ASSESSMENT OF THE PRIVATE HEALTH CARE SECTOR IN MOROCCO

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Moncef Bouhafa
Hugh Waters

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Edited and Produced by

Population Technical Assistance Project
1611 North Kent Street, Suite 508
Arlington, VA 22209 USA
Phone: 703/247-8630
Fax: 703/247-8640
E-mail: poptech@bhm.com

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ABBREVIATIONS

ANCP	*l'Association Nationale des Cliniques Privées*
BMCE	*Banque Morocaine du Commerce Extérieure*
CDD	Control of Diarrheal Diseases
CNFRH	*Centre National de Formation en Reproduction Humaine*
CNOM	*Conseil National de l'Ordre des Médecins*
CNOPS	*Caisse Nationale des Oeuvres de Prévoyance Sociale*
CNSMP	*Confédération Nationale des Syndicats des Médecins Privés*
CPR	contraceptive prevalence rate
CSM	contraceptive social marketing
DHS	Demographic and Health Surveys Project
EC	European Commission
EPPS	*Enquête de Panel Population et Santé*
FIPROMER	*Fédération des Industries des Produits de la Mer*
FNSP	*Fédération Nationale des Syndicats des Pharmaciens*
FP	family planning
GDP	gross domestic product
GOM	Government of Morocco
GP	general practitioner
IEC	information education and communication
IUD	intrauterine device
JSI	John Snow Inc.
MCH	maternal and child health
MDH	Moroccan dirham
MMR	maternal mortality rate
MOH	Ministry of Health
NGO	nongovernmental organization
NHA	national health accounts
OCs	oral contraceptives
ORS	oral rehydration salts
ORT	oral rehydration therapy
OTC	over-the-counter
PFI	*prélèvement fiscal à l'importation*
PHR	Partnerships for Health Reform
PSI	Population Services International
SMSM	*Société Morocaine des Sciences Médicales*
SOMARC	Social Marketing of Contraceptives Project
STD	sexually transmitted disease
TA	technical assistant
TFGI	The Futures Group International
TFR	total fertility rate

TVA	*taxe sur la valeur ajoutée*
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollars
VAT	value-added tax
VII	Vaccine Independence Initiative
VSC	voluntary surgical contraception
WHO	World Health Organization

EXECUTIVE SUMMARY

The Government of Morocco (GOM) can and should encourage the private sector to offer comprehensive and high-quality health care to the growing segment of the Moroccan population that can afford to pay for it—health care that meets recognized standards and that includes preventive care, family planning (FP), and maternal and child health (MCH) services. This document offers a strategy for the United States Agency for International Development (USAID) to assist the Ministry of Health (MOH) in meeting the challenge of providing such care.

Five principal strategies are proposed in the document, all interlinked and all supporting the concept of the private general practitioner (GP) as a family doctor who provides comprehensive, high-quality health services including reproductive care, FP, child health care, and preventive services. The five strategies are as follows:

- Training and capacity building for private doctors
- Institutional and organizational strengthening for public-private collaboration
- Expansion of social marketing
- Demand generation and client information materials
- Policy and financing reform

Morocco has made impressive gains in family planning and maternal and child health (FP/MCH) in the past decades. But despite the improvements in FP/MCH indicators, there remains a strong urban/rural disparity in health status and access to services. Serious nutritional problems still exist in some parts of the country. Maternal mortality and child deaths from dehydration and respiratory illnesses remain strong concerns. Within the FP program, method mix is highly skewed toward oral contraceptives, and there is a high drop-out rate.

Faced with increased funding burdens as USAID phases out its direct assistance for the purchasing of contraceptives, the MOH is counting on the private sector to play a greatly increased role in providing FP services in the near future. A recent market segmentation study predicts that the potential number of contraception users will increase from 1.9 million to 3 million in 2007. Assuming the public sector increases its FP service provision by 20 percent, the private sector will need to triple its current level of service provision in order to meet the increased demand. Almost all of the contraception currently supplied in the private sector comes through pharmacies—to date, private doctors have played a minor role in providing contraception.

