

PROJECT PAPER

Project No. 608-0151

HEALTH MANAGEMENT IMPROVEMENT

MOROCCO

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AGENCY FOR INTERNATIONAL DEVELOPMENT  <b>PROJECT PAPER FACESHEET</b>		1. TRANSACTION CODE <div style="border: 1px solid black; display: inline-block; padding: 2px;">A</div> A = ADD C = CHANGE D = DELETE	PP <hr/> 2. DOCUMENT CODE 3
3. COUNTRY/ENTITY Morocco		4. DOCUMENT REVISION NUMBER <div style="border: 1px solid black; width: 20px; height: 15px; margin: 0 auto;"></div>	
5. PROJECT NUMBER (7 digits) <div style="border: 1px solid black; padding: 2px;">608-0151</div>	6. BUREAU/OFFICE A. SYMBOL NE B. CODE <div style="border: 1px solid black; padding: 2px;">03</div>	7. PROJECT TITLE (Maximum 40 characters) Health Management Improvement Project	
8. ESTIMATED FY OF PROJECT COMPLETION  FY <div style="border: 1px solid black; padding: 2px;">84</div>		9. ESTIMATED DATE OF OBLIGATION A. INITIAL FY <div style="border: 1px solid black; padding: 2px;">81</div> B. QUARTER <div style="border: 1px solid black; padding: 2px;">1</div> C. FINAL FY <div style="border: 1px solid black; padding: 2px;">813</div> (Enter 1, 2, 3, or 4)	

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$1 -)						
A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	699		699	2281		2281
(GRANT)	( 699 )	( )	( 699 )	( 2281 )	( )	( 2281 )
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S.						
1.						
2.						
HOST COUNTRY		340	340		1790	1790
OTHER DONOR(S)						
TOTALS	699	340	1039	2281	1790	4071

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>81</u>		H. 2ND FY <u>82</u>		K. 3RD FY <u>83</u>	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) PH	580			699		974		608	
(2)									
(3)									
(4)									
TOTALS				699		974		608	

A. APPROPRIATION	N. 4TH FY		Q. 5TH FY		LIFE OF PROJECT		12. IN-DEPTH EVALUATION SCHEDULED  MM   YY <div style="border: 1px solid black; padding: 2px;">04   82</div>
	O. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	
(1) PH					2281		
(2)							
(3)							
(4)							
TOTALS					2281		

13. DATA CHANGE INDICATOR: WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PFP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PIC FACESHEET.

14. ORIGINATING OFFICE CLEARANCE SIGNATURE: TITLE: USAID Director	15. DATE DOCUMENT RECEIVED IN AID W. OR FOR AID W. DOCUMENTS, DATE OF DISTRIBUTION  DATE SIGNED: <div style="border: 1px solid black; padding: 2px;">MM   DD   YY 10   17   810</div>
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PROJECT AUTHORIZATION  
AND REQUEST FOR ALLOTMENT OF FUNDS

Name of Country: Morocco

Name of Project: Health Management  
Improvement Project

Number of Project: 608-0151

Pursuant to Part I, Chapter 1, Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to Morocco (the "Cooperating Country") of not to exceed six hundred and ninety nine thousand dollars (the "Authorized Amount") to help in financing certain foreign exchange and local currency costs of goods and services required for the project as described in the following paragraph.

The Project consists of assisting the GOM/Ministry of Health in the development of the central Ministry's scarce management resources and in making improvements in specific administrative and management sub-systems. It aims to improve the quality and quantity of the country's health services by increasing the effectiveness and efficiency of the GOM health delivery system.

I approve the total level of A.I.D. appropriated funding planned for this project of not to exceed \$2,281,000, during the period of FY 1981 through FY 1984.

I hereby authorize negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority subject to the following essential term and covenant and major condition; together with such other terms and conditions as A.I.D. may deem appropriate:

Source and Origin of Goods and Services

Goods and services financed by A.I.D. under the project shall have their source and origin in the Cooperating Country or in the United States, except as A.I.D. may otherwise agree in writing.

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Alfred D. White  
Assistant Administrator  
Bureau for Near East

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Date

## II. INTRODUCTION: BACKGROUND AND SUMMARY PROJECT DESCRIPTION

### A. Background

The Ministry of Public Health of Morocco is charged with the responsibility of promoting the health of 20 million Moroccans, spread out across 725,000 square kilometers of territory. To do this, they have built and are attempting to expand an infrastructure which, at present, includes 97 hospitals, 252 health centers (103 urban and 149 rural) and 753 dispensaries (208 urban and 645 rural). In addition to curative care and treatment, the Ministry provides a full range of preventive services including infectious disease control, sanitation, immunization, maternal and child health and family planning. To operate the hospitals, ambulatory facilities and other programs, it employs in excess of thirty-five thousand workers, of which 1,200 are physicians and 15,000 are para-medical workers of various categories.

In the almost twenty-five years since independence, the MOPH has had many successes in its attempt to improve the health of Moroccans. Life expectancy has risen from forty-five to fifty-five years. In the last fifteen years, the crude death rate has fallen by 26 percent (from 19 per 1,000 to 14 per 1,000). Malaria has been effectively brought under control. The Ministry has also had some failures, however. Infant mortality remains very high (approximately 133/1,000 live births) and both the crude death rate and the infant mortality rate compare unfavorably with other middle income countries, being close to double those of Thailand and the Philippines, which have comparable ENPs. Severe to moderate malnutrition

still affects a large proportion of children four years of age or below.\* As expected, these problems (infant mortality and malnutrition) are significantly higher in rural and in poor urban areas than elsewhere.

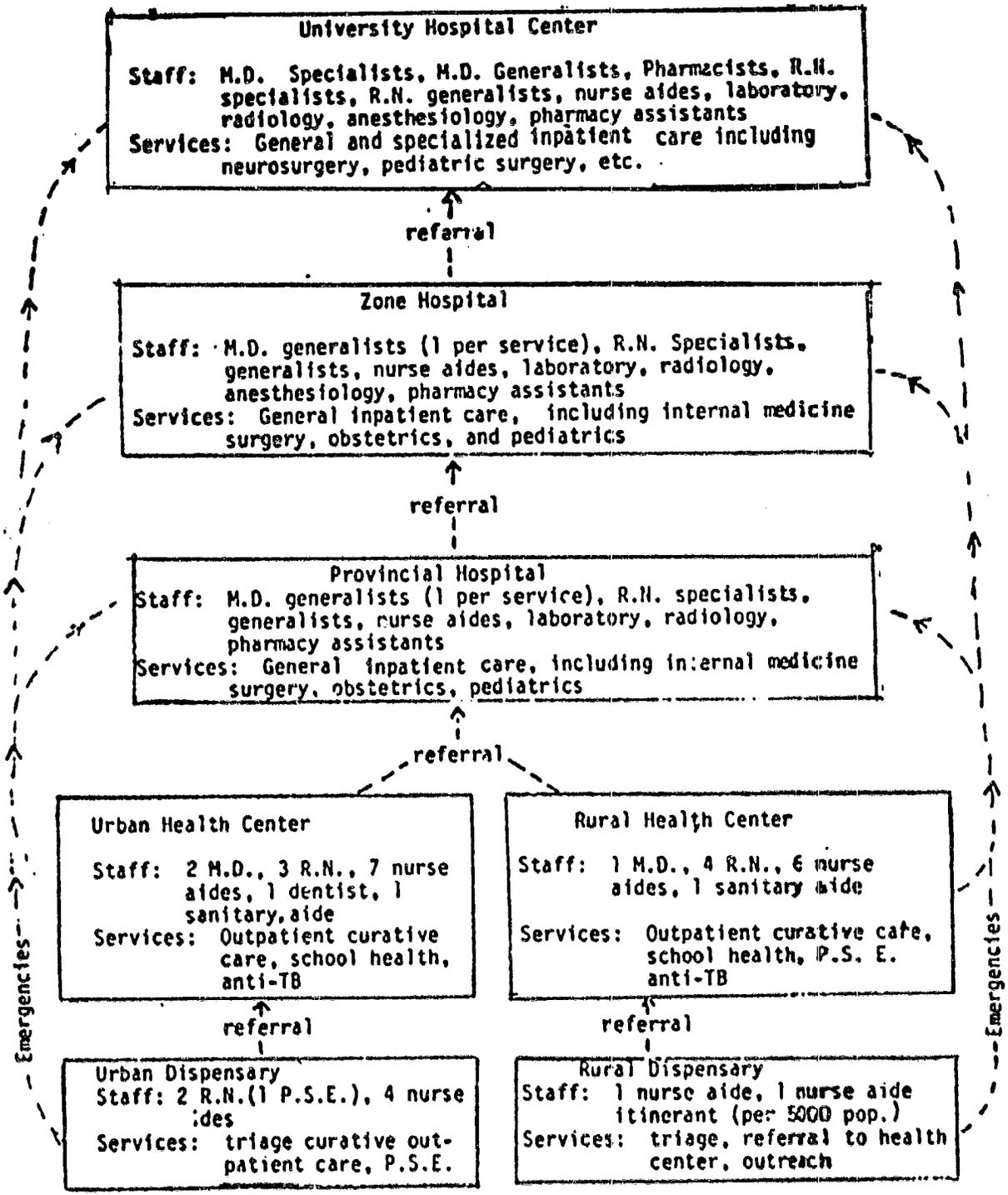
While macro-health indicators can say something about the ultimate successes and failures of a health system, to truly understand its problems and prospects, one must examine the system itself. Some aspects of the Moroccan health system particularly relevant to the concerns addressed by the Health Management Improvement Project are summarized below.

The basic design of the Moroccan health infrastructure is a sound one. This infrastructure consists of a system of service, care and referral which attempts to deliver appropriate care at each of its levels. These include itinerant health workers, dispensaries, health centers, specialized health centers, hospitals and specialized hospitals -- all linked together in a hierarchical and layered system of referral and technical support. This infrastructure, presented schematically in the diagram on the following page, attempts to make basic services easily available to a widely distributed population and yet it recognizes and makes provision for access to more specialized services as needed.

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\* The GOM National Nutrition Survey of 1971 reported that 40% of children four years of age or younger were affected by severe to moderate malnutrition (Bulletin de la Sante Publique, Ministry of Public Health, 1973).

### Organization of Health Services



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The infrastructure may be well designed, but there are important problems in its operations. One problem stems from real resource constraints and the fact that the infrastructure is only partially implemented. To meet the goal of easily-accessible basic services, the design of the infrastructure calls for 176 urban and 292 rural health centers, distributed according to standards based on population density. Of these, 103 urban and 143 rural centers are operating. It calls for 495 urban and 681 rural dispensaries, of which 42% of the urban and 94% of the rural dispensaries are operating.

A more basic problem, however, concerns how the existing infrastructure is functioning -- with the quality of the services that are actually provided at the lowest levels of the system. The Ministry has difficulty staffing, supplying, directing, supervising and monitoring this infrastructure. Positions go unfilled for long periods of time. Dispensaries often run out of supplies, for distributional problems as much as for real shortages. Technical directions are often not properly executed and supervision is often infrequent and haphazard, with the expected result of poor quality and uneven service. The monitoring and reporting system is only capable of identifying problems which have been allowed to go uncorrected for long periods so that they become critical before corrective action can be taken.

The basic services provided by the centers and dispensaries appear to be technically well designed in several ways. First, taken together, they cover the full panoply of services implicit in the notion of primary health care. These include maternal and child health, family planning,

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water and sanitation, immunization, control of locally endemic diseases and case finding and treatment of communicable diseases. Secondly, the delivery of services appropriately attempts to go beyond the use of the stationary infrastructure and to actively bring service to the population. It includes mobile teams (e.g., as in malaria and schistosomiasis control), home health visits (e.g., as in the MCH and tuberculine programs) and health education (e.g., as the programs in family planning and nutrition). Thirdly, the programs appear to be well designed from the perspective of their technical content. They use relatively simple but appropriate technologies with detailed work and procedural guidelines for the health workers who are trained in their execution.

Just as with the general operation of the infrastructure, however, when one goes beyond the master plan and design and looks at the actual functioning of substantive programs, major problems are encountered. There are problems with the scheduling, execution, supervision and control of most of the specialized health service programs. This affects both their quality and their cost. Within the same substantive program, there are often marked differences in the quality of the services being provided between provinces and, at times, between circumscriptions within the same province. One suspects that there are also significant cost differences, but this is difficult to judge in that the accounting system makes it virtually impossible to determine program costs at meaningful operational levels.

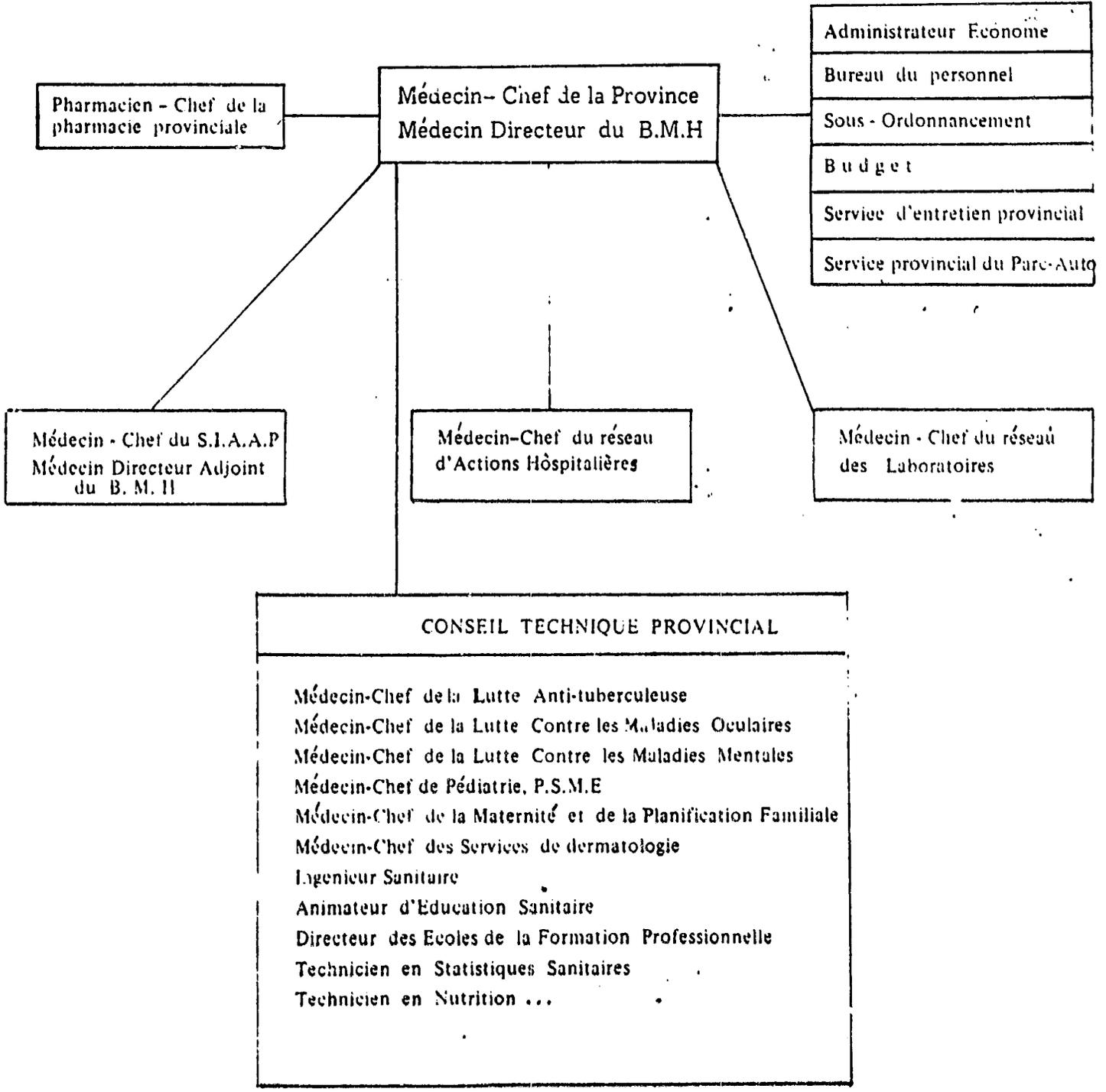
There are several inter-related and underlying causes for the Ministry's difficulty in operating what are basically "sound programs in a sound infrastructure." The first of these, as has been indicated, are

resource constraints. This is a genuine limitation on the services provided. This might change if new financing schemes are tried but, practically speaking, no one is expecting major new resources for the health sector.

A second cause of the Ministry's problems in operations is the organization of the Ministry itself. As with many other ministries of health which provide curative services as well as run preventive programs, there is a system of dual responsibility. The central Ministry is responsible for curative care (both residential and ambulatory) and for preventive services, but through two different chains of command. Curative services and the infrastructure which provides them are directly responsible for their supply, direction and supervision to the chief medical officer (medecin-chef) of the province. Preventive services (and some specialized curative ones) are organized vertically and are directly responsible to the various divisions for the central Ministry. (See organization charts, following pages). These vertical programs have some specialized workers of their own but, for the most part, they draw upon supposedly multi-purpose health workers of the provincial health system and, in particular, that of the Service d'Infrastructure d'Action Ambulatoire Provincialou Prefectoral (SIAAP: the ambulatory health care system of the MOH). The divisions of the central Ministry provide technical supervision and direction to SIAAP workers when they work on their respective programs. Thus, the SIAAP worker is administratively responsible to the medecin-chef and technically responsible to one or more of the central Ministry's divisions, depending on the activities in which he or she is engaged.



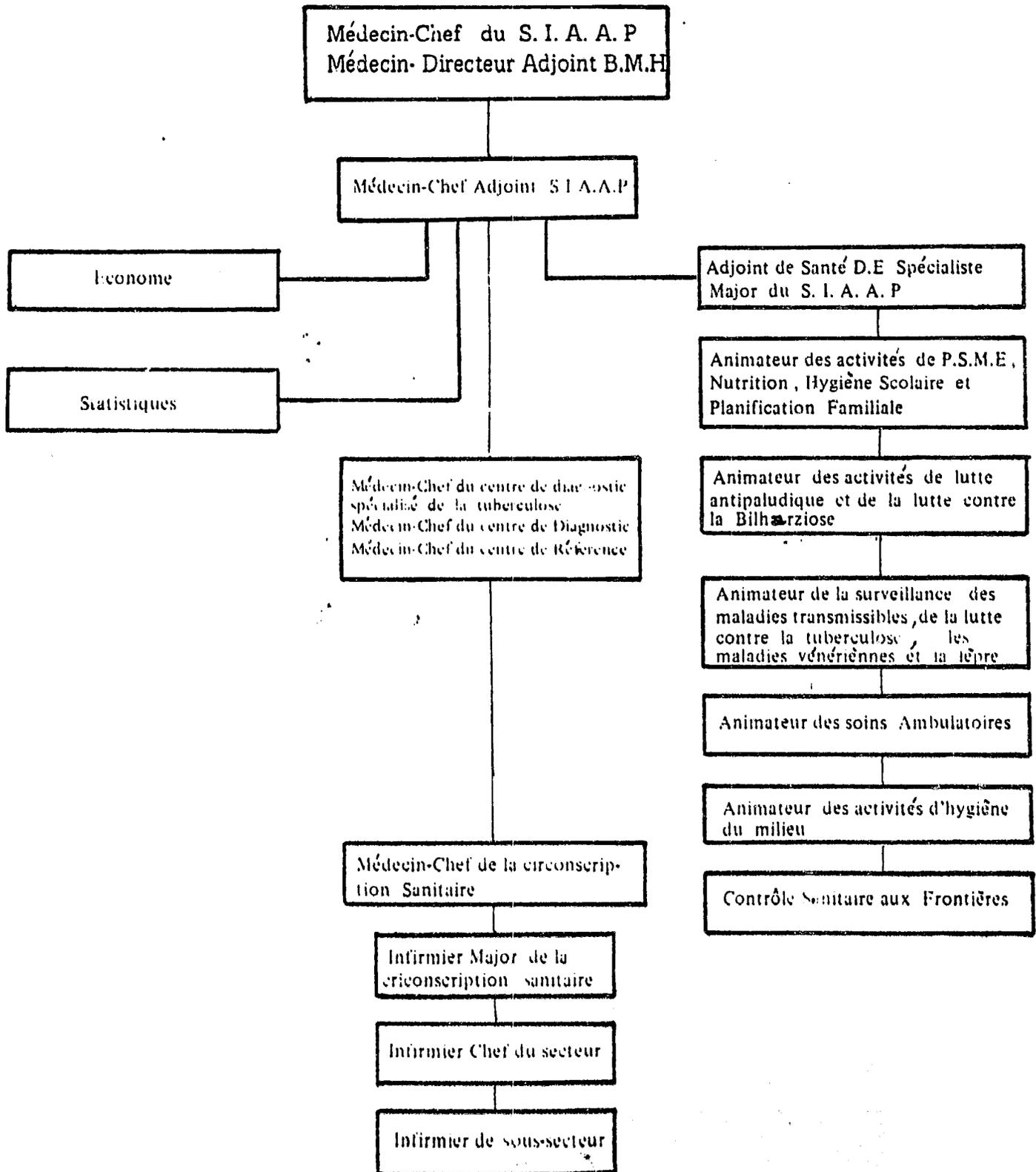
# ORGANISATION SANITAIRE D'UNE PROVINCE MEDICALE



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**ORGANISATION DU SERVICE DE L'INFRASTRUCTURE  
D'ACTIONS AMBULATOIRES PROVINCIAL OU PREFECTORAL**

( S. I. A. A. P )



There is at present no organized process by which the vertical programs and the SIAAP can together rationally prioritize and reconcile implied discrepancies in the work plans of the vertical programs. Such reconciliation must de facto take place. But it often does so in a haphazard way. Its adequacy depends on the capabilities and interest of the medecin-chef and his staff. All this has a most important result for the supervision and control of programs. If the various vertical work plans are not effectively reconciled, they lose their most important function -- being a guide and a standard against which to control work and program performance.

