mission's Strategic Objective 1 of reduced fertility and improved health of children under five and women of childbearing age and its two principle results of increased use and increased sustainability of FP/MCH services.

Over the past year, PHR has provided a long-term policy advisor to the Mission, the Ministry of Health and the Ministry of Population (which is now part of the Prime Minister's Office) to move forward the implementation of USAID's policy agenda framework. The long term advisor has also coordinated policy work for USAID, work plan development and PHR's activities with other CAs involved in policy efforts of USAID, in particular, the JSI Phase V bilateral project, POLICY, SOMARC, and Tulane (the Evaluation Project and now MEASURE). Within this context the following key areas of work were identified and are discussed in detail in Section 4 of this Country Activity Plan (CAP). They include:

- ▲ support for achieving a GOM plan for financing of the FP program, and of contraceptives in particular (referred to as the "contraceptive phase-over"); and
- ▲ improving the policy and regulatory environment for family planning and maternal and child health services in both the public and private sectors.

PHR's LTA will be departing Morocco in July 1998, and ongoing activities included in this work plan will continue through short-term consultancies, using local consultants to the extent possible, and international consultants as required, supported by a management team from the Bethesda home office. PHR also proposes that coordination of our work plan and technical support to many of the outlined activities be carried out by a part-time local consultant who is familiar with the planning and maternal and child health sub-sectors in Morocco, and whose prior experience and academic background are relevant to PHR's ongoing work. PHR recognizes that continued close collaboration with the various ministries, CAs and other institutions, and the consistent support of talented and credible personnel, are key factors to the success of this work plan and to the sustainability of its achievements.

This CAP is based on agreements reached among USAID/Morocco, the Global Bureau, the ANE Bureau, various MOH counterparts, PHR, and relevant cooperating agencies. The purpose of this CAP is to provide the framework for PHR's activities through 1999 by defining objectives, results, and indicators. The CAP contains some information on recent accomplishments and the status of activities which are already underway, and is intended to serve as a "roadmap" for continuing PHR activities over the next year (June 1998 - June 1999). Estimates of costs and levels of effort required to carry out the plan are also included. Field support-funded activities as well as those supported by the ANE Regional Bureau and the Global Bureau's Child Survival Office are included in this CAP. All activities are subject to the availability of funding.

02. Background

2.1 Overview of Morocco's Family Planning and Child and Maternal Health Sector

In 1966, a Royal Memorandum was issued which laid the foundations for Family Planning in Morocco. One year later, the Moroccan Family Planning program was launched through the Ministry of Public Health. That same year, a law was passed that removed all penal sanctions associated with the use of modern contraceptives. Ten years later, a program of home visits for family planning motivation (VDMS or Visites à Domicile de Motivation Systematique) was implemented to broaden the access of the Moroccan population to family planning services.

Morocco has made impressive progress in reducing fertility. Since the end of the 1970's, total fertility in Morocco has fallen from 5.9 children per woman to 3.08 in 1997. Contraceptive prevalence has increased dramatically in the last 15 years. Today almost two thirds of married women use a modern method of contraception, compared to only one quarter of married women in 1980. In rural areas, the use of modern contraceptive methods has increased from less than one married woman in six to four in ten in 1995. Urban rates for the same time period were from four in ten married women in 1980 to 6.4 in ten in 1995 (EPPS, 1995).

Family planning is now strongly supported at all levels of Moroccan society. His Majesty the King and members of the Moroccan Government have publicly stated their concerns about population growth rates, and recently, attention has focused on the relationship between demographic growth and socio-economic development.

USAID has played a central role, along with other donors, for over two decades in developing and supporting the provision of family planning and maternal and child health services in Morocco. The MOH and USAID agree that the best strategy to ensure continuous and uninterrupted support for the family planning program is to obtain government support, at the highest levels, for the idea that Family Planning is a national development goal and that government resources will be available for the program, regardless of the economic situation of the country, for the near term and for the long term future. PHR's assistance, along with the assistance of other CAs, is designed to facilitate that process.

USAID's accomplishments were achieved primarily through a strengthening of the public sector service delivery network, and, more recently, through social marketing and growing service provision in the for-profit private sector. Given the tremendous achievements made to date, USAID has designated Morocco a "graduating" country in the Population, Health and Nutrition (PHN) sector, with bilateral assistance slated to end in December 1999.

2.2 The Role of Other Donors in Supporting Morocco's Health and Family Planning Sector

See Annex A, Table drafted by Helen Soos in Spring 1998 reflects donor support by Program, Recipient Agency, Objectives, Output and Budget.

03. Overall Framework for PHR Technical Assistance

3.1 Goals and Objectives

The overall goal of PHR activities in Morocco is to provide technical assistance to increase the government financial resources for family planning/maternal and child health, and help improve the policy environment supporting FP/MCH services. All activities are in support of USAID/Morocco's transition plan and contribute to ensuring sustainability of FP/MCH programs in Morocco. Specifically, PHR contributes to the R4 Strategic Objective 1; Intermediate Result 1.2: Improved policy environment supporting FP/MCH services.

To accomplish this goal, PHR, in collaboration with other CAs assisted USAID/Morocco in developing and refining the Mission's Policy Reform Agenda, Objectives and Indicators (See Annex B, SO1 Policy Reform Agenda; and Annex C, Policy Reform Identification sheets). PHR was requested by USAID/Morocco to contribute to the following USAID Policy Reform Objectives for Strategic Objective 1.

Objective 1: Maintain high levels of contraceptive prevalence as USAID funding for operating expenses for the FP program is phased out.

Problem Statement: Implement the Phase V contraceptive phase over plan which calls for MOH financing 100% of public sector contraceptive needs by the end of 1999 to ensure a steady supply of FP products upon termination of USAID bilateral assistance.

Objective 2: Reduce the unnecessary and often substantial costs of taxes and other administrative costs associated with the purchase of imported essential FP and MCH commodities. Decrease the total cost of locally (GOM) purchased imported contraceptives and vaccines.

Problem Statement: Reduce administrative and customs costs for imported FP/MCH commodities.

Objective 3: Improve the population's access to affordable, appropriate, high quality FP/MCH service providers.

Problem Statement: Improve the regulatory framework which affects the use of health personnel in the public and private sectors.

Objective 4: Maintain high EPI coverage rates independent of outside donor support.

Problem Statement: Continue to assure 100% procurement of public sector vaccine needs for the EPI program as Morocco moves beyond its current reliance on a vaccine revolving fund arrangement (with UNICEF and USAID assistance) to a second level of assuring ongoing sustainability of vaccine supply through direct government procurement.

Objective 5: Assure financial sustainability of FP/MCH services after USAID bilateral assistance ends in 1999.

Problem Statement: Diversify the resource base for FP/MCH services.

3.2 Collaboration with other Cooperating Agencies

USAID/Morocco's Policy Reform Agenda in Annex B was revised by PHR's long-term advisor in collaboration with USAID and the other CAs providing assistance to USAID/Morocco. The Agenda illustrates the areas of collaboration and accomplishments to date. It also outlines PHR and the various other projects' roles in contributing to the Mission's Strategic Objective 1.

04. Assistance Under the PHR Project

The PHR activities outlined below were approved by USAID/Morocco on April 7, 1998, and contribute to USAID/Morocco's Strategic Objective 1: Reduced fertility and improved health of children under five and women of childbearing age; and increased use and sustainability of FP/MCH services; and Intermediate Result 1.2: Improved policy environment supporting FP/MCH services. Furthermore, the Objectives stated in this Section of the CAP refer to USAID/Morocco's Policy Objectives in support of IR 1.2. PHR will be responsible for contributing to the successful achievement of these objectives through a series of technical assistance activities. The objectives, results and activities are slightly revised from the PHR approved work plan for January '98 - June '99 (see Annex D) and are based on discussions held with USAID/Morocco, PHR's long-term advisor and PHR's Deputy for Operations on June 9, 1998.

4.1 Objective 1

Maintain high levels of contraceptive prevalence as USAID funding for operating expenses for the FP program is phased out. *Implementation of the Phase V contraceptive phase over plan which calls for MOH financing 100% of public sector contraceptive needs by the end of 1999 to ensure a steady supply of FP products upon termination of USAID bilateral assistance.*

4.1.1 Rationale

USAID has funded the majority of the Moroccan FP program for the past 25-30 years, and until recently virtually all of the contraceptive distribution has been free and through the public sector. USAID bilateral assistance in PHN is scheduled to end in December 1999. Experience in other countries shows that contraceptive prevalence rates are likely to decline when major donor resources decline unless certain measures are in place to ensure sustainability. Sufficient budget allocations for operating expenses are key, and USAID has a responsibility to assist the MOH in lobbying for increased GOM budget allocations for Family Planning.

4.1.2 Intended Results and Activities

Result 1.1 Development of an advocacy strategy and accompanying documentation to be used to lobby for sufficient GOM funding of a national public sector Family Planning program.

Activities:

1. Prepare a briefing document (dossier) for the Contraceptive Phase-over.

PHR has been responsible for coordinating, in conjunction with other cooperating agencies and local counterparts, the preparation of a briefing dossier for the MOH to use to negotiate with

high levels of the Moroccan government to increase the annual family planning budget beginning in the 1998-99 budget year. The MOH will use this dossier to lobby other ministries and decision makers in order to increase support across the government for the family planning program. The dossier itself includes a Power point slide presentation, a 20-page technical briefing document and a short Public Relations (PR) piece. It includes input from several USAID cooperating agencies (PHR, POLICY, Phase V bilateral Projects) which have or are conducting new studies on the local cost of contraceptives, local procurement options, cost savings and benefits of FP, the current and potential market for contraceptives, and a multi-country survey on tax waivers/reductions for contraceptives, immunizations, and ORS. The dossier also exploits the results of completed or ongoing studies supported by USAID or other donors. In addition, a 49,000 household study on maternal and infant mortality supported by the Arab League (PAPCHILD) provides data disaggregated by region on mortality, morbidity, fertility and use of FP/MCH services, as well as clinical reproductive health data on a sub-sample of women. The results of all these of studies have been fed into the dossier, which has been presented in draft to USAID and the MOH.

Status: PHR fielded a short-term consultant in December 1997 to conduct a cost-benefit analysis of the FP programs and provide input into the Power point presentation. The first draft dossier was presented to USAID and the MOH in December 1997. PHR's long-term advisor has revised and completed the Power point presentation and accompanying 20-page text and submitted it to USAID and the MOH for final review and approval. We are awaiting final approval from the Minister of Health. Once approved, PHR will contract with a local firm to translate the approved Power point presentation and accompanying text into Arabic. In addition, a summary PR piece will be drafted to highlight key points and data supporting an increased, long-term GOM FP budget commitment.

Timing: Subject to approval by the MOH, the final dossier will be ready by July 1998.

2. In collaboration with the MOH finalize the presentation and strategy for advocacy.

Currently, the plan is that the MOH will use this dossier for lobbying efforts with other ministries and decision makers in order to increase support across the government for the family planning program. The final strategy will be developed after the Minister of Health's approval. If for some reason the Minister does not approve the presentation, PHR will work closely with the Mission and key counterparts to decide how to revise the dossier and/or how to proceed with other stakeholders.

Status: The strategy for the presentation of this briefing dossier has changed over time in response to the political environment and inclusion of different stakeholders. In early 1997, PHR's activity was to present an internal dossier to the MOH; this took place in July 1997. After that meeting, the strategy turned to convincing the MOF. Subsequently, this strategy has been modified to include advocacy to the whole government.

The current strategy, depends on the results of discussions held mid-June between the Director of Population and the Minister of Health. If there is agreement that the current dossier is ready to be finalized with minimal revisions, it should be ready by July 1998. The actual presentation of the "dossier" by the MOH to the Cabinet and/or Parliament would then take place during the Summer of 1998.

Timing: Waiting for approval.

3. Assist the MOH in implementing the advocacy strategy.

Status: PHR proposes to use our local coordinator/consultant to assist the MOH in implementing its advocacy strategy. Expatriate and/or other local consultants will also be used to support the strategy activity as necessary.

Timing: TBD.

4. Follow-up.

Status: PHR proposes to use our local coordinator/consultant to assist the MOH and USAID/Morocco with follow-up on the contraceptive phase-over activities.

Timing: Ongoing.

4.2 Objective 2

Reduce the unnecessary and often substantial costs of taxes and other administrative costs associated with the purchase of imported essential FP and MCH commodities. Decrease the total cost of locally (GOM) purchased imported contraceptives and vaccines. *Reduce administrative and customs costs for imported FP/MCH commodities.*

4.2.1 Rationale

Import taxes and customs duties are waived for donor funded commodities (i.e. contraceptives and vaccines). When these same products are purchased directly by the GOM, substantial taxes and import duties greatly increase the cost of these products to the GOM. In July, 1997, a major USAID policy agenda benchmark was achieved, with PHR's assistance, with the reduction of import taxes on vaccines and selected other essential drugs from 57% to 9.5%. As the GOM purchases more and more of its own contraceptives (nearly 50% of needs by FY' 98 and 100% by FY'00), the tax burden becomes more significant and greatly decreases the purchasing power of the MOH for these essential commodities. USAID and the MOH would like to build upon the successful efforts with vaccines to help lobby for the same benefits for contraceptives.

4.2.2 Intended Results and Activities.

Result 2.1 Reduce the Costs of Contraceptives

Activities:

1. Conduct and present a worldwide survey on tax waivers for contraceptives, vaccines and other public health products.

In response to a request from the MOF, PHR conducted a multi-country survey on tax waivers for public health commodities, including contraceptives, vaccines, and ORS, in order to inform local decision making on whether or not to decrease similar taxes in Morocco. UNICEF and USAID offices have been surveyed as part of the study. In July, 1997, Morocco announced significant customs tax reductions and the waiver of import taxes on vaccines; efforts to ensure these same tax benefits for contraceptives are underway.

Status: The LTA will include information that has just arrived from Jordan and will make a presentation to USAID/Morocco in June 1998. With approval from USAID/Morocco, PHR will proceed with a translation of the information provided by the survey and a Power point presentation in French.

Timing: Submission of survey report by end of June. Translation of survey information and report by mid-July.

2. Analysis of the cost structure and marketing (distribution) chain for contraceptives.

PHR has also been requested to analyze the structure of the cost of contraceptives and the marketing chain to determine where the possibilities for reducing costs of contraceptives lies. The policy objective is to reduce the unnecessary and often substantial costs of contraceptive purchases made directly and locally by the MOH. This will help increase the purchasing power of the MOH for these products. This activity is related to other PHR efforts to reduce the tax burden on contraceptives, which is also being pursued as a strategy to reduce the cost to the MOH of procuring contraceptives, as well as efforts by JSI to reduce the administrative burden and customs charges for imported contraceptives. PHR will exploit the results of previous studies, determine what information is missing or needs to be confirmed or updated in these studies, and conduct new analyses as needed to:

- ▲ a) determine the relative magnitude of savings to the MOH to procure contraceptives according to different options. For example, two of the options will likely be:
 - △ 1) reduction in VAT taxes on contraceptives; and
 - △ 2) reduction in the distributor's margin.
- ▲ b) determine the relative losses in income to the Ministry of Finance and other entities (other decision makers, including Customs) so that the MOH can have data to support their discussions and lobbying efforts with these decision makers.