At the same time, there will need to be a switch to long-term methods. The public sector must be able to offer contraception to rural, traditional women. Predictions show that unmet need could decrease from the current 16.1 percent to just 1.3 percent in 2005. For this reduction to happen, the private sector will need to increase provision dramatically in the urban and peri-urban areas

where there are pharmacies and GPs. The MOH will need to target rural, traditional women—who represent 40 percent of the current unmet need.

The private sector is already a very important source of contraception and health care in Morocco. Private providers and pharmacies are the main source of supply for 37 percent of Moroccan women using contraception (DHS 1995), with pharmacies being the predominant source of contraception supply in the private sector. Private doctors provide health care to an estimated 40 percent of the population (John Snow Inc. 1997), and those doctors account for just over half (52 percent) of curative consultations (World Bank 1996).

The private medical and pharmaceutical sectors are rapidly increasing in size. In fact, if current growth trends were to continue, Morocco would have nearly 10,000 private physicians in the year 2007. The number of private doctors per 1,000 people would increase from 0.21 to 0.30, and the percentage of the Moroccan population receiving health care in the private sector would increase from the current 40 percent to 57 percent by 2007.

The growth in the supply of private sector health care and FP presents an excellent opportunity for the GOM to expand and improve health care for the overall population. Currently, much of the MOH budget goes for tertiary care in hospitals, which consume 75 percent of the MOH recurrent budget (World Bank 1996). Rural areas of the country have limited access to health care.

To date, private sector physicians have offered essentially curative health care and have not seen the GP as the provider of a package of family-oriented care. During the 2000–2003 transition period, USAID can play a very important role in facilitating collaboration between the public and private sectors, and in helping GPs to develop as family providers who offer a package of health care that includes FP and preventive services for pregnant women and children. For these changes to be successful, a number of financing, policy, and regulatory constraints must be overcome. These constraints are described in the document in Section 2.3, and include the following:

1. An advertising restriction on private health care in general and drugs in particular

2. Products considered as drugs being limited to distribution through pharmacies (This restriction applies to most contraception and public health products such as oral rehydration salts (ORS), vaccines, and vitamin supplements.)

3. Taxation on contraceptives and other essential FP/MCH products

4. A lack of viable third-party financing

The main strategy proposed for the private sector is to build up a network of private sector providers who offer a range of preventive care to their existing clients and are in effect “family health providers.” The main points of this strategy are set out in Section 4.1. To have maximum

effectiveness, this strategy depends on a number of supporting strategies that are set out in Sections 4.2 to 4.6. The estimated human and financial resources are explained in Section 5. An overview of the strategies, as well as policy constraints, is presented in a table format as Appendix D.

Overall Approach—Building a Network of Family Health Providers

During the transition period, USAID should help develop a network of comprehensive health providers who provide a high-quality, yet affordable, package of reproductive and preventive health services to the growing numbers of urban Moroccans that can afford to pay. Investments have already been made in identifying and training GPs in FP. Further investments are proposed so that the GP becomes a family health provider offering a range of care to his or her patients, including an affordable package of reproductive and preventive health care. Initially this package would include FP and reproductive health, vaccination, and prenatal care. Other elements could be added if funding were available.

But for the GPs to become true family health providers, a number of other things need to happen. First, the GPs' need to be provided with technical training, and their skills in marketing and management need to be improved. Second, institutional mechanisms need to be in place to apply standards of care and to monitor quality. Third, a range of high-quality, socially marketed products should be available in the market. Fourth, demand for services needs to be generated through mass media and client education. Fifth, changes in regulations and improvements in financing are needed to ensure that GPs can provide the full health care package to a growing number of potential clients.