A third cause of the discrepancy between the paper infrastructure and programs and their effective operation is the success of the Moroccans in expanding their infrastructure and in proliferating their programs. The Moroccan health delivery system has grown so much so rapidly that it has outstripped the ability of its fundamental administrative systems to support it. The same administrative procedures and systems are being used to service a thousand centers and dispensaries as were being used to service a hundred, despite the fact that there are now over 35,000 people working in the system instead of less than three thousand. Administration has grown in quantity not quality. There are now, for example, 100 persons in personnel replicating the identical activities that were performed by ten. The activities may have made sense when there were only ten people doing them. They do not now. Yet a similar situation exists in most other administrative support functions including pharmaceutical and material logistics, accounting and budgeting and the collection and tabulation of health statistics and reports.

The problem of resource constraints and those of organizational structure and administrative support are related in two important ways. As there are not likely to be new major resources for the health system in the immediate future, further improvements in the services delivered by the health system must come from increased efficiency and effectiveness. Also, significant improvements in effectiveness and efficiency are likely to improve the changes of the Ministry's ability to obtain additional resources, both from the Moroccan government and from outside sources. The current response of the Ministry of Finance to the MOPH's request for additional resources for program expansion is: "You cannot even manage what you have now. Put your house in order and then come back and talk to us again." MOH officials have made clear their understanding of this dilemma. Indeed, the central importance of this project derives from the Ministry's decision to defer initiation of any major new activities or expansion until the Ministry has reformed its internal management.

The Ministry has started the hard task of doing just that. A new Secretary General, a career civil servant with a Ph.D. in Public Administration, has been appointed with the specific directive of improving management and administration. He, in turn, has brought new people into positions of responsibility who have started examining their problems and making changes. These include a new Director of Technical Affairs, a new Director of Personnel (formerly responsible for setting up a new personnel system in higher education) and a new Director of Infrastructure. This new leadership has already instituted some management and administrative reforms including the decentralization of some budgeting, personnel and procurement responsibilities to the provinces.

Last year, the Ministry sought the assistance of AID in its management and administration improvement efforts. AID responded by sending a consultant from the Johns Hopkins University to Rabat to meet with the Ministry and ascertain if and how AID might provide assistance. The consultant met with relevant counterparts at the Ministry in August and September of 1979 and concluded the following: that deficiencies in administrative and management systems were indeed a serious impediment to the effective delivery of basic health services; that the Ministry was committed to making improvements in this area; and that they required outside help, particularly in technical areas such as data processing and program budgeting. Specific systems identified as being of special importance to the Ministry were budgeting and accounting, personnel, health statistics and logistics.

This visit was followed by further discussions between USAID/Rabat and the Ministry and the preparation of a PID. It led to an overall analysis of the Ministry's management problems in March, 1980, by a two person team of outside consultants. Their analysis attempted to order and prioritize the Ministry's management problems and to identify how potential solutions might be grouped into an integrated project. The results of this analysis can be summarized as follows:

1. The areas of administration identified as problems by the Ministry were, with some additions and deletions, critical for improving effectiveness and efficiency of the health delivery system.

2. The process of administrative reform in these different areas of administration was essentially similar, so that a coordinated improvement plan ought to be drafted.

3. The process of improvement was more a process of institutional reform and change than one of acquiring new hardware and that this must be taken into consideration in the design of an overall improvement project.

4. Critical to the success of the overall effort would be upgrading and concentrating the management resources at the central Ministry.

5. Inclusion of managers at lower levels of the structure in the design of specific improvements, as well as their training during implementation, would be similarly critical to the project's overall success.

In September, 1980, a team from AID/Washington went to Rabat to work with the mission and Ministry in designing a Health Management Improvement project.

B. Summary Project Description

1. Project Summary

The project subsequently designed by USAID, the Ministry and the AID/W team is as follows:

A two-person team of resident U.S. advisors will work with the new MOH management team to design and introduce major changes in Ministry management systems and procedures. These changes will be in two areas:

a) Ministry overall management capacity, with particular concentration on planning, data management and evaluation; and

b) Specific administrative sub-systems, including Personnel, Health Statistics, Budgeting and Accounting, Pharmaceutical Logistics, and

**Material + Transport Logistics.**

Short-term consultants (approx. 30 person-months) will supplement the skills of the US/MOH team in specialized areas such as software preparation, curriculum development, file-system design, data-processing system design, etc.

With further regard to team composition, it is noted that the project will require a wide range of skills, crossing several "sub-disciplines" of management. The scope of the project will require, moreover, a labor-intensive, "hands-on" approach by the U.S. consultant team. For these reasons, the project design calls for a resident team of two persons (assigned concurrently for 3 years), who will have complementary skills and experience. A single consultant would not be able -- for lack of both time and technical capability -- to work effectively in such a variety of areas. Three long-term advisors would possibly be appropriate to the task, but would also cross a "treshhold" of direct U.S. participation not advisable for this project. In the judgement of USAID, the MOH and the AID/W PP teams, two resident advisors -- plus specialized short-term consultants -- represent an optimum mix of technical assistance. The two resident advisors would be individually screened and recruited by the MOH under separate host country contracts. The short-term consultants will be recruited, as needed, under existing Agency IQC's, grants and contracts such as those with MSH, CDC, and APHA.

The project will also provide some ancillary data processing equipment to a) tie in the MOH DP equipment to the existing computer at the

Secretariat of Plan, and b) enable the creation of an integrated, MOH wide data management system. A modest amount of audio-visual equipment will also be provided to facilitate in-country training (see below) of MOH staff in new management procedures.

U.S. and 3rd country participant training will prepare MOH managers in specific technical or administrative skills supportive of this project. In-country training -- primarily regional workshops and seminars for MOH field staff -- will a) solicit the views of provincial personnel re: proposed changes in MOH procedures; and b) train these personnel in the new systems/procedures adopted by the MOH as a result of the project.

The Goal of these activities is to improve the health of Morocco's rural and urban poor by improving the quality and quantity of health services available to them. Improvements in these services are unlikely, however, in the absence of significant progress toward achievement of the projects' Purpose which is /to improve the quality and quantity of the country's health services by increasing the effectiveness and efficiency of the GOM health delivery system. This objective will be realized by a) improving the capacity of the Ministry to manage itself at all levels (central, provincial, circumscription) and b) by institutionalizing changes in specific management and administrative support systems (operational planning and control, personnel, logistics, budget and accounting, service and use statistics) which are impairing effective management and administration.

## 2. Project Strategy

The strategy for accomplishing the project purpose consists of

coordinating three major activities:

- a. The development of the central Ministry's scarce management resources.

This involves collecting and concentrating the Ministry's best management talent (via a new organizational unit); upgrading that talent (via new people, new training and new technical assistance) and redirecting it (via activities incorporated into the plan of this project).

- b. Making improvements in specific administrative and management subsystems.

This involves using the new and upgraded management group within the Ministry (with additional support in the form of outside technical assistance) to work with administrative divisions and operational programs at all levels of the health system to identify, plan and carry out improvements in specific administrative systems.

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- c. Improving operational management and administration at all levels of the health system.

This involves doing long-term and medium-term as well as on-the-job training at various levels of the health system as appropriate. Some of this training will be technical and job-specific, relating to doing the new tasks that are part of the changes in the administrative subsystems (e.g., new forms and procedures). Some training, however, will be in substantive management and problem solving skills which are necessary if the products of the more efficient administrative systems are to affect work performance at the lowest levels of the delivery system.

### 3. Project Tactics

Critical aspects of the project's tactics (how the project's strategy is to be carried out and implemented) are as follows:

a. Concerning identification of administrative subsystems to be improved: The Ministry has concluded (with outside collaboration) that making improvements in the following management and administrative subsystems is essential to improve the efficiency and effectiveness of the delivery system:

1. health statistics
2. personnel administration
3. budgeting and cost accounting
4. pharmaceutical logistics
5. material logistics
6. coordination and control of operational plans

b. Concerning the sequence of improvement activities: The Ministry does not have the capacity to address all its problems of management and administration simultaneously. For reasons of management importance,

technical logic, as well as of organizational politics, project activities will be undertaken sequentially. Thus, the US/MOH will direct their attention initially to improving the personnel system; second, to operational planning and control and health statistics; third, to budgeting and cost accounting; and, finally, to logistics.

c. Concerning the grouping of project activities into manageable work tasks: To implement a project effectively, the numerous specific activities which compose it must be grouped into coordinated work tasks. This grouping should be guided by three considerations. The tasks should have identifiable beginnings and endings with results that can be evaluated. They ought to reflect an organization's structure so that specific groups within the organization can be given overall responsibility for carrying them out. They ought to reflect technical economies of scale so that technically integral tasks are not unnecessarily fractionalized or duplicated. These tasks (or 'modules') are as follows:

1. Improvement of central Ministry management analysis and program and evaluation capacity.
2. Improvement of Ministry data processing and analysis capacity.
3. Improvement of operational records management (service use statistics).
4. Increasing the coordination of program planning and operations.
5. Improvements in personnel system.
6. Improvements in programmatic budgeting and accounting.
7. Improvements in pharmaceutical distribution and supply.
8. Improvements in logistics system (material and transport).
9. Project evaluation.

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Tasks 1, 2 and 9 reflect sets of activities which improve the overall management capacity of the central Ministry and are of critical importance to the successful implementation of the other six tasks. These other six tasks, numbers 3 through 8, correspond directly to the sub-systems which this project will install/improve in the MOPH. These six tasks also correspond roughly to their relevant administrative divisions within the MOPH as follows: Task No. 3: Division of Statistics and Informatics; No. 4: Division of Plannification; No. 5: Division of Personnel; No. 6: Division of Budgeting and Accounting; No. 3: Division of Pharmacy; and No. 8: Division of Material. The three "overall" modules, i.e., numbers 1, 2 and 9 will be coordinated by the MOPH Directorate of Plannification.

#### 4. Project Outputs

Each of the above tasks represents a coordinated process for transforming the project inputs into outputs. These outputs are as follows:

- a. a Ministry with an institutionalized capacity for identifying, designing and implementing solutions to its problems;
- b. a data processing system flexible enough to handle the Ministry's changing administrative processing and management analysis needs;
- c. an institutionalized and operating process for coordinating and monitoring the implementation of basic health services;
- d. an efficient system for collecting, processing and communicating information essential for operating basic health programs;

3. a more efficient system for personnel administration which facilitates timely execution of essential personnel actions;

f. a budgeting and accounting system which facilitates rational allocation and control of resources by allowing the determination of actual program costs;

g. a more efficient procurement, storage and distribution of essential pharmaceuticals;

h. a more efficient logistics system for material supplies.

#### 5. End of Project Status

As discussed above, current management constraints in the MOH are preventing efficient utilization of scarce resources and are contributing to inequitable distribution of health services in Morocco. Because of these constraints and, despite the country's significant unmet health needs, the Ministry has concluded that it must defer initiation of new or expanded health activities until it can put its internal house in order.

Completion of this project is therefore an essential but intermediate step toward the larger Ministry goal of improving its system.

The project outputs, then, are not ends in themselves. Instead, they will provide the MOH with a now-lacking, necessary capacity to affect these broader changes.

The MOH has indicated forcefully that it intends to use this capacity. End-of-project conditions will therefore include those improvements in the health system which will result from application of the project's outputs. These include health facilities adequately staffed and equipped to provide previously unavailable health services; outreach programs

designed to maximize available resources and targetted on identified health problems; and -- as a result of savings realized through more effective utilization of resources -- the extension of health services to more people.

As a further consequence of these improvements, the health status of Morocco's poor will be improved. At present, the target population of Morocco's public health system frequently ignores the system -- in the correct assumption that Ministry clinics and dispensaries are not staffed or equipped to provide meaningful services. Revitalization of these local-level facilities will make them far more responsive to local health needs. Subsequent public perception of this fact will increase utilization of the system and, thereby, extend the benefits of the health system to people now lacking access to alternative health care.

#### 6. Project Inputs

The human and material inputs which will be provided by the GOM and USAID for carrying out the project can be summarized as follows:

a. GOM personnel: This will include the addition of at least five new full time persons at the central Ministry as well as the participation of supervisors and workers at all levels of the health system as the project is implemented.

b. GOM material inputs: The GOM will supply material inputs in the form of facilities for members of the implementation team (Moroccan and U.S., both long-term and TDY); data processing support in the form of access to the computer of the Secretariat of Plan; the use of other

ministry facilities as required (classrooms, etc.); and the normal recurring supplies associated with the improved administrative systems (forms, etc.).

c. Aid-financed personnel: AID will provide technical expertise in the form of two long-term advisors (three years each) in management and administrative systems and thirty person-months of specialized short-term consulting.

d. AID training: AID will provide for eight person-years of long-term and thirty months of short-term training outside of Morocco. AID will finance in-country short-term training to be carried out by the Institute for Public Administration in Casablanca. (AID will also assist in in-country training indirectly; as both long-term and short-term U.S. consultants will be involved in the preparation of seminars, workshops and short courses which will be given through the MOH's already existing training program.)

e. AID supplied commodities: Though the commodity portion of the project is small, AID will assist in providing some data processing equipment (to augment the MOH capacity currently at the Secretariat of Plan) and spare parts as well as some media equipment for use in the training program.

This brief description of the Moroccan Health Management Improvement project is presented schematically in Annex 1.

## 7. Project Feasibility

This project will touch on several aspects of the MOH management system. Further, the project will involve a relatively large number of discrete actions (see Annex 2) which must be completed to ensure

attainment of project outputs. Two general points should be noted however:

i) The project is comprehensive but not complex. Each of the project's activities, and the outputs they produce, are well within the capability of a competent management team. This is to say that the project, while fairly sweeping in its potential impact on the MOH, still represents a practical, conventional approach to management reform. The resident U.S. consultants recruited to assist in this project will have had prior experience elsewhere in the successful achievement of similar management improvement efforts.

ii) The MOH is strongly committed to this project. Reorganizational steps now underway in the Ministry are being implemented with specific regard toward facilitating project execution. The individual MOH members of the US/MOH management team were assigned on the basis of their ability to effectively participate in the design and implementation of project actions.

These two considerations -- of practical feasibility and strong organizational commitment -- lend this project a particularly <sup>STRONG</sup> likelihood of success.

### III PROJECT DESCRIPTION

#### A. Problem and Strategy

The Ministry of Public Health of Morocco is making a genuine effort to provide basic health care to a growing and widely distributed population. It has designed a full set of basic health services programs (immunization, communicable disease control, water and sanitation, maternal and child health and family planning) which it is attempting to implement through a large ambulatory health infrastructure (over a thousand health centers and dispensaries). The infrastructure and programs are well designed but, in practice, they work poorly. Their operation is dependent on administrative and management systems designed to handle the needs of a structure one tenth the size of the present (and growing) health delivery system.

Thus, we see that program plans are poorly coordinated and are effectively ignored during program implementation. Management and supervision are haphazard so that program quality control is both poor and uneven. A larger volume of data are collected but little are processed, analyzed or communicated in ways that would make them useful for management control. Budget and accounting practices prohibit the determination of actual program costs and impede attempts to rationalize resource allocation decisions. The personnel system is incapable of matching people and jobs in an effective and timely manner, thereby contributing to low morale and poor work performance. There are unnecessary delays and shortages in the distribution of essential supplies. These and other problems of management and administration prevent the Ministry from providing more and better services unless major new

resources are infused into the health sector. They also affect the willingness of both the Government of Morocco and of external donors to give the Ministry new resources -- because of its inability to administer effectively what is already has.

The purpose of the Moroccan Health Management Improvement project is to increase the quality and quantity of basic health services by improving the effectiveness and efficiency of the health delivery system. The basic strategy of the project envisions a coordinated attack on the Ministry's management and administration problems on three fronts: (1) It seeks to mobilize and strengthen the Ministry's scarce resources in management analysis, planning and evaluation; (2) to use this strengthened resource to effect improvements in specific administrative and management systems; and (3) to use the process of designing and implementing administrative system changes to upgrade the skill of managers at all levels. These project actions will interact and reinforce each other. Improved management skills will make the systems work better and improved management systems will more effectively utilize the skills of the program managers.

The rationale for each of these elements of the project strategy is described below:

1. Mobilizing and strengthening the Ministry's scarce management analysis skills

The project strategy emphasizes the establishment, within the Ministry, of a technical resource in the area of program and management analysis. The rationale here is that a cost-effective way of improving overall management and administrative practices within the Ministry is to

establish a critical mass of specialized managers and technicians who can take the lead in identifying and analyzing management problems, in working out and implementing solutions and in coordinating the management development efforts of the Ministry. Organizationally, this resource will take the form of a new Directorate of Planification attached directly to the Office of the Secretary General. The new directorate will, in effect, elevate and relocate the Division of Infrastructure and merge into it the present Divisions of Operations Research and Health Statistics. The Directorate will take on some new functions and add new personnel. It will have three divisions: Planning; Operations Research and Evaluation; and Health Statistics and Informatics. It will coordinate the efforts of the project in designing and implementing improvements in the Ministry's administrative subsystems and in providing training in operational management in the field as well as at the center.

## 2. Improving administrative and management support systems

The quality of basic services provided by a health ministry depends on several factors. Among other things, it depends on the extent to which the design of the health infrastructure is appropriate to the needs and circumstances of the country. Also, it depends on the range, scope and technical design of the programs that are offered through the infrastructure. Well designed infrastructures and programs, however, are necessary but not sufficient conditions for the delivery of quality basic health services. Several other conditions must be met. The centers and dispensaries that run the programs must be adequately staffed -- by well trained and motivated

health workers. Essential medical and non-medical material supplies and equipment must be provided in a timely and efficient manner. There must be close technical and operational direction of program delivery in the form of supervised and controlled work plans. There needs to be an informational base and a useable method for evaluating the effect and cost of providing specific health service programs. Thus, the quality of services depends in a direct way on the effectiveness and efficiency of the administrative system (organized groups of people with specialized skills and equipment performing related routine tasks) which carry out critical support functions: staffing, logistics, planning, supervision, cost-accounting, and data collection and analysis.

In Morocco, the GOM Ministry of Health has determined (with outside collaboration and corroboration) that poor performance in each of these areas of administrative support severely denegrades the actual quality of the health services which it provides. Thus, this project seeks to effect improvements in the following areas of administrative support:

- a. operational planning and control
- b. collection, processing, communication and analysis of operational health statistics
- c. personnel administration
- d. programmatic budgeting and cost accounting
- e. pharmaceutical logistics
- f. material logistics

### 3. Upgrading skills of managers

The third basic element of the project strategy concerns improving the general management ability of people throughout the health delivery system.

Because of the importance of this element, i.e., the need to institutionalize improved management skills in the Ministry, it has been included in the project as a major component of the strategy. Some of this training will be directed at those who operate specific administrative systems or need, for example, to fill out new forms differently. Much of the training, however, will be directed at the more general management skills necessary to use the improved administrative systems effectively. While the details of the specific training will be decided upon in implementation, some general training needs are apparent now. These include:

a. Long-term graduate degree training in selected areas of management and administration (including management information systems and operations research) for members of the central Ministry, particularly selected members of the Directorate of Planification.

b. Short-term training in general management and in program design and implementation (setting objectives, standards, monitoring, reporting, scheduling, etc.) for members of central Ministry program divisions, medecin-chefs and chefs of the circonscription.

c. Short-term training in specific technical areas related to the Health Management Improvement project (such as PERT scheduling methods) for central Ministry and provincial personnel.

d. Short-term and in-service training for the provincial staff of the medecin-chef and for some chefs of the circonscription in operational planning and control techniques.

e. Short-term and in-service training for the chefs of the circonscription in work planning, scheduling and coordination for small teams.

## B. Project Tactics: Major Project Tasks and Outputs

As discussed in Section II. B., the activities which are to be carried out in the Moroccan Health Management Improvement project are grouped into nine principal tasks. Six of these represent the specific administrative systems which are to be improved. Of the other three, one represents the improvement of the central Ministry core management analysis capacity. Another represents improvement in data processing capacity. The last represents project evaluation and review activities which have been built explicitly into the implementation of the project and elevated to the importance of a specific major project task.

Each of the six administrative support tasks is the principal responsibility of some specific division of the Ministry: personnel administration, of the Division of Personnel; operational planning and control, of the technical programs together with the *medecin-chefs* and the *chefs* of the circumscription (but with a new coordination function to be given to the new Division of Planning); operational health statistics, of the Office of Health Statistics (soon to become the Division of Statistics and Informatics); budgeting and accounting, of the Division of Budgeting and Accounting; pharmaceutical logistics, of the Division of Pharmacy; and material logistics, of the Division of Material.