Status: A preliminary visit will be made by PHR consultant Miloud Kaddar to gather and analyze existing information (Oubinichou, JSI, January 14, 1998 study and others), identify gaps in the information, develop a plan to collect the missing information, and develop a detailed SOW for a local consultant/organization who will carry out the study under PHR's technical direction. The timing of the actual study will be determined by the PHR consultant in coordination with the Mission and MOH.

Timing: Development of SOW: June 28 - July 6, 1998; Complete study locally in August; Begin study: September 1998; Finalize December 1998.

3. Develop, in collaboration with the MOH, an advocacy strategy for reducing the costs of purchasing contraceptives.

Based on findings from the study above, PHR will develop options and/or make recommendations to the MOH on ways to reduce costs to the GOM of contraceptive purchases. PHR will also collaborate with the MOH in the drafting of a strategy to advocate for the preferred options.

Status: This activity is dependent on the cost analysis study. PHR's local coordinator/consultant will assist in the development of the advocacy strategy with the MOH and local study team.

Timing: December 1998 - March 1999.

4. Assist in implementation of advocacy strategy for reducing the costs of purchasing contraceptives.

Status: Details of this activity will depend on the results of 2 and 3 above. PHR proposes to use our local coordinator/consultant and study team for assistance to the MOH in implementing the strategy.

Timing: TBD

5. Draft proposal of legislation in support of reduction of purchasing costs of contraceptives.

Based on information from the cost study and selected options by the MOH, PHR will develop a scope of work for local consultants to review current legislation and propose Tax code and administrative changes to the MOF and other decision makers.

Status: PHR's local coordinator, with assistance from PHR's home office staff, will draft and negotiate an appropriate scope of work for this activity. PHR's coordinator will assist in identification of local consultants familiar with Morocco's regulatory and legal statutes to develop appropriate legislation in collaboration with relevant ministries and government officials.

Timing: February 1999.

4.3 Objective 3

Improve the population's access to affordable, appropriate, high quality FP/MCH service providers. *Improve the regulatory framework which affects the use of health personnel in the public and private sectors.*

4.3.1 Rationale

The main limiting factor to midwives and other paramedical personnel practicing in under-served areas are the rules and regulations that limit what procedures and acts they can perform (particularly in private independent practices) without direct physician supervision. PHR's activities are designed to both improve service coverage in under served areas and to assure a certain legal status for private independent paramedical providers. The MOH already has experience in revising rules and regulations governing General Practice Physicians and this experience can be built upon for drafting and negotiating new legislation to liberalize paramedical practice in Morocco.

USAID may also assist the MOH and other provider groups (Medical and Midwifery Societies) to examine, propose and negotiate revisions to other rules and regulations which affect the delivery of FP/MCH services (possibilities currently on the MOH agenda for June 1997-July 30,1998 include: liberalization of paramedical provider rules; maternal and infant health texts; immunization; medical profession recertification requirements; all rules and regulations surrounding the procurement, sale and distribution of medicines; as well as other fiscal and administrative reforms.). PHR will assist in some of these as funding and USAID priorities permit.

4.3.2 Intended Results and Activities

Result 3.1 New codes/regulations drafted.

Activities:

1. Review and analysis of codes and regulations relating to the provision of paramedical services.

In May and June, 1998, PHR's long term advisor worked with the MOH to gather documentation of current Moroccan legislation governing physician and paramedical practice. The 1994 USAID supported review of laws and rules pertaining to provision of FP services provides important and adequate information on the status of human resource roles and responsibilities and sufficient recommendations for changes, at least in the area of FP.

Status: In recent meetings with the Director of the Department of Legal Affairs of the MOH, she suggested that these two pieces were sufficient for her needs and asked that PHR move directly on to activity 2 below.

Timing: N/A

2. In collaboration with the MOH, medical associations, midwives and others stakeholders, draft codes and regulations in support of paramedical professions and assist in negotiating the legal process.

The Director of the Department of Legal Affairs of the MOH confirmed in June 1998 that the MOH is already in the process of drafting new legislation to liberalize paramedical rules. PHR will draft a scope of work to assist the MOH to draft new legislation and sensitize government

decision makers and other stakeholders to these changes. The SOW will include a review of international experience in liberalizing the regulatory environment to permit paramedical providers more autonomy in service delivery, particularly as private sector providers. The overall objective is to expand coverage of service delivery to under-privileged, under-served populations and to increase the status and quality of paramedical services.

Status: PHR home office staff will coordinate with our local coordinator in Morocco to draft and negotiate a draft a scope of work for Mission and MOH review. PHR intends to hire local expertise with legal and regulatory expertise and knowledge of the health service sector in Morocco. As part of this activity, PHR also proposes to research relevant experience in other developing countries, particularly other Arab countries.

Timing: Scope of work drafted in August ; Begin analysis in October/November 1998. Draft of codes in March 1999. Work will be conducted by local consultants and an international consultant, (if necessary). As a result of the regulatory review and analysis above, PHR will provide additional assistance in drafting changes to the codes and regulations governing the provision of paramedical services. This activity will be a continuation of work for the local legal expertise contracted to perform the analyses. The local team will work under the guidance and supervision of PHR staff, as appropriate.

3. Study Tour for two - three staff from the Department of Legal Affairs, MOH.

At the request of the Department of Legal Affairs and in support of the two activities above, PHR will organize a study tour for two to three staff members of this department to 1-3 countries

Status: The purpose of the study tour is to provide Morocco with examples of other countries which have gone through the process of legislative reform to liberalize paramedical providers. Specific details on objectives, timing and the location of the study tour needs further discussion with the Chief of the Department of Legal Affairs in order to assure a successful and meaningful experience that is relevant to changes anticipated in Morocco. Countries which have been proposed include: Turkey, Tunisia and Ghana. PHR will be identifying additional country candidates. PHR has identified a Tunisian consultant, Rachid Ben Amor, who has vast experience in Morocco and in the health sector in Tunisia. He has worked on numerous USAID projects, and is currently conducting training with TRG in Morocco. Mr. Ben Amor is a possible candidate for assisting PHR and the MOH, with the assistance from our home office Training Officer, in organizing and leading the study tour. In a meeting with the Director of the Department of Legal Affairs, she confirmed that she will submit names and possible timing to PHR as soon as possible.

Timing: The Director of Legal Affairs has been requested to submit possible dates as soon as possible.

4. European Francophone International Confederation for Midwives Conference.

Per a request from the Direction de la Planification et des Ressources Financiers, PHR will make arrangements for one midwife to attend this international midwives conference in Montpellier, France. The Conference will focus on research regarding midwife practices and will provide a one-day workshop targeting the specific needs of midwives from developing countries. The purpose of this 3 day workshop is to provide francophone midwives with more efficient and effective tools to improve their service delivery and tools to better evaluate their daily services.

The purpose is also to stimulate the participation of francophone midwives to provide more scientifically based services in order to improve the care they offer to women and children.

Status: PHR has drafted a letter to the MOH from USAID, stating that PHR can make arrangements and pay for one midwife to attend. MOH will be responsible for the airfare. The Deputy Director for Operations has been in touch with conference organizers.

Timing: December 2 - 4, 1998

5. Other Regulatory Reforms in support of Family Planning and Maternal and Child health programs as necessary, subject to availability of funding.

4.4 Objective 4¹

Maintain high EPI coverage rates independent of outside donor support. Assure 100% procurement of public sector vaccine needs for the EPI program.

4.4.1 Rationale

Morocco has been the most successful of the handful of countries that have adopted a revolving fund arrangement for the purchase of public sector vaccine needs, referred to as the Vaccine Independence Initiative (VII). When the VII was signed between Morocco and UNICEF in 1992 there were no local pharmaceutical companies in Morocco capable of providing an uninterrupted and adequate level of high quality vaccines to meet the needs of the public sector vaccine program. USAID contributed \$1,100,000 to the fund in 1994 and 1995. With the signing of the VII, the GOM's contribution to the financing of public sector vaccine needs increased from 50% in 1992 to 80% in 1993 and to 100% by 1994. Since 1995, the VII has been used to procure 100% of public sector vaccine needs as well as essential vaccination equipment (such as sterilization equipment, syringes and cold chain equipment). Vaccination coverage rates are high; by 1995, 85% of infants 12-23 months were fully vaccinated (BCG, measles, and 3 doses of DPT and polio) (EPPS, 1995). The VII was always meant to be a medium term solution to the vaccine procurement problem; in the last year, the MOH has identified several issues/concerns with the revolving fund and has also noted that local pharmaceutical companies may now be able to provide an adequate quantity of high quality vaccines at competitive prices to the MOH. The MOH has requested USAID assistance to help them determine the best long term strategy for moving from the VII to long term sustainability through direct government procurement and the possible addition of new vaccines.

¹PHR's contribution to this Objective is dependent on funding from the Global Bureau's Child Survival Office.

4.4.2 Intended Results and Activities

Result 4.1 Establishment of a permanent mechanism that responds to 100% of the vaccine requirements for the public sector.

Activities:

1. Assist the MOH in identifying current constraints in immunization financing in relation to medium and long-term objectives.

Status: To be funded out of the Global Bureau's Child Survival Office under PHR's Special Initiative, *Immunization Financing*. This activity is dependent on availability of funding and selection of Morocco as one of the countries for Initiative's case studies. These case studies will look at the entire range of immunization financing issues and make recommendations for improvements. Meetings with WHO and Child Survival staff in Geneva taking place in June may impact the scope and funding of this Initiative. While PHR realizes the importance of this activity in Morocco, further elaboration of a scope of work and commitment will depend on the concurrence of the Global Bureau.

Timing: Miloud Kaddar to address MOH during June/July visit. Study to begin in September.

2. Assist the MOH in development of a plan for continued financing of the EPI program (post Vaccine Initiative).

Status: See status above.

Timing: TBD

4.5 Objective 5

Assure financial sustainability of FP/MCH services after USAID bilateral assistance ends in 1999. Diversify the resource base for FP/MCH services.

4.5.1 Rationale

Previous USAID assistance in the early 1990's included research on financing of health services and development of early insurance plans. Current efforts are limited to increasing the MOH's capacity to deal with financing issues, by helping them to conduct a National Health Accounts exercise and by providing training in health economics. National Health Accounts are needed to provide baseline data on sources and expenditures in the health sector as a starting point for decision making for resource diversification, to help put contraceptive and FP/MCH budgetary needs in the context of overall MOH budgetary needs and priorities, and to help the MOH advocate effectively in financial discussions with MOF and other decision makers and donors.

4.5.2 Intended Results and Activities

Result 5.1 Improve the capacity of MOH to manage its diverse resource base.

Activities:

1. Assist the MOH in analyzing the National Health Accounts in order to better understand financing sources and health expenditures.
2. Support the participation of the MOH in NHA regional workshops in the ANE Region.

PHR will support development of national health accounts (NHA) in Morocco as part of a regional effort to institutionalize this important health policy tool in the Near East region. Health economists within the MOH of Morocco are already highly motivated to learn and implement NHA and anxious to take part in a regional NHA network and regional NHA workshops in the Near East. Funding for this activity will be part of the ANE Bureau regional NHA initiative. PHR's approach in Morocco and the region will emphasize building local capacity in NHA preparation and analysis to ensure sustainability. The World Bank is also providing funds for NHA in its upcoming project. Specifically, this initiative would:

- ▲ Allow Morocco to participate in the proposed regional NHA initiative in the Near East, including joint workshops, and promoting the exchange of experiences between participating countries using existing networks and other forums.
- ▲ Produce a set of NHA accounts and final report for Morocco describing the sources and uses of all health care expenditures which is a basic requirement for management of the allocation of health sector resources, and assessment of the impact of policy interventions.
- ▲ Ensure that the NHA process is sustainable in Morocco by having the local NHA team lead the work, with PHR providing:
 - △ training in the theory and practice of NHA
 - △ technical assistance as required to develop the best estimates possible given the available data, and in a manner which allows comparability with NHA results from countries within the region and internationally
- ▲ Disseminate the findings to policy-makers in Morocco and promote national-level discussions of the policy implications of the results of the NHA analysis

The following outlines the specific steps to be taken in order to complete the scope of work which will be funded out of the ANE Regional Bureau.

1. Identification of local NHA team. PHR's resident advisor in Morocco worked with the MOH to select a team of two to work full-time on NHA for approximately one year. It is anticipated that the labor costs will be covered by the GOM as a host country contribution to NHA.

2. Workshop 1: Initial planning and training workshop (5 days) in Amman, Jordan in May 1998. This workshop was originally planned for only the Jordan NHA team, but NHA teams in Morocco and Lebanon requested to attend. This initial workshop focused on basic concepts of NHA, how to estimate expenditures for the major account categories and an introduction to the NHA software (including a case study assignment). A major output of the workshop was the development of a NHA work plan by each country team.
3. After the first workshop, the local NHA team will spend approximately ten months collecting data and preparing account estimates. PHR and WHO will provide funding (approximately \$5,000 each) to cover local costs for data collection, field visits and data analysis. The local team will receive long-distance technical support to review and analyze data, evaluate estimates, and answer questions from a research specialist based at HSPH who will assist the local teams via E-mail, fax, phone and courier. The local NHA team will also receive one TA visit from one of the Technical Advisors.

In Morocco, some initial data collection to test the capacity of public health facilities (hospitals, district medical offices which are responsible for health centers and dispensaries and several laboratories) to collect data on specific sources and expenditures has already taken place. This test met with mixed results. For example, only about 50% of those questioned responded and most needed hands-on assistance from the central MOH economists in charge of the test to be able to find the information requested and to fill out the questionnaires.

4. Workshop 2: Interim technical workshop (4 days) in March 1999 for the NHA team from Morocco and other countries in the region to discuss problems, share findings, and consult with outside technical experts.
5. The local NHA team spends approximately four months to finalize account estimates and draft the NHA report. PHR will provide long-distance technical support to review the NHA accounts and technical review of the final report, and one TA visit from the Technical Advisor. NHA preliminary results will be available in country by June 1999.
6. Workshop 3: Final workshop to present estimates, discuss experience, recommend follow-up activities. The estimated date for the workshop is July 1999.
7. PHR will provide technical and editorial input for finalization of NHA report (100 to 150 pages), translation (French/English), and production. Final production (in Bethesda or in Morocco) and distribution of the NHA country report by December 1999.
8. PHR will assist the local NHA team prepare a presentation of the NHA results and analytical findings to be given at a workshop for policy-makers in December 1999 to promote national-level discussions.
9. Participation of Morocco team in a regional seminar in Spring 2000 to disseminate NHA findings and experience to donors, relevant international agencies, and other countries in the region.

Products

- ▲ Trip reports for TA visits.

- ▲ Completed NHA for Morocco.
- ▲ Completed report on the results of the NHA analysis.
- ▲ Moroccan team trained in NHA.
- ▲ Wide dissemination of results and of USAID technical leadership to regional NHA development.

Status: The first two activities under the NHA portion of the work plan as outlined above are complete (two Moroccans selected and participated in the Jordan workshop). Implementation of the complete scope of work is now dependent on approval from the Directeur de la Planification et des Ressources Financières who has some concerns about how to integrate PHR's NHA methodology into the ongoing work that his Direction has initiated and who will assist in the follow-up assistance needed to institutionalize the collection and analysis of expenditures.