The proposed strategy would build on the private sector–public sector partnership created in Morocco during the Phase V Project. The role of the MOH will be important in improving quality control through the Ministry's contributions to the training of the doctors and in establishing standards and mechanisms to monitor quality. In addition, the Ministry could help provide message consistency in the production of information, education, and communication (IEC) materials for use by the GPs. In the true sense of partnership, private doctors would be expected to contribute to the local costs of the training and to pay for some of the materials that they would receive.

This network of family health providers should be linked together in terms of the services that it offers, the prices that it charges, and the way it is presented to the public. The network could be linked to the highly successful social marketing effort of Al Hilal, but should not necessarily use the same logo and denomination since the network doctors will provide more than just FP services. The social marketing program should expand from the existing successful range of contraceptives to include other health products, such as iron supplements, antibiotics, and vaccines. Point-of-sale materials could be provided through the pharmaceutical industry (with production subcontracted by the *Syndicat des Pharmaciens*), with the MOH ensuring message

consistency. Media campaigns that promote the package and the doctors could be supported through a local version of the Advertising Council that would ensure sustained promotional efforts for the family health provider network, as well as for other health programs in the future.

Specific recommendations are divided into five strategies, all interlinked and mutually supporting. Those five strategies and recommendations are described below.

Training of General Practitioners

Doctors will be trained in a package of reproductive and preventive health services. Training would be done in short weekend courses that can attract doctors, and it would combine management and marketing skills with technical skills. Doctors should also receive training in how to manage their practices and how to better market their services. Doctors who successfully complete the training will receive a certificate from a recognized institution, such as the *Centre National de Formation en Reproduction Humaine* (CNFRH) or the *Société Morocaine des Sciences Médicales* (SMSM), and will benefit from a distinctive marketing symbol that could be developed and would build on the existing experience with logos and slogans. This network of doctors would agree to charge affordable fees for preventive services, would be trained, and must be able to be advertised (as a network) through mass media.

The training would include the following components:

1. A course for GPs in the management of a private clinic, including communication and promotion strategies

2. Training for private doctors in specific MCH topics, including nutrition, Control of Diarrheal Diseases (CDD), sexually transmitted disease (STD) treatment, and safe motherhood

3. Preparation of a module and training for doctors administering the *certificat médical pre-nuptial*—including reproductive health, FP, and safe motherhood with a strong emphasis on counseling

Institutional and Organizational Strengthening

The sustainability of collaborative efforts between the public sector and private doctors depends to a large extent on the development of appropriate institutional mechanisms for collaboration and for sharing information. These would include the following:

1. Set up a quality assurance and feedback mechanism within existing institutions in the same geographic areas in which the training of private doctors takes place. Emphasize peer review and incorporating established standards for FP/MCH programs. This quality assurance mechanism would be based on exchanges

between private doctors living in the same area, with additional visits made by members of the SMSM. The peer review mechanism for quality control should be explicitly linked to a logo or another mechanism used to identify a network of providers as quality providers of FP/MCH services.

2. At the national level, work with the *Confédération Nationale des Syndicats des Médecins Privés* (CNSMP), SMSM, *Conseil National de l'Ordre des Médecins* (CNOM), and the *Fédération des Pharmaciens* to institutionalize continuous training and accreditation mechanisms.

3. Organize study tours of quality management in the context of delivering private health care service.

Expansion of Social Marketing

The considerable social marketing experience, channels, and expertise gained through contraceptive social marketing in Morocco can be productively turned to the social marketing of other health products, thus linking these products to developing the concept of the family doctor. Specifically, there is considerable potential for the social marketing of ORS, vaccines, iron supplements, and antibiotics for the treatment of STDs.

USAID has already supported the Biosel brand of ORS, which has achieved fairly wide distribution. Biosel is not yet financially sustainable and is not completely accepted by pharmacists and physicians. It has contributed to the gradual disappearance of the only other affordable commercial brand on the market (Diarit), also manufactured by Cooper Maroc. Sales of both Diarit and Biosel have also been adversely affected by widespread free distribution of ORS in MOH facilities. As with vaccines, contraceptives, iron supplements, and other essential health products, the MOH faces funding constraints for the purchase of ORS.