Strengthening central Ministry management capacity, strengthening data processing capacity and project evaluation and review are all the primary responsibility of the various divisions of the Directorate of Planification.

These nine major tasks, or modules, of activities compose the plan of the project. These tasks are each designed to produce a specific project output. A list of the modules, the MOH group with primary responsibility for carrying out the tasks, and the outputs are listed on the following page.

TASKS:	RESPONSIBLE GROUPS:	OUTPUTS:
1. Improvement of central Ministry management analysis capacity	Directorate of Planification	Improved institutional capacity to solve management problems
2. Improve data processing capacity	Division of Statistics and Informatics	Data processing capability flexible enough to handle Ministry's needs
3. Improve operational records management	Division of Statistics and Informatics	Efficient system for collecting, analyzing and communicating operational statistics
4. Improve program planning and implementation	Division of Planification	Institutionalized process for coordinating vertical health programs
5. Improve personnel administration	Division of Personnel	Efficient and timely system personnel administration
6. Improve programmatic budgeting and accounting	Division of Budgeting and Accounting	Budgeting and accounting system which determines program costs and facilitates rational resource allocation
7. Improve pharmaceutical distribution and supply	Division of Pharmacy	Efficient procurement, storage and distribution of pharmaceuticals
8. Improve material transport and logistics	Division of Material	Efficient logistics system for material supplies and equipment
9. Project Evaluation and Review	Outside reviewers and Division of Planification	No direct final project output; intermediate output is modification of project activities

Of these nine project tasks, five of them (numbers 3, 5, 6, 7 and 8) go about producing their outputs (improved administrative systems) in basically similar ways. Each of these tasks has seven major activities in common:

1. Review and clarification of the respective responsibilities, functions and needs of the central Ministry and of field operations, particularly at the province and circumscription levels.

Some of the Ministry's problems stem from over-centralization of administrative functions. The Ministry recognizes this and has recently taken steps to decentralize some authority and responsibility. It has given the *medecin-chefs* the ability to do certain kinds of local purchasing and hiring that were previously reserved for Rabat. Decentralization is a two-edged sword, however. It can reduce administrative demands at the center, but it creates the need for increased capacity at lower levels. If such increases in capacity do not take place, all that is effectively decentralized is administrative inefficiency. To prevent this negative outcome, it is necessary to examine anew: (a) the authority and information that are needed to effectively run programs at the lowest levels of the system; (b) the management and technical capacity needed to discharge these responsibilities effectively; and (c) the center's needs for monitoring overall performance and quality and for fulfilling statutory requirements (e.g., the legal requirements of a unified civil service system in personnel). The process of this redefinition of responsibility itself must be a decentralized one, in that it must involve representatives of the center, the province and the circumscription in a dialogue in which their respective problems and requirements are identified and clarified.

2. Using a seminar-workshop and follow-on discussions to specify management information requirements at each level of the system.

Just as "armies travel on their stomachs", "ministries manage by their information". As two experts phrased it: "The managerial function

consists of utilizing and analyzing information so as to organize resources to achieve specified objectives." (Donald Farrar and John Meyer, Managerial Economics, Prentiss-Hall, Englewood-Cliffs, N.J., 1979, p. 8).

Having identified their respective responsibilities, each level of management and administration must identify what information it minimally needs to discharge those responsibilities. This will be done via a two or three day seminar-workshop in which general issues of 'management by objectives' and 'management by information' will be discussed. The project team (US/GOM) will hold follow-on discussions with each specific group or level or program involved and attempt to finalize a statement of information needs.

3. Review and evaluation of current administrative procedures, including the method and format of data collection, storage, processing, analysis, reporting and use.

This activity will involve observation and data collection in the field by the project team. For example, in the case of personnel, they will examine the work of the units of the Personnel Division and of the performance of personnel-related tasks at selected provinces and circumscriptions. They will evaluate prescribed administrative practices as well as their practical execution.

4. Designing a set of improvements in the administrative system which attempts to reconcile needs and resources.

In most cases, because of the Ministry's under-utilization of data processing and because of duplication in the collection of information, this set of activities will include the redesign of forms and data collection instruments; appropriate use of data processing capabilities, whether currently available or as developable under the project; and the redefinition of administrative procedures and work tasks.

5. Appraising concerned persons within the Ministry of the rationale, value and use of the new practices, procedures, forms, etc., as well as training in their use.

Personnel directly involved with the new systems will receive appropriate technical training. Beyond this specialized training, however, other MOH and provincial personnel -- including medecin-chefs, their colleagues and subordinates -- will be trained in the purpose and use of the new procedures.

This activity will be carried out via the large in-service training system which is one of the Ministry's few support systems that is working reasonably well. It is a provincially-based system which allows for in-service training to take place down to the lowest levels of the infrastructure. The use of this system would require preparation of training materials and the training of trainers at the province level.

6. Parallel or tandem implementation of the revised practices and procedures in a demonstration province.

This would typically be very brief, usually only for one month, as a means of identifying what ought to be, at most, marginal problems in implementation (e.g., some aspect of training needs to be clearer, longer, etc.) and facilitating nation-wide implementation.

7. Evaluation, modification, implementation and institutionalization of the new administrative systems.

Training and implementation of the revised administrative systems will take place in the remaining provinces and regions.

Project actions concerning improving the operational planning process (No. 3) and improving data processing capacity (No. 2) are discussed briefly below:

Improving the Coordination and Control of Operational Work Plans

The organization of operational work tasks in the Moroccan health delivery system is similar to that of many other countries. The health workers assigned to the health infrastructure ultimately report to the chief physician (medecin-Chef) of the province, who is responsible for the supervision of the ambulatory treatment system. However, programmatic supervision and technical direction (for other than ambulatory care) come from the technical divisions of the central Ministry. These are usually organized on functional lines (e.g., malaria control, schistosomiasis control, etc.). This results in somewhat overlapping tiers of responsibility -- not, in itself necessarily bad in that it can minimize the effects of poor supervision at one level or another. However, it also results in poor coordination among vertical programs so that the simultaneous execution of all plans by the health workers is often incompatible or impossible and their reconciliation is often poorly thought out and haphazardly executed. Such reconciliation is usually a function of the strength, personality and disposition of the individual medecin-chef or of occasional informal coordination among some central Ministry programs.

The project attempts to address this issue of poor coordination of operational planning by upgrading the management capacity of the Directorate (Division) of Planification to do integrated planning and by attempting to set up an institutional process of give and take (see below) within the central/provincial health system. This latter process

recognizes the key role of the medecin-chef and other provincial staff in ensuring effective program implementation and, therefore, seeks to reinforce their actual participation in the new operational planning system. The activities that are projected to take place in this process can be summarized as follows:

1. Providing additional staff and training for the new Division of Planification. This training will focus on operational and work planning and include the use of a computerized, integrative scheduling package. This package will greatly facilitate the mechanical aspects of the task of integrating the work plans of the vertical programs at various levels in the delivery system hierarchy.

2. Involving both the staffs of the vertical programs and of the medecin-chefs in a series of seminar-workshops in order to focus their attention on and clarify the problems of coordinating operational plans, to upgrade their skills in putting together such plans and to help insure that their draft individual plans are technically compatible.

3. Technical integration of the draft plans of the various vertical programs and of the medecin-chefs using the assistance of the computerized scheduling system.

4. The identification, evaluation and resolution of inconsistencies in the vertical plans. This will involve additional work meetings between the participants of the previous seminars.

5. Conducting seminar workshops for the majors of the circumscription and other staff of the medecin-chef covering how to use the integrated plans in coordinating monthly work schedules in the infrastructure.

Improving the Ministry Data Processing Capacity

The data processing task of module or the project seeks to create a capacity which will meet the Ministry's varied data processing needs in a way which is easily maintainable and usable, cost-efficient and yet flexible enough to handle its anticipated growth needs for the intermediate future. This alternative does not require the purchase of a computer by the Ministry, but seeks to take advantage of the existence of a large and underutilized computer at the Ministry of Plan.\* It attempts to maximize the Ministry's scarcest resource in this area, the human resource (people skilled in data processing and analysis) and not computer throughput. It is predicated on acquiring and developing a fairly non-traditional data processing capacity, particularly in the area of software. Specifically, it seeks to acquire a single integrated software system which will be composed of the following subsystems:

1. An integrated file access system which will allow rapid retrieval of data from various technical and support divisions of the MOPH.
2. A generalized report writing system for processing recurring reports and tabulations.

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\* It may require some additional hardware (e.g., communications interface) for the Plan computer. The exact requirements will be specified as a part of the project implementation process.

3. A conversational data analysis package which will enable the processing of simple statistics and graphics.

4. A hierarchical critical path scheduling system which will facilitate coordinating the plans of the Ministry's various programs.

5. Traditional preprogrammed reports for recurring computer runs and special formatting.

6. Batch input programs for transforming new data into base base files.

The generalized reporter-writer, the conversational data analysis package and the hierarchical scheduling system will all use the generalized file access system as their means for accessing data. This will greatly facilitate system maintenance in that a single data access system will have to be maintained rather than several. It will also allow for a dynamic and flexible system which can be easily adapted to the Ministry's needs as they change over time.

## C. Project Inputs

### U.S. Government:

The U.S. Government contribution to this project will include long and short term consultants; costs for long-term U.S., short-term U.S., and short-term 3rd country training; some data processing equipment and audio-visual supplies; and miscellaneous costs for evaluation, inflation, and contingencies.

#### 1. U.S. Consultants:

The centerpiece of the U.S. contribution will be the technical services of two resident advisors to the MOH, plus 30 person months of short term consultants in specialized management and technical fields. The resident consultants (3 years each, to be in place concurrently) must have extensive experience in building management skills, and in institutionalizing administrative procedures in developing countries.

USAID notes that the GOM Ministry of Health has approached the U.S. for this assistance largely because of the Ministry's recognition of U.S. dominance/superiority in the general field of management and particularly management information systems. This recognition is particularly significant in view of the Ministry's (indeed the Moroccan Government's) reflection of traditional, highly centralized French bureaucratic structure. The Health Ministry is aware of the limitations posed by the French model -- and, of course, by failure to correct inefficiencies in many of its uniquely Moroccan management systems -- and has concluded that U.S. management expertise represents the most effective response to these problems. Beyond considerations of comparative U.S. advantage, however, is the fact that this assistance has been requested in the first place. Management and administration improvements affect the essence of the

Ministry as an institution - touching on lines of authority, job definition, relative placement of divisions and positions, etc. The fact that the Health Ministry is prepared to submit these sensitive issues to joint US/GOM assessment and improvement indicates a very high degree of confidence in the "political" as well as the technical aspects of U.S. assistance. For these reasons, particular care must be given to the selection of the U.S. consultants. The comprehensiveness with which the specific activities of these consultants have been discussed in this Paper reflects the care, and the intensity, with which the U.S. PP team and their GOM counterparts have approached the project.

The MOH has already begun work on a number of activities which will contribute to increased effectiveness of the consultants and to the success of the overall project. These include organizational activities, such as setting up the new Directorate of Planification, connected to the office of the Secretary General; initiation of a management training program for the director of this Unit, and a study of work problems in the Division of Personnel. The work of the project consultants will be to assist the Ministry in carrying out and adapting the other activities called for in the project plan so that the project's objectives can be achieved. The scope of work for the resident consultants will be as follows:

- a. Analyze the information, planning, administrative and logistics systems of the MOH to identify problems and impediments to more effective management.
- b. Propose necessary modifications to MOH management systems and procedures.

- c. Assist in efforts to revise and upgrade management systems, including data management operations.
- d. Assist in analysis of MOH budgeting and accounting procedures; recommend and assist in implementing necessary changes in B&A procedures.
- e. Assist in preparation of a management training plan, including provision of in-country as well as out-of-country training programs.
- f. Train MOH personnel in new management procedures; participate in selection of appropriate personnel for further professional training.
- g. Identify short-term consultant requirements in specialized and/or technical areas.
- h. Assist the MOH design and implement a continuing program evaluation procedure.

Each of the two consultants should possess the following qualifications:

- Advanced training in management, with training in statistics and/or data management.
- Extensive experience in analysis and correction of management problems in large private or public sector organizations.
- French/<sup>or Arabic</sup> language competence at least equivalent to the S-3, R-3 level.

At least one (but not necessarily the same) consultant should possess the following additional qualifications:

- Familiarity with Planning-Programming-Budgeting Systems (PPBS)
- Specific experience in health planning/programming/management in a developing country.

Short-term consultant requirements will be determined on a case-by-case basis by the US/MOH team. The MOH will advise USAID of its short-term consultant requirements, and USAID will recruit qualified individuals via existing IQCs, grants and contracts. Illustrative areas of short-term consultant participation include data processing, preparation of a uniform file system, curriculum development and procurement/logistics systems.

2. Commodities:

Commodities to be provided under the project fall into two categories:

- a) ancillary data processing equipment; and
- b) audio-visual equipment.

The precise items of DP equipment to be provided will be determined by the resident consultant team, in consultation with the MOH and USAID. The PP team has concluded, however, that the project will not require major investment in additional computers or other large hardware items. There is a requirement for interface equipment which will connect MOH data processing facilities to the Honeywell-Bull computer at the Secretariat of Plan; and a software system which will integrate various functions, including file access, report writing, data analysis, etc.

A discussion of the reasons for and applications of DP equipment under this project is included in Section IV, Technical Analyses.

Audio-visual and training equipment provided under the project includes projectors, screens, slides and transparencies (eight sets) to be used by the MOH in its series of in-country training/orientation programs for provincial health personnel. These training programs, to be carried out during the life of the project, will train Ministry field staff in the use of new forms, procedures, responsibilities, etc., introduced by the project.

### 3. Training:

The project includes funding for 8 person years of U.S. long-term; 29 person months of U.S. and third country short-term; and a series of in-country training sessions and workshops to train MOH field staff in their responsibilities under the Ministry's revised management procedures. The MOH, in consultation with the U.S. consultant team and the Secretariat of Plan, will select the candidates for U.S. and third-country training. The MOH has begun, however, the process of identifying personnel who will be prepared to commence training during the first year of the project.

The in-country training programs will be built into the Health Ministry's annual schedule of regional in-service training sessions. These project-related sessions will be additional to the normal schedule, however, and will utilize new curricula to be developed by the MOH and the U.S. consultant team - probably with assistance from U.S. short-term consultants.

### B. GOM

The GOM intends to recruit five (5) new technicians, including 2 information

systems analysts/computer programmers; one (1) budget specialist; and one (1) personnel specialist, who will work in direct support of this project.

In addition, the GOM will pay the round-trip transportation costs to the U.S. for approximately nine (9) participants; and round-trip transportation costs to a third country for approximately six (6) participants. The GOM will also pay the salaries of the participants during their training.

Other GOM costs include salaries of trainers/trainers; travel/per diem costs of trainers, medicine chefs, and majeurs for their participation in regional seminars and workshops; office facilities and supplies for the U.S. consultants; and in-country transportation costs for U.S. and MOH project personnel.

Project inputs are summarized below. (For a detailed, annual budget, see the Project Budget, page 90):

U.S.

1) <u>Personnel</u>	<u>897,000</u>
- 2 U.S. resident advisors for 3 years each (\$600,000)	
- 1 Admin Assistant, <u>local hire, (\$45,000)</u> *	
- 30 person months consultants (\$252,000)	
2) <u>Training</u>	<u>547,000</u>
- 8 person years U.S. long-term (\$176,000)	
- 20 person months U.S. short-term (\$50,000)	
- 9 person months 3rd country (\$14,000)	
- In-country English long training (\$21,000)	
- In-country seminars/workshops (\$286,000)	

\* Moroccan or third country national; to be recruited in Morocco

3) <u>Commodities</u>	<u>\$ 370,000</u>
- Data processing equipment (\$265,000)	
- Audio-visual equipment (\$105,000)	
4) <u>Evaluation</u>	<u>10,000</u>
5) <u>Inflation @ 15% p/a (\$274,000) and</u>	
<u>Contingencies @10% p/a (\$183,000) :</u>	<u>457,000</u>
U.S. Sub-Total:	<u>\$ 2,281,000</u>

GCM

- Personnel (salaries)	<u>\$ 1,328,000</u>
- Travel costs for participants	<u>15,000</u>
- Office space	<u>9,000</u>
- Depreciation costs	<u>68,000</u>
- Transport	<u>12,000</u>
- <u>Contingencies, Inflation (10% &amp; 15% respectively)</u>	<u>358,000</u>
GCM Sub-Total:	<u>1,790,000</u>

PROJECT TOTAL: \$ 4,071,000

***IV*** PROJECT SPECIFIC ANALYSES

## A. TECHNICAL ANALYSIS

The purpose of this technical analysis is to examine and evaluate the technical feasibility and effectiveness of the project. To meet the needs of persons who require a more thorough and detailed description and analysis, an appendix "Improving Management and Administration for Health Service Delivery in Morocco: A Systematic Analysis", is attached to the end of this project paper.

This technical analysis discusses the following topics:

- The problem (why a project addressed to management improvement?)
- The project's strategy and tactics
- The technical tools to be used to carry out the strategy and tactics.

### I. TECHNICAL ANALYSIS OF THE PROBLEM

There are two aspects to be considered in the technical analysis of the problem toward which the project is directed -- improvement of the effectiveness and efficiency of the Morocco health delivery system:

- Does it make sense for the Ministry to address this problem?
- Does it make sense for AID (given its mandate) to assist the Ministry in doing so?

Both of these issues are addressed in order.

#### A. The Need for Improved Management Systems in the Ministry of Health

While the amount of resources required to implement the management improvement project are small, there are numerous other good uses to which they might be put. They could be used to fill out the planned health

infrastructure; to more fully implement some presently effective programs, such as schistosomiasis, to alleviate the scarcity of some material input such as pharmaceuticals, etc. Despite the virtually infinite variation in the number of reasonable alternatives that the Ministry could undertake with project funds, it has put its priority on improving management and administration for the following reasons:

1. Program effectiveness depends on institutional effectiveness.

It rests not simply on sophistication of technology or brilliance of program design but on the management of implementation and the control of quality, cost and schedule.

2. The institutional effectiveness of the Ministry is an important factor constraining its ability to deliver present programs effectively as well as its ability to expand or introduce new programs.

The management and administration system of the Ministry has not changed significantly since independence. The same systems and procedures used to place and direct 5000 persons are being used to place and direct 35,000. The same system used to supply and supervise a handful of delivery units is being used for over a thousand geographically disperse dispensaries and health centers. The results are that quality and cost control are poor, with great variation between regions and among units within the same region. Positions are difficult to identify and fill with a consequent degradation in employee morale and performance. Service and use statistics are cumbersome to obtain, as well as duplicative, and yet often are not used so that administration is attempting to keep its head above water in a sea of paper which often diverts it from more important tasks. There are delays and

inefficiencies in supply and logistics which exacerbate real scarcities. With all these immediate problems, management has little time to step back and evaluate where it is and where it wants to be. These problems have been recognized by the new leadership of the Ministry, as well as by outside groups such as the World Bank, UNFPA and AID (both in technical reports and in the CDSS). It has also been recognized by the Ministry of Finance in responding to the MOPH's budget requests with the retort: "You cannot manage effective what you have now, so how could you use additional resources effectively?"

B. The Relevance of Management Improvement in the Ministry to Primary Health Care (i.e., Project Consistency with AID Health Assistance Policy)

The improvement of management and administration in the MOPH is the immediate measurable objective of the project. It is not the ultimate objective, either for the Ministry or for AID. While efficiency is a goal worthy of being pursued in and of itself, there is a rationale for pursuing it in this case which goes outside and beyond itself. Efficient management and administration are necessary conditions for primary health care delivery. Thus, because of present inefficiencies, availability of effective primary health care in Morocco is limited by management and administration problems. It is important to note, however, that addressing these problems does not logically guarantee improvement in the primary health care system. This will depend on the priorities in delivery toward which the Moroccans will direct their more efficient system. At the present time, there are strong indications to support the judgment that they will use the tool of a more

efficient organization to better design and target the mix of services they provide, i.e., toward under-served and highly vulnerable groups.

Both Morocco and the United States are signatories of the Declaration of Alma Alta which recorded and ratified contemporary views on "primary health care." Of the twenty-one recommendations of the conference, roughly one third dealt with issues of health management and administration. In effect, the conference viewed the improvement of primary health care systems as resting on three pillars:

- altering the mix of services, with more emphasis on prevention, with greater emphasis on "appropriate care" (i.e., more emphasis on ambulatory as compared to residential treatment), and with greater emphasis on the integration of services at all levels;
- redirecting the targeting of services with more emphasis on high risk or high impact groups and on under-represented or under-serviced groups, namely the rural poor;
- the improvement of quality and cost control by controlling the gross inefficiencies which usually plague ministries of health by improving health management and administration.