Timing: Illustrative timing per list of activities is stated above.

3. Organize and conduct regional training courses in health economics in collaboration with the Association Maghrebine des Economistes.

The purpose of this activity is to identify specific training needs, organize and conduct regional training in health economics for the Maghreb Region. These training should be undertaken in collaboration with Réseau Economie de la Santé Maghrébine (RESSMA) and other local groups as appropriate. The plan is to develop and conduct training for 10-15 Moroccans, as well as other participants from the Maghreb, once a year in 1998 and in 1999.

Status: The MOH has requested PHR's assistance in designing and conducting a training course in health economics, and the ANE Regional Bureau has agreed to fund such a course. PHR proposes to send Miloud Kaddar to Morocco to meet and discuss with counterparts the focus and objectives of a regional short-course, identify participants from the region, and begin to plan for the course. Since there are also other relevant training courses given in the region, Kaddar should discuss these as options to designing a course through PHR.

Timing: Preliminary visit in June 28 - July 6, 1998 for Miloud Kaddar. Proposed training to take place in November or December 1998, and the second for summer 1999.

4.6 Objective 6

Inform and Advise USAID/Morocco and the Government of Morocco on health policy issues.

Status: PHR's policy advisor updated the policy indicators for the Mission's 1998 R. presentation (see Annex B and C). All other activities under this Objective will be carried out by USAID/Morocco. PHR's core-funded dissemination activities will continue to provide support in

this area through a variety of formats. The Mission and Moroccan counterparts may also request PHR's Resource Center for information of particular relevance to the health policy issues of interest.

05. Management and Monitoring Plan

5.1 Personnel and Institutions

Since June 1997, PHR's activities in Morocco have been developed, coordinated and implemented, for the most part, by our resident policy advisor² in collaboration with USAID/Morocco, the MOH, other GOM stakeholders and Cooperating Agencies. PHR's resident policy advisor will be returning to work in PHR's home office in July 1998. In order to continue coordination and management of PHR's activities in Morocco, PHR proposes to provide a part-time local Coordinator/consultant residing in Morocco to coordinate (and negotiate, as appropriate) the continuing technical assistance activities and maintain effective liaison among USAID/Morocco, MOH counterparts, other relevant stakeholders, and PHR's home office management team. S/He will serve as PHR's point person in Rabat for project activities, reporting directly to and under the supervision of PHR's home office; this person will work for the prime contractor (Abt) and will have a clearly defined scope of work. (See Annex E - draft position description.)

5.2 In-Country Staff

As discussed in the paragraph above, PHR proposes to hire a local, part-time coordinator with technical expertise in the area of family planning and maternal and child health to serve as our liaison and contact in Rabat. PHR is currently recruiting this candidate and will attempt to present several options to USAID and the MOH in September 1998. Our proposed candidate(s) will meet with USAID/Rabat and MOH counterparts prior to his/her recruitment. Qualifications for the coordinator are summarized below:

PHR Coordinator: The successful candidate for the *Coordinator* position must have extensive technical experience in family planning and maternal and child health activities and issues in Morocco. Ideally, the candidate will have, at a minimum, an MA in Economics or a relevant field, experience working independently as a consultant or contractor for USAID or another donor agency in Morocco, and be trilingual (French, Arabic and English). The candidate should also have strong written, oral and presentation skills and have demonstrated good interpersonal skills in a highly sensitive political environment.

PHR's local Coordinator will report directly to Cheri Rassas, PHR's Deputy Director for Operations and Officer in Charge, for general direction and supervision, and will coordinate with other members of PHR's ANE management team based in Bethesda per the Management Plan outlined below. PHR proposes that, with MOH approval, the local Coordinator maintain the office of PHR's resident advisor in the MOH and be provided with a computer and printer (already

²Dan Kress, PHR economist, visited Morocco for ten days in December 1997 to conduct estimates of the demographic and financial impact of the Moroccan family planning program, which were used in the "dossier".

procured for PHR's long-term advisor) and telephone in order to effectively carry out his/her role of coordination and liaison. The Coordinator will establish a work schedule at the MOH, and set up regular meetings at USAID and with MOH counterparts to ensure information flow, progress reports and updates on PHR's activities.

If for any reason a suitable candidate cannot be found, PHR will continue to manage the activities from its home office in Bethesda under the supervision of the Deputy Director for Operations.

5.3 U.S.-Based Staff

U.S.-based staff will provide both technical and managerial support and oversight to PHR's local Coordinator and all technical assistance identified in the work plan activities. The U.S.-based staff will consist of the following personnel:

- ▲ The **PHR Deputy Director for Operations**, Cheri Rassas, will be the Officer in Charge and will have overall responsibilities for PHR's activities in Morocco.
- ▲ The **PHR ANE Coordinator**, Jean-Jacques Frere, will be responsible for the technical quality control of all PHR activities, coordinating with other U.S.-based donors working in Morocco, providing technical support in planning and implementing field activities, reviewing technical work and monitoring progress.
- ▲ The **Program Officer** for Morocco, Phara Georges, will carry out the day-to-day management of the project from the U.S., including (1) serving as PHR's point person for all project activities and the main contact for the local Coordinator, (2) helping to identify and field appropriate staff and consultants for field visits, (3) liaising with USAID/Washington, (4) assuring that all reports and other products are submitted as scheduled, and (5) providing overall managerial, coordinating, and administrative support to the local Coordinator and international and Moroccan consultants. This Program Officer is fluent in French and has extensive experience in management of USAID projects, management of consultants and subcontracting arrangements, USAID's competitive procurement regulations, and has strong financial analysis and management skills.
- ▲ Other **technical personnel** to conduct short-term assignments. These resources may include PHR's technical staff, consultants, research analysts, and the PHR Technical Director, who will provide overall technical guidance, as needed.

5.4 Reporting

PHR has established procedures for maintaining communications and reporting both within PHR and with its clients. The PHR local Coordinator will communicate on a regular basis with PHR's home office, the MOH and USAID/Morocco staff to keep them informed of project plans and activities, and to ensure their input into PHR activities and coordination with other CAs. As indicated in the Management Plan above, PHR's home office will work closely with its local Coordinator to maintain up-to-date information on the status of all activities. PHR's home office

will be responsible for submitting quarterly reports to USAID/Morocco, as well as annual reports and revised work plans.

06. Evaluation Plan

PHR's performance will be measured against the objectives, and target dates set out in this CAP. PHR management will internally review the progress of the Morocco CAP activities each quarter with the task manager, and the results of these reviews will be incorporated into PHR quarterly reports and performance assessments. PHR will also review the progress of our activities with the COTR for PHR, USAID/Morocco, MOH officials, consultants, and local counterparts at regional institutions. Any recommendations and changes will be made in collaboration with MOH officials, USAID, and PHR management.

07. Training Plan

7.1 Training for Results

Training is a result-based outcome of PHR's strategy to support USAID/Morocco's Policy Objectives under IR 1.2: Improved policy environment supporting FP/MCH services. PHR will conduct a series of training activities to support the following USAID/Morocco Policy Objectives:

Objective 3: Improve the population's access to affordable, appropriate high quality FP/MCH services providers, and *Improve the regulatory framework which affects the use of health personnel in the public and private sector*; **Result 3.1 New codes/regulations drafted.**

Training Activities to Support Objective 3, Result 3.1:

- ▲ ***Study and Observation Tour*** for two to three staff members of the Department of Legal Affairs, Ministry of Health. *Training Objective:* To provide examples of other host countries that have gone through the process of legislative reform to liberalize paramedical providers.
- ▲ ***Conference*** for one participant from Direction de la Planification et des Ressources Financiers to attend the European Francophone International Confederation for Midwives Conference in Montpellier, France. *Training Objective:* To obtain technical updates on midwifery practices, and participate in discussions designed for midwives from developing countries to exchange information and experiences, and acquire tools for improving service delivery and quality of care.

Objective 5: Assure Financial Sustainability of FP/MCH Services after USAID bilateral assistance ends in 1999. *Diversify the resource base for FP/MCH services.* **Result 5.1: Improve the capacity of MOH to manage its diverse resource base.**

Training Activities to Support Objective 5, Result 5.1:

- ▲ ***National Health Accounts (NHA) Workshop II***, March 1999. *Training Objective:* For the NHA team from Morocco to discuss problems, share findings, and consult with outside technical experts. This workshop will serve as a Follow-on to an Initial Planning and Training Workshop which took place in May 1998 in Amman, Jordan. The first workshop focused on basic concepts of the NHA, how to estimate expenditures for the major account categories, and use of the NHA software application developed by PHR.

- ▲ ***NHA Workshop III***: A final workshop to present estimates, discuss experiences, and recommend follow-up activities.

- ▲ ***Regional Training Courses*** in Health Economics in Collaboration with the Association Maghrebien des Economistes. *Training Objectives*: The purpose of this activity is to conduct regional training in health economics for the Maghreb Region. This activity will be undertaken in collaboration with the Reseau Economie de la Sante Maghrebien (RESSMA) and other local groups as appropriate. The plan is to develop and conduct training for 10-15 Moroccans, as well as other participants from the Maghreb, once a year in 1998 and 1999, respectively.

7.2 Training Program Development

Each scheduled training activity will be conducted with substantial involvement from PHR consultants, local Moroccan consultants, and the Ministry of Health. The involvement of Moroccan experts will help ensure that all training activities will be grounded in the Moroccan context.

7.3 Reporting

PHR will prepare reports on the outcomes of all training events in support of the Morocco CAP, including dates, purpose, number and gender of participants trained, results of training, and lessons learned for future PHR training implementation.

7.4 Monitoring and Evaluation

PHR will administer mid-program, end-of program and post-program evaluations as appropriate to measure the results of training.

Annex A: SO1-Population Health/Table Drafted by Helen Soos

Donor	Program	Recipient Agency	Objective/Region	Output	Dates	Budget
World Bank	PRISS: Health Sector Investment	Ministry of Public Health	Improve provincial Health Services	-Rural and provincial hospital construction -Material/training	1992-1998	104.00
World Bank	Social Priorities Program: BAJ Basic Health	Ministry of Public Health	Improve access to curative and preventive health services in 20 poorest provinces	-TB/respiratory, STD, rural hygiene -Provide medicine/contraceptives -Safe motherhood	1996-2001	68.00
World Bank	Health Financing and Management (DFGSS)	Ministry of Public Health	Expand integrated FP/MCH and AID/STD services	-MIS for hospital -Legal and financial framework -Health insurance system -Pilot for medical indigents	1998-2004	60.00
European Union	Health/Pop	Ministry of Public Health	Expand integrated FP/MCH and AID/STD services	In design stage	1998-2004	18.80
EU	Support for Maternal and Neonatal health 20 provinces	Ministry of Public Health	Improve Coverage, quality and supervision of prenatal care, pregnancy, child birth and new born	-physical, material infrastructure -Management -Operational research	1997-2001	8.00
EU	AIDS/15 provinces	Ministry of Public Health	Improve treatment and prevention of AIDS through surveillance and syndromic treatment	-Treatment standards-312,000 cases -Training -National Strategy	1996-2001	1.00
UNFPA	Family Planning/Pop. Policy/Demographic census	Ministry of Public Health Ministry of Population, and NGOs	-Improve reproductive health -Population statistics, policy and development	-Integrated health services -Demographic survey, etc.	1997-2001	8.00
UNFPA	Advocacy, Education, Analysis	Ministries of Public Health, Population,	-Advocacy for women and population issues, through NGOs, schools, etc.	-Population in school curriculum -Gender analysis -Environment protections	1997-2001	11.00

UNICEF	Advocacy, IEC	NGOs, Ministries	Mobilize activities to promote children	Documentation, information, dissemination	1997-2001	1.66
UNICEF	Primary Health Care	Communities local and central government	Insure adequate health care for 600,000 people	-Expand health services -Strengthened management -Access to essential drugs - Cost recovery/ funding	1997-2001	4.39
UNICEF	Complementary Programs	Rural districts, NGOs, governments	Focus in Al Haouz, Essaouira, Ourzazate Provinces: cities of Casa, Rabat-Salé Tanger, Fes, Marrakech	-water -sanitation/hygiene -urban -poor-women	1997-2001	9.50
Japan	Aid to Local Grassroots Projects (APL)	Local associations, institutions, schools	To respond to local grassroots requests (non governmental)	-Rural health/ Ambulances -Social Marketing -Construction/ renovation -SIDA education -Hospital/clinic equipment	Annual	0.30
Spanish	Health clinics/Hospital support	Clinics/hospitals	Improve health services	-8 clinics built/ expanded -Energy, X-Ray and other services established/improved -4 NGOs strengthened in FP, Mothercare, water/ sanitation.	1996-1998	0.08
Germany GTZ	Family Planning	Ministry of Public Health	-Improve access to basic health -Essaouira region	-Long term advisor -FP services -Maternal/Child Health	1995-1999	2.45
Africa Development Bank	Reinforcement of Rural Health Care	Ministry of Public Health	-Improve rural health	-Infrastructure -Provision of essential drugs, vaccines, supplies	1993-1999	28.92
Arab League	PAPCHILD	Ministry of Public Health	-Demographic survey	Demographic survey	1997	N/A

Annex B: USAID/Morocco- Policy Reform Agenda

POLICY ISSUE	ACCOMPLISHMENTS AND CURRENT STATUS	ACTIVITIES (1998-99)	PARTNERS (USAID-CAs)	PARTNERS (GOM/donors)
1. Phase-over: (Indicator: MOPH accurately predicts and advocates effectively for adequate resources for FP/MCH)				
A. Implement the Phase V contraceptive phase over plan which calls for <i>MOPH financing 100% of public sector contraceptive needs by the end of 1999 to ensure a steady supply of FP products upon termination of USAID bilateral assistance</i>	THIS is THE HIGHEST PRIORITY POLICY ISSUE for USAID and multiple actions by different CAs, USAID and the MOPH are underway. Good progress up to now ,which needs to be continued and include tangible progress indicators.	- Dossier preparation (draft by end of Dec 97, distribution, review in January and half day meeting to suggest revisions and strategize on how/where/by whom to use dossier)	PHR	MOPH -DP, DPRF,