1. USAID should provide technical assistance through field support to promote Biosel in the private sector and to introduce vaccines, iron supplements, and antibiotics for STDs as part of the line of socially marketed products to be managed by the proposed social marketing nongovernment organization (NGO). The association should be encouraged and supported to develop a separate health product line with a distinct image from the Al Hilal brand that is currently very FP focused and should remain that way.

2. USAID should work with the MOH, the *syndicats*, and the *Fédération des Pharmaciens* to change regulations and practices restricting the commercial sale of health products to pharmacies.

3. The main strategy for ORS in the transition phase should be to promote ORS to doctors and pharmacists, thus building on networks already established for the

promotion of the Al Hilal contraceptive products. Before beginning the ORS social marketing, USAID should support market research to assess the image of Biosel in the eyes of pharmacists, physicians, and the general public. USAID will not support either the production or distribution of Biosel.

4. For the social marketing of other health products—including vaccines, iron supplements, and antibiotics for STDs—the principal target audience will be doctors, with a secondary target of pharmacists. This strategy of targeting the doctor for these socially marketed products will help to increase the viability of the private GP as a family doctor, and will reduce some of the financial pressure on the public sector to provide those products.

Demand Generation and Client Information Materials

The USAID special objective for the period 2000–2005 is to institutionalize key interventions, which will facilitate sustainability of population, health and nutrition programs. A viable approach to sustainability is to create a mechanism by which airtime can be paid for by commercial sponsors who are interested in identifying their products with the family health doctors or with a socially marketed ORS. In the Moroccan context, there is potential for USAID to create such a mechanism.

Ideally this structure should be in the form of an association of advertising agencies, sponsors, credible personalities from civil society, and the MOH in a technical role. This mechanism would be a cost-effective way to promote private sector–public sector partnerships similar to those that have worked in the United States, such as the Partnership for a Drug Free America and the fight against AIDS. Senior Moroccan observers have indicated that such an association could be self-supporting after a few years if USAID (with the support of a U.S. foundation) could provide initial support.

Such an agency could leverage the creative resources of the advertising industry, as well as of the growing market research industry, and could pay for airtime for private sector family doctors and for socially marketed products. This advertising could generate as much as US$250,000 for airtime.

An alternative would be to include the functions of the proposed advertising council in the mandate of the proposed social marketing NGO. The advantage of such an approach is that USAID invests in developing one association and creates a stronger link between the services and products and the demand generation activity. The possible disadvantage is that a single-issue-oriented agency might not mobilize the interest and energy of the broader sector of the advertising agency and the commercial sponsors.

To deal with the production of client materials, USAID could build capacity within the *Fédération National des Syndicats des Pharmaciens* (FNSP). This group already produces materials for pharmacists including a magazine, *Caduce,* that covers a number of topics of interest to pharmacists. The FNSP, with some technical assistance, has the potential to subcontract the

production of high-quality materials that can be distributed through pharmacists and private doctors and could be given to clients.

Policy and Financing Reform

USAID should strengthen the ability of the MOH to identify and quantify the impact of key policy barriers, including taxation and import duties on key FP/MCH products, the ability of doctors to directly distribute vaccines and ORS, the ability of doctors to organize (to increase coverage), and the ability of physicians to advertise services and products. USAID should support the plans of the government, in collaboration with the World Bank and the European Commission (EC), to expand the coverage of health insurance systems and to include preventive and FP/MCH care in insurance reimbursement packages.

Implementation of this strategy should strongly emphasize capacity building for the parts of the MOH that conduct research, propose policies, and advocate with the government on behalf of public health interests. Wherever possible, such implementation should be in collaboration with the SMSM, CNSMP, and the CNOM. Wherever external technical assistance is used, it should be for the transfer of skills to Moroccan counterparts. The activities to support this strategy include the following:

1. Support research, in collaboration with the MOH and with local institutions.

2. Continue to support the capacity of the MOH—through research and through advocacy training—to lobby for reduced duties and taxes on essential contraceptives and other products.