The conference does not address the issue of the order in which the three pillars should be put into place. In the Moroccan context, however, the situation is such that further movement cannot be made in building the first two pillars without now giving some attention to the construction of the third. In terms of both the mix and targeting of services, the MOPH has shown commitment to changes mandated by the concept of primary care. Its entire infrastructure is based on a concept of hierarchical referral (the triage) and an attempt to get effective care down to the community level and not leave it concentrated in the hospitals. It is now considering

the possibility of adding another level to its infrastructure which would locate services even closer to the community. It has shown, both in its oral statements and in its budget priorities, an emphasis on preventive activities, such as its new program in schistosomiasis and the expansion of its program in immunization. Finally, it has recognized how its own management and administration is constraining its activities in these other areas and has begun to take action. New personnel have been appointed with a mandate to improve management and administration. These include the new Secretary General, who is a professional administrator with a Ph.D. in Public Administration; a new Director of Personnel and a new Director of Infrastructure. Further investments of time and resources in this area, as envisioned by the project, seem to be a wise decision for the Moroccans, given their commitment to the development of an effective system for basic health care. It is an appropriate problem area for AID to provide assistance, both because of its mandate and because of the prospect of project success given the commitment on the part of the Moroccans.

## II. TECHNICAL ANALYSIS OF PROJECT STRATEGY AND TACTICS

The technical analysis of the problem and strategy will discuss, in order, the following topics:

- -- the basic strategy;
- -- the tactics of implementation;
- -- the content of the major project activities.

### A. Technical Analysis of the Project Strategy

The basic strategy of the project, described previously, consists of a coordinated "one-two punch" of concentrating and upgrading scarce management skills and then using this to make improvements in specific

management and administration subsystems. As an overall project strategy, this prepresents a viable and effective approach. It recognizes the following facts:

1. the scarcity of well-skilled managers and administrators in the Ministry;
2. the principle of "concentration of force" or organizational reform, i.e., that there must be a critical mass of management talent (which could be dissipated if spread too quickly across an entire organization) if organizational reforms are to be carried out;
3. the dynamic nature of the environment in which the Ministry operates, and the need not simply to mold the organization in a new pattern, but to give it the capacity to rationally adapt to a changing environment over time.

Thus, the project wisely attempts to do more than simply make improvements in a few administrative systems. It attempts to use the process of making these improvements to upgrade the Ministry's capacity for making other administrative and management changes in the future. The process of making the improvements becomes an important learning and development experience for the Ministry's new management group. But even more importantly, the process of making the improvements upgrades management skills at lower levels of the organization. It provides medium, short-term and, most importantly, on-the-job training to managers in the system, from the staffs of the medecin-chefs to those of the circumscription. It is aimed at not only new data and new procedures, but at having people use this in doing their jobs better.

## B. Technical Analysis of the Tactics of Implementation

Not only is the basic strategy of the project technically sound but the tactics of implementation appear to be sound also. In this regard, we can make the following observations:

1. The selection of particular subsystems on which the management improvement efforts are to be focused makes good management sense. It is the result of a careful and comprehensive analysis of the Ministry's management and administration needs, of the identification of major problem areas, and of some attempt to prioritize among both problems and solutions.

2. The division and organization of the project into the nine major modules is technically sound in that each module has identifiable and measurable results, which makes both for better control and better morale and motivation.

3. The sequencing of the activities to be carried out in implementing the various modules is technically sound in that it recognizes the complementarity and technical interdependence of many specific activities and attempts to build this into a master system (e.g., dependence of certain administrative improvements on having a data processing system in place; and the dependence of the design of the data processing system on a careful examination of administrative system requirements).

4. The sequencing of activities, particularly the order of addressing particular subsystems, is technically appropriate in terms

of organizational politics, in that it defers handling more controversial or sensitive systems until successes can be shown in those that are less so. It is done deliberately, based on the empirical judgments of the Ministry.

### C. Technical Analysis of Project Activities

Finally, we need to say something about the technical adequacy of the content of the activities which all together make up the project. Pertinent technical evaluations and judgments in this regard might be summarized as follows:

1. The activities themselves appear to be defined at an appropriate level of specificity, in that they provide guidance as to the important aspects of the process of implementation, yet deliberately leave open important details to the uncertainties of implementation. For example, while they specify descriptive characteristics of the data processing system from the perspective of the end-user, they leave open the details of the particular hardware system on which the software would be implemented, realizing that this is a technical detail which must be decided on the basis of comparative cost and effect information during the process of implementation.

2. The ensemble of activities properly takes a holistic view of the management process, avoiding the common pitfall of focusing on a single or smaller number of functional aspects. It focuses (both separately and together) on elements of data collection; data processing;

data analysis and reporting; data communication and organizational structure; as well as the skill and methods with which management uses data in making and carrying out decisions.

3. The activities as a whole recognize that organizational change must be a communicative process: to avoid getting a one-sided perception of problems, to overcome organizational inertia and resistance, and to stimulate discussion and better approaches and solutions. Thus, in each specific sub-system, an important element of communication is built into the process. For example, there are seminars to facilitate the interaction between the medecin-chefs and the central ministry for purposes of clarifying problems in operational work planning. Similarly, there are seminar-workshops between the majeurs and the central ministry administration in order to clarify responsibilities, perceptions and problems and to identify potential solutions concerning the personnel system.

4. The activities show cognizance of the costs as well as the benefits of more and better information and build into each sub-system improvement in the early identification and definition of management's real information needs.

5. The total of activities also shows cognizance of the two sides of the coin of the organizational centralization-decentralization issue, and attempts to address that issue in a pragmatic way. They build into the implementation process the interaction between persons from the central ministry administration divisions and technical programs and from the provincial infrastructure. This is done to facilitate the

clarification of their respective responsibilities and to minimize conflict and build consensus in the process of clarification.

6. The activities also realistically take into account both the material and human resources of the Ministry. They set up a series of goals which undoubtedly challenges the ministry in their implementation, yet they include nothing that, with good luck, hard work and competent technical assistance, cannot be accomplished.

### III. TECHNICAL ANALYSIS OF SOME SPECIFIC PROJECT TOOLS

In addition to evaluating a project's overall strategy, tactics of implementation and content of activities, it is important, when "high technology" elements are involved, to evaluate the intended use and potential abuse of the specific technical tools involved. In this project, there is one such tool which deserves this special attention and analysis -- electronic data processing.

The transfer of EDP technology is an area of activity which remains controversial for AID. Because of the present world-wide dominance and superiority of American technology in this area, there are numerous requests, some appropriate, some not, for AID to assist in the acquisition of this technology. There is no uniformity of opinion within AID as to how the agency ought to respond to such requests, which are often the occasion for intense debate and discussion. The contribution of such discussion to a reasonable evaluation of the particular proposed use of EDP will depend on the ability of the participants to evaluate each case de novo on its own merits and on the establishment of explicit criteria and questions for evaluation.

In the present case, the need for and strategy and tactics of the project have already been evaluated. The technical analysis of the use of EDP in the project must be done within the broader context of this evaluation: in terms of its contribution to the effective execution of the project's strategy and tactics. Thus, we can summarize the issues for the technical analysis of the use of EDP in the project in terms of the following questions:

-- What is the contribution of the proposed use of EDP to the achievement of the project's objectives?

-- Are there other ways to achieve the project's objectives without the use of EDP or by using EDP in some other way?

The particular uses of EDP in carrying out the project's strategy and tactics, and evaluations of these uses, are summarized below:

#### A. Operational records

The ministry is choking on undigested paper. The project attempts to relieve this situation by better identifying information needs, streamlining data collection instruments so as to reduce duplication and by providing for the electronic processing of certain data. If information is to be useful to management, it must be processed in a timely fashion. The size of the Moroccan infrastructure is such that without some assistance in the form of EDP, most forms cannot be summarized or analyzed in time to provide descriptions and reports which are of practical use in management and supervision.

## B. Personnel

The project proposes to use EDP in the personnel system, not to automate it, in that the actual files will remain manual, but simply as a way of identifying where a file is so that it can be accessed in a reasonable time and of facilitating the tracking of civil service positions. It no longer makes any kind of sense to continue to attempt to maintain manual indexes (which are grossly inaccurate and months out of date) to the files of 35,000 workers and to track 25,000 thousand civil service positions. The use of EDP is essential to improvement in this area.

## C. Operations planning

The coordination and integration of operational work plans for a dozen programs across thirty-nine provinces physically, given enough bodies, can be done manually. Doing so is time-consuming and person-consuming to the point of being quite impractical. Even more importantly, it does not allow for any experimentation, for any attempt at combining plans in more than one way, nor for "playing out" their implications. This is an important ability for management to have and it cannot have it without access to an easy to use, flexible data processing system.

## D. Administrative systems (budgeting, accounting and logistics)

The major problem in budgeting and accounting is the inability to determine programmatic costs. For a variety of good historical, political, administrative and managerial reasons, the project does not attempt to replace the current system in this area with a PPBS. Rather, it attempts to provide a way for programmatic cost information to be integrated into the present accounting system without major increases in workload. It is

based on an ability to easily combine, in multiple ways, information from different programs, from different regions and from different operating files. It is completely infeasible to do this without access to an EDP system which allows for the storage of information once, for its extraction in varied ways, and for the combination and integration for different managerial and administrative purposes. This applies also to the logistics and supply systems whose information can also be integrated with that of budget and accounting.

E. Management analysis

Probably the most important single use of EDP in the project is in the area of management analysis. The purpose here is to allow management to ask questions which are important for its planning and decision making and for its getting answers to these questions in a usable and timely way. Thus, for example, it might want to ask questions about the recurring costs of different changes in the health infrastructure; or concerning numbers of positive malaria cases by province by month. While some questions can be answered independently of the use of EDP, in practice, many cannot. And if management cannot easily get answers to questions, it may just not ask them. Thus, the use of EDP in management analysis becomes an important tool for achieving one of the project's major objectives -- the improvement of the Ministry's management capacity.

B. SOCIAL SOUNDNESS ANALYSES

Summary

The successful implementation of this project depends not only on the introduction of technological innovation but also upon the institutionalization of significant behavioral change. The project will encourage decentralization in a highly centralized bureaucracy, open communication where, currently, relationships and information flow are rigidly hierarchical, and foster integration of data analysis, planning and administration, now distinct functions. To achieve these objectives, the project includes a critical training component which is complemented by training activities in other MOPH programs. The careful design, testing and implementation of this component will not only introduce new technological approaches but also new ways of working and relating. The current motivation for self-examination and change is high in the central ministry and in several provinces. The project will benefit from this motivation and commitment as well as the convergence of a number of like-minded individuals in a dynamic team. The major challenge will be to translate this commitment into substantial institutional change which extends to all levels of the health delivery system.

\* \* \*

The bureaucratic setting in which these changes are to take place is derived from a model originally developed during the military occupation of Morocco by the French.

The health administration came into being with the creation of the Directorate of Public Health in 1926 with a central division and extremely hierarchical regional divisions headed by Chief Regional Medical Officers acting as the full representatives of the Directorate as coordinators of all medical activities.

<sup>1</sup> Numéro Special Consacré à la Santé Publique au Maroc. Maroc Médical. Jan. 1950:31 (translated from the French).

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The Chief Medical Officer of each of seven regions was attached to the military administration and had considerable independent authority and latitude in the execution of public health programs.

Since independence, while this basic structure remains intact, a number of fundamental changes have been introduced to deliver health services more effectively and extensively to an ever-expanding population. These changes have included:

1. In line with national policies, there have been numerous administrative subdivisions of geographic regions into provinces and provinces into smaller divisions with a consequent proliferation of provincial administrations for the objectives of bringing national services and administration closer to the population. In health, there are currently 39 provinces of widely divergent population, area, access and characteristics, each designed to be administered independently by a Chief Medical Officer.

2. To staff the expanded bureaucracy and to keep up with the rapidly growing population, there has been a massive expansion of personnel and an extensive program of facility construction. Nonetheless, the health infrastructure is only partially complete and many key posts remain unfilled.

3. At the same time, there has been a centralization of certain administrative functions, notably personnel.

4. To enhance the MOPH's management effectiveness, there have been several reorganizations of existing services and divisions on both the national and provincial levels.

There are considerable strengths in the existing system, notably an effective triage system which channels patients to appropriate treatment levels. However, there is widespread recognition in the MOPH that there are also elements which have remained stagnant and which are not adapted

## Social analysis

to the current needs of a greatly expanded bureaucracy and to the realities of delivering better health services to a wider population. This project grows out of this recognition and will capitalize on the motivation and commitment to change antiquated but highly institutionalized systems of management and administration.

Current patterns of communication and information flow tend to be hierarchical and rigid on both institutional and inter-personal levels. Data collection is organized hierarchically with each facility preparing statistical resumes of work loads by activity and of equipment and supply use. These data are aggregated at subsequent levels to compile provincial and national statistics. Much of the information transmitted is "noisé": irrelevant, often inaccurate and tending to conceal rather than reveal information needed for effective programming and management. In line with the provincial staffs' view of themselves as executing Agents with little in the way of programming or planning responsibility, data is collected primarily to fulfill bureaucratic requirements. It is used in supervision only to signal gross discrepancies in performance. Communication from the central level tends to be in the form of directives and requests for information or for explanations of activities and delays. In addition, the central ministry distributes aggregated performance statistics. These tend to be slow in coming and do not feed back into management. In contrast with the communications patterns just described, information about epidemics and other emergencies is rapid, effective and program-oriented at all levels.

The project addresses institutional communication needs in several ways. First, the project will raise the quality and relevance of information gathered. Second, it will seek to develop the capacity to analyse data

## Social analysis

on all levels of the health system. Finally, by improving data processing on the central level, it will reduce the turn-around time of getting relevant information back to the provincial level where it can be incorporated into program management. A critical aspect to be addressed in the training component will be the building of the capacity of provincial level administrators to utilize data effectively in management. Training designed to encourage increased inter-personal communication skills on all levels of the system will also contribute to more effective management.

Changes introduced in project activities, such as those in personnel and budget, will address and affect the entire Moroccan health system. The realization of project components in each of the provinces will depend upon the availability of key personnel and their effective motivation and training. Currently, there is considerable variation in staffing levels and patterns in the provinces with shortfalls from identified needs in every administrative category. The project's personnel component will permit open positions to be more readily identified and filled except where there are absolute resource constraints. Nevertheless, it will be important in developing training plans and materials to take into account possible staffing variations so that successful implementation is not dependent upon full staffing of provincial administrations.

Several additional factors contributing to the extensive need for management improvement and training have been identified. These include the lack of administrative training or experience by physicians assigned key administrative roles and inadequate training for others filling administrative roles.

The training needs identified in this section are being addressed under this project and in related MOPH activities.

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Under the project, the MOPH will carry out the training of central and provincial level personnel in the use of new techniques (including data analysis, management and communications skills) using curricula developed by project and MOPH staff. Key provincial administrators will be oriented and trained as trainers in workshops and seminars. In addition, construction is underway of a public health school, to be attached to the MOPH, that will train new provincial medical officers and other personnel in public health and administration. Reforms in the medical school curriculum have been instituted as well which will better orient future doctors in the problems, objectives and administration of public health programs. Testing for appropriateness and effectiveness of training materials and techniques developed under the project is essential to achieving training objectives.

C. BENEFICIARY ANALYSES

The long-term beneficiaries of this project are the people of Morocco who will enjoy more effective delivery of appropriate health services.

- Improved data collection and analysis will enable the MOPH to identify priority health problems and target populations.
- Improved coordination between technical and administrative services will permit more cost-effective programming and thus a better use of limited resources.
- Improved logistics systems will allow for higher quality services to be offered more efficiently to a wider audience.
- Improved program evaluation capability at all levels will permit the MOPH to maintain higher standards through more effective and more appropriate supervision.
- Improved communications skills will benefit not only management of programs but also, if extended to patients, the more effective delivery of services.
- Improved personnel systems will raise employee morale and job performance.

The immediate beneficiaries of the project include the approximately 35,000 MOPH personnel who will benefit as employees and in the performance of their work. Currently, employees at all levels of the health system suffer from administrative delays in being assigned, promoted and transferred and receiving benefits which can only be redressed by the central ministry and frequently require a trip to the capital. The extent of worker grievances were revealed in the recent strike of MOPH employees. Additional training will also permit employee advancement and improved job performance and satisfaction.

Women stand to benefit from this project both as consumers of health care and as members of the health team. The participation of women is

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growing at all levels of the Moroccan health system. At the present time, women are concentrated at the lower service levels of the system and appear to lack equivalent opportunities for advancement into administrative roles. Few women are found in management positions, particularly on the provincial level. As more women enter the public health system, undoubtedly more will be trained and promoted for administrative roles. However, in the short term, so that this project does not exacerbate the training gap existing between male and female employees, the MOPH has been asked, wherever possible, to identify women for the skills training to be carried out under this project.

## D. FINANCIAL ANALYSIS

### 1. Project Viability

In recent years, the health sector has not only had to deal with problems of poor management and low efficiency, it has had to operate under the constraints imposed by a national program of economic austerity.<sup>1/</sup> This has resulted in limited budgetary resources for the health sector which reflects the economic difficulties the GOM has had to face. In addition, low worker productivity, duplication, cumbersome operating procedures and commodity wastage of resources from the health delivery system have exacerbated the problem of resource shortages.

However, even accounting for the MOPH's budget constraints, the Health Management Improvement Project is financially viable in that its projected recurrent budgetary impact will be minimal; project costs should easily be absorbed and supported by the MOPH. Incremental recurrent expenditures associated with this project are small and represent only a fraction of one percent of funds projected to be allocated to the health sector for recurrent expenses by the time AID project inputs have ended. (See Table I, following page). In fact, the project may actually result in a cost savings for the MOPH (see the Economic Analysis).

### 2. GOM Commitment to Supporting Health Sector Activity

Having little in the way of an independent source of income, the MOPH is almost totally dependent on public revenue to support its operations.

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<sup>1/</sup> Primarily due to a shortage of foreign exchange reserves and a large debt service burden.

TABLE I

IMPACT ON THE MOPH RECURRENT BUDGET OF INCREMENTAL EXPENDITURE ASSOCIATED WITH THE HEALTH MANAGEMENT IMPROVEMENT PROJECT

(000 DH) \*\*\*\*

CY/FY	AID Inputs* (000 DH)	Incremental MOPH Recurrent Expenditure (000 DH) **	Projected MOPH Allocation (000 DH) ***	Incremental recurrent exp. as a % of total MOPH recurrent Allocation
1980	--	--	632,200****	--
1981	3,751	42.2	725,000	.006%
1982	4,693	49.0	833,000	.006%
1983	3,405	47.9	958,000	.005%
1984	--	47.6	1,102,000	.004%

\* Includes inflation and contingencies and is based on the Financial Plan

\*\* Includes inflation; does not include contingencies and is based on the Financial Plan

\*\*\* Allocations are estimated to increase 15% per annum over the next four years. Rate of increase is based on the average of percent changes in health sector revenue from CY 1976 to 1980.

\*\*\*\* \$1 = 3.80 DH

\*\*\*\*\* Actual recurrent budget allocation for 1980.

WORKSHEET FOR TABLE 1

Total Recurrent cost (incremental) to the MOPH:

	(\$000)	(inflation)	(\$000)	(DH 000)*
1981	14 + 60 **	x 15%	= 11.1 =	42.2
1982	26 + 60	x 15%	= 12.9 =	49.0
1983	24 + 60	x 15%	= 12.6 =	47.9
1984	22 + 60	x 15%	= 12.3 =	46.7

\* \$1 = 3.8 DH

\*\* Five additional MOH personnel

Medical care is virtually free in Morocco, even for those who can afford to pay for services. Thus, although incremental expenditure connected with this project is small, it is, nonetheless, important to examine trends in national budgetary allocations to the health sector in order to determine (1) the GOM's continued commitment towards funding health programs in the face of resource constraints and (2) the likelihood of increases in budgetary allocations in the future to support the expansion of more equitably distributed and cost-effective health service programs that may result from this project.

An examination of the national recurrent and investment budgets (broken down by ministry) of the past four years (see Table 2) indicates that allocations to the health sector have increased. National policy has supported programs that reduce social and regional disparities and, consequently, the GOM has given priority to development efforts in the health and education sectors. From CY 1977 to 1980, allocations to the health sector increased at an average rate of 15% per annum. Much of this increase went towards meeting rising costs due to inflation, now estimated to be running around 11 to 15% per year. As a consequence, the health sector's share of the national budget has remained a fairly constant percentage, averaging around 4.5% of total GOM recurrent expenditures and 1.6% of total investment expenditures. A comparison of these figures to those of other developing countries with a similar GNP per capita <sup>1/</sup>, these percentages are a bit below the international average for health expenditure which fluctuates around 5 to 6% for recurrent expenses and around 2% for investment expenses. Per capita health expenditure in Morocco is around \$9.50 which compares favorably with other countries at a similar level of development.

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<sup>1/</sup> GNP per capita in Morocco for 1980 is estimated to be around \$670.