<p>Indicator: Proportion of operating costs associated with the USAID FP/MCH program financed by the GOM.</p> <p>Benchmark: Dossier presentation/distribution.</p>	<p>Achievements: -Both GOM and USAID are respecting the engagements outlined in the bilateral agreement (in US dollar terms - the accord is written in US dollars, not percentages). -As a result of lobbying efforts over time, and in particular 2 activities in 1997 (Contraceptive logistics consultation in May 1997 (JSI) and Comite Directeur presentation in July 1997 (PHR) consensus has been reached on the need for the GOM to assume these costs. -Efforts to lobby the GOM for this large budgetary increase are underway, in particular the preparation of a Dossier for the MOPH to present to the rest of the GOM, parliament and other influentials. The dossier will also include a study of the costs and benefits of future investments in FP. -Efforts to identify and judge options to decrease the cost of contraceptives procured with GOM resources (e.g. tax waivers or reductions (see below) , multi year contracts, possible UNFPA purchases) (Local cost study in Sept 1997 (JSI).</p> <p>Comments: Because of the increased cost to the GOM of procuring contraceptives themselves, the GOM budget for contraceptives will need to be increased from \$3 million in 1998 to at least \$6 million in 1999 and then continue increasing slowly until it stabilizes at around \$7-9 million in 2005. The proposed UNFPA project (1998-2001) includes approximately \$2 million in contraceptives for 2000 and 2001 which should provide some relief in the immediate post-transition period. Related efforts to strengthen the contraceptive logistics projection and procurement system should be pursued as well (see logistics workplan).</p>	<ul style="list-style-type: none"> - Cost-benefit analysis (Dec 97) - Dossier presentation/distribution - Summary of phase-over experiences in other countries - Study tour - Target -cost training and study (projections per year and per sector) - Annotated bibliography on FP/MCH research - Procurement options study and presentation - Follow up of Tulane studies? PAPCHILD? -Fall back actions if dossier isn't successful - conference? Others? 	<p>"</p> <p>"</p> <p>JSI</p> <p>JSI</p> <p>POLICY</p> <p>JSI</p> <p>JSI</p> <p>Measure? Others?</p> <p>TBD</p>	<p>CERED</p> <p>"</p> <p>"</p> <p>MOPH -DP</p> <p>TBD</p> <p>MOPH- DP, DPRF, SAIS, INAS?, CERED</p> <p>MOPH, INAS</p> <p>MOPH - DP</p> <p>MOPH - DP, DPRF, SAIS</p> <p>TBD</p> <p>Other donors: UNFPA, World Bank</p>
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<p>B. Assure 100% procurement of public sector vaccine needs for the EPI program.</p> <p>Indicator: MOPH continues to replenish at 100% the vaccine revolving fund.</p>	<p>History of VII (Vaccine Independence Initiative):</p> <p>Morocco has been the most successful of the handful of countries that have adopted the VII. The VII was signed between Morocco and UNICEF in 1992. In 1994, USAID contributed \$600,000 to the vaccine revolving fund for Morocco and in 1995 added another \$500,000, which left the US contribution to the fund at \$1,100,000. (USAID/Rabat contribution of \$900,000 and \$200,000 from USAID/Washington). With the signing of the VII, the GOM's financing of public sector vaccine needs increased from 50% in 1992 to 80% in 1993 and to 100% by 1994. Since 1995, the VII has been used to procure essential vaccination equipment (such as sterilization equipment, syringes and cold chain equipment) as well as vaccines. Vaccination coverage rates are high; by 1995, 85% of infants 12-23 months were fully vaccinated (BCG, measles, and 3 doses of DPT and polio) (EPPS, 1995).</p> <p>In summer 1997, USAID received a request from the MOPH to increase USAID's contribution to vaccine revolving fund to ensure that vaccines would be available for the national immunization days planned for October and November. After discussions with UNICEF, it was determined that instead of increasing the fund,</p>	<p>-Monitoring that GOM continues to replenish at 100% the vaccine revolving fund and monitoring immunization coverage rates for target diseases.</p> <p>- Identifying and helping to remedy problems.</p> <p>- Activities aimed at simplifying or streamlining administrative procedures as part of 1998-99 workplan.</p>	<p>JSI?/PHR?</p> <p>JSI?/PHR?</p> <p>JSI?</p>	<p>MOPH - DP</p>
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<p>C. Reduce administration and customs costs for imported FP/MCH commodities</p> <p>Indicator:</p> <p>Import tax waivers or reductions granted for public health commodities (contraceptives, vaccines, others).</p> <p>Benchmark:</p> <p>Import tax waivers or reductions granted for contraceptives.</p>	<p>Import tax waivers or reductions on procurements of contraceptives, vaccines and other public health commodities:</p> <p>Achievements:</p> <ul style="list-style-type: none"> -Discussions between PHR, G/PHN and MOF took place in 1996 re: contraceptives, vaccines and other public health commodities. - MOPH requested and received tax reductions and waivers for vaccines in July 1997. The 1997/98 Code des Douanes, Loi de Finance includes the following provisions for vaccines, which decreased the price of vaccines by 33%: 1) Customs tax (droit de douane) reduced from 25% to 2.5% of the price of the goods 2) Import tax (prelevement fiscal a l'importation - PFI) eliminated. It previously was 12% of the price of the goods and 3) Value added tax (VAT) (tax a la valeur ajoutee-TVA) reduced from 20% to 7% of (price + customs tax + import tax). - Tax-waiver multi-country survey by PHR in process, completion date Dec 1997. <p>Comments: Taxes on vaccines have been reduced. The MOPH decided to not try to include contraceptives as part of the 1997/98 request, since the likelihood of a favorable response for contraceptives was lower than that for vaccines (and some other medical products, such as blood), and the MOPH did not want to jeopardize the possibility that these other commodities would receive an unfavorable response. Tax reductions on contraceptives may be more difficult, but continue to be pursued, along with other efforts to reduce the cost of imported commodities (described below) and locally procured commodities (described in phase-over section - above).</p> <p>Storage and associated charges which accumulate while commodities clear customs procedures:</p> <p>Comments: The MOPH currently spends a fair amount of money (to be quantified as part of Oubnichou's final report) on storage and associated charges for contraceptives and vaccines which accumulate while imported commodities remain in custom's hands while waiting for administrative procedures to be completed. These costs are a net transfer from one part of the government (MOPH) to another (Customs) and there are currently no incentives for the goods to clear customs quickly. These procedures are also a drain on MOPH personnel time, since the personnel responsible also have other responsibilities. Efforts to reduce these unnecessary costs would be useful TA and would help reduce the overall cost to the MOPH for the FP/MCH program.</p>	<p>- Tax-waiver multi-country survey by PHR in process, completion date Dec 1997, results will feed into dossier and discussions with MOF, who requested that the experience of other countries granting these same tax waivers or reductions would help them justify a favorable decision in Morocco</p> <p>TBD</p>	<p>PHR</p> <p>JSI</p>	<p>MOPH, MOF</p> <p>MOPH</p>
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<p>D. Diversify resource base for FP/MCH services</p> <p>Indicator:</p> <p>Private sector Gps trained/certified to provide target (define) FP/MCH services as % of all private sector GPs.</p> <p>Benchmarks:</p> <p>Strategy to increase the role of the private sector in providing key FP/MCH services formulated and implemented.</p> <p>Increased public sector capacity to plan and implement financing reforms as evidenced by (add tangible outcomes if this additional benchmark is desired)</p>	<p>Public Sector: These efforts are focused on the financial sustainability of public sector FP/MCH services, in terms of the MOPH's capacity to deal with financing issues, the client's ability to pay for part or all of the cost of these services, third party payers.</p> <p>Achievements:</p> <ul style="list-style-type: none"> - Previous USAID assistance in early 1990s with financing of health services. - Completion of Tulane household expenditures study - by Dec 1997. <p>Comments: A National Health Accounts exercise is needed for Morocco to help put contraceptive and FP/MCH budgetary needs in the context of overall MOPH budgetary needs and priorities and to help advocate effectively in discussions with MOF and others. Other financing reforms that Morocco is considering or undertaking will also have an impact on providing incentives or disincentives for the population to use FP/MCH services. A trend toward promoting client participation in the financing of health services is apparent and it will be necessary to ensure that essential FP/MCH services are explicitly included in these plans.</p> <p>Private Sector: Estimations which form the basis of the phase over plan include assumptions that the private sector role in providing FP services and supplies will increase from approximately 40% currently to 60% by 2005. Specific activities to encourage the private sector to assume a larger role in FP/MCH service provision, particularly for those groups of the population who can pay for private sector services, are being pursued and should be strengthened.</p> <p>Achievements:</p> <ul style="list-style-type: none"> -SOMARC project activities and accomplishments -Earlier JSI Phase V project had a public/private partnership component, which was streamlined in the 1997 workplan to focus on the general practitioners training only. - Ongoing training of private sector MDs (generalists) in FP. The purpose is to increase private provision of FP services. -Activities to establish a common vaccination calendar for public and private providers: Public/private consensus conference on vaccination calendar in July 1997 and follow up regional meeting in Casablanca on November 30. <p>Comments: Currently, trained private providers are not allowed to</p>	<ul style="list-style-type: none"> - National Health Accounts exercise to provide baseline data on sources and expenditures in the health sector and a starting point for decision making for resource diversification. - TBD -Other financing issues related to Phase-over, such as ensuring or monitoring that FP/MCH services are included in insurance plans, other social insurance, determining prices of FP/MCH acts, etc. Leveraging the resources in the new World Bank loan for the health sector in this area could bring substantial dividends to the GOM and USAID. -Market private sector general practitioners who have successfully completed MOPH trainings. -Market segmentation study and follow up consensus building on the future roles and responsibilities of the private sector in FP -? Journee de reflexion with pharmaceutical industry on FP 	<p>PHR</p> <p>PHR</p> <p>JSI, SOMARC</p> <p>POLICY (The Futures Group)</p> <p>POLICY (The Futures Group)? JSI?</p>	<p>DRPF</p> <p>DRPF</p> <p>Donors: World Bank, EU, UNFPA has planned a "willingness to pay for FP" study as part of its 1997-2001 project.</p> <p>MOPH, private sector</p>
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<p>E .Advocacy: Dialogue with the key partners and influentials to enable the MOPH to intensify its efforts to inform and sensitize the public and decision-makers to FP/MCH issues</p> <p>Benchmark:</p> <p>Signed convention between MOPH and Ministry of communications for free or reduced air time for TV and radio spots.</p>	<p>Obtain free or reduced cost air time for TV and radio public health spots from the Ministry of Communication and private media concerns:</p> <p>Achievements:</p> <ul style="list-style-type: none"> -1996 discussions between USAID G/PHN, PHR and POLICY team and the Ministry of Communications (MOC) showed that MOC was interested and favorable. -MOPH negotiations for reduced cost/free air time for certain media time (with JSI assistance) since then. -MOPH has drafted a convention with MOC to guarantee free and reduced cost access, expect it to be signed before the end of 1997. <p>This issue is currently at the implementation stage (stage #5 on the USAID assessment of progress grid), since free and reduced air time is currently being given to the MOPH. It will be institutionalized through a formal government agreement (MOPH and MOC) by the end of 1997. So this issue should be achieved at 100% by the end of calendar year 1997.</p> <p>Advocate at high levels to promote efforts to reduce maternal mortality.</p> <p>Achievements:</p> <ul style="list-style-type: none"> - Efforts (maternal mortality play, materials for decision makers, film, lobbying, press conference, etc) have been very successful in raising awareness. Her Highness Princess Lalla Fatima has taken a special interest in this issue and graciously presided over a command performance of the maternal mortality play at the National Theater Mohammed V in September. HM the King Hassan II has also spoken on the issue publicly in his address for National Vaccination day in October 	<p>Monitor implementation in IEC program.</p> <p>TBD in 1998-99 workplan.</p>	<p>JSI</p> <p>JSI</p>	<p>MOPH -DP/IEC, MOC</p> <p>MOPH-DP/IEC, NGOs</p>
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3. Human resource reform:				
<p>Advocate for increased GOM resources and commitment for the training and placement of greater numbers of midwives for the improvement of maternity services throughout the country</p> <p>Indicator: Ratio of the number of midwives to the number of women of reproductive age.</p> <p>Benchmark: Percent of graduated midwives who are posted in public sector positions.</p>	<p>-First class of midwives (206) graduated in July 1997 from the recently established 3 year midwifery program. Another 198 are expected to finish in 1998. Up to 1995, the number of midwives trained per year was very small (only 3-25 per year).</p> <p>- The MOPH is committed to absorbing as many of these newly graduated midwives into the public sector as the government budget will allow by the end of 1997. Their employment possibilities in the private sector will be greatly enhanced with expansion of the roles and responsibilities of paramedical personnel. (See next issue)</p> <p>-Comment: Advocacy efforts successful - issue near completion.</p>	<p>100% complete on training, need to monitor final decision on postings at beginning of 1998.</p>	<p>PHR</p>	<p>MOPH - DRH. DP</p>
<p>Revise <i>roles and responsibilities of paramedical personnel (and perhaps pharmacists) to improve service coverage in under-served areas and work to assure a certain legal status for private independent paramedical providers.</i></p>	<p>Comment: This issue is the logical follow up to the midwife training issue (above). The main limiting factor to midwives and other paramedical personnel practicing in under-served areas are the rules and regulations that limit what procedures and acts they can perform (particularly in private independent practices) without direct MD supervision. The MOPH already has experience in revising rules and regulations governing GPs, and this experience can be built upon for paramedical personnel.</p> <p>-Accomplishments:</p> <p>The 1994 review of laws and rules pertaining to provision of FP services is a good reference for human resource roles and responsibilities, at least in the area of FP (June 1994 and Nov 1995 summary).</p> <p>The ability of pharmacists to prescribe oral contraceptives should also be considered.</p>	<p>- A review similar to the 1994 review of laws and rules, but this time pertaining to all FP/MCH services and focused on overall roles and responsibilities of paramedical staff (and pharmacists) to determine needed reforms in personnel roles and responsibilities.</p> <p>-Other activities TBD with Mme. Meshak.</p>	<p>PHR PRIME (revising pre-service curricula for paramedical staff)</p>	<p>MOPH - DRC, DP, AMSF, L'Ordre de Mediciens</p>

4. Quality Assurance policy and support:				
Elaborate, validate, and disseminate FP, EOC, IMCI <i>service standards and clinical protocols, to ensure that these services are rendered under optimum conditions</i>	<p>-Clinical protocols developed: FP standards finished in 1992 currently being updated; MOPH/WHO/UNICEF standards for maternity and neonatal care published in 1996, training manuals for EOC and life saving skills completed in 1997; standards for diarrheal diseases in 1992 and ARI in 1993. IMCI in process. Clinical service standards for VSC, IUD and injectables will be completed by end of 1997.</p> <p>-Comment: Issue near completion in terms of clinical standards developed, but focus needs to change to dissemination of current protocols in public sector (JSI) and in private sector (SOMARC). Focus of issue should move to dissemination of protocols, establishing and implementing quality standards, and ensuring that quality standards are followed at health facility level.</p>	<p>- Most standards developed as part of training modules for FP, EOC or IMCI</p> <p>- Pre-service education efforts also have standards component</p>	<p>JSI</p> <p>PRIME</p> <p>SOMARC - distribution of standards in private sector</p>	
Institutionalize the use of maternal audits for all maternal deaths that occur in public health services	The MOPH is currently working on this issue and expects that this could contribute greatly to efforts to reduce maternal mortality.	TBD	?	MOPH - DP, CHU, others
Endorse the principle of <i>medial profession recertification requirements (e.g. via continuing education credit) for the provision of FP/MCH services</i>	Some information on this, but I haven't researched it thoroughly.	TBD	<p>JSI (through the Quality Assurance activities)</p> <p>FPMD is also working on trainings that could serve as initial courses to offer CME credits.</p>	