3. Provide key decision makers in the government with international comparisons of different third-party payment systems, their advantages and disadvantages in the context of Morocco, and options for regulating the quality and the feedback of service delivery information in the context of third-party payment systems.

4. Support the plans of the government to reform health insurance to (a) increase coverage, (b) increase services covered, and (c) adding FP/MCH services.

5. Provide training to MOH officials concerning advocacy and the use of data for lobbying for public health interests.

6. Conduct study tours for key government, insurance, and CNOM officials to provide Moroccan decision makers with examples of how other countries have dealt with the issues of taxation and with the regulation of FP/MCH products and health insurance reform.

1. INTRODUCTION

This report is based on an assessment of the potential of the private sector that was carried out mainly in Morocco by a two-person team made up of Moncef M. Bouhafa (Team Leader) and Dr. Hugh Waters. The Team visited Morocco from 5 August to 2 September 1998.

The Team worked closely with Nancy Nolan and Helene S. Rippey at the United States Agency for International Development (USAID) Mission in Rabat, and it met with senior officials of the Ministry of Health (MOH), as well as with representatives of the cooperating agencies working in Morocco. The Team made site visits to Agadir and Tangier. It also met with senior officials in the private sector. (For a complete list of contacts, please refer to Appendix C). The authors would like to thank all of those individuals who were interviewed for making themselves available to the Team.

The Team also had access to a number of documents, reports, and studies (listed in Appendix B) that helped improve its understanding of the unique situation in Morocco.

A draft report was submitted to USAID on 28 August 1998, and comments were received from the mission during a debriefing session on 1 September 1998.

2. OVERVIEW OF FAMILY PLANNING AND MATERNAL AND CHILD HEALTH AND THE PRIVATE HEALTH SECTOR IN MOROCCO—POTENTIAL AND CONSTRAINTS

2.1 The Status of Family Planning and Maternal and Child Health

Morocco has made impressive gains in family planning and maternal and child health (FP/MCH) in the past decades. But despite the improvements in FP/MCH indicators, a strong urban/rural disparity remains in health status and in access to services. Serious nutritional problems still exist in some parts of the country. Maternal mortality and child deaths from dehydration and respiratory illnesses remain strong concerns. Within the family planning (FP) program, method mix is highly skewed toward oral contraceptives (OCs), and there is a high drop-out rate.

2.1.1 Family Planning

The contraceptive prevalence rate (CPR) for married women of reproductive age has steadily increased—from 7 percent in 1967, to 19 percent in 1980, and to 59 percent in 1997. The total fertility rate (TFR) has declined accordingly—from 7.0 in 1962, to 5.9 in 1979, and to 3.1 in 1997. In 1997, the CPR was 51 percent in rural areas and 66 percent in urban areas. The contraception method mix is highly skewed toward OCs, which represented 70 percent of all methods used in 1997, compared to 10 percent for the intrauterine device (IUD), 2 percent for the condom, and 5 percent for female sterilization (Bennett, Smith, and Smith 1993; PAPCHILD Survey 1997).

Despite the increase in the CPR, women who are limiters—who do not want more children—are not well served by the current emphasis on OCs. The 1995 DHS shows that almost two-thirds (66 percent) of all women using contraception are limiters. With 70 percent of these women using OCs, there is clearly room for a substantial group of those women to switch to long-term methods, which are more cost-effective and have a lower failure rate.

High discontinuation rates also present a problem for family planning. In 1995, 40.3 percent of all users had stopped using their method before the end of the first year of use. For the pill, the corresponding figure was 39.6 percent, compared with 16.6 percent for the IUD (1995 DHS).

Faced with increased funding burdens as USAID phases out its direct assistance for the purchasing of contraceptives during the 2000 - 2003 transition period, the MOH is counting on the private sector to play a greatly increased role in providing FP service in the near future. A recent market segmentation study supported by The Futures Group International (1998b) predicts that the potential number of contraception users will increase from 1.9 million to 3 million in 2007. If we assume the public sector increases its provision of FP services by 20 percent, the private sector will need to triple its current level of service provision to meet the increased

demand. Almost all of the contraception currently supplied in the private sector comes through pharmacies—to date, private doctors have played a minor role in providing contraception.