TABLE 2

GOM RECURRENT AND INVESTMENT EXPENDITURES  
BY MINISTRY IN BUDGET PRESENTATION  
1977 - 1970 (Millions of Dirhams)

MINISTRY	1977 BUDGET						1978 BUDGET						1979 BUDGET						1980 BUDGET					
	RECURRENT			INVESTMENT			RECURRENT			INVESTMENT			RECURRENT			INVESTMENT			RECURRENT			INVESTMENT		
	% DH	% DIR	% A	DH	% DIR	% A	DH	% DIR	% A	DH	% DIR	% A	DH	% DIR	% A	DH	% DIR	% A	DH	% DIR	% A	DH	% DIR	% A
EDUCATION	2.24	25	23	535	5	12	203	24	121	430	5	19	302	27	-	746	9	485	383	28	45	526	6	79
FINANCE (1)	12.74	14	-33	4212	36	38	1049	12	-14	242	29	-29	1524	13	238	318	36	-2	1016	17	16	2091	31	-12
DEFENCE (6)	15.74	18	21	450	17	14	1925	20	32	1514	19	22	2122	19	-	1580	17	-9	2112	21	412	1500	18	-
PUBLIC WORKS & COMMUNICATIONS	217	2	-2	2544	23	43	259	3	118	1044	18	45	111	2	-	1146	10	-23	221	2	22	2478	20	147
TRANSPORT	871	10	17	147	2	53	1203	13	438	64	7	64	1265	12	-	46	6	21	1225	12	19	67	7	22.9
AGRICULTURE	409	5	110	1315	11	124	444	5	115	783	10	40	551	5	-	948	11	121	611	5	11	772	9	-18
HEALTH	406	46	122	195.5	1.6	56	4123	5.3	122	165	1.8	25	519	4.7	10.5	117	1.4	-19	630.2	4.3	16.1	181	0.4	18.7
CONSUMER SERVICES	42.1	5	214	272	2	30	181	2	11	57	3	5	28	2	-	3	-	-19	47	4	143	12	-15	124
JUSTICE	16.9	2	8	28	2	30	181	2	11	57	3	5	210	2	-	61	7	18	251	2	14	78	2	53
INDUSTRIES & MINES (5)	49	6	13	30	6	75	56	6	14	61	7	13	55	5	-	178	2	144	64	5	116	187	1.1	15
ENERGY & MINES (5)	-	-	-	-	-	-	-	-	-	-	-	-	25	2	-	226	4	-	27.9	-	212	240	2.2	26
TRANSPORT (4)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	241	3	-	83	7	-	241	5	150
OTHER	1016	19	287	425	4	14	1008	11	40	141	2	69	1742	15	125	226	3	157	1322	10	29	337	4	149
TOTAL	3286	100	18	1144	100	14	2427	100	16	627	100	18	1144	100	14	2427	100	14	10,671	100	14	9,928	100	25

NOTES: (1) Including Subsidies  
(2) Excluding Transfers  
(3) Excluding in Ministry of Commerce & Industry Unit 12/7173  
(4) Excluding in Ministry of Public Works Unit 12/7173  
(5) Amended 6/1979  
(6) Does not include all costs associated with the Sahel conflict. Includes A-II (2/1/79) and A-14 (3/4/80)

Sources: Moroccan Budget Documents 1977-1980

### 3 Trends in Health Sector Expenditure

Examining past trends in health sector investment and recurrent expenditure is useful to determine what the funding priorities of the MOPH may be in the future. To understand the environment within which this project will be operating, it is crucial to ascertain what the MOPH's program priorities for funding are and how willing MOPH officials are to consider change. The project will influence this environment by improving the management and decision making capability of the MOPH. Likewise, the existing environment of the MOPH will influence the direction and relative impact of the project. A willingness on the part of MOPH officials to be flexible when prioritizing programs for funding will mean a more successful project.

Traditionally, the expansion and improvement of hospital operations has been of highest priority for the MOPH. The recurrent and investment budgets of the MOPH have reflected the importance of hospitals: 67% of the health sector's 1973-1977 Development Plan budget went towards financing hospital related activity versus 28% for preventive programs. In addition, it is estimated that as much as 75% of the MOPH's recurrent budget goes towards financing hospital operations.

However, in recent years, the MOPH has stated its commitment to promoting preventive programs and expanding/improving basic health service delivery. The new 1981-1985 Development Plan for the health sector (not yet approved) bears this out. Preventive related programs account for 49% of the Plan's proposed budget. Proposed investment expenditure for hospitals is down to 50% of the budget. Moreover, as resources are tight and only 40% of the MOPH's investment proposal is expected to be approved, priority program areas that will receive funding first include: MCH, vaccination

programs, disease surveillance, family planning, sanitation and improvements to the basic health service system.

Most important, the MOPH has given priority to developing and institutionalizing its capacity for making more cost effective and rational investment decisions that are financially supportable. This project will help to establish that capability by first, providing access to the kind of cost and expenditure data necessary to do comparative cost and budgetary impact analyses of proposed health sector investment alternatives. Second, the improved capacity for collection and analysis of health statistics developed by this project will enable the MOPH to more readily ascertain the relative effectiveness of various programs currently being funded. Third, an improved capacity for comparing relative hospital expenditure and effectiveness with occupancy rates and length of stay will allow the MOPH to increase the efficiency of hospital operations; thus, reducing per capita costs and keeping the lid on unnecessary expenditure to curative programs. MOPH officials have stated that the new plan is flexible and can be altered to reflect what is learned from the project.

#### 4. The Budgetary Process

It is important to examine the budget practices of the MOPH (and related problems) as these practices will effect how resources are allocated within the health sector. Among the major management problems the project will address are the current budget and accounting procedures of the MOPH. By improving these procedures to obtain a better idea of where expenditures are made and how money flows through the system, a more equitable distribution of resources which is responsive to the needs of the population can be made. A summary of how the current budget and accounting practices

of the MOPH exacerbate problems of resource allocation within the health sector is outlined below.

At present, the budget and accounting system of the MOPH is not organized in a fashion that allows the determination of program and facility costs. Cost and expenditure data are aggregated in a manner that prohibits the determination of where expenditures are actually made within the health sector. Given this, the current method of credit allocation (where one credit equals one Dirham) is a reasonable and even somewhat flexible solution for a system that cannot base the disbursement of funds on actual costs. Nonetheless, as a consequence of these procedures, there are problems:

(a) The current method of credit allocation introduces a unit value and weighting factor that is biased towards the larger hospitals in urban areas and thus reinforces the existing inequalities of the system. Credits for SIAAP health centers and dispensaries are based on a set number of consultancies per inhabitant which are estimated, at least for rural areas to be very low. Thus begins the vicious circle: utilization is low because services are poor. Low utilization means fewer credits which, in turn, means fewer resources going to the SIAAP, thus reinforcing the poor quality of its service delivery system.

(b) Because the current system does not enable the tracing of program and facility expenditures, there is no way to control where credits are spent. For example, because utilization and operating expenses of urban health centers are higher than those of rural dispensaries, the former can siphon off and absorb more than its share of the pool of credits to the detriment of the latter.

(c) Finally, the present system of budgeting does not allow the MOPH to justify program requirements. The structure of the budget is such that budget formulation (either investment or recurrent) and program planning are not linked. If recurrent program requirements can be linked to targeted objectives, MOPH officials can better negotiate their funding needs from the Ministry of Finance.

## E Economic Analysis

As indicated in the Financial Analysis, investment and recurrent costs associated with this project are minor and will represent only a small percentage of the projected recurrent expenditure<sup>s</sup> of the health sector. Moreover, each dollar invested in this project will stimulate the health system to utilize present levels of resource inputs more effectively. This should result in economic outputs represented by cost savings and an improvement in the quality of health services delivered to the population.

Specific outputs of the project are outlined below:

(1) An improved budget and accounting system.

Knowing program costs and expenditures will enable MOPH officials to make cost comparisons of ongoing and proposed health activities to ascertain their relative financial viability. In addition, such information should result in more cost-effective programming and hence a better allocation of resources within the health sector;

(2) An improved personnel system.

Improving access to, and <sup>the</sup> availability of data on health personnel should make the system more responsive to employee needs as well as to the functional requirements of delivering health services. As a consequence of the health system being more responsive to personnel needs, worker morale should improve and productivity increase;

(3) Improved operations data collection and analysis.

Improving the quality and accessibility of health statistics should improve the operations and efficiency of the health delivery system by making it more responsive to the health problems and environment of the population. In addition, the system will provide data on the relative effectiveness of various health activities which will enable MOPH officials to make better informed investment decisions in the course of program planning;

(4) Improved transport and logistics systems.

Improving transport and logistic operations should help insure a timely delivery of necessary commodities to health facilities in need of resupply. An improved logistics capability will reduce waste and spoilage of perishables due to improper inventory, storage and delivery. Also, a better transport system will mean more effective supervision of health workers and hence better worker performance. Two less specific but nonetheless important outputs on this project that will increase the efficiency of MOPH operations include the increase capacity of the MOPH to identify management and administrative problems and the ability to do integrated operational planning.

Overall, these activities should not only result in an improvement in the quality of health services delivered but also result in savings to the MOPH from (1) more efficient operations, e.g., less duplication of activities and less cumbersome operating procedures (including less forms to fill out), and (2) less effort spent in reorganizing and redoing tasks fouled up as a consequence of faulty management and poor decision making.

For illustrative purposes, it can be assumed that cost savings that accrue from this project due to increased worker productivity, smaller personnel requirements, less commodity wastage and more cost-effective programming, could represent as much as 1.0% of the total (1980) health sector budget or roughly \$2 million a year. If so, the entire investment and recurrent cost of this project could be recouped in savings in less than 3 years.

In addition to accrued savings, project inputs capitalize on economies of scale and make maximal use of existing personnel and material resources. For example: (1) Trainers to be used to reorient health workers to the new operating procedures of the MOPH and to instruct them in the use of new forms are already on the payroll; and (2) The intended computer hardware and software package (representing the largest single recurrent cost to the MOPH) can be integrated to handle different MOPH service functions simultaneously. There is no need for separate computer and information systems for each service function (e.g., for personnel, budget, statistics, etc.). In addition, the terminals to be installed within the MOPH will hook into the underutilized computer of the Ministry of Plan. Once Plan's computer is put into service for the MOPH, the machine will be used closer to capacity and the marginal cost of its operation to the GOM should go down.

In sum, through this project, the economic planning processes of the MOPH will be enlarged and strengthened. Target groups will be better served at lower costs and MOPH decision makers will be able to more effectively analyze their resource allocation problems in terms of welfare and efficiency functions. Out of this kind of planning exercise should emerge a "real" capacity to better manage the health sector as program requirements can be costed out, prioritized and linked to targeted objectives.

## F. Administrative Analysis

### GOM:

The Health Delivery Management Project will be executed by the Planning Directorate of the Moroccan Ministry of Public Health. The Planning Directorate is a new administrative unit in the Ministry which is directly under the Secretary General. Its principal functions include the development of health sector plans, the aggregation and analysis of health statistics and the evaluation of health sector activities.

The creation of a Planning Directorate within the MOPH reflects an increasing concern by the Ministry with improving the management and planning capabilities of the health system. It is part of an overall reorganization plan which has been under consideration in the Ministry for almost a year. The legal and procedural requirements for reorganization have almost been completed and the Ministry expects to implement the reorganization at the beginning of 1981.

The establishment of a unit in the Ministry which would have responsibility for planning, program management and analysis was one of the priorities of the AID health management project, for it was determined that the improvement of management subsystems within the Ministry would have a far greater impact if at the same time the Ministry's capacity to plan, coordinate, and evaluate health sector programs could also be increased.

The location of the Planning Directorate within the Ministry gives it equal status with the major operational directorates. The inclusion of the Health Statistics Division within the Directorate gives it direct access to the data

and statistical division staff needed to carry out its major functions. This reorganization is not expected to cause any major disruptions in the development of the health management project. The staff of the Infrastructure Unit, who have been working with AID for a year on the health management project, will become the staff of the Planning Directorate. The Unit has already hired two additional professionals in anticipation of its expanded responsibilities, and there are plans to further enlarge the Directorate when the reorganization becomes official.

The current head of the Infrastructure Unit is a physician who is enrolled in a three-month WHO-sponsored health planning course which terminates December, 1980. He has had considerable experience in the Public Health system and has been actively involved in the development of the AID health project.

AID's experience with the Ministry over the past year has demonstrated the ability of the MOPH to continue the project development process uninterrupted even in the absence of key personnel. (The head of the Infrastructure Unit was absent during the visit of the project paper team ; nevertheless the team's needs for assistance, information, and field support were ably met by other Ministry personnel).

The addition of staff to the Planning Division of the Ministry will not be constrained by the GOM, for it is government policy to provide employment for all university graduates. The head of Personnel in the MOPH explained that because of this policy, the Ministry could hire additional staff as needed in Planning as well as in other areas.

The Planning Directorate will have in addition a Peace Corps volunteer

(who began work in the Ministry in late September, 1980), who has more than thirty years of experience in system analysis and related work. USAID/Rabat has been working successfully with the Moroccan MOPH for more than ten years in maternal-child health and family planning. Both the Ministry and AID have long expressed an interest (since 1975) in extending this cooperation to other areas in the health sector. Previous efforts to design a project have been unsuccessful because of the failure of USAID/Rabat and the MOPH to identify a project which was both feasible and mutually acceptable. The consistent support of both USAID/Rabat and the MOPH during the rather lengthy period (more than one year) required for the development of this project demonstrates the strong desire of both to implement this project.

#### USAID

USAID/Rabat will assume the responsibility for administrative backstopping of this project. Although the long-term consultants (discussed below) will be recruited via host-country contracts, USAID will provide technical guidance to the MOH in the process of consultant screening, selection and contract negotiation. The MOH and the resident consultants will identify and schedule short-term consultants for the project. USAID, however, will execute the project documentation (PIO/T's) and/or consultant requests (e.g., through CDC, MSH, APHA, etc.) needed to assign the short-term advisors.

USAID will order project commodities by PIO/C's, according to standard procurement procedures.

Project participants will be similarly processed in the standard fashion, via Mission prepared PIO/P's. As described in the Evaluation Plan, below, USAID will closely monitor the progress of the project via periodic contractor

performance reports; comparison of scheduled project outputs to the PERT; on-site review of progress; and participation in two intensive project evaluations.

In assuming these responsibilities, USAID has noted its need for recruitment against an existing vacancy in the Health, Population & Nutrition (PHN) Office. This additional person will be necessary to ensure that this project, -- as well as USAID's other population, health and nutrition projects -- are effectively managed.

### CONSULTANTS

The health management project calls for two long-term consultants (3 years), an administrative assistant (local hire), and an as yet undetermined number of short term consultants who will provide a total of 30 person months of technical assistance for specific components of the project (see Technical Analysis). It is expected that a great deal of the administrative and coordinative responsibilities for the project will be assured by these long term consultants.

The skills required for the long term advisors should include management experience in personnel administration, supervision and training, budgeting and accounting, information systems, planning and systems development, preferably in the health sector. These advisors must be able to communicate well in French and work effectively in a developing country environment. Knowledge of French administrative systems and practices would be very useful but is not essential.

It is difficult to specify the academic degrees required for these positions, for there are several which, when combined with the above mentioned experience, would be considered adequate. These would include Phd.'s in Health Care

Administration, Business Administration, or Public Administration, or masters degrees (with good work experience) in Business Administration, Public Administration, Health Care Administration, Systems Analysis or Engineering. One of the two long term Consultants could conceivably be an MD with an MBA or MHCA and experience in administration.

Although the management skills and experience of each consultant should be broad, selection of the two individuals should reflect a high degree of complementarity, i.e., to maximize their utility to the MOH.

The two consultants will be recruited separately under host country contracts. Nonetheless, in the interests of smooth project coordination and communication, one of the two consultants should be designated Senior consultant or Chief of Party.

#### OTHER GOM

The Secretariat of Planning is the only GOM agency outside of the MOPH which will be actively involved in the implementation of the health management project. The MOPH has arranged to use the Plan computer to process data from the new systems. The exact details as to how, how much, and how often the computer is to be used will have to be spelled out during the implementation of the project. There are other ministries which use the Plan computer, so there are administrative and financial arrangements in use which can serve as guidelines for the Plan-MOPH agreement. The time-sharing costs quoted by Plan appear to be reasonable. (See Technical, Financial Analyses). The computer is currently operating far below capacity, therefore the addition of MOPH data processing activities will not exceed the Secretariat of Plan's ability to provide computer time.

## V. PROJECT IMPLEMENTATION

### A. Implementation Plan

As noted above, USAID and the MOH propose that the resident advisors be recruited under host-country personal services contracts; that short-term consultants be provided under existing Agency IQC's, grants and contracts (e.g., MSH, CDC, APHA, etc.); and that commodity procurement, participant training and in-country project costs be administered by USAID under PIO/C's - PIO/T's and on the basis of vouchered GOM claims for cost reimbursement.

A schedule of specific actions to be undertaken in the course of project implementation is set forth on the following pages. For convenience and clarity, this schedule collapses and summarizes a larger number of discrete project actions which together comprise the project. The reader interested in a more detailed list and sequence of these individual actions may examine Annex 2, "Major Project Modules" and its accompanying PERT chart. The enumeration of individual project actions in the narrative description of the modules corresponds to the enumeration of these activities in the PERT.

PROJECT IMPLEMENTATION SCHEDULE

Mid-Late October, 1980	PP approved
November, 1980	ProAg signed
December, 1980	US/GOM Letter of Implementation Exchanged
November - December, 1980	Candidates for GOM PSC'S screened by AID/W + USAID + GOM
January, 1981	Contractors identified; Contract negotiation with GOM
January, 1981	MOH Division of Planification Established; Director designated
January - March, 1981	Additional MOH staff recruited; internal training activities commenced
March, 1981	Resident (contract) consultants arrive in-country

March - May 1981

Data processing studies commenced

Establish implementation plan for Personnel System

Establish Section Plan for Division of Plan

Establish Action Plan for review of statistical system

June - Aug., 1981

Order DP hardware and commence programming

Set up computerized index in Personnel + start process of reorganizing files

First Planning workshop

Inventory and evaluation of operational records forms

<p><u>Sept. - November, 1981</u></p> <p>De-bug and implement DP system</p> <p><u>Dec., 1981 - Feb., 1982</u></p>	<p>Personnel system in place</p>	<p>Draft Plans prepared by each MOH vertical program</p> <p>Integrated Plans reviewed + approved</p>	<p>Seminar/workshop with provincial staff; redesign of forms</p> <p>Training in use of new forms; forms introduced into MOH management system</p>
<p><u>March - May, 1982</u></p> <p>Evaluation: April, 1982</p>		<p>Work commences on MOH budget system:</p> <ol style="list-style-type: none"> <li>1) Provincial meetings to discuss distribution of responsibility;</li> <li>2) Establish inter-ministerial team for determination of budget structure;</li> <li>3) Individual budget review with each program;</li> <li>4) Draft program budget structure</li> </ol>	
<p><u>June - Aug., 1982</u></p> <ul style="list-style-type: none"> <li>- Review accounting procedures and practices</li> <li>- Design revised B + A forms + procedures</li> <li>- Ministry of Finance review of revised forms/procedures</li> </ul>		<p>Program budget structure reviewed/ approved</p>	
<p><u>Sept. - Nov., 1982</u></p> <ul style="list-style-type: none"> <li>- Print new B+A forms</li> <li>- Train people in new procedures</li> <li>- Parallel run, with old B+A system of new accounting system</li> </ul>		<p>Preparation of budget using new guidelines</p>	

Dec., 1982 - Feb., 1983

- Commence work on logistics systems; review + clarify responsibilities of provinces + Center
- Meet with MOH field staff to determine problems + needs

Revised budget system operational

March, 1983 - May 1983

Design logistics systems improvements

June - Aug., 1983

- Print new forms
- Training in new logistics procedures

Sept. - Nov., 1983

- Parallel run of old + new logistics systems for pharmaceuticals, transport and other material
- New logistics systems in place

December, 1983 : Summary Evaluation

## B. Evaluation Plan

This project will be monitored/evaluated in three ways:

- 1) USAID review of quarterly contractor performance reports, with particular reference to project performance/and timing against the PERT schedule.
- 2) USAID "output" review at key junctures in the PERT. These reviews will cover the following areas (Enumeration corresponds to the PERT):
  - a) Status of training for staff from MOH Division of Plan (9001)
  - b) Operation of the Data Processing section (9002)
  - c) Operation of the revised Personnel systems (9003)
  - d) Operation of the revised Health Statistics system, "data directory", new forms (9004)
  - e) Operation of new Planning System (9005)
  - f) Operation of the revised B&A system (9006)
  - g) Operation of the Pharmaceutical (9007) and Material (9008) Logistics Systems

USAID assessments of project performance in these key areas will focus on their confirmance the PERT schedule; their apparant effectiveness vis-a-vis previous MOH operations; and the apparant extent to which the new/revised sub-systems have been unstitutio-nalized within the MOH management structure.

- 3) The project includes provision for two intensive evaluations. The first evaluation will be performed after one year (April, 1982); the second at the end of the project (December, 1983). Both evaluations will involve AID personnel plus outside consultants. The project schedule will be refined as necessary on the basis of the findings of the first evaluation.