Annex C: USAID/Morocco-Policy Reform Identification

Strategic Objective # 1

Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services

Policy Issue: Contraceptive phase-over plan

Policy Reform Objective: Maintain high levels of contraceptive prevalence as USAID funding for operating expenses for the FP program is phased out.			
Problem Statement: Implement the Phase V contraceptive phase-over plan which calls for MOPH financing 100% of public sector contraceptive needs by the end of 1999 to ensure a steady supply of FP products upon termination of USAID bilateral assistance.			
Background/rationale: USAID has funded the majority of the Moroccan FP program for the past 25-30 years. USAID bilateral assistance in PHN is scheduled to end in December 1999. Experience in other countries shows that contraceptive prevalence rates are likely to decline when major donor resources decline unless certain measures are in place to ensure sustainability. Sufficient budget allocations for operating expenses are key and USAID has a responsibility to assist the MOPH in lobbying for increased GOM budget allocations for FP.			
Key counterpart/stakeholders: Ministry of Public Health, Ministry of Population, CERED, Ministers and high level officials of the GOM; key parliamentarians, other donors (especially UNFPA, EU, World Bank), AMPF (local IPPF affiliate), pharmacists, pharmaceutical lobby, health care workers, health care lobbies, households			
Indicator: Proportion of operating costs associated with the USAID FP/MCH program financed by the GOM.			
Benchmark: Presentation and distribution of a Dossier by the MOPH to the GOM to lobby for sufficient GOM funding of the public sector FP program.			
Key Steps	Means of Verification	Plan	Completed
Identification (10%)	N/A		
Formulation (10%)	Cost benefit study completed (PHR report)	Dec 97	Dec 97
Validation (20%)	Dossier developed with MOPH and other stakeholders (PHR report)	Dec 97	Dec 97
Adoption (20%)	Dossier presented to GOM (PHR report); GOM allocates additional budget for 1999 (PHR report, GOM budget)	Feb 98 July 98	
Implementation (40%)	GOM assumes increasing % of operating costs of FP program; 100% by January 2000 (R4 indicator, MOPH/USAID yearly submission)	Jan 2000	

Comments on achievements: The MOPH and the Ministry of Population have demonstrated an increased commitment this FY to working with USAID to achieve this policy objective. The MOPH continues to increase its financial contribution to the FP program; for contraceptives alone, the MOPH spent \$1.453 million in 1997. However, analyses conducted this year show that resources in addition to the regular MOPH budget will need to be mobilized to make up for decreases in USAID assistance over medium and longer term, since the current MOPH budget (<5% of the total government budget and equal to less than \$12 per person) is much too limited to absorb these additional needs. Thus, efforts which originally were meant to lobby the MOPH for additional resources are now redirected to assisting the MOPH (and other supportive stakeholders) to lobbying the GOM for additional resources for the MOPH to implement the public sector FP program. In addition, complementary efforts are underway to increase the private sector contribution to the FP program.

Multiple activities to achieve this policy objective are planned for FY'98 and FY'99 through the Partnerships for Health Reform (PHR), POLICY, and JSI (bilateral) projects. In addition to the dossier and lobbying efforts, these currently include: a summary of phase-over experiences in other countries, study tours to other countries where USAID is phasing out of PHN, a procurement options analysis and presentation, a target-cost study and trainings to estimate contraceptive needs by source (public/private) until the year 2010 and to develop local capacity to conduct these analyses in the future and an annotated bibliography on FP/MCH research in Morocco.

Strategic Objective # 1
 Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services
 Policy Issue: Vaccine procurement

Policy Reform Objective: Maintain high EPI coverage rates (by 1995, 85% of infants 12-23 months were fully vaccinated against the major childhood illnesses) independent of outside donor support.

Problem Statement: Continue to assure 100% procurement of public sector vaccine needs for the EPI program, as Morocco moves beyond its current reliance on a vaccine revolving fund arrangement (with UNICEF and USAID assistance) to a second level of assuring ongoing sustainability of vaccine supply through direct government procurement.

Background/rationale: Morocco has been the most successful of the handful of countries that have adopted a revolving fund arrangement for the purchase of public sector vaccine needs, referred to as the Vaccine Independence Initiative (VII). The VII was signed between Morocco and UNICEF in 1992 - at that time there were no local pharmaceutical companies in Morocco capable of providing an uninterrupted and adequate level of high quality vaccines to meet the needs of the public sector vaccine program. USAID contributed \$1,100,000 to the fund in 1994 and 1995. With the signing of the VII, the GOM's contribution to the financing of public sector vaccine needs increased from 50% in 1992 to 80% in 1993 and to 100% by 1994. Since 1995, the VII has been used to procure 100% of public sector vaccine needs as well as essential vaccination equipment (such as sterilization equipment, syringes and cold chain equipment). Vaccination coverage rates are high; by 1995, 85% of infants 12-23 months were fully vaccinated (BCG, measles, and 3 doses of DPT and polio) (EPPS, 1995). The VII was always meant to be a medium term solution to the vaccine procurement problem; in the last year, the MOPH has identified several issues/concerns with the revolving fund and has also noted that local pharmaceutical companies may now be able to provide an adequate quantity of high quality vaccines at competitive prices to the MOPH. The MOPH has requested USAID assistance to help them determine the best long term strategy for moving from the VII to long term sustainability through direct government procurement and the possible addition of new vaccines.

Key counterpart/stakeholders: MOPH, UNICEF, local pharmaceutical companies, pharmaceutical lobby, health care workers, health care lobbies, households

Indicator: Assure that a mechanism is in place to meet 100% of public sector vaccine needs.

Benchmark: Plan for continued financing of the EPI program (post Vaccine Independence Initiative) developed.

Key Steps	Means of Verification	Planned	Completed
Identification	N/A		
Formulation	N/A		
Validation	Identify current constraints in vaccine financing mechanism (VII - vaccine revolving fund) (PHR report)	Sept 98	

Adoption	Plan for continued financing of the EPI program (post Vaccine Independence Initiative) developed. (PHR report, copy of plan)	Dec 99	
Implementation	Plan for continued financing of the EPI program (post Vaccine Independence Initiative) implemented.	2000	
<p>Comments on achievements: The GOM and USAID met the objective for this policy issue by 1995, with the design and full implementation of the VII. Continuation of the VII assumes a continued reliance on outside donor assistance for procurement and competitive pricing. However, because of recent developments in Morocco, the MOPH is interested in moving beyond that mechanism to ensuring 100% direct government procurement of vaccine supply.</p>			

Strategic Objective # 1

Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services

Policy Issue: Administrative/customs costs

Policy Reform Objective: Reduce the unnecessary and often substantial costs of taxes and other administrative costs associated with the purchase of imported essential FP and MCH commodities. Decrease the total cost of locally (GOM) purchased imported contraceptives and vaccines. Increase the purchasing power of the MOPH for imported contraceptives and vaccines.

Problem Statement: Reduce administrative and customs costs for imported FP/MCH commodities.

Background/rationale: Import taxes and customs duties are waived for donated commodities (i.e. contraceptives and vaccines). When these same products are purchased directly by the GOM, substantial taxes and import duties greatly increase the cost of these same products to the GOM (all import taxes and duties combined to about 57% of the price of vaccines and slightly less for contraceptives in early FY'97). As the GOM purchases more and more of its own contraceptives (nearly 50% of needs by FY'98 and 100% by FY'00), these costs become more significant and greatly decrease the purchasing power of the MOPH for these essential commodities. In addition to taxes, the MOPH currently spends a fair amount of money on storage and associated charges for contraceptives, vaccines and other commodities which accumulate while these imported goods remain in custom's hands while waiting for administrative procedures to be completed. These costs are a net transfer from one part of the government (MOPH) to another (Customs) and there are currently no incentives for the goods to clear customs quickly. These procedures are also a drain on MOPH personnel time, since the personnel responsible also have other responsibilities. Efforts to reduce these unnecessary costs would help reduce the overall cost to the GOM for the FP/MCH program.

Key counterpart/stakeholders: Ministry of Public Health, Ministry of Finance, ONEP, port authorities, local pharmaceutical companies, local Pharmaceutical Lobby, international pharmaceutical companies, private health care providers, pharmacists, households

Benchmark: Tax waiver or reductions granted for vaccines (completed 7/97) and contraceptives.

Key Steps	Means of Verification (for contraceptives only, since vaccines are at 100%)	Planned	Completed
Identification	Local market study completed (JSI report)	Oct 97	Dec 97
Formulation	World-wide survey completed and presented to MOPH (PHR report) Administrative/port charges for USAID purchases documented (JSI report)	April 98 June 98	
Validation	Tax code and administrative changes proposed to MOF and other decision makers (PHR report)	Dec 98	
Adoption	Tax code changes (PHR report, GOM tax codes)	June 99	
Implementation	New tax codes implemented (GOM tax codes)	July 99	

Comments on achievements: - As a result of USAID supported efforts, import tax waivers and reductions for vaccines agreed to and specified in the 1997-98 Code des Douanes, Loi de Finance, July 1997. The following provisions are now included: customs tax reduced from 25% to 2.5%; import tax of 12% eliminated; VAT reduced from 20% to 7%. The MOPH decided to not try to include contraceptives as part of the 1997/98 request, since the likelihood of a favorable response for contraceptives was lower than that for vaccines (and some other medical products, such as blood), and the MOPH did not want to jeopardize the possibility that these other commodities would receive an unfavorable response.

Tax reductions on contraceptives may be more difficult, but continue to be pursued. Activities planned for FY98 and 99 include: completion of a multi-country survey on tax waivers and reductions for contraceptives, vaccines and other public health commodities. Results will feed into discussions with the Ministry of Finance, scheduled for the 2nd and 3rd quarters of FY '98. In addition, efforts to document administrative holdups and costs are underway and will be used to inform lobbying efforts to streamline customs procedures.

Strategic Objective # 1

Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services

Policy Issue: Diversify resource base

Policy Reform Objective: Assure financial sustainability of FP/MCH services after USAID bilateral assistance ends in 1999.			
Problem Statement: Diversify resource base for FP/MCH services (particularly by expanding the role of the private sector).			
<p>Background/rationale: Private Sector: Estimations which form the basis of the phase over plan include assumptions that the private sector role in providing FP services and supplies will increase from 37% in 1995 to 56% by 2005. Specific activities to encourage the private sector to assume a larger role in FP/MCH service provision, particularly for those groups of the population who can pay for private sector services, are being pursued and will be strengthened. They include a market segmentation study of FP services using DHS data to better understand the profile of clients served by public and private sector providers and follow up consensus building on the future roles and responsibilities of the private sector in FP. Previous USAID supported assistance included a public/private partnership component in the JSI Phase V project, which was streamlined in the 1997 workplan to focus primarily on the private sector general practitioners training, in order to increase private provision of FP services. SOMARC assistance includes social marketing of contraceptives will also continue during the phase-over period. Other private sector work is also planned to contribute to a private sector assessment which will lead to a strategy to increase the role of the private sector. Public Sector: Previous USAID assistance in early 1990s with research on financing of health services and development of early insurance plans. Current efforts are limited to increasing the MOPH's capacity to deal with financing issues, by helping them to conduct a National Health Accounts exercise and by providing training in health economics. National Health Accounts are needed to provide baseline data on sources and expenditures in the health sector, as a starting point for decision making for resource diversification, to help put contraceptive and FP/MCH budgetary needs in the context of overall MOPH budgetary needs and priorities, and to help the MOPH advocate effectively in financial discussions with MOF and other decision makers and donors. The World Bank and EU are currently discussing plans to provide assistance to the MOPH relative to other financing reforms under consideration in Morocco, which will potentially have an impact on the use of FP/MCH services, including health insurance reform and possible public sector cost recovery.</p>			
Key counterpart/stakeholders: MOPH, local network of health economists, households, private sector providers (generalists, Ob/Gyns, midwives, nurses), pharmacists, local pharmacy lobby, World Bank, EU			
<p>Benchmarks: Private Sector: Market segmentation study completed in order to form a basis for the development of a strategy to increase the role of the private sector in providing key FP/MCH services.</p> <p>Public Sector: Increased public sector capacity to plan and implement financing reforms as evidenced by a completed National Health Accounts (NHA) exercise.</p>			
Key Steps	Means of Verification	Planned	Completed
Identification	N/A		
Formulation	(POLICY and PHR workplans)	March 98	
Validation	Market segmentation study complete (POLICY report)	Dec 98	
	National Health Accounts (NHA) report complete (GOM/PHR report)	March 99	
Adoption	Private sector strategy developed	June 99	
Implementation	Private sector strategy implemented	2000-01	
Comments on achievements: New issue.			

Strategic Objective # 1

Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services

Policy Issue: Advocacy

Policy Reform Objective: Convince Moroccans, from high level decision makers to the population at large, of the importance of supporting efforts in FP/MCH.

Problem Statement: Dialogue with key partners and influentials to enable the MOPH to intensify its efforts to inform and sensitize the public and decision makers to FP/MCH issues.

Background/rationale: The two main efforts are to 1) guarantee free or reduced cost air time to the MOPH and 2) advocacy efforts geared toward reducing maternal mortality. **Free or reduced cost air time:** The MOPH spends substantial resources on Information, Education and Communications (IEC) efforts of multiple Divisions of the MOPH to promote a number of different services. Until recently, these efforts were often uncoordinated and duplicative. The MOPH and USAID decided to better coordinate these efforts and to try to reduce the costs for media time by negotiating discounts for all MOPH IEC activities as a package, rather than as separately with different Divisions within the MOPH. These negotiations have been so successful that the MOPH has gone even further to negotiate free or reduced cost air time for TV and radio public health spots from the Ministry of Communication and private media concerns. Recently, the MOPH and the MOC have decided to formalize this arrangement by signing a convention between the two Ministries. This will guarantee the MOPH free or reduced cost air time for public service announcements and other IEC activities to promote better health and the appropriate use of health services, so that these arrangements do not have to be negotiated annually. **Advocate to reduce maternal mortality:** Although child health efforts receive substantial high level support, efforts to reduce maternal mortality, have not historically benefitted equally. High level support is critical to guarantee resources and to put pressure on the government and private providers to act to resolve the unacceptably high levels of maternal mortality (332 maternal deaths per 100,000 live births for the period 1985-1991 and currently estimated at 228 deaths per 100,000 live births in 1997, among the highest levels in North Africa.) In the past year, significant achievements have been made in sensitizing high level decision makers to the enormity of the issue. Current efforts are planned to continue and increase the level of sensitization and to move the discussion towards allocation of resources and dialogue to evaluate and implement solutions.

Key counterpart/stakeholders: MOPH, MOC, high level decision makers, members of the Royal Family

Benchmark: Signed convention between MOPH and Ministry of Communications for free or reduced air time for TV and radio spots.

Key Steps	Means of Verification	Planned	Completed
Identification	N/A		
Formulation	N/A		
Validation	N/A		
Adoption	Draft convention presented by MOPH to MOC (JSI report, copy of draft from MOPH)	Sept 97	Sept 97
Implementation	Signed convention (copy of convention, MOPH)	April 98	

Comments on achievements: Free and reduced air time is currently being provided to the MOPH, in anticipation of signature of a formal convention between the MOPH and MOC. The process is being held up slightly by the elections, which took place in November and constitution of the new government, which just occurred on March 15.