At the same time, there will need to be a switch to long-term methods. The public sector must be able to offer contraception to rural, traditional women. The Futures Group International study, based on predictions by the United Nations Fund for Population Assistance (UNFPA), shows that unmet need could decrease from the current 16.1 percent to just 1.3 percent in 2005. For this decrease to happen, the private sector will need to increase provision dramatically in the urban and peri-urban areas where there are pharmacies and general practitioners (GPs). The MOH will need to target rural, traditional women—who represent 40 percent of the current unmet need.

2.1.2 Maternal and Child Health

The under-5 mortality rate (per 1,000) has declined from 138 in 1979 to 46 in 1997, while the under-1 (infant) mortality rate (per 1,000) has decreased from 122 in the early 1970s, to 91 in 1979, and to 37 in 1997. Vaccination coverage rates are high: 89 percent of children aged 12 to 23 months are completely vaccinated—93 percent in cities and 85 percent in rural areas. These high rates have been achieved almost exclusively through the public sector, but there is increasing interest on the part of both private providers and the MOH in having private physicians administer more vaccines. The government faces financing constraints related to the purchase of vaccines (see Section 2.3.1). For the private GP, providing vaccines is a way of strengthening relationships with patients as a family doctor.

Recent efforts to expand the use of oral rehydration salts (ORS) have resulted in an ORS use rate of 28 percent for episodes of child diarrhea, but diarrheal disease itself is still a common cause of child morbidity.[1] In a 1989 study that is currently being repeated, diarrheal disease and respiratory illnesses were found to be the two leading causes of childhood deaths (*Royaume du Maroc* 1990). The need for ORS in the country is discussed in more detail in Section 4.4 of this report.

Malnutrition and micronutrient deficiencies are still common in Morocco; 17 percent of children under 5 are wasted, stunted, or both (World Bank 1996). A 1994 survey on iron and iodine deficiency found that 22 percent of children aged 6 to 12 months were iodine deficient; 36 percent of children aged 6 months to 5 years, along with 46 percent of pregnant women, suffered from iron-deficiency anemia (World Bank 1996). A 1998 study reports that more than 41 percent of Moroccan children in certain areas of the country have mild subclinical vitamin A deficiency (Schlossman 1998).

Salt iodization is currently taking place in Morocco with equipment procurement that has been supported by the United Nations Children's Fund (UNICEF). One difficulty is that many salt

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[1] The 1995 DHS showed that 10 percent of children under 5 years had a diarrheal episode in the 2-week period before the survey, down from 14 percent in 1992.

producers are small scale and thus face financial difficulties in converting to iodized salt. According to the MOH, approximately 60 percent of the salt currently produced in the country is iodized.

The MOH is also tackling the problem of iron-related anemia. Iron supplementation for pregnant women and children up to 2 years of age is standard policy in MOH facilities. Not all pregnant women are covered; however, the 1997 PAPCHILD survey shows that only 42 percent of pregnant women had at least one prenatal visit. But this number is much higher in urban areas (69 percent), and private doctors could, in fact, cover many pregnant women, thereby reducing the financial strain for the MOH of purchasing iron supplements.

Vitamin A fortification of either vegetable oil or sugar is a promising strategy for combating the high levels of subclinical vitamin A deficiency, and it could well be a feasible and successful intervention in Morocco. Vegetable oil is a staple product, and vitamin A (in the form of retinyl palmitate) is lipo-soluble. However, potential support for vitamin A food fortification is more appropriately addressed through other sources of USAID funding and is, therefore, not further discussed in this private sector assessment.