VI PRELIMINARY PROJECT BUDGET  
(\$000)

PROJECT INPUTS	Year 1		Year 2		Year 3		Total	
	AID	GOM	AID	GOM	AID	GOM	AID	GOM
<u>I. Technical Assistance</u>								
<u>A. Long Term</u>								
1. 2 advisors @ \$100,000/year/advisor	200		200		200		600	
2. 1 administrative assistant (local hire) @ \$15,000/yr	15		15		15		45	
<u>B. Short term</u>								
1. 24 months of U.S. consulting assistance @ \$10,000/month	80		80		80		240	
2. 6 months of Moroccan consulting assistance @ \$2,000/month	4		4		4		12	
<u>SUBTOTAL (I)</u>	<u>299</u>		<u>299</u>		<u>299</u>		<u>897</u>	
<u>II. Training</u>								
<u>A. Long Term (U.S.)</u>								
1. 4 participants (2 year programs) 8 person years @ \$22,000/yr	44		88		44		176	
<u>B. Short Term</u>								
1. <u>U.S.:</u> 5 participants (4 months each) - 20 person months @ \$2,500/month			30		20		50	
2. <u>Third Country:</u> 6 participants (1.5 months each) - 9 person months @ \$1,500/month	2		5		7		14	
3. <u>English language:</u> 10 participants								
a. beginning to advanced; 6 participants x 500 hours x \$5.25/hr	15						15	
b. intermediate to advances; 4 participants x 280 hours x \$5.25/hour	6						6	

	Year 1		Year 2		Year 3		Total	
	AID	GOM	AID	GOM	AID	GOM	AID	GOM
<b>C. In-Country</b>								
1. Training of Trainers - 100 participants								
a. per diem: \$35/day x 28 days x 100				98				98
b. instructional materials: \$30 x 100				3				3
c. honorarium - Moroccan guest lecturers: 21 lecturers/day x 24 days x \$100 lecturers				5				5
2. Seminars/workshops - 3/yr x 3 yrs x \$20,000/seminar	60		60		60		180	
<b>SUBTOTAL (II)</b>	<b>127</b>		<b>289</b>		<b>131</b>		<b>547</b>	

### III. Commodities

#### A. Equipment

##### 1. Data Processing

a. Admin. Processing, Batch Terminal (includes printer) @ \$15,000 plus installation (20%) plus 30% ins. and transport)				45				45
b. 6 Terminals \$2,000/term plus 30% ins. and transport)	16						16	
c. Time share charges (rate ?)		*		*		*		*
d. Miscellaneous (disc, tape, etc.)	50		100				150	
e. Depreciation allowance @ 10% of cost per year (assumes 10 year equipment life)		7		21		19		47
f. Spare parts @ 30% of cost (includes ins. and transport)	5		11			11		27
g. Equipment maintenance (30% of cost)	5		11			11		27
<b>2. <u>Training</u></b>								
a. 8 slide projectors plus slides @ \$100 each plus 30% (ins. & transport)	1							1
b. 8 overhead projectors plus 800 acetate sheets (100/projector @ 50¢/sheet) @ 365 each plus 30% (insurance & trans)	4							4
c. 8 screens @ \$100/screen plus 30% (insurance and transport)	1							1

	Year 1		Year 2		Year 3		Total	
	AID	GOM	AID	GOM	AID	GOM	AID	GOM
d. 8 tape recorders plus 80 cassettes (90 min @ \$2.50/cassette; 10/recorder) @ \$75 each plus 30% (ins & trans)								1
e. 8 mini photocopiers @ \$2,500/copier plus 30% (ins & trans)								26
<u>subtotal (training equipment)</u>								<u>33</u>
f. spare parts @ 30% of cost (includes insurance and transport)	10		10		10			30
g. Maintenance (30% of cost)	10		10		10			30
h. Depreciation allowance @ 20% of cost/year (assume 5 year equipment life)		7		7		7		21
B. <u>Preparation and Testing of Revised Forms</u>	4		4		4			12
<u>SUBTOTAL (III)</u>	133	14	191	28	46	26	370	68
<u>IV. Evaluation</u>								
A. Final evaluation					10			10
<u>SUBTOTAL (IV)</u>					10			10
<u>V. Other GOM Contributions</u>								
A. Transport (vehicle & gasoline for TA team and counterparts (\$.40/mile x 10,000 miles/year)		4		4		4		12
B. <u>Office Space for TA Team (\$20/mo)</u>		3		3		3		9
C. <u>Foreign Travel for Participants</u>		3		7		5		15
D. <u>Salaries</u>								
1. Participants								
a. Overseas training		48		160		240		448
b. in country		140		280		280		700
2. New central MOPH staff								
a. 5 technicians		60		60		60		180
<u>SUBTOTAL (V)</u>		258		514		592		1,364

	Year 1		Year 2		Year 3		Total	
	AID	GOM	AID	GOM	AID	GOM	AID	GOM
TOTAL PROJECT INPUTS	<u>559</u>	<u>272</u>	<u>779</u>	<u>542</u>	<u>486</u>	<u>618</u>	<u>1,824</u>	<u>1,432</u>
Inflation (15% per annum)	84	41	117	81	73	93	274	215
Contingencies (10% per annum)	56	27	78	54	49	62	183	143
GRAND TOTAL	699	340	974	677	608	773	2,281	1,790

\* Budget is illustrative and may be amended by up to 15% between line items without formal project amendment. In addition, costs for various items are estimates and may have to be adjusted upwards or downwards as appropriate.

PROJECT GOAL:

IMPROVE HEALTH OF MOROCCANS, ESPECIALLY RURAL AND URBAN POOR BY IMPROVING QUALITY AND QUANTITY OF BASIC HEALTH SERVICES

GENERALIC REDEFINITION OF MOROCCAN HEALTH MANAGEMENT IMPROVEMENT PROJECT

PROJECT PURPOSE:

IMPROVE QUALITY AND QUANTITY OF HEALTH SERVICES BY IMPROVING EFFECTIVENESS AND EFFICIENCY OF HEALTH DELIVERY SYSTEM

PROJECT OBJECTIVES:

IMPROVE CAPACITY OF MINISTRY TO MANAGE ITSELF AT ALL LEVELS: CENTRAL PROVINCE CIRCUMSCRIPTION

INSTITUTIONAL CHANGES IN MANAGEMENT AND ADMINISTRATIVE SUPPORT SYSTEMS: Planning, Budget and Accounting, Logistics, Health Statistics, Personnel

PROJECT STRATEGY:

DEVELOPMENT OF CENTRAL MINISTRY'S SCARCER MANAGEMENT RESOURCES: new unit, people, training, practice

IMPROVEMENTS IN SPECIFIC MANAGEMENT AND ADMINISTRATIVE SUB-SYSTEMS: Planning - Control, Personnel, Health Statistics, Accounting, Logistics

IMPROVEMENT OF OPERATIONAL MANAGEMENT AND ADMINISTRATION AT ALL LEVELS OF HEALTH DELIVERY SYSTEM

PROJECT TACTICS:

CONCERNING IDENTIFICATION OF PARTICULAR SUBSYSTEMS TO BE IMPROVED

CONCERNING THE SEQUENCING AND SCHEDULING OF MAJOR PROJECT ACTIVITIES

CONCERNING THE GROUPING OF PROJECT ACTIVITIES INTO MANAGEABLE WORK TASKS

PROJECT OUTPUTS:

INSTITUTIONAL CAPACITY TO SOLVE MANAGEMENT PROBLEMS

DATA PROCESSING CAPACITY FLEXIBLE ENOUGH TO MEET MINISTRY'S NEEDS

EFFICIENT SYSTEM FOR COLLECTING, ANALYZING, & COMMUNICATING OPERATIONAL INFORMATION

INSTITUTIONAL PROCESS FOR COORDINATING, CONTROLLING, VERTICAL HEALTH PROGRAMS

EFFICIENT, TYPICAL SYSTEM OF PERSONNEL ADMINISTRATION

BUDGET AND ACCOUNTING SYSTEM WHICH DETERMINES PROGRAM COSTS, FACILITATES RATIONAL RESOURCE ALLOCATION

EFFICIENT PROCUREMENT, STORAGE, DISTRIBUTION OF ESSENTIAL DRUGS

EFFICIENT PROCUREMENT, DISTRIBUTION, MAINTENANCE OF MATERIAL, EQUIPMENT, TRANSPORT

PROJECT TASKS AND ACTIVITIES:

1000 IMPROVE CENTRAL MINISTRY MANAGEMENT ANALYSIS CAPACITY

2000 IMPROVE CENTRAL MINISTRY DATA PROCESSING CAPACITY

3000 IMPROVE OPERATIONAL RECORDS MANAGEMENT

4000 IMPROVE PROGRAM PLANNING AND CONTROL

5000 IMPROVE PERSONNEL ADMINISTRATION

6000 IMPROVE PROGRAMMATIC BUDGETING AND ACCOUNTING

7000 IMPROVE PHARMACEUTICAL PROCUREMENT, STORAGE, DISTRIBUTION

8000 IMPROVE MATERIAL AND TRANSPORT LOGISTICS

9000 PROJECT EVALUATION AND REVIEW

PROJECT INPUTS:

GOM PERSONNEL: FULL-TIME AT BUREAU OF ADMINISTRATION PART-TIME THROUGH OUT HEALTH SYSTEM

GOM FACILITIES AND SUPPLIES: OFFICE SPACE REPAIRING ESTIMATES DATA PROCESSING EQUIPMENT, CUSTODIANS, ETC

USAID PERSONNEL: FUND ADVISORS FOR THREE YEARS FOUR YEARS SHORT-TERM TECHNICAL ASSISTANCE

USAID TRAINING: EIGHT PERSON YEARS LONG TERM, 30 PERSON MONTHS SHORT TERM IN-COUNTRY TRAINING

USAID COMMODITIES: SPARE PARTS AND SOME GEP EQUIPMENT, MEDIA-TRAINING SUPPLIES, MISC.

## MAJOR PROJECT MODULES

- 1000 Improvement of central ministry management analysis and program planning and evaluation capacity
- 2000 Improvement of ministry data processing and analysis capacity
- 3000 Improvement of operational records management (service and use statistics)
- 4000 Increasing the coordination of program planning and operations
- 5000 Improvements in personnel system
- 
- 6000 Improvements in programmatic budgeting and accounting
- 7000 Improvements in pharmaceutical distribution and supply
- 8000 Improvements in logistics system (material and transport)
- 9000 Major project review and evaluation activities

1000 IMPROVEMENT OF CENTRAL MINISTRY MANAGEMENT ANALYSIS AND PROGRAM  
PLANNING AND EVALUATION CAPACITY

OBJECTIVES:

- \* Upgrade management analysis capability within central Ministry
- \* Provide a corps of skilled personnel for implementation and overall coordination of management improvement activities of Ministry.

PROCESS:

- \* Will focus on hiring additional personnel and on upgrading skills and resources of existing personnel.
- \* Requires creation of an appropriate organizational instrument.

ACTIVITIES:

- 1001 Establishment of an organizational unit with special responsibilities in management analysis (Directorate de Planification)
- 1002 Selection, appointment of a director for unit
- 1003 Identification of number and content of additional positions
- 1004 Recruitment, promotion of persons for new positions
- 1005 Training activities
- 1006 Special studies and evaluations related to specific problems identified in the process of improving administrative systems
- 1007 Special studies and evaluations
- 1008 Special studies and evaluations

## 2000 IMPROVEMENT OF CENTRAL MINISTRY DATA PROCESSING AND DATA ANALYSIS CAPACITY

### OBJECTIVES:

- \* Use appropriate computer technology to make more effective and efficient the Ministry's storage, retrieval, reporting and analysis of data (particularly in the control and evaluation of day-to-day operations).
- \* System must be flexible and adaptable to many and changing needs of Ministry; must be easy to use and maintain.

### PROCESS:

- \* Focuses on review of present and anticipated needs, evaluation of technical alternatives, acquisition and use of hardware and software, training of operations personnel and debugging, modification and implementation of system.

### ACTIVITIES:

- 2001 Setting up of a team (headed by Director of Division of Statistics and Informatics to coordinate Ministry data processing activities
- 2002 Review, clarification and prioritization of Ministry's present and anticipated DP requirements
- 2003 Technical and economic evaluation of technical DP alternatives (with most likely option being use of Ministry of Plan computer)
- 2004 Final selection and detailed systems specifications
- 2005 Hardware acquisition (including phone lines and terminals)
- 2006 Software development, modification  
(This is described in more detail in a technical appendix)
- 2007 Training of operations personnel
- 2008 Debugging, modification and implementation
- 2009 Dissemination and communication of system capabilities

3000 IMPROVEMENT OF OPERATIONS RECORDS MANAGEMENT  
(SERVICE AND USE STATISTICS)

OBJECTIVES:

- \* Improve the quality and flow of operational information within the Ministry;  
  
i.e., increase relevance, reliability, validity, integrability, deducibility and representativeness of information collected and of its pattern of communication.

PROCESS:

- \* Involves review of information needs and requirements of program and field management of Ministry (has additional beneficial effect of sharpening focus of programs themselves), redesigning forms and training various levels of persons in their use.
- \* Is a communicative process involving interaction between administrative and technical personnel, central program and field personnel.

ACTIVITIES:

- 3001 Preparation and conduct of seminar-workshop for top management of major program-divisions and for medecin-chefs
- 3002 Follow-up discussions with each program-division and with selected medecin-chefs to discuss information needs
- 3003 Preparation and review of draft statements of management information needs at each level
- 3004 Review and redesign of forms and instructions for their use (will include a "data dictionary" and a map of document flows)
- 3005 Drafting and modification of an implementation plan for introduction of new forms and procedures (can be phased by program, by province and by infrastructural unit)
- 3006 Printing of forms
- 3007 Training and workshops for majors and staff
- 3008 Field training and implementation

- 3009 Coding and processing at central ministry
- 3010 Reports and analyses from processed information
- 3011 Evaluation, review of problems
- 3012 System modifications as required

## 4000 INCREASING THE COORDINATION OF PROGRAM PLANNING AND OPERATIONS

### OBJECTIVES:

- \* Create an institutional capacity and initiate an institutional process to increase the coordination and integration of operational program planning.
- \* "Play out" or project the implications at the lowest work levels (dispensaries, etc.) of the aggregation of program plans.
- \* Aid in the resolution of inconsistencies among operational program plans.
- \* Provide a mechanism for controlling implementation of program work plans.

### PROCESS:

- \* Involves establishing an institutional mechanism, a technical methodology, an improved data processing and integration capacity and facilitate organization (program-division) interaction and communication.

### ACTIVITIES:

- 4001 Identification of the institutional locus for operations planning
- 4002 Adaptation of a technical integrated planning methodology (which will utilize a computerized PERT system)
- 4003 Seminar workshops with program-divisions and medecin-chefs on preparation of plans for program operations at sub-province level for next year
- 4004 Preparation of draft individual plans by program-divisions
- 4005 Analysis and integration of draft plans
- 4006 Identification, evaluation and resolution of inconsistencies
- 4007 Communication of coordinated plans to medecin-chefs and majors
- 4008 Implementation and use of master plan to monitor monthly progress by program by province and circumscription.

## 5000 IMPROVEMENTS IN PERSONNEL SYSTEM

### OBJECTIVES:

- \* Upgrade efficiency of personnel administration in ministry.
- \* Reduce time required to process application, transfer, hiring, promotion, pay raise, etc.
- \* Improve employee morale.

### PROCESS:

- \* Review and specify procedural changes.
- \* Develop new file access and storage medium to facilitate and speed access to files and principal personnel tasks.

### ACTIVITIES:

- 5001 Review and clarify central ministry-provincial personnel responsibilities
- 5002 Review record-handling procedures
- 5003 Specify record access and report needs (volumes and frequencies)
- 5004 Design an integrated storage-access (will involve both automated and manual components) system
- 5005 Acquire storage facilities (space, medium)
- 5006 Establish computerized indices
- 5007 Design provincial-central control procedures
- 5008 Design new forms (as appropriate)
- 5009 Train in new forms and procedures
- 5010 Parallel run of new system
- 5011 Evaluation, modification and final implementation

## 6000 IMPROVEMENTS IN PROGRAM BUDGETING AND ACCOUNTING

## OBJECTIVES:

- \* Enable the Ministry to better determine program costs and to combine this with program effect information obtained from operations statistics.
- \* To supplement, in a complimentary manner, the Ministry's current budget system.
- \* To increase efficiency and speed of present accounting and commitment system.

## PROCESS:

- \* An interactive process involving persons both from Budget and Accounting and from Program Operations divisions.
- \* Involves determining a workable system of program categories and elements; upgrading data processing capacity; redesigning forms and work procedures to utilize program categories and data processing capacity; training and implementation and use.

## ACTIVITIES:

- 6001 Review and clarify central ministry-provincial allocation and purchasing responsibilities
- 6002 Establish program working group
- 6003 Conduct divisional budget and accounting workshops
- 6004 Individual division program design discussions and drafting of sample program structure
- 6005 Review and approval of program structure
- 6006 Assessment of data processing volumes and frequencies
- 6007 Design of data files and reports
- 6008 Clarification of control procedures
- 6009 Design of new budget and accounting forms, procedures and guidelines
- 6010 Discussion with Ministry of Finance and modification of forms, procedures, guidelines

- 6011 Printing of new forms for budget and accounting
- 6012 Training in new forms and procedures (both at central ministry and at provinces)
- 6013 Parallel run of new accounting procedures
- 6014 Parallel of new budget documents
- 6015 Evaluation and modification

## 7000 IMPROVEMENTS IN PHARMACEUTICAL DISTRIBUTION SYSTEM

## OBJECTIVES:

- \* Eliminate problems in system of storage and distribution of drugs which, in an environment of scarcity, results in regular and unnecessary shortages.
- \* Upgrade over-all effectiveness and efficiency of pharmaceutical distribution and disbursement system.

## PROCESS:

- \* Will involve specification of responsibilities, clarification of problems at several levels, and design, discussion and implementation of administrative improvements.

## ACTIVITIES:

- 7001 Review and clarify respective responsibilities of central pharmacy and of provinces, in particular, role of provincial hospitals as regional distribution centers
- 7002 Conduct group meetings and have follow-on discussions and field visits with representatives of major levels of users (clinics, dispensaries, hospitals, etc.) and suppliers and distributors (central pharmacy and provincial hospitals) to clarify problems in the present system and potential solutions
- 7003 Review of current administrative procedures and practices (request, inventory and distribution forms and procedures, time lags, etc.)
- 7004 Design of a set of integrated improvements which will include forms redesign, use of data processing for inventory and records management, etc.
- 7005 Training personnel in use of new forms and in new procedures and practices
- 7006 Parallel run of new system
- 7007 Evaluation, modification and final implementation

## 8000 IMPROVEMENTS IN LOGISTICS SYSTEM

## OBJECTIVES:

- \* Eliminate problems of unnecessary shortages and time lags in receipt of material caused by inefficiency in the material supply system of the Ministry.

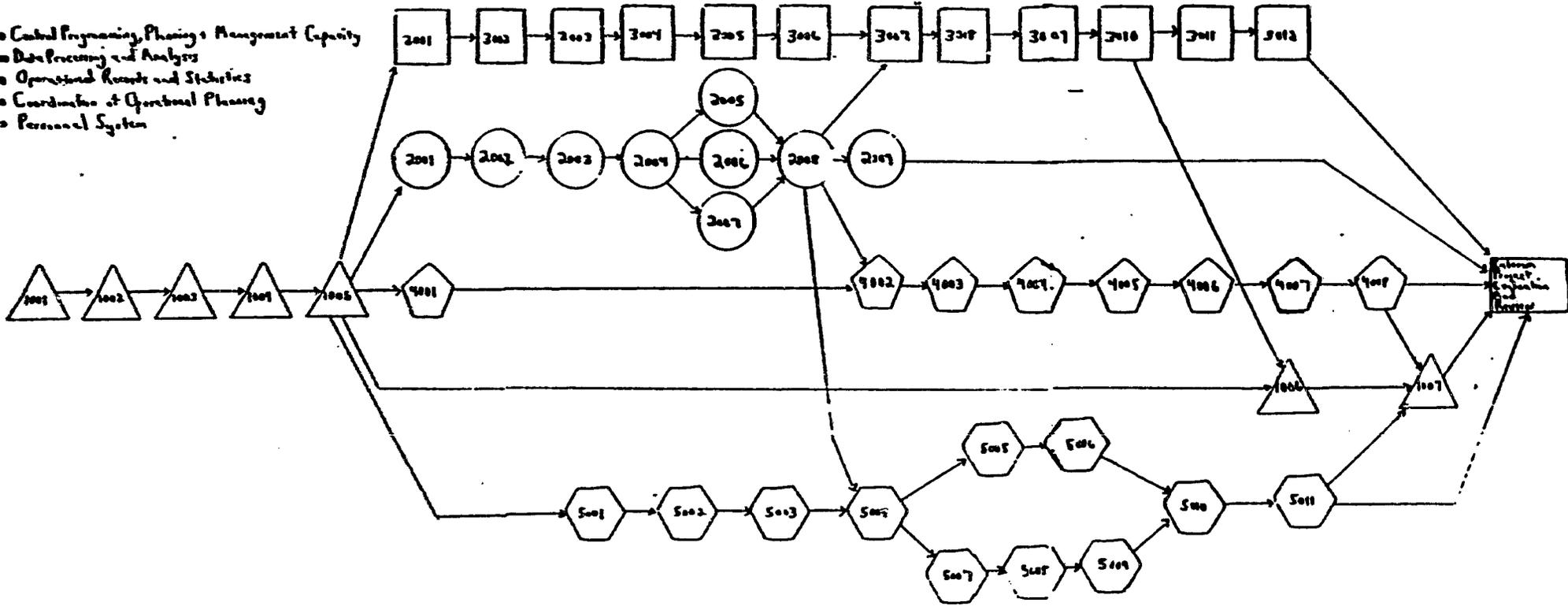
## PROCESS:

- \* Will involve specification of respective responsibilities of provinces and central ministry (with a view to determining activities appropriate to each level), clarification of problems in present system and design and implementation of administrative practices and procedures (including data collection and processing) which might alleviate some of the present problems.