Maternal Mortality Advocacy Efforts (maternal mortality play, materials for decision makers, film, lobbying, press conference, etc) have been very successful in raising awareness. Her Highness Princess Lalla Fatima has taken a special interest in this issue and graciously presided over a command performance of the maternal mortality play at the National Theater Mohammed V in September. HM King Hassan II has also spoken on the issue publicly in his address for National Vaccination day in October.

Strategic Objective # 1

Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services

Policy Issue: Regionalization/decentralization

Policy Reform Objective: Sustain gains in FP/MCH in a newly organized and administered health system.			
Problem Statement: Assist and closely monitor regionalization/decentralization in the MOPH so that gains in FP/MCH will be maintained and improved within this new administrative structure.			
<p>Background/rationale: In 1997, after much discussion and debate over the previous several years, the GOM decided to move ahead with decentralization of political power and of administration of a number of line ministries, including the Ministry of Health. These decisions resulted in a Regionalization Law, which outlined the framework for regionalization (April, 1997) and a Decree, which specified the makeup of 16 geographic regions and provided guidance for implementation of the law (August, 1997). The newly elected Regional Counselors were elected in November, 1997, and line ministries have been working to interpret the law and decree and to determine which roles and responsibilities will stay with the Central and District levels, and which will be designated to the 16 new Regions. Since new Ministers were not named until just last week, as of now, only half of the 16 regions have Regional Coordinators for Health. Administrative structures and determination of initial roles and responsibilities should speed up in the next view months, since the new government and new slate of Ministers were finally appointed on March 15, 1998.</p> <p>Regionalization/decentralization could greatly affect accomplishments in FP/MCH since it will force changes in the role of the central and peripheral structures, and include, for the first time a third regional level. This could completely alter the way in which peripheral services are currently supported. USAID plans to assist the MOPH to manage FP/MCH programs in this new systems and may also help monitor the process of regionalization/decentralization and its impact on FP/MCH indicators in these geographical areas. These activities are still under discussion.</p>			
Key counterpart/stakeholders: 16 Regions, Central and district level MOPH managers and staff, Regional authorities and newly elected officials, health service providers, households			
Note: <i>The benchmarks, indicators and means of verification are still under development. All benchmarks, indicators and means of verification mentioned here should be viewed as illustrative.</i>			
Benchmark: <i>Develop indicators and use to monitor decentralization in pilot regions</i>			
Key Steps	Means of Verification	Planned	Completed
Identification	<i>N/A</i>		
Formulation	<i>Develop indicators to test and means of data collection</i>	<i>Dec 98</i>	
Validation	<i>Use indicators to monitor decentralization in pilot regions</i>	<i>June 99</i>	
Adoption	<i>Evaluate process of decentralization and relation between decentralization and FP/MCH results in pilot regions. Determine best indicators of decentralization to use in MIS. Vet indicators as part of MIS nationwide</i>	<i>Sept 99</i>	
Implementation	<i>"Subsume" indicators into MIS, use information to revise decentralization rules and regulations.</i>	<i>2000</i>	
<p>Comments on achievements: New issue. Decentralization is just getting underway and as of March 15, 1998, only half of the 16 Regions have been officially assigned a Regional Coordinator for Health. Even these 8 are Acting Regional Coordinators, until the new Minister, who was named on March 15, 1998, officially designates Regional Coordinators for all 16 Regions. The fact that decentralization is new and politically motivated provides both challenges to and opportunities for the health sector in general and for FP/MCH programs in particular.</p> <p>Activities supported by USAID will be purposefully limited to a select number (2-4) of the 16 newly formed regions where USAID is supporting pilot activities in MIS, Safe Motherhood and IMCI.</p>			

Strategic Objective # 1

Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services

Policy Issue: Additional midwives

Policy Reform Objective: Reduce the unacceptably high levels of maternal mortality in Morocco by lobbying for additional health care workers trained and capable of providing essential maternity services.			
Problem Statement: Increase GOM resources and commitment for training and employment of greater numbers of midwives in the public and private sector for the improvement of maternity services.			
Background/rationale: Maternal death rates in Morocco are among the highest in the Arab world and much greater than in other middle income countries (a Maternal Mortality Ratio (MMR) of 332 maternal deaths per 100,000 live births 332 maternal deaths per 100,000 live births for the period 1985-1991, MMR currently estimated at 228 deaths per 100,000 live births in 1997 (preliminary data from PAPCHILD, 1998). Rural rates are also much higher than urban rates. One of the main reasons for these high rates and urban/rural disparities is a lack of trained providers in both the public and private sectors to deal with complications of pregnancy and delivery, as well as appropriate prenatal and postpartum care for uncomplicated pregnancies. Midwives have proved to be excellent, cost-effective providers of this type of care in other settings throughout the developing and developed world. Thus, USAID has made great efforts over time to lobby for increases in the numbers of trained midwives and increases in the number of budgetary posts within the public sector for these additional trained providers. In addition, efforts will be undertaken to monitor and promote the employment of private midwives.			
Key counterpart/stakeholders: MOPH, Midwives, physicians, Midwifery Association, Medical Order, pregnant women, households			
Indicator: Number (and percent) of graduated midwives who are practicing midwifery. By March, 1998, these figures are expected to be 180 midwives placed (87% of the total number of midwives graduated in 1997).			
Key Steps	Means of Verification	Planned	Completed
Identification	N/A		
Formulation	N/A		
Validation	N/A		
Adoption	N/A		
Implementation	New, larger class of midwives graduated (MOPH, PHR report)	July 97	July 97
	Decision on posting of midwives made (MOPH, PHR report)	Jan 98	Dec, Jan, March 98
Comments on achievements: The first class of 206 midwives were graduated in June, 1997 following a new midwifery curriculum implemented since 1994 in the 8 paramedical schools in Morocco. Before 1997, the numbers of midwives graduating per year were very small (3-25 per year) and the midwifery program was at the graduate level only. By January 1998, 80 new government posts were created for midwives or nurse midwives, with an additional 100 posts scheduled to be approved by the end of March 1998. The majority of the midwives posted to these new positions come from the class graduated in 1997, although some were selected from the smaller midwifery classes of 1995 and 1996.			
This policy issue is now 100% complete. Monitoring future graduations and postings of midwives in the public and private sector will continue in 1998-1999. Since rules and regulations regarding private midwifery practice currently greatly hinder the ability of midwives to practice independently, thus limiting the population's access to more affordable maternity care, policy efforts on the subject will move in 1998-1999 to human resource reform issues (see p.8). For example, employment possibilities for midwives in the private sector will be greatly enhanced with regulatory reform to expand of the roles and responsibilities of paramedical personnel.			

Strategic Objective # 1

Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services

Policy Issue: Human Resource Reform

Policy Reform Objective: Improve the populations' access to affordable, appropriate, high quality FP/MCH service providers.			
Problem Statement: Improve the regulatory framework which affects the use of health personnel in the public and private sectors.			
Background/rationale: These issues are a logical follow up and expansion of the midwife training and employment issue (p.7 above). The main limiting factor to midwives and other paramedical personnel practicing in under-served areas are the rules and regulations that limit what procedures and acts they can perform (particularly in private independent practices) without direct physician supervision. The MOPH already has experience in revising rules and regulations governing General Practice Physicians and this experience can be built upon for paramedical personnel. A 1994 USAID supported review of laws and rules pertaining to provision of FP services is a good reference for human resource roles and responsibilities, at least in the area of FP. USAID will also assist the MOPH and other provider groups (Medical and Midwifery Societies) to examine and propose revisions to other rules and regulations which affect the delivery of FP/MCH services (for example, private practice and medical ethics rules, breast-feeding, vaccination calendars for the public and private sectors). These activities are designed to both improve service coverage in under served areas and to assure a certain legal status for private independent paramedical providers. In addition, in order to guarantee that practicing physicians keep up their skills and consistently are capable of providing the most recent, high quality FP/MCH services to their patients, USAID will assist the MOPH and local medical societies to determine the mechanisms by which they can implement medical profession recertification requirements (e.g. via continuing education credits for physicians).			
Key counterpart/stakeholders: MOPH, Medical and Midwifery Societies, private providers, doctors, midwives, other paramedical health providers, women of reproductive age, households			
Indicator: New rules and regulations proposed.			
Benchmark: Completed analysis of paramedical rules and regulations.			
Key Steps	Means of Verification	Planned	Completed
Identification	Discussions with MOPH and Policy working group (PHR reports, workplan)	Nov 97-Jan 98	Dec 97
Formulation	Determination of activities as part of 1998-99 workplan. (PHR workplan)	Jan 98	
Validation	Completed analysis of paramedical rules and regulations and proposals for reform. (PHR report)	Oct 98 March 99	
Adoption	Negotiate with stakeholders and adopt reform of paramedical rules and regulations. Draft and adopt reforms. (PHR report)	Mar 99	
Implementation	New codes/regulations adopted. (Codes from MOPH, report)	2001	
Comments on achievements: Currently on schedule, several new activities added to this policy issue in 1997. Identification stage complete and formulation stage waiting for final approval, which is expected in March, 1998. MOPH commitment to these reforms is currently very high. USAID anticipates good progress in this area during the transition period. The one point of caution is in terms of reforms related to increasing the role of the private sector, which may come under some scrutiny with the new administration.			

Strategic Objective # 1

Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services

Policy Issue: Service/quality standards

Policy Reform Objective: Put tools in the hands of service providers to ensure that FP/MCH services delivered in the public and private sector are of high quality.			
Problem Statement: Elaborate, validate and disseminate family planning, emergency obstetrical care and integrated management of childhood illness service standards and clinical protocols.			
Background/rationale: Clinical protocols and quality standards are useful tools for service providers to remind them of proper procedures and to keep their skills up to date with the latest scientific and technological advancements. These tools also help managers to monitor and improve the quality of care in health facilities. USAID has provided substantial assistance in the development of clinical protocols and good progress has been made to date. FP standards, which were elaborated in 1992 are currently being updated; MOPH/WHO/UNICEF standards for maternity and neonatal care were published in 1996, training manuals for emergency obstetrical care and life saving skills and standards, which complement the maternity and neonatal standards, were near completion at the end of 1997; standards for diarrheal diseases were completed in 1992 and for acute respiratory illnesses in 1993. Clinical service standards for integrated management of childhood illness (IMCI), voluntary surgical contraception (VSC), intra-uterine devices (IUDs) and injectable contraceptives are all in the process of being finalized. In service and pre-service training standards are also being developed.			
The policy issue is near completion in terms of clinical standards developed; the future focus is on dissemination of current protocols in the public sector and private sectors. In addition, emphasis in 1998-1999 will move to dissemination of protocols, establishing and implementing quality standards, and ensuring that quality standards are followed at the health facility level.			
Key counterpart/stakeholders: MOPH, Medical and Midwifery Societies, private providers, doctors, midwives, other paramedical health providers, women of reproductive age, households			
Benchmark: Agreement on a process for development and maintaining quality standards (Quality Standard Seminar achieves its objectives)			
Key Steps	Means of Verification	Planned	Completed
Identification	N/A		
Formulation	N/A		
Validation	Clinical Standards developed	By Dec 97 for most	By Dec 97 for most
Adoption	Clinical Standards finalized and disseminated (standards for IUD, Long term methods, safe motherhood and IMCI are continuing in 1998)	Sept 98	
	Quality Standards developed	Dec 98	
Implementation	Agreement on a process for development and maintaining quality standards	Dec 98	
Comments on achievements: Many of the clinical standards are already at the implementation stage (at 100% achievement) and some are still to be finalized or refined. Thus, this policy issue was judged to be at 40% achievement by the end of 1997. A Quality Standard Seminar is planned for late 1998 to come to agreement on a process for development and maintaining quality standards.			

Strategic Objective # 1

Intermediate Result: IR2: Increased Sustainability of FP/MCH services: Improved policy environment supporting FP/MCH services

Policy Issue: Maternal death audits

Policy Reform Objective: To help health service providers and managers to routinely and systematically identify the causes of and contributing factors for maternal deaths in the facilities in which they work and to use this information to improve the quality of maternal care under their control.			
Problem Statement: Institutionalize the use of maternal death audits for all maternal deaths that occur in public health services.			
Background/rationale: Maternal death rates in Morocco are among the highest in the Arab world and much greater than in other middle income countries (a Maternal Mortality Ratio (MMR) of 332 maternal deaths per 100,000 live births 332 maternal deaths per 100,000 live births for the period 1985-1991, MMR currently estimated at 228 deaths per 100,000 live births in 1997 (preliminary data from PAPCHILD, 1998). The care that a woman receives during pregnancy, childbirth and during the postpartum period (up to 42 days after childbirth) can have a profound effect on the outcome of her pregnancy. An effective means of ensuring that health facilities are providing the best maternity care possible is to have a system for routinely monitoring why individual deaths occurred, determining which of the deaths and which of the causes were preventable, and then instituting measures to decrease the number of preventable deaths by combating the preventable causes. Maternal death audits have been used successfully in many developed and developing countries to do just that. The MOPH is currently very interested in instituting routine monitoring of maternal deaths and expects that this could contribute greatly to other efforts currently being implemented to reduce maternal mortality. Some MOPH facilities are already testing different methods and tools for monitoring maternal deaths, and the MOPH is working on a circular which will go out to all hospital directors requiring them to institute the routine reporting, monitoring and evaluation of maternal deaths using audits. USAID will assist the MOPH to evaluate their multiple options and develop and test, in two regions, tools and methods for routine maternal death audits in all health facilities, including but not limited to hospitals.			
Key counterpart/stakeholders: MOPH, hospital and health center directors, private providers, doctors, midwives, other paramedical health providers, women of reproductive age, households			
Indicator: MOPH distributes a circular to require the use of maternal death audits for all maternal deaths in public health facilities.			
Benchmark: Tools for maternal death audits developed. Tools for maternal death audits tested in pilot regions.			
Key Steps	Means of Verification	Planned	Completed
Identification	N/A		
Formulation	Tools for maternal death audits developed.	June 98	
Validation	Tools for maternal death audits tested in pilot regions.	Dec 98	
Adoption	MOPH approves policy and distributes a circular to require routine use of maternal audits in all public health services	June 99	
Implementation	Public health services implement routine collection and use of maternal death audits	2000	
Comments on achievements: New issue.			