Maternal mortality is still an important cause for concern. The maternal mortality rate (MMR) fell from 332 per 100,000 live births in 1992 to 228 in 1997 (PAPCHILD survey), but this rate remains substantially higher than the rate of 50 per 100,000 births in Tunisia and 140 in Algeria (World Bank 1996). In rural areas of Morocco, the MMR is 307 per 100,000 live births.

2.2 The Potential of the Private Sector

The private sector is already a very important source of contraception and health care in Morocco. Private providers and pharmacies are the main source of supply for 37 percent of Moroccan women using contraception (1995 DHS), with pharmacies being the predominant source of contraception supply in the private sector. Private doctors provide health care to an estimated 40 percent of the population (John Snow Inc. 1997), and account for just over half (52 percent) of curative consultations (World Bank 1996).

The private medical and pharmaceutical sectors are rapidly increasing in size. Private doctors increased in number from 2,884 in 1990 to 5,394 in 1996 (Royaume 1998c). During the same time, the number of private pharmacies grew from 1,697 to 2,815. Every year, an estimated 1,000 new physicians come into the health sector in Morocco.[2]

In fact, if current growth trends were to continue, there would be nearly 10,000 private physicians in the country in the year 2007. The number of private doctors per 1,000 population would

[2] An estimated 700 to 800 physicians graduate from Moroccan medical schools each year, and another 200 to 300 Moroccan physicians train abroad, then return to Morocco.

increase from 0.21 to 0.30, and the percentage of the Moroccan population receiving health care in the private sector would increase from the current 40 percent to 57 percent by 2007 (Population 1998; John Snow Inc. 1997; Royaume 1998c).

In terms of health expenditures, the private sector is already a more important source than the government. World Bank (1997) estimates show that in fiscal year 1996–1997 health care expenditures in the private sector (including households and private insurance) were 1.6 times greater than government expenditures for health. By 2005, this difference is expected to increase to 1.9 times, with private health insurance becoming a more significant source of financing.

As the number of private physicians and pharmacies grows, the private health sector is becoming an increasingly viable partner for the MOH and for donors. Organizations such as the *Confédération Nationale des Syndicats des Médecins Privés* (CNSMP), which is made up of provincial physicians' trade unions, and the *Société Morocaine des Sciences Médicales* (SMSM) are becoming better funded and well organized. Those organizations are interested in promoting public health priorities and in securing training opportunities for their members.

The *Conseil National de l'Ordre des Médecins* (CNOM) is currently made up of representatives from the private sector (11 members), the MOH (5 members), the military health system (3 members) and medical professors (3 members). The CNOM plans to switch within the next year to a system in which each of those sectors will have a representation more proportional to the number of doctors it represents. The president of the CNOM is appointed by the king. The CNOM is financed partially by the state and partially by doctors' dues—private doctors in Morocco are required to register and to pay annual dues.

The growth in the supply of health care and FP in the private sector presents an excellent opportunity for the Government of Morocco (GOM) to expand and improve health care for the general population. Currently, much of the MOH budget goes for tertiary care in hospitals, which consume 75 percent of try have limited access to health care—nearly two-thirds (66 percent) of the rural population live more than 30 minutes travel time away from a modern health care provider, and 43 percent live 60 minutes or more away (Royaume 1998c).

The GOM can and should encourage the private sector to offer comprehensive and high-quality health care to the growing segment of the Moroccan population that can afford to pay for it—health care that meets recognized standards and that includes preventive care as well as FP/MCH services. This document offers a strategy for USAID to assist the MOH in meeting this challenge. At the same time, the MOH should take advantage of the expanding reach of the private sector in order to reallocate public resources to rural areas where private doctors and pharmacies will continue to have limited presence.

To date, private sector physicians have offered essentially curative health care, without a vision of the GP as the provider of a package of family-oriented care. During the 2000–2003 transition period, USAID can play a very important role in facilitating collaboration between the public and

private sectors, and in helping GPs to develop as family providers who offer a package of health care that includes FP services and preventive services for pregnant women and children. For this transformation to be successful, a number of financing, policy, and regulatory constraints must be overcome. Those constraints are discussed below in Section 2.3; strategies to resolve them are presented in Section 4.6.