## ACTIVITIES:

- 8001 Review and clarification of respective central ministry and provincial responsibilities in material supply
- 8002 Conduct group meeting and have follow-on discussions with representatives of central and provincial supply and with groups they are supposed to serve so as to clarify problems and identify some potential solutions
- 8003 Review of current procedures and practices in material supply
- 8004 Design a set of integrated improvements which will involve redistribution of responsibilities, and use of augmented ministry data processing capability as appropriate
- 8005 Training of personnel in use of new forms and in new procedures and practices
- 8006 Parallel run of new system
- 8007 Evaluation, modification and final implementation

- ▲ 1000 Control Programming, Planning & Management Capacity
- 2000 Data Processing and Analysis
- 3000 Operational Records and Statistics
- ◇ 4000 Coordination of Operational Planning
- ⬡ 5000 Personnel System





PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

ANNEX #3  
 Title of Project: \_\_\_\_\_  
 Form 27 1981 to FY 1983  
 Total U.S. Funding: \_\_\_\_\_  
 Date Prepared: September 1980

Project Title &amp; Number: HEALTH MANAGEMENT IMPROVEMENT (608-151)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																																			
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To improve the health status of Morocco's poor by improving the quality and quantity of health services available to them.</p>	<p>Measures of Goal Achievement:</p> <ol style="list-style-type: none"> <li>Declines in age-specific morbidity/mortality rates;</li> <li>Declines in incidence of disease and health disorders targeted by the GOM health system;</li> <li>Decline in age-specific fertility rates.</li> </ol>	<ol style="list-style-type: none"> <li>Health status surveys</li> <li>Hospital and clinic records</li> <li>MOM field worker records</li> <li>Data from MOM "vertical" programs (T.B., schistosomiasis, V.D. ect.)</li> <li>Fertility and/or contraceptive prevalence surveys.</li> </ol>	<p>Assumptions for achieving goal targets:</p> <ol style="list-style-type: none"> <li>MOM will allocate ample resources for ambulatory health services</li> <li>To a considerable extent, health status is a function of the availability of good health services</li> <li>Moroccans will seek health/FP care from an improved MOM health delivery system; 4. Contraceptive use prevalence is positively related to availability of services, and inversely related to infant mortality.</li> </ol>																																			
<p>Project Purpose:</p> <p>To improve the quality and quantity of health services in Morocco by increasing the effectiveness and efficiency of the GOM health delivery system.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> <li>Improved MOM capacity to manage itself at all levels; central, provincial, circumscription.</li> <li>Institutionalized improvements in MOM management and administrative support systems: Planning, Personnel, Logistics, BSA, Health Statistics.</li> <li>Existence of adequate human, material and financial resources at field levels for the MOM.</li> </ol>	<ol style="list-style-type: none"> <li>Observations of MOM programs</li> <li>MOM work plans</li> <li>Health client surveys</li> <li>Clinic caseload analyses</li> </ol>	<p>Assumptions for achieving purpose:</p> <ol style="list-style-type: none"> <li>Ineffective and/or overtaxed MOM management procedures are a severe limiting factor to improved health services delivery;</li> <li>Organizational and administrative changes will be approved by MOM, Ministry of Plan, Ministry of Finance.</li> </ol>																																			
<p>Outputs:</p> <ol style="list-style-type: none"> <li>Improved capacity to solve management problems;</li> <li>Improved, flexible data processing capacity;</li> <li>Efficient system for collecting, analyzing and using operational statistics;</li> <li>Improved process for coordinating health programs;</li> <li>Efficient Personnel Administration system;</li> <li>Efficient Budget and Accounting System</li> <li>Efficient Procurement and logistics *)</li> </ol>	<p>Magnitude of Outputs:</p> <p>MOM budget and program records permit determination of program costs. Improvements in personnel administrative procedures which will permit a regularly scheduled updating (i.e., monthly or quarterly) of records relevant to hiring, transfers, promotions, and other personnel actions. The # of major vertical integrated programs utilizing new program budgeting system. The # of information collection documents redesigned and used. *)</p>	<ol style="list-style-type: none"> <li>USAID observation; 2. Contractor reports; 3. Project evaluation; 4. MOM documents, including B and A records, personnel records, operational reports from divisions and provinces.</li> </ol> <p>*) The # of divisions plus provinces utilizing revised data processing procedures. # seminars, training sessions provided for M-C, Majeurs &amp; other health personnel at local, provincial, central level.</p>	<p>Assumptions for achieving outputs:</p> <ol style="list-style-type: none"> <li>Use of a US/GOM team approach plus careful selection of training/trainees, will result in effective institutionalization of new mgt. systems and procedures in the MOM;</li> <li>MOM identifies adequate counterpart personnel</li> <li>MOM sustains commitment to implement the project.</li> </ol>																																			
<p>Inputs: (\$ 000)</p> <table border="0"> <tr> <td>1. Personnel</td> <td>U.S.</td> <td>(897)</td> </tr> <tr> <td>2. Training</td> <td></td> <td>(547)</td> </tr> <tr> <td>3. Commodities</td> <td></td> <td>(370)</td> </tr> <tr> <td>4. Evaluation</td> <td></td> <td>( 10)</td> </tr> <tr> <td>5. Inflation @ 15% per an</td> <td></td> <td>(274)</td> </tr> <tr> <td>6. Contingencies @ 10% p/a</td> <td></td> <td>(183)</td> </tr> <tr> <td>SUB - TOTAL</td> <td></td> <td>\$ 2,281</td> </tr> </table> <table border="0"> <tr> <td colspan="2">GOM</td> </tr> <tr> <td>1. Personnel</td> <td>(1,328)</td> </tr> <tr> <td>2. Facilities + Transport</td> <td>( 21)</td> </tr> <tr> <td>3. Travel Costs</td> <td>( 15)</td> </tr> <tr> <td>4. Depreciation</td> <td>( 68)</td> </tr> </table>	1. Personnel	U.S.	(897)	2. Training		(547)	3. Commodities		(370)	4. Evaluation		( 10)	5. Inflation @ 15% per an		(274)	6. Contingencies @ 10% p/a		(183)	SUB - TOTAL		\$ 2,281	GOM		1. Personnel	(1,328)	2. Facilities + Transport	( 21)	3. Travel Costs	( 15)	4. Depreciation	( 68)	<p>Implementation Target (Type and Quantity)</p> <ol style="list-style-type: none"> <li>Two long-term (3 yrs) 30 p/a short-term</li> <li>8 person/years long-term (U.S.) 30 p/a short-term (U.S. and 3rd country) In-country short-term</li> <li>EDP equipment Training supplies and equip. Misc. Office equipment.</li> </ol> <p>GOM INPUTS (COM* T)</p> <ol style="list-style-type: none"> <li>Contingencies + Inflation (358)</li> </ol> <table border="0"> <tr> <td>SUB - TOTAL</td> <td>\$ 1,790</td> </tr> <tr> <td>PROJECT TOTAL</td> <td>\$ 4,071</td> </tr> </table>	SUB - TOTAL	\$ 1,790	PROJECT TOTAL	\$ 4,071	<ol style="list-style-type: none"> <li>Project Agreement</li> <li>Contract w/U.S. CONSULTANTS; TAC's</li> <li>PIO/C's, PIO/T's, purchase orders, ect.</li> <li>Audits</li> </ol>	<p>Assumptions for providing inputs:</p> <ol style="list-style-type: none"> <li>The U.S. has significant comparative advantage in the field of health management improvement.</li> <li>U.S. management procedures can be effectively grafted onto a traditional French-style government bureaucracy.</li> </ol>
1. Personnel	U.S.	(897)																																				
2. Training		(547)																																				
3. Commodities		(370)																																				
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\*) System for transport and other materials.

ENVIRONMENT ASSESSMENT

USAID/Morocco has concluded that no further environmental examination is necessary. This project is unlikely to have any significant effect on the physical environment, and no negative effect on the human environment of Morocco.

## 5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual fund sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Fund.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE?  
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PRODUCT?

## A. GENERAL CRITERIA FOR PROJECT

1. FY 79 App. Act Unnumbered; FAA Sec. 653 (b); Sec. 634A. (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure)?

1. (a) The Appropriations Committees will be notified in accordance with normal Agency procedures. b) Yes.

2. FAA Sec. 611(a). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

2. a) Yes  
b) Yes

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

3. No further legislative action is required

4. FAA Sec. 611(b); FY 79 App. Act Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?

4. N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

5. N/A

6. FAA Sec. 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

6. N/A

A.

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

7. N/A

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

8. US technical consultants will assist in implementation of the project. US universities will provide training for host country nationals

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

9. The Project Agreement will so provide.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

10. Morocco is a near excess currency country. US owned ~~excess~~ currencies will be used as and if available for this project.

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

11. Yes

12. FY 79 App. Act Sec. 608. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar, or competing commodity?

12. N/A

## B. FUNDING CRITERIA FOR PROJECT

### 1. Development Assistance Project Criteria

a. FAA Sec. 102(b); 111; 113; 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained

1. a) The project will improve the efficiency of the Moroccan Governments' health delivery system, and thereby increase the quality and quantity of health services available to the country's poor.

217

## B.1.a.

basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106, 107.

Is assistance being made available: (include only applicable paragraph which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

(2) [104] for population planning under sec. 104(b) or health under sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research.

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(i) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(ii) to help alleviate energy problems;

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster;

- b) N/A  
 c) This project was proposed by the Moroccan Government, which has committed significant human and financial resources toward its implementation;  
 d) Pregnant and lactating mothers are a high priority target population of the GOM health system

e) N/A

1. N/A

2. A primary objective of the project is to improve operational efficiency of Morocco's integrated health delivery system by greater coordination of clinic + outreach programs; ensuring availability at local levels of medecins, contraceptives, personnel, etc; improving surveillance and assessment of local level health problems.

3. N/A

4. N/A

## B.1.b.(4).

(v) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

\* (vi) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

c. [107] Is appropriate effort placed on use of appropriate technology?

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to the Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental and political processes essential to self-government.

g. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase or productive capacities and self-sustaining economic growth?

2. Development Assistance Project Criteria (Loans Only)

2. N/A

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, including reasonableness of repayment prospects.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

B.

3. Project Criteria Solely for Economic Support Fund

3. N/A

a. FAA Sec. 531(a). Will this assistance support promote economic or political stability? To the extent possible, does it reflect the policy directions of section 102?

b. FAA Sec. 533. Will assistance under this chapter be used for military, or paramilitary activities?

## 5C(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

- |  |  |
|--|--|
| 1. <u>FAA Sec. 602.</u> Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed?  | 1. Yes   |
| 2. <u>FAA Sec. 604(a).</u> Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him?  | 2. Yes   |
| 3. <u>FAA Sec. 604(d).</u> If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the United States on commodities financed?  | 3. Yes   |
| 4. <u>FAA Sec. 604(e).</u> If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?  | 4. N/A   |
| 5. <u>FAA Sec. 608(a).</u> Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?   | 5. Yes   |
| 6. <u>FAA Sec. 603.</u> (a) Compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates. | 6. Procurement/shipping procedures for project commodities will comply with applicable US laws and regulations |
| 7. <u>FAA Sec. 621.</u> If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the  | 7. Yes   |

A.7.

facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?

9. FY 79 App. Act Sec. 105. Does the contract for procurement contain a provision authorizing the termination of such contract for the convenience of the United States?

8. Contract will so provide.

9. Contract will so provide

B. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the United States not exceed \$100 million?

B. Provisions N/A

C. Other Restrictions

1. FAA Sec. 122 (e). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-bloc countries, contrary to the best interests of the United States?

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the United States, or guaranty of such transaction?

C.

1. N/A

2. N/A

3. Yes

4. Yes



UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON D C 20523

NEAR EAST ADVISORY COMMITTEE MEETING

DATE: November 13, 1980  
TIME: 10:00 A.M.  
PLACE: 6439

SUBJECT: PP - Health Management Improvement - Morocco (608-0151)

The Near East Advisory Committee will meet as scheduled above to discuss the subject project and the attached Issues Paper.

Please refer all questions to the chairperson.

Attachments  
Issues Paper  
PP

Project Review Committee:  
NE/TECH/HPN, J. Weissman, Chairperson  
NE/NENA/TM, G. Lewis  
NE/DP/PR, G. Donnelly  
NE/PD/NENA, P. Holmes  
GC/NE, S. Carlson  
DS/HEA, T. Lukas  
NE/TECH/SA, J. Romagna  
NE/TECH/SA, P. Johnson

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NE/PD, S. Lintner  
NE/PD, A. Hotvedt  
GC/NE, J. Kessler  
PPC/PDPR, S. Klein  
PPC/PB, J. Segal  
NE/NENA, J. Phippard  
G. Lewis  
PPC/WID, A. Fraser  
SER/CM/ROD/NE, K. Cunningham  
SER/COM/NE, R. Looper  
DS/DIU/DI, N. Thompson  
NE/PD, G. Shivers  
NANEAP/PC, Mr. Taylor, M-806 Conn Ave, NW  
OPTC/PC, Mr. J. Beauter, M-701, 806 Conn Ave, NW

UNITED STATES GOVERNMENT

# Memorandum

TO : Near East Advisory Committee

DATE: November 6, 1980

THRU: NE/TECH, Lewis P. Reade *LR*  
FROM : NE/TECH/HPN, Juliana Weissmann *JW*

SUBJECT: Issues Paper: Morocco: Health Delivery Management (608-0151)  
(NEAC, November 13, Room 6439 N.S.)

The project is to strengthen the management and administrative systems of the Moroccan Ministry of Public Health in order to increase the quantity and quality of primary care services delivered to the Moroccan people. The project activities will focus first on the redesign of selected management and information systems at the central and provincial levels. The new systems will be tested and then, through training and seminars, employees at all levels in the Ministry will be taught to use the new methods to analyze problems, plan, monitor and evaluate programs, and provide more cost efficient services.

The project reflects the concerns and priorities of the Moroccan Ministry of Health. The scope of the project is narrower than that envisioned by the PID, but it reflects the Ministry's priorities in health management and represents a level of activity which USAID and the GOM feel that the MOH can sustain.

The USAID/Rabat and AID/W staff who worked on the PP were impressed by the consistent, high level attention given by Moroccan Ministry of Health officials during the development of this project. Close consultations with MOH officials during preparation of the PP insured the concurrence of the MOH in the strategy and content of the project. In view of the above, we recommend project approval.

The Project Review Committee supports the goals of the project and agrees that it is technically sound. There were, however, several issues which were raised during the PP review.

## 1. Project Implementation Plan:

The contracting mechanism described in the PP, which calls for the use of two host country PSC's for long-term advisors and a variety of AID direct contracting activities for short-term technical assistance, training, commodity procurement, etc., appeared to the PRC to present certain problems with regard to AID policy and regulations as well as problems of coordination and administrative control.

This approach was initially suggested as a means of fielding a team



quickly; however, a preliminary search for candidates for the two PSCs revealed that the majority of qualified individuals were attached to universities or consulting firms and that further efforts to use this approach would delay, rather than expedite the implementation of the project. These findings were communicated to USAID/Rabat, and the Mission has agreed to execute a PP revision to reflect the use of a single host country contractor for all project activities and to prepare an RFP. The implementation schedule will be revised to reflect these changes.

The use of a single contractor will require an upward revision of the budget, from \$2.3 million to approximately \$3.0 million which was the level tentatively approved at the PID NEAC. (The PP budget was originally prepared for a single host country contractor and totaled \$2.927 million.) We recommend the addition of \$50,000 to the training budget to reflect the increased cost of third country and short-term training.

2. Several issues relative to the evaluation plan of the project were discussed by the PRC. These included: 1) the extent to which the project would improve services to Morocco's poor; and 2) the balance of power and responsibility in the MOH and the impact of training and other project activities on this balance (i.e., centralization versus decentralization); 3) the need for joint USAID/GOM/contractor participation in the design and implementation of evaluation activities.

The PRC recommended that the evaluation of the project be strengthened to provide both beginning and end of project status reports which would be developed jointly by the above mentioned parties. These would include, for example, the number and kind of health services delivered, the operational efficiency and skills of MOH personnel in the collection and use of health statistics, population coverage, perception of change in quantity and quality of services among users, and other data which would provide a base against which to measure the impact of the project's activities on the outer reaches of the health system and on the ultimate beneficiaries.

3. The MOH plans to use the Ministry of Plan computer for its data processing activities. A written agreement to this effect will have to be obtained before the project can be implemented. The PRC recommends the addition of a condition precedent to this effect.

4. The PRC recommends an additional condition precedent to the effect that the Government of Morocco designate counterpart staff prior to the arrival of resident advisors.

5. The Project Paper does not contain a request for assistance from the Government of Morocco. The PRC recommends that USAID obtain this for inclusion in the PP.

6. The PRC also discussed the desirability of a project covenant which would commit the MOH in principle to expansion and improvement of rural health services, especially into areas with least access.

**Clearances:**

NE/NENA:GLewis (draft)  
NE/DP:GDonnelly (draft)  
NE/PD:PHolmes (draft)  
NE/TECH/SA:JRcmagna (draft)  
NE/TECH/SA:PJohnson (draft)  
NE/TECH/HPN:WOldham (draft)  
DS/HEA:TLukas (draft)  
GC/NE:SCarlson (draft)

**Attachments:**

NEAC Review Cable (State 81906)  
Mission Response Cable (Rabat 2661)

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DISCUSSIONS AMONG GOVERNMENT AGENCIES HAVE BEEN POSITIVE. SOME DATA IS AVAILABLE NOW FOR PRELIMINARY ESTIMATES OF MICRO/MACRO COSTS OF HEALTH SYSTEM. USAID HAD REQUESTED SERVICES FRENCH SPEAKING HEALTH ECONOMIST TO UNDERTAKE SUCH ANALYSIS IN CONTEXT OF DEVELOPING PROJECT PAPER. THIS WILL NECESSRILY BE PART OF FOLLOW-ON DESCRIBED BELOW.

ACTION OFFICE NETC-04  
INFO MENA-03 PPOE-01 PPP0-02 PPEA-01 AADS-01 CMGT-02 C/R-02  
DIU-04 DSNE-01 POP-04 CR8-01 RELO-01 STA-10 MAST-01  
POI 1 /039 A4

4. MACRO-MICRO FOCUS OF PROJECT: NEAC RAISED QUESTION WHETHER MANAGEMENT IMPROVEMENT WILL FOCUS BENEFIT ON URBAN AND CURATIVE AS OPPOSED TO RURAL AND PREVENTIVE SERVICES. FOCUS OF PROJECT WILL BE ON HOW, THROUGH BETTER MANAGEMENT, PREVENTIVE SERVICES CAN BE IMPROVED. HOSPITAL MANAGEMENT IS AN ALMOST SEPARATE DISCIPLINE AND FRENCH COOPERATION IS TENTATIVELY EARMARKED FOR THE CURATIVE SYSTEM. QUESTIONS OF HOSPITAL MANAGEMENT HAVE NOT BEEN DISCUSSED WITH AID. OBVIOUSLY THERE ARE LINKAGES BETWEEN CURATIVE AND PREVENTIVE AND BOTH WILL BENEFIT FROM IMPROVED MANAGEMENT AND SYSTEM EFFICIENCIES. IN FACT IN EXISTING MOH ORGANIGRAM, TASKS AND FUNCTIONS, AS WELL AS ACTUAL PROFESSIONAL TIME ALLOCATED TO DIVISION OF TECHNICAL AFFAIRS HEADED BY ALAOUI ARE MORE THAN 40 P/C DEVOTED TO PREVENTIVE SERVICES. PROJECT WILL STRENGTHEN ORIENTATION TOWARD PREVENTION PARTICULARLY IN BUDGET ALLOCATION PROCESS AND PROVINCIAL PLANNING AND EXECUTION.

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TO SECSTATE WASHDC 3799  
INFO AMEMBASSY TUNIS

UNCLAS SECTION 1 OF 2 RABAT 2661

AIDAC  
TUNIS PLEASE PASS J. ROMAGNA

E.O. 12958: N/A  
SUBJECT: HEALTH DELIVERY MANAGEMENT (608-0151) PROJECT  
DEVELOPMENT PLANS

REF: STATE 81908, STATE 096905

1. SUMMARY: WASHINGTON'S TIMELY REVIEW OF PID AND CENDING OF REFTEL FACILITATED TOY OF WOLFF AND ROMAGNA AND OUR DIALOGUE WITH MINISTRY OF HEALTH. VISIT WAS EXTREMELY HELPFUL IN DEVELOPING FRAMEWORK FOR SUBSEQUENT FINAL PROJECT DESIGN AND OPTIONS AVAILABLE TO MOH. USAID/MOH PLEASED WITH DIRECTION OF PROJECT AND ANXIOUS ARRANGE FOR FOLLOWUP TO PREPARE PP AND SORT OUT VARIOUS IMPLEMENTATION QUESTIONS. REQUEST AID/W ASSISTANCE IN ORGANIZING APPROPRIATE TEAM AS DESCRIBED BELOW PARA 3. NE/TECH ROMAGNA AND FORT PARTICIPATION WILL BE CRITICAL. OUR RESPONSES TO ISSUES RAISED BY NEAC (REFTEL) SHOULD HELP CLARIFY OUR PROJECT DEVELOPMENT PLANS.

2. DECENTRALIZATION: DECENTRALIZATION IS AS MUCH PROCESS AS STATUTES. MOROCCAN GOVERNMENT IS COMMITTED TO DECENTRALIZATION. QUESTIONS ARE HOW MUCH AND HOW FAST. LOCAL ELECTED LEADERS ARE BEING ENGAGED IN PLANNING PROCESS FOR HEALTH AS WELL AS OTHER DEVELOPMENT ACTIVITIES. THERE ARE EXAMPLES OF DECENTRALIZATION ALREADY IN PROCESS. MOH HAS THIS YEAR ALLOWED PROVINCIAL HEALTH OFFICERS (PHO) BUDGETARY DISCRETION IN BUYING DIRECTLY APPROXIMATELY 80 9/0 OF CERTAIN TYPES PHARMACEUTICALS/MEDICINES. PERIODIC CONSULTATION MEETINGS BETWEEN PHOS AND MINISTRY OFFICIALS ARE BEING HELD. PHOS HAVE DESIGNED/DEVELOPED AND ARE IMPLEMENTING INDIVIDUAL PROVINCE PLANS FOR SPRING IMMUNIZATION CAMPAIGN (IN PROCESS). AS PART OF NEX 3 YEAR PLAN PREPARATION EXERCIES, PROVINCIAL LEADERS HAVE BEEN ASKED TO PROVIDE A CRITIQUE OF IMPEDIMENTS AND BLOCKAGES TO DEVELOPMENT WHICH CAN BE RESOLVED THROUGH DECENTRALIZATION, ETC. FURTHER EXPLORATION OF THE LIMITS AND EFFICIENCIES OF DCENTRALIZATION SHOULD BE POSSIBLE IN PP DEVELOPMENT EFFORT BUT REAL TEST IS OBVIOUSLY ONE OF PROJECT IMPLEMENTATION ELEMENTS.

3. BUDGETARY FORMULATIONS: WHILE BUDGET HEADINGS AND LINE ITEMS ARE STANDARDIZED THROUGHOUT GOVERNMENT, TWO POTENTIAL AREAS OF FLEXIBILITY ARE IMMEDIATELY EVIDENT FOR BETTER COST ACCOUNTING. ONE IS TO ADD USER CODES IN ACCOUNTING SYSTEM. CODES HAVE BEEN DEVELOPED BUT NEVER EMPLOYED EXCEPT BY THE MOTOR POOL IN HAND TABULATED ANALYSES. SECOND APPROACH WHICH MAY ALSO SLIGHTLY INCREASE AVAILABLE RECOURCES IS TO VIEW DEVELOPMENT OF PREVENTIVE SERVICES AND RELATED INFRASTRUCTURE AS AN INVESTMENT EXPENSE WITHIN THE 5 YEAR DEVELOPMENT BUDGET. INITIAL

5. MOH ALLOCATION OF PROFESSIONAL TIME: AS ROMAGNA WILL REPORT, MOH WILL NEED TO CREATE POSITIONS OR REALLOCATE CERTAIN PERSONNEL TO NEWLY DEFINED FUNCTIONS IN ORDER TO IMPROVE ITS PLANNING, MANAGEMENT AND EVALUATION OF BASIC HEALTH SERVICES. CRITICAL ELEMENTS ARE: A) STAFFED AND FUNCTIONING HEALTH PLANNING UNIT WITH NECESSARY AUTHORITY AND STAFF CAPABILITY IN INFORMATION ANALYSIS BOTH IN HEALTH STATISTICS SECTION AND AT PROVINCE LEVEL. ROMAGNA HAS AGREED TO INCLUDE ADDITIONAL MOH STAFFING REQUIREMENTS IN HIS WRITTEN ANALYSIS OF MANAGEMENT OPTIONS.

6. FAMILY PLANNING AND BASIC HEALTH ACTIVITIES: TO REITERATE AND REEMPHASIZE A FUNDAMENTAL POINT, MOH DELIVERS HEALTH SERVICES THROUGH AT TRIAGE SYSTEM AT WHOSE BASE IS THE ITINERANT NURSE WORKING OUT OF DISPENSARY. FP SERVICES ARE AMONG HIS MANY RESPONSIBILITIES. MAIN TASKS OF ITINERANT ARE BEING REDEFINED FROM ALMOST EXCLUSIVE PRIORITY EFFORT ON MALARIA AND TB CONTROL TO BASIC PREVENTIVE HEALTH SERVICES GEARED TO SEASONAL DISEASE PATTERNS. IMPROVED FAMILY PLANNING OUTREACH SERVICES BY ITINERANTS IN COMBINATION WITH OTHER BASIC HEALTH SERVICE TASKS PLUS SOMEWHAT MORE EMPHASIS ON FP ARE FOCUS OF "VONS EXTENSIONS". IN OTHER (NOW VONS) PROVINCES FAMILY

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OR EARLIER) FOR APPROXIMATELY 3-4 WEEKS TO COMPLETE  
DETAILED DEFINITION OF PROJECT SCOPE.

ACTION OFFICE NE/TC-04

INFO MENA-03 PPCE-01 PPPB-02 PPEA-01 AAO5-01 CMGT-02 CTR-02  
DIU-04 OSNE-01 POP-04 CH8-01 RELO-01 STA-10 MAST-01  
POPR-01 /039 A4

C. BUCEN, COMPUTER HARDWARE SPECIALIST: TO IDENTIFY  
INFORMATION HANDLING/PROCESSING EQUIPMENT REQUIREMENTS  
AND DEVELOP PROCUREMENT LISTS; AND TO CRAFT TECHNICAL  
ANALYSIS FOR PROJECT PAPER. ESTIMATED TIME APPROXIMATELY  
THREE WEEKS.

INFO OCT-01 /836 W

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TO SECSTATE WASHDC 3888  
INFO AMEMBASSY TUNIS

D. SOCIAL SCIENTIST: TO PREPARE/COORDINATE SOCIAL  
SOUNDNESS AND BENEFICIARY ANALYSIS, DEFINE MANAGEMENT  
LINKAGES, OUTLINE MANAGEMENT AND COMMUNICATIONS SEMINAR  
WORKSHOP NEEDS/PLANS AS WELL AS DEVELOP EVALUATION PLAN.  
TWO POSSIBLE CONSULTANTS HAVE BEEN IDENTIFIED: PROF.  
ROBERT FURNEA OF UNIVERSITY TEXAS WHO PARTICIPATED IN  
DRAFTING OF MOROCCAN POPULATION STRATEGY STATEMENT, AND  
PAM JOHNSON OF NE/TECH. ESTIMATED TIME REQUIRED FOUR WEEKS.

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9. TECHNICAL EFFORT ABOVE SHOULD BE TEAM EFFORT  
COORDINATED, WE BELIEVE, BY G. FORT. PROPOSED MULTI-  
DISCIPLINARY TEAM SHOULD BE ABLE DEVELOP TECHNICAL FINDINGS  
AS BROKEN DOWN IN PID PP 19-20 AND INTEGRATE WITH DRAFT  
PROJECT PAPER/IMPLEMENTATION PLANS. SOME PROGRESS THESE  
ITEMS WAS MADE DURING RECENT ROMAGNA CONSULTANCY, AND  
VOLUMINOUS SET OF MOH FORMS COLLECTED. RELEVANT DOCUMENTS  
COLLECTED AND DRAFTS FROM TWO MAJOR MEETINGS WITH MOH  
ARE BEING SENT TO WASHINGTON FOR NE/TECH REVIEW AND AS  
BACKGROUND FOR JUNE PROJECT DESIGN TEAM.

PLANNING SERVICES ARE BEING IMPLEMENTED IN VARIOUS  
COMBINATIONS/CONFIGURATIONS WITH OTHER SERVICES DEPENDING  
ON PROVINCIAL MANPOWER RESOURCES AND INITIATIVES. HOWEVER,  
PERFORMANCE IS SPOTTY AND NEEDS IMPROVEMENT. COMPETITION  
FOR STAFF BETWEEN THE HEALTH & FP PROJECTS SHOULD NOT BE A  
PROBLEM AT IMPLEMENTATION LEVEL. ONLY REAL POTENTIAL  
HEADACHE IS TIME OF DECISION MAKERS. PROPOSED PLANNING  
UNIT, ORGANIZATIONAL CHANGES AND STAFF ADDITIONS AS WELL  
AS IMPROVED MANAGEMENT SHOULD RELIEVE CONGESTION AT HIGH  
LEVELS.

10. SEPTEL FOLLOWS WITH SUMMARY ROMAGNA RECOMMENDATIONS.  
MINISTRY RESPONSE ENTHUSIASTIC. WE BELIEVE GROUND  
PREPARED FOR INTENSIVE FINAL PROJECT DESIGN VISIT IN JUNE.  
PLEASE ADVISE. MOFFAT

7. "FIELD TRIALS" IS A CONFUSING TERM FOR WHAT WILL LIKELY  
HAPPEN IN PROVINCIAL DEMONSTRATION PROVINCES. PROJECT WILL  
NOT FOCUS ON SERVICES PER SE AS FP PROJECT WILL IN VOMS  
EXTENSIONS. RATHER PROJECT IMPLEMENTATION WILL FOCUS ON  
PROCESSES BY WHICH PRIORITIES CAN BE CLARIFIED, SERVICES  
IMPROVED AND STREAMLINED, DUPLICATION AVOIDED, ECONOMICS  
EFFECTED AND COMMUNICATION PROMOTED. SOME ELEMENTS WILL  
NEED A TRIAL BEFORE BEING SUGGESTED TO ALL PROVINCES OR MADE  
INTO PERFORMANCE STANDARDS OR REGULATIONS. SOME ELEMENTS WILL  
REQUIRE SPECIALIZED PERSONNEL AND THUS CAN ONLY BE INTRODUCED  
WHERE TRAINED STAFF ARE IN PLACE. EVEN ELEMENTS SUCH AS  
SIMPLIFIED RECORDS WILL REQUIRE A FIELD TEST IN TYPICAL WORK  
SITUATIONS. TO MAXIMIZE IMPACT ON HEALTH STATUS, FIELD TRIALS  
OF ALTERNATIVE SYSTEMS OR MANAGEMENT TECHNIQUES SHOULD NOT BE  
CONFINED TO PRE-SELECTED PROVINCES. SINCE SITUATION AND  
CONDITIONS VARY BY PROVINCE, WHAT WORKS IN MEKNES WHICH IS  
50 P/C URBAN MAY BE WRONG FOR SETTAT WHICH IS 80 P/C RURAL. ON  
THE OTHER HAND INTER-PROVINCE LINKAGES/COMMUNICATIONS ARE  
NECESSARY TO SOME DEGREE. WE SUGGEST REGIONAL MEETINGS IN  
ALTERNATE PROVINCES FOR MEDECIN-CHEFS, PUBLIC HEALTH NURSES,  
STATISTICIANS, ADMINISTRATIVE STAFF ETC. TO HELP FACILITATE  
CHANGE, AVOID DUPLICATION AND ENSURE COORDINATION AMONG  
PROVINCIAL PROGRAMS. MANAGEMENT IMPROVEMENTS WILL NOT BE  
EFFECTIVE IN ISOLATION FROM PREVENTIVE HEALTH SERVICE  
DELIVERY SYSTEM. SPILLOVERS TO ALL PROGRAMS ARE EXPECTED.

8. NEXT STEPS IN PROJECT DEVELOPMENT: BASED ON BROAD  
ANALYSIS OF HEALTH SYSTEM COMPLETED BY ROMAGNA/WOLFF AND  
DISCUSSION APRIL 7 WITH ALAOUI WE ARE ANXIOUS TO PROCEED  
WITH DEVELOPING DETAILED PROJECT DESCRIPTION ASAP. RECENT  
ANALYSIS OF SYSTEM AND WORK ACCOMPLISHED DURING ROMAGNA  
VISIT SUGGESTS PP CAN BE COMPLETED DURING JUNE IF 4-PERSON  
TEAM OF THE FOLLOWING PERSONS/SKILLS CAN BE MADE AVAILABLE:

A. CATHY FORT, NE/TECH HEALTH ECONOMIST, TO COORDINATE  
OVERALL EFFORT AND PREPARATION OF DRAFT PP AND TO BE  
PERSONALLY RESPONSIBLE FOR ECONOMIC ANALYSIS AND FINANCIAL  
PLAN. ESTIMATED TIME 9 WEEKS BEGINNING END MAY.

B. JOHN ROMAGNA, NE/TECH SYSTEMS ANALYST, WHO WILL NOT BE  
BACK IN WASHINGTON FOR SEVERAL WEEKS, IS NEEDED MID JUNE

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INTERVENTIONS AND WOM'S OPERATIONS RESEARCH ACTIVITY WHICH  
MIGHT AVOID COMPETITION FOR STAFF.

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 PPEA-01 GCFL-01 GCNE-01 IA-01 IIA-02 IDCA-01 AADS-01  
 DSNE-01 CMB-01 HEV-09 STA-18 MAST-01 POPR-01 /047 A1

INFO OCT-88 /035 R

DRAFTED BY AID/NE/TECH/HPN:C FORT:L

APPROVED BY AID/AA/NE:A D WHITE

AID/NE/TECH:M MAGNANUS

AID/NE/NENA:M HUNTINGTON (DRAFT)

AID/NE/OP:B LAHMAID (DRAFT)

AID/NE/PO:R BELL (DRAFT)

AID/PPC/POPR:B SIDMAN (DRAFT)

AID/GC/NE:S CARLSON (DRAFT)

AID/OS/NEA:T LUKAS (DRAFT)

AID/NE/PO/PDS:G SHIVERS (INFO)

DESIRED DISTRIBUTION

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TO AMEMBASSY RABAT PRIORITY

UNCLAS STATE 081908

AIDAC

E.O. 12065: N/A

TAGS:

SUBJECT: HEALTH DELIVERY MANAGEMENT PID (688-0151) - NEAC  
REVIEW

1. NEAC WAS HELD MARCH 28 WHERE APPROVAL WAS GIVEN TO  
FURTHER DEVELOP THE PID TO A PP. ISSUES PAPER WILL BE  
POUCHED. GENERAL OPINION WAS THAT THE PID WAS CLEAR AND  
WELL WRITTEN. THE MAJOR ISSUES RAISED AND DISCUSSED ARE AS  
FOLLOWS:

A. PID DOES NOT REALLY DEFINE A STRATEGY OF PROJECT DE-  
VELOPMENT AND IMPLEMENTATION BUT DOES SHOW NEED TO WORK IN  
AREA OF MANAGEMENT IMPROVEMENT. QUESTIONS CENTERED ON HOW  
WILL PROPOSED SERIES OF TOY'S DEVELOP INTO A PP WITH A  
COHERENT SET OF MANAGEMENT INTERVENTIONS. ALTHOUGH NEAC  
AGREED THAT STEP BY STEP APPROACH TO PROJECT DESIGN MAY BE  
MOST APPROPRIATE TO GOM INTERESTS AT THIS TIME, WE ARE  
CONCERNED HOW MOH AND USAID WILL HANDLE EXTENSIVE TOY  
BURDEN. ALSO, PAGE 19 OF PID INDICATES A 3-5 PERSON DESIGN  
TEAM (FOLLOWING VISIT OF HIS/SYSTEMS ANALYST NOW IN FIELD).  
WOULD THIS TEAM BE EXPECTED PREPARE ITEMS LISTED PP. 19-28  
OF PID AND COMPLETE BULK OF PP? WOULD APPRECIATE USAID  
CLARIFICATION ON PROPOSED STEPS FOR PP DESIGN.

B. QUESTION WAS RAISED ON WHETHER MOH WOULD PROVIDE  
SUFFICIENT STAFF TIME TO IMPLEMENT PROJECT INCLUDING  
FIELD TRIALS. NEAC CONCURRED THAT RESPONSIBILITY FOR PRO-  
VIDING ADEQUATE NUMBER OF TOP PERSONNEL RESTS WITH MOH AND  
SHOULD CONSTITUTE HOST COUNTRY CONTRIBUTION. TO ASSURE  
GOM UNDERSTANDS AND IS COMMITTED TO PROGRAM, BELIEVE  
SPECIFIC ROLE, STAFFING AND FUNCTIONS OF MOH MUST BE  
SPELLED OUT IN PP AND GRANT AGREEMENT. GIVEN CLEAR MOH  
INTEREST IN BROADENING ITS FAMILY PLANNING ACTIVITIES TO  
INCLUDE HEALTH OUTREACH ELEMENTS AS WELL AS STAFFING,  
ETC., RECOMMENDATION WAS MADE THAT PROJECT DEVELOPERS  
SEEK OUT AND DESIGN CONNECTIONS BETWEEN BASIC HEALTH

C. LIKEWISE, SAME VIEW HELD ON ISSUE REGARDING MOROCCAN'S  
WILLINGNESS TO DECENTRALIZE. WHAT AUTHORITIES, RESPON-  
SIBILITIES NEED TO BE DECENTRALIZED? WHAT IS NATURE/  
EXTENT OF MOH PLANNING FOR DECENTRALIZATION? WHAT WOULD  
THIS ENTAIL? HOW WILL PHASING OF DECENTRALIZATION BE  
MEASURED? MOROCCANS MUST BE COMMITTED TO THIS OR PROJECT  
CANNOT SUCCEED. PP MUST CLEARLY DEFINE WHAT IS EXPECTED  
AND WHAT MOROCCANS INTEND TO PURSUE.

D. REGARDING ISSUE OF WILLINGNESS OF MOH TO REVISE CUR-  
RENT BUDGET FORMULATIONS, IT WAS FELT THAT FINANCIAL  
ANALYSIS NORMALLY UNDERTAKEN DURING PROJECT DEVELOPMENT  
SHOULD DETERMINE DIRECTION AND MAGNITUDE OF CURRENT MOH  
FUNDING TRENDS AND ESTIMATE COST OF RUNNING EXISTING  
BASIC HEALTH SERVICES SYSTEM. ANALYSIS WOULD SERVE  
DOUBLE PURPOSE OF (1) PROVIDING MOH PLANNERS A BENCHMARK  
TO MEASURE IMPACT OF CURRENT AND FUTURE INPUTS ON HEALTH  
BUDGET AND (2) DETERMINING WHAT MAY BE REQUIRED IN WAY  
OF COST AND BUDGET REORGANIZATION TO GIVE BETTER IDEA OF  
PROJECT FEASIBILITY AND SUCCESS.

E. FROM DISCUSSION OF BUDGET ISSUES GREW CONCERN AS TO  
WHETHER A MACRO-LEVEL PROJECT OF THIS NATURE WHICH  
EMPHASIZES IMPROVING MANAGEMENT WILL TEND TO FOCUS ON  
CAPITAL INTENSIVE, LARGELY CURATIVE AND URBAN ORIENTED  
SYSTEMS AS OPPOSED TO THE EXTENSION OF BASIC HEALTH  
SERVICES INTO RURAL AREAS DEPRIVED OF ADEQUATE COVERAGE.  
PP SHOULD PROVIDE ASSURANCES OF MOH COMMITMENT TO PLACE  
EMPHASIS ON IMPROVING THE OPERATION OF THE BASIC HEALTH  
SERVICES SYSTEM AND ITS EXTENSION INTO RURAL AREAS.  
MISSION MAY WANT TO CABLE ON THIS FUNDAMENTAL QUESTION OF  
EMPHASIS.

F. QUESTION WAS RAISED AS TO WHETHER PROJECT WILL RE-  
CEIVE FY 88 OR 81 FUNDING. NEAC AGREED PROJECT WAS USEFUL

EFFORT AND SHOULD BE FULLY DEVELOPED EVEN THOUGH BUREAU  
CANNOT GUARANTEE FUNDING AT THIS TIME. FOLLOWING PP  
APPROVAL BUREAU WILL SUPPORT STRONG REQUEST FOR FY 88 OR  
81 FUNDS.

G. REGARDING LANGUAGE SKILLS OF PARTICIPANTS, IT IS NOT  
CLEAR WHETHER THERE IS SUFFICIENT MONEY IN BUDGET TO PRO-  
VIDE ENOUGH ENGLISH LANGUAGE TRAINING TO THOSE WHO MAY  
NEED IT. IT WAS RECOMMENDED THAT THIS ISSUE BE FURTHER  
EXPLORED DURING PP DEVELOPMENT.

H. NEAC INDICATED NEED FOR FURTHER JUSTIFICATION OF  
EQUIPMENT REQUIRED FOR DEMONSTRATION PROJECT. RECOMMENDA-  
TION WAS THAT PP NEEDS TO MORE CLOSELY DEFINE LINK  
BETWEEN FIELD TRIALS AND NEEDED EQUIPMENT. ALSO, NORMAL  
IMPLEMENTATION CONSIDERATIONS (E.G., SOURCE AND ORIGIN,  
HOW PROCURED, ETC.) SHOULD BE SPELLED OUT.

I. NEAC RECOGNIZES COMPETENCE AND HAS CONFIDENCE IN USAID  
STAFF TO DEVELOP PROJECT. BUT GIVEN THE INNOVATIVE-  
NESS AND COMPLEXITY OF PROJECT, THE LACK OF CLEAR DEFINI-  
TION OF PROJECT INTERVENTIONS, THE UPCOMING TURNOVER IN  
HEALTH/POP STAFF AND NEED FOR CONTINUITY, NEAC CONCLUDED  
IT PREFERENCES AID/W REVIEW AND APPROVAL OF PROJECT. VANCE