Annex D: Workplan

Annex E: Level of Effort

PHR Illustrative LOE USAID/Morocco - July '98 - June '99

PHR Assistance	Timing	LOE in-country	Total LOE	Trips	Responsible individuals Staffing	Estimated Cost
<i>Objective 1: Result 1.1</i>						
1. Briefing document (dossier)	12/97-7/15/98				LTA	
2. Presentation of dossier & Advocacy strategy	12/97 - 9/98	3 weeks	3 weeks		LTA Local Purchase Order	
3. Implement advocacy strategy	9/98 - 12/98	2 weeks 2 weeks 3 weeks	2 weeks 4 weeks 3 weeks	1	PR Expert - expat local PR firm or expert	\$45,000
4. Follow up	1/99 - ?	TBD			Home Office team	
<i>Objective 2: Result 2.1</i>						
1. Tax waiver	12/97-7/98		1 week		LTA Home Office team Production/Translation	\$0 - Special Initiatives
2. Cost structure analysis	7/98 - 12/98	1 week 2 weeks	1 week 2 weeks	1	Miloud Kaddar Local consultant team	\$15,000
3. Advocacy strategy	12/98 - 3/99	2 weeks 4 weeks	3 weeks 4 weeks	1	PR/Advocacy - expat Local PR firm or expert	\$30,000
4. Implementation of strategy	TBD	2 weeks	2 weeks		Study team	\$20,000
5. Legislation proposal	2/99	2 weeks	2 weeks		Local team of experts	\$20,000
<i>Objective 3: Result 3.1</i>						
1. Analysis of codes & regulations	5/98-7/98				LTA Mme Meshak	-----

PHR Assistance	Timing	LOE in-country	Total LOE	Trips	Responsible individuals Staffing	Estimated Cost
2. Draft codes	9/98-1/99	9 weeks 3 weeks	9 weeks 4 weeks	1	Local legal experts x 3 1 international consultant	\$55,000
3. Study Tour	9/98 - 1/99	4 weeks 3 weeks 2 weeks	4 weeks 3 weeks 2 weeks	3	2 DLA staff members Consultants @ country	\$85,000
4. Midwife Conference	12/98	1 week	1 week	1	Local midwife	\$2,000
5. Regulatory Reforms	TBD					-----
<i>Objective 4: Result 4.1</i>						
1. Immunization Financing	TBD				Miloud Kaddar	\$118,000 ³
2. Plan development	TBD					
<i>Objective 5: Result 5.1</i>						
1. NHA	5/98-5/2000	1 week 2 weeks	1 week 2 weeks 4 weeks	3	NHA Coordinator PHR Technical Advisor Project Support	\$227,500 ⁴
2. Regional training	6/98-8/99	1 week	4 weeks	3	Miloud Kaddar	\$100,000
<i>Management and Coordination</i>	Overall		8 weeks 4 weeks	2	C. Rassas J. J. Frere P. Georges	\$135,000
TOTALS						\$407,000
▲ Field Support						\$118,000
▲ Global - Child Surv.						<u>\$327,500</u>
▲ ANE Regional Bur.						\$852,500

*This is an illustrative list and will be modified as PHR contacts appropriate staff and consultants.

³Funded by Global Bureau's Child Survival Division.

⁴Funded by ANE Regional Bureau

Annex F: Job Description

DRAFT-Terme de Référence pour le Coordonnateur de PHR, Rabat, Maroc

I. Introduction

Les Partenariats pour la réforme de la Santé est un projet de cinq ans (1995 - 2000) financé à partir du Bureau de Santé et Nutrition du Centre pour la Population, la Santé, et la Nutrition (PHN), USAID/Washington. Le Projet était créé pour supporter la réforme dans le secteur sanitaire et propager la connaissance sur les problèmes d'une étendue mondiale du secteur sanitaire. L'accent est mis sur la réforme qui contribue à suivre de prêt les objectifs stratégiques globaux de l'USAID sur la population, la survie de l'enfant, la santé maternelle et les activités de VIH/SIDA. Le Projet se concentre sur le développement et l'implémentation des réformes qui servent à améliorer l'équité, l'efficacité, la qualité et la durabilité des établissements sanitaires.

L'USAID ainsi qu'un nombre de donateurs ont joué, pendant plus de deux décennies, un rôle important dans le développement et le soutien des programmes de planning familial et les services de santé maternelle et infantile (FP/MCH) au Maroc. Le Ministère de la Santé et l'USAID partagent la notion selon laquelle le bon fonctionnement du programme de planning familial est étroitement lié à ce que les hauts fonctionnaires du gouvernement acceptent l'idée que le planning familial a pour but de contribuer au développement national et aussi il faudrait que le gouvernement mette ses ressources, à tout moment et en dépit de la situation économique du pays, à la disposition du programme. Dans ce contexte l'objectif principal des activités de PHR au Maroc est de fournir une assistance technique pour augmenter les ressources financières du gouvernement pour le planning familial/la santé maternelle et infantile et aider à améliorer le milieu politique travaillant en faveur des services de FP/MCH.

Pour coordonner la mise en oeuvre des activités actuelles du PHR au Maroc avec l'USAID et le Ministère de la Santé, PHR cherche un Coordonnateur qui jouera le rôle d'agent de liaison principal du Projet à Rabat. Ce sera un emploi à temps partiel (50% du temps) pour une période initiale d'un an. PHR utilisera périodiquement des consultants locaux et, parfois, internationaux pour mettre en oeuvre les activités dans le plan de travail, avec l'aide d'une équipe de gestionnaires venant des Etats Unis.

II. Terme de Référence

Engager le Coordonnateur Local de PHR sous l'accord de consultant à temps partiel (50% du temps) avec Abt Associates, Inc. à Bethesda, Maryland. Le Coordonnateur fonctionnera, pour la durée du contrat, sous la direction du Directeur Adjoint de PHR chargé des Opérations. Le Coordonnateur sera assister dans sa fonction par le personnel basé aux Etats Unis et maintiendra un contact et support réguliers. Il/elle s'occupera des tâches suivantes :

- a. Créer un bureau au sein du Ministère de Santé sous l'accord de l'USAID et le Ministère et Maintenir un emploi du temps consistant et régulier.

- b. Maintenir régulièrement contact avec les responsables de PHR aux Etats Unis. Informer PHR de tout problème, contraindre et le progrès des activités.
- c. Etablir et maintenir régulièrement contact avec le Bureau de Population et Santé de l'USAID/Maroc, les contreparties du Ministère de la Santé (Les Départements de Population, des Affaires Juridiques et de Règlement, de Planification et des Ressources Financières), le Centre de Recherche Démographique (CERED) dans le Bureau du Premier Ministre et autres.
- d. Servir d'agent de liaison entre les tous clients pour faciliter la bonne marche des activités et priorités dans le plan de travail de PHR.
- e. Sous la supervision et direction de PHR aux Etats Unis, aider à préparer et négocier des termes de références requis pour faire avancer les activités du plan de travail avec le Ministère de la Santé, l'USAID et d'autres dépositaires.
- f. Sous la direction de PHR aux Etats Unis et en collaboration avec l'USAID et le Ministère de la Santé, aider à définir les qualifications requises pour mettre en oeuvre les activités du plan de travail de PHR. Aussi, aider à définir si le terme de référence demandera à ce qu'une assistance technique soit fournie par le siège aux Etats Unis.
- g. Aider à trouver des consultants locaux et aussi des cabinets ayant la capacité de mener des activités précises comme recommandées par PHR.
- h. Donner support aux consultants internationaux de PHR--aider à négocier le timing des Devoirs Temporaires (TDYs), organiser des réunions avec l'USAID et les contreparties marocains et d'autres supports logistiques comme nécessaires.
- i. Participer à la mise en oeuvre des activités du plan de travail dans la mesure de son expertise et de sa disponibilité.

III. Qualifications

Le candidat idéal pour le poste de Coordonnateur de PHR aura les qualifications suivantes :

- ▲ Une connaissance technique et pratique dans le domaine du planning familial et les activités et problèmes relatifs à la santé maternelle et infantile au Maroc;
- ▲ Une expérience ayant rapport aux objectifs du plan de travail de PHR. Par exemple, planning familial, santé maternelle et infantile, financement des contraceptifs, plaidoyer, analyse des coûts, législation et règlement cadre pour le personnel paramédical et pour FP/MCH;
- ▲ Une bonne maîtrise du langage (écrit et oral) et une bonne manière de présenter;
- ▲ Etre capable de travailler dans un milieu politique très sensible;
- ▲ Une expérience avec l'USAID ou d'autres donateurs;\

- ▲ Une expérience dans la gestion des projets et/ou les études techniques;
- ▲
- ▲ Une maîtrise en Economie, la Santé Publique ou un domaine similaire;
- ▲ Une maîtrise du français, l'arabe et l'anglais.

IV. Processus de Sélection

PHR contactera des contreparties clefs au Maroc pour solliciter des noms de candidats qualifiés pour le rôle de Coordonnateur selon les critères donnés au-dessus. Le personnel de PHR examinera les candidats, aura des entretiens avec eux (si possible par téléphone), et vérifiera les références des candidats qualifiés. PHR passera les noms des trois meilleurs candidats à l'USAID/Maroc et aux contreparties du Ministère de la Santé. Alors PHR choisira le candidat préféré pour le poste en consultation avec USAID/Maroc et les contreparties du Ministère de la Santé. Et PHR notifiera ce candidat pour une confirmation finale et passera ensuite à la procédure d'engagement selon les politiques de recrutement de Abt Associates pour un consultant. Cette procédure aura bientôt lieu pour permettre d'avoir un Coordonnateur présent avant le départ du conseiller de PHR et le personnel de l'USAID pour les congés d'été.

DRAFT- Scope of Work for the PHR Coordinator, Rabat, Morocco

I. Introduction

The Partnerships for Health Reform (PHR) is a five-year (1995 - 2000) project funded out of the Office of Health and Nutrition in the Population, Health and Nutrition (PHN) Center, USAID/Washington. The Project was designed to support health sector reform and to advance knowledge about health sector problems worldwide. Emphasis is given to reforms that contribute to meeting USAID's overall strategic objectives for population, child survival, maternal health and HIV/AIDS activities. The Project focuses on developing and implementing reforms that improve equity, efficiency, effectiveness, quality and sustainability of health systems.

USAID has played a central role, along with other donors, for over two decades in developing and supporting the provision of family planning and maternal and child health (FP/MCH) services in Morocco. The MOH and USAID agree that the best strategy to ensure continuous and uninterrupted support for the family planning program is to obtain government support, at the highest levels, for the idea that Family Planning is a national development goal and that government resources will be available for the program, regardless of the economic situation of the country, for the near term and for the long term future. In this context, the overall goal of PHR activities in Morocco is to provide technical assistance to increase the government financial resources for family planning/maternal and child health (FP/MCH), and help improve the policy environment supporting FP/MCH services.

In order to coordinate the implementation of PHR's ongoing activities in Morocco with USAID and the MOH, PHR is recruiting a Coordinator who would serve as the Project's primary liaison and contact in Rabat. This will be a part-time position (up to half-time) for an initial period of one year. PHR will implement its work plan activities through short-term consultancies, using local consultants to the extent possible, and international consultants as required, with the support of a management team from the U.S.-based office.

II. Scope of Work

PHR's local Coordinator be hired on a part-time (up to half-time) consultant agreement with Abt Associates, Inc. in Bethesda, Maryland. S/he will report directly to PHR's Deputy Director for Operations for general direction and supervision per the terms of the contract. The Coordinator will be supported by technical, operational and support staff from the US home office and will maintain regular contact and support. S/he will be responsible for performing the following tasks:

- a) Establish an office in the MOH per USAID and MOH agreement and maintain a consistent, regular work schedule (i.e. 5 mornings/week; Monday, Wednesday, Friday).
- b) Maintain regular contact with PHR's management team in its US-based office in Bethesda. Keep PHR informed of issues, constraints/conflicts, and progress of activities.
- c) Establish and maintain regular contact with USAID/Morocco's Office of Population, Health and MOH counterparts (Department of Population; Department of Legal and Regulatory Affairs, Department of Planning and Financial Resources), CERED (the Center for Demographic Research in the Prime Minister's Office) and others as appropriate.

- d) Serve as liaison among the various clients (GOM) counterparts and USAID) in order to facilitate the ongoing activities and priorities of PHR's work plan.
- e) Under the supervision and direction of PHR's home office, assist in drafting and negotiating scopes of work, with MOH, USAID, and other stakeholders, required to advance the work plan activities.
- f) Under the direction of PHR's home office and in collaboration with USAID and the MOH, assist in identifying required qualifications for implementing activities in the PHR work plan. Also, assist in identifying whether the scope of work requires expatriate technical assistance.
- g) Assist in the identification of local consultants and firms with capabilities to carry out specific activities, as requested by PHR.
- h) Provide support to PHR's international consultants - assist in negotiation of timing for TDYs, set up meetings with USAID and Moroccan counterparts, and other logistic support as required.
- I) Depending on areas of expertise and availability of time, participate in implementation of work plan activities.

III. Qualifications

The ideal candidate for the position of PHR Coordinator will have the following qualifications:

- ▲ Familiarity and technical expertise related to the family planning and maternal and child health activities and issues in Morocco;
- ▲ Experience relevant to PHR's work plan objectives: i.e. family planning, maternal and child health, contraceptive financing, advocacy, cost analysis, legislation and regulatory framework for paramedical staff and for FP/MCH;
- ▲ Strong written and oral skills, including presentation skills;
- ▲ Demonstrated ability to work in a highly sensitive political environment;
- ▲ Prior work with USAID or other donor agencies;
- ▲ Experience managing projects and/or technical studies;
- ▲ Minimum of Masters in Economics, Public Health or relevant field;
- ▲ Excellent French, Arabic and English.

IV. Process for Selection

PHR will contact key counterparts in Morocco to solicit names of qualified candidates to perform the role of Coordinator per qualifications above. PHR staff will review candidates, interview (by phone, if necessary), and check references of the qualified candidates. PHR will submit the names of its top 3-4 candidates with recommendations to USAID/Morocco and to the appropriate MOH counterparts. In consultation with USAID/Morocco and the MOH counterparts, PHR will select the preferred, qualified candidate for the position. With USAID and MOH concurrence, PHR will notify the top ranked candidate for the position, confirm interest and availability and complete the recruitment process per Abt Associates consultant policies. Ideally, this process should take place as soon as possible to assure that PHR will have its local Coordinator selected prior to the departure of PHR's long-term advisor and USAID staff, who will be on leave for the summer.

Annex G: Study Tour

TERME DE RÉFÉRENCE

POUR LA TOURNÉE D'ÉTUDE DU MINISTÈRE DE LA SANTÉ MAROCAIN

Une activité d'assistance technique du Projet Partenariats pour la Réforme de la Santé (PHR) contenue dans le Plan d'Activité pour le Maroc

BUT

Le but visé par cette tournée d'étude est de fournir au Maroc des exemples d'autres pays qui ont libéralisé les lois régissant l'approvisionnement du service médical par auxiliaires médicaux. L'étude portera à la fois sur le processus de la réforme dans le milieu législatif et son exécution, ainsi que les effets qu'auront les nouvelles décisions législatives.

CONTEXTE

Le deuxième objectif du PHR, selon son Plan d'Activité du Pays, est "l'amélioration de la structure réglementaire concernant l'utilisation des agents de santé dans le secteur public et le secteur privé". L'une des activités prioritaires liée à cet objectif est d'aider le Ministère de la Santé à libéraliser les règles concernant la fonction des auxiliaires médicaux. Le résultat recherché réside dans l'amélioration des services paramédicaux dans les zones sous-desservies en permettant aux auxiliaires médicaux d'étendre leurs fonctions et ce, avec une surveillance moindre.

Le facteur principal qui limite le plus l'exercice des sage-femmes et de tout autre personnel paramédical qui travaillent dans les parties reculées du pays se situe au niveau des règles restreignant les procédures et actes médicaux que ces derniers sont capables à pratiquer (spécialement dans la pratique indépendante privée) sans la supervision directe d'un médecin. Le Ministère de la Santé a eu dans le passé à réviser les règles gouvernant ceux qui exercent la profession de médecin général. On pourra se baser sur cette expérience du Ministère de la Santé pour rédiger et négocier la nouvelle législation portant sur la libéralisation de la pratique paramédicale au Maroc.