There is enormous potential for the private health sector to offer quality FP/MCH services. But the potential of the private sector is not limited to service providers and pharmacies. Morocco has sophisticated media, as well as talented advertising agencies, that have already been involved in public health activities. The supply of medical equipment is also a growth industry, and experience shows that effective partnerships can be developed with private agencies for the distribution of equipment and materials related to FP/MCH services (such as the IUD distributed by the company Reacting).

2.3 Constraints to the Development of the Private Sector

A series of key issues, detailed below, threatens the potential of the private sector as a provider of family health care. Ultimately, USAID's efforts to support a public sector–private sector partnership and the development of private providers will depend on the successful resolution of those constraints.

2.3.1 Financing Constraints

There is, in general, a financing crunch in the health sector in Morocco—a crunch that affects the provision of FP/MCH services in both the public and the private sector. The health sector remains underfunded relative to comparable countries. Total health expenditures represented 3.4 percent of gross domestic product (GDP) in 1995, compared to 7 percent in Algeria and 4.9 percent in Tunisia (World Bank 1996). The government spends just 4.9 percent of its budget on health and FP--just half of the level recommended by the World Health Organization (WHO) (PHR 1998a). Meanwhile, the MOH is faced with significant additional funding obligations for recurrent costs—including the supply of contraceptives, vaccines, and ORS, which were previously paid for by donors.[3]

Specific policy issues also restrict the availability of financing for private health services. There is ample anecdotal evidence that significant numbers of private GPs are currently facing financing

[3] The government needs an estimated $7 million to pay for contraception over the next 2 years (figure from the 1998 Family Planning Advocacy Document). Similarly, ORS was previously provided free of charge by UNICEF but now must be purchased by the MOH. The MOH has paid for 100 percent of its vaccine supplies—including vaccines, syringes, and cold chain equipment—for the past 4 years through the Vaccine Independence Initiative (VII), a revolving fund that allows the MOH to use local currency to procure vaccines through UNICEF. USAID contributed US$1.1 million to this fund in 1994–1995. But the increasing amount of vaccines administered because of increased coverage and population growth, as well as the need to add new vaccines, has stretched the capacity of the VII.

problems, and funding pressures are likely to increase as the number of private doctors grows. The issues cited by private doctors and others as creating financial barriers for private sector growth include the following:

1. **A lack of viable third-party financing**. Health insurance coverage is currently limited to 15 percent of the population. Reimbursement by the main insurance provider, the *Caisse Nationale des Oeuvres de Prévoyance Sociale* (CNOPS), is often slow and not at market rates. Without more widely available insurance, the use of private health services by Morocco's working class will certainly remain restricted. For private GPs to successfully offer a package of family-oriented health care, health insurance will need not only to be more widely available, but also to cover FP/MCH services.

2. **Taxation on contraceptives and other essential FP/MCH products**. This problem clearly affects both the public and private sectors. Duties of up to 40 percent are charged on imported contraceptives, as well as on the raw materials needed for manufacturing OCs. Recently, duties and taxes on vaccines have been sharply reduced, but taxes remain an important barrier to the widespread use of other essential FP and health products. Private physicians state that the supplies and equipment necessary to provide FP/MCH services are often not available to them at a reasonable price.

3. **Public sector competition with the private sector**. A basic package of FP/MCH services is available free of charge in MOH health facilities, sharply reducing the individual's incentive to go to private providers for these services.

4. **Competition from pharmacies that dispense drugs without prescriptions**. Private doctors feel that they lose substantial revenue because pharmacies give out drugs without a doctor's prescription, as mandated. A conservative outside estimate is that 30 percent of drug sales are generated within the pharmacy. From the patients' viewpoint, bypassing the doctor often makes financial sense—an average cost of a pharmacist's recommended treatment is about 30 Moroccan dirham (MDH), while average consultation with a private doctor costs 60–80 MDH before