La contrepartie principale du PHR en ce qui concerne cette activité est Mme Meshak, Directrice du Département des Affaires Juridiques au sein du Ministère de la Santé. PHR a d'ores et déjà entamé la compilation et la revue des codes et règles existants relatifs à l'approvisionnement du service qu'effectuent les cabinets médicaux. Au mois de juin 1998, PHR s'est rencontré avec USAID/Rabat et Mme Meshak. Au cours de la réunion, il a été mentionné que le Ministère de la Santé est en train de rédiger une nouvelle législation pour la libéralisation des règles paramédicales. L'une des activités prioritaires du Ministère de la Santé est la participation de deux ou trois membres du Département des Affaires Juridiques dans la tournée d'étude dans un à trois pays ayant de l'expérience dans le dit domaine.

OBJECTIFS

L'objectif de la tournée d'étude est de raccourcir le processus d'apprentissage pour permettre au Maroc de réaliser une réforme législative et de trouver la meilleure façon possible de mettre en exécution les nouvelles lois relatives aux fonctions des auxiliaires médicaux. L'étude devrait répondre particulièrement aux questions suivantes :

1. Quel fut le processus suivi par le pays pour réaliser sa réforme législative?
2. Quels furent les facteurs contribuant à la bonne marche du processus? Que serait-il souhaitable de prévenir?
3. Quels furent les obstacles principaux et/ou les sources d'opposition? Comment furent-ils surmontés?
4. Quel fut le processus de mise en application de la nouvelle législation et des nouvelles règles?
5. Quels furent les facteurs contribuant à la bonne marche du processus? Que serait-il souhaitable de prévenir?
6. Quels furent les obstacles principaux et/ou les sources de discorde. Comment furent-ils surmontés?
7. Une formation supplémentaire des auxiliaires médicaux fut-elle nécessaire? Comment fut-elle réalisée?
8. Quelles furent les mesures prises afin d'assurer la qualité des soins?
9. Existe-il un nouveau système d'accréditation des diplômés pour les auxiliaires médicaux? Si oui, quel en est son fonctionnement?
10. Quels étaient les premiers objectifs de l'effort en faveur de la réforme législative? Quels furent les résultats et impact escomptés? Furent-ils atteints?
11. Quel fut l'impact réel du changement sur à l'approvisionnement du service paramédical? Sur sa qualité? Et sur sa tarification ou son coût?

ACTIVITÉS SPÉCIFIQUES

1. Mettre en place des critères pour la sélection des pays dans lesquels aura lieu la tournée l'étude. La Turquie, la Tunisie, le Ghana, et le Chili figurent parmi les pays candidats possibles qui ont été déjà proposés.
2. Collecter et réviser quelques informations de base sur les pays candidats et procéder à une sélection finale.

3. Identifier un agent de liaison principal dans chaque pays sélectionné. L'agent de liaison devrait:
 - ▲ avoir une formation en santé publique, de préférence en population et santé maternelle,
 - ▲ connaître les règles des auxiliaires médicaux, préférentiellement le processus suivi pour libéraliser les règles relatives à l'approvisionnement des services par les auxiliaires médicaux,
 - ▲ avoir accès aux dirigeants et aux représentants des organisations clefs qui peuvent contribuer à la réalisation des objectifs de la tournée d'étude et
 - ▲ être en mesure de préparer l'ordre du jour et d'organiser les contacts et les réunions pour l'étude, y compris une connaissance du protocole officiel (local) requis.
4. Le Ministère de la Santé donnera au PHR les noms des membres du personnel et le moment convenable pour effectuer cette tournée d'étude afin que les arrangements pour le voyage, l'autorisation médicale et d'autres permissions nécessaires soient assurés.
5. PHR travaillera avec les agents de liaison pour développer un programme d'étude pour chaque pays. Le programme inclura:
 - ▲ une réunion initiale avec l'agent de liaison du pays qui fera une vue d'ensemble et présentera les données de base,
 - ▲ des réunions avec les dirigeants au niveau fédéral, et si approprié, aux niveaux régional et municipal,
 - ▲ des réunions avec les représentants des organisations clefs, par exemple, les associations paramédicales et l'association médicale locale (une source classique de discord),
 - ▲ peut-être une visite aux cabinets pour rencontrer et observer les auxiliaires médicaux,
 - ▲ une rencontre avec l'agence responsable de la formation paramédicale et/ou de la certification des auxiliaires médicaux et
 - ▲ un temps de répit pour préparer le rapport sur les activités et les résultats.
6. PHR fera les arrangements pour le voyage et assurera l'autorisation médicale, l'assurance maladie, et d'autres permissions nécessaires du pays. Si l'USAID n'a pas de représentation dans l'un des pays sélectionné (exemple Chili), PHR aura besoin d'obtenir et conformer au protocole local concernant la visite des ressortissants étrangers auprès des dirigeants du gouvernement et d'autres représentants.
7. Conduire une tournée d'étude de cinq jours dans deux pays. Les participants dans la tournée d'étude:
 - ▲ deux à trois membres du Départements des Affaires Judiciaires,
 - ▲ un membre du personnel de PHR,

- ▲ l'agent de liaison du pays et
 - ▲ un interprète si nécessaire.
8. Les participants marocains feront un compte rendu pour le Ministère de la Santé et l'USAID/Rabat au retour de la tournée d'étude.
 9. Les participants marocains finaliseront le rapport (rédigé pendant la visite) sur les activités et résultats de la tournée d'étude et ils le rendront au Ministère de la Santé et à l'USAID/Rabat dans un mois après la fin de la tournée. Le personnel de PHR peut aider à reproduire le rapport.

PERSONNEL ET NIVEAU D'EFFORT

La Directrice Adjointe des Opérations du PHR, Cheri Rassas, s'occupera de la supervision en général de la tournée d'étude. (Niveau d'effort est couvert par les coûts alloués).

La Responsable du Programme pour le Maroc du PHR, Phara Georges, prendra charge de la collection et la revue des données de base sur les pays candidats, dirigera la sélection finale, identifiera l'agent de liaison principal dans chaque pays sélectionné et l'engagera comme consultant, suivra le Ministère de la Santé pour les noms et la disponibilité de ceux qui participeront dans tournée d'étude (niveau d'effort de 10 jours) et, pour chaque pays, travaillera avec l'agent de liaison pour préparer l'ordre du jour, engager si nécessaire un interprète comme consultant, obtenir et conformer au protocole local dans le cas des pays où l'USAID n'est pas représenté, participer à l'étude et aider avec la production du rapport (niveau d'effort de 15 jours). Pour deux pays, le niveau d'effort montera à 40 jours.

L'Assistante du Programme du PHR, Hanan Toukan, fera les arrangements pour le voyage et assurera l'autorisation médicale, l'assurance maladie et d'autres permissions nécessaires du pays. (Niveau de 3 jours par pays).

DATE ET EMPLOI DU TEMPS

26 juin	Terme de référence rédigé et budget complété
3 juillet	Ministère de la Santé et USAID/Rabat approuvent ou fournissent un feedback sur le terme de référence et le budget
10 juillet	Terme de référence et budget finalisés
17 juillet	Ministère de la Santé fournit au PHR les noms et moment de disponibilité
Juin - 31 juillet	Revue des données de base et sélection des pays
31 juillet	Identification et engagement de l'agent ou les agents de liaison
31 août	Préparer l'ordre du jour, organiser les réunions, obtenir les autorisations

Septembre/octobre	Conduire la tournée d'étude et faire le compte rendu
Décembre/janvier	Finaliser le rapport

DEVOIRS (Responsable)

1. Ordre du jour détaillé pour chaque tournée d'étude (PHR)
2. Rapport d'Activités et Résultats en français (Participants du Ministère de la Santé)
3. Version anglaise du Rapport d'Activités et Résultats (PHR)

La Tournée d'Étude par le Ministère de la Santé du Maroc : Auxiliaires Médicaux

CRITÈRES DE SÉLECTION DES PAYS

Le pays :

- ▲ a déjà libéralisé les règles relatives aux fonctions des auxiliaires médicaux.
- ▲ a réussi à mettre en application la réforme législative faite.
- ▲ est riche en information (plein de données ou informations accessibles)
- ▲ est favorable à la tournée d'étude.
- ▲ remplit les critères pour faciliter les logistiques et réduire les coûts :
 - △ francophone
 - △ proche du Maroc géographiquement parlant.
 - △ bureau de l'USAID existe

Statement of Work

for MOH Morocco Study Tour: Paramedical Providers

**A Technical Assistance Activity of the Partnerships for Health Reform (PHR) Project
under the Country Activity Plan for Morocco**

Purpose

The purpose of the study tour is to provide Morocco with examples of other countries which have liberalized the regulations relating to the provision of medical services by paramedical providers. The study tour will look at both the process of legislative reform and implementation and impact of new legislation and regulations.

Background

PHR's Objective 2 under its Country Activity Plan (CAP) is to "Improve the regulatory framework which affects the use of health personnel in the public and private sectors". A priority activity under this objective is to assist the MOH to liberalize the regulations relating to the provision of medical services by paramedical providers. The desired impact is to improve service coverage in under-served areas by allowing paramedical providers to deliver a wider range of medical services with less supervision.

The main limiting factor to midwives and other paramedical personnel practicing in under-served areas are the rules and regulations that limit what procedures and acts they can perform (particularly in private independent practices) without direct physician supervision. The MOH already has experience in revising rules and regulations governing General Practice Physicians and this experience can be built upon for drafting and negotiating new legislation to liberalize paramedical practice in Morocco.

PHR's main counterpart for this activity is Mm. Meshak, Director of the Department of Legal Affairs of the MOH. PHR has already begun a compilation and review of existing codes and regulations relating to the provision of paramedical services. In June 1998, PHR met with USAID/Rabat and Mme. Meshak who confirmed that the MOH is already in the process of drafting new legislation to liberalize paramedical rules. A study tour for two to three staff members of the Department of Legal Affairs to one to three countries that have previous experience in this area is a priority activity for the MOH.

Objectives

The objective of the study tour is to shorten the learning curve for Morocco to achieve legislative reform and implement new regulations for paramedical providers in the most successful manner possible. Specifically, the study tour should answer the following questions:

1. What process did the country go through to achieve legislative reform?
2. What were the success factors? What should be avoided?
3. What were the main obstacles and/or sources of opposition, and how were they overcome?
4. What was the process to implement the new legislation and regulations?
5. What were the success factors? What should be avoided?
6. What were the main obstacles and/or sources of opposition, and how were they overcome?
7. Was additional training of paramedicals necessary? How was this accomplished?

8. What measures have been taken to ensure quality of care?

9. Is there a new certification process for paramedical providers? If yes, how does it work?

10. What were the original objectives of the legislative reform effort? The hoped for results and impact? Were they achieved?

11. What has been the actual impact of the change on supply of services? On quality? On pricing/cost?

Specific Activities

Establish criteria for selection of countries to visit (see draft criteria attached). Possible candidate countries already suggested are Turkey, Tunisia, Ghana, and Chile.

Collect and review background information on candidate countries and make a final selection.

Identify a primary contact in each selected country. Contact person should:

- ▲ have a background in public health, preferably in population and maternal health
- ▲ be familiar with regulation of paramedicals, preferably with first-hand knowledge of the process undergone to liberalize the regulations relating to the provision of medical services by paramedical providers
- ▲ have access to high-level officials and representatives of key organizations relevant to the study tour objectives
- ▲ be able to arrange agenda and all contacts and meetings for the study tour, including familiarity with local official protocol required

MOH to provide PHR with names of staff members and timing availability for this study tour so that travel arrangements, medical clearances, country clearances, etc. can be accomplished.

PHR to work with country contact to develop study tour agenda in each country which would likely include:

- ▲ initial meeting with country contact who would give overview and background presentation
- ▲ meetings with high-level government officials on the federal level, and if appropriate, on the regional and municipal levels
- ▲ meetings with representatives of key organizations like paramedical professional associations and the local medical association (a classic source of opposition)
- ▲ possibly visit facilities to meet with and observe paramedical providers practicing independently

- ▲ meet with agency responsible for paramedical training and/or certification
- ▲ time to prepare report on activities and findings

PHR to make travel arrangements and secure medical clearances, health insurance, and country clearances. If a country is selected where USAID does not have a mission (e.g. Chile), PHR will need to find out and comply with the local protocol for third-country nationals to visit and meet with government officials and other representatives.

Conduct five-day study tour in two countries. Study tour participants:

- ▲ two to three staff members of the Department of Legal Affairs
- ▲ a PHR staff-person
- ▲ the country contact person
- ▲ an interpreter if necessary

Moroccan participants to debrief MOH and USAID/Rabat upon return from study tours.

Moroccan participants to finalize report (drafted during the visit) on the activities and findings of the study tours and deliver to the MOH and USAID/Rabat within one month of completion of tour. PHR staff can assist with production of report.

Personnel and LOE

PHR Deputy Director of Operations, Cheri Rassas, to provide overall supervision. (LOE covered with allocated costs).

PHR Program Officer for Morocco, Phara Georges, to assist with collection and review background information on candidate countries, guide final selection, identify a primary contact in each selected country and hire him/her as a consultant, follow-up with MOH for names and availability of staff to participate in study tour, (10 days LOE). For each country: work with country contacts to prepare agenda, hire interpreter as a consultant if necessary, find out and comply with the local protocol in the case of non-USAID countries, participate in study tour, assist with report production. (15 days LOE per country). Total LOE is 40 days assuming 2 countries.

PHR Program Assistant, Hanan Toukan, to make travel arrangements and secure medical clearances, health insurance, and country clearances. (3 days LOE per country)

PHR Training Coordinator, Shril Smith, for compliance with USAID training regulations. (3 days LOE)

Country Contact, PHR consultant, for each country to arrange agenda and all contacts and meetings for the study tour, conduct initial meeting of the study tour giving an overview and background presentation, and guide the remaining meetings and visits. (10 days LOE per country)

Interpreter, PHR consultant, to provide French-foreign language interpretation services for all meetings as necessary. (5 days LOE per country)

Timing and Schedule

June 26	Draft SOW and budget completed
July 3	MOH and USAID/Rabat approve or provide feedback on SOW and budget
July 10	SOW and budget finalized
July 17	MOH provide PHR with names and timing availability
June - July 31	Review of background information and selection of country(ies)
July 31	Identify and hire Country Contact(s)
August 31	Prepare agenda, arrange meetings, secure clearances
September/October	Conduct Study Tours and Debriefings
December/January	Finalize Reports

Deliverables (responsible)

1. Detailed agenda for each country study tour (PHR).
2. Report of Activities and Findings in French (MOH staff participants).
3. English version of Report of Activities and Findings (PHR).

MOH Morocco Study Tour: Paramedical Providers

Criteria for Country Selection

- ▲ Has already liberalized the regulations relating to the provision of medical services by paramedical providers.
- ▲ Has implemented the regulatory reform successfully.
- ▲ Data-rich (data/information are ample and easily accessible).

- ▲ Willing to receive study tour.
- ▲ Criteria to facilitate logistics and reduce costs:
 - △ French-speaking
 - △ Geographically near Morocco
 - △ USAID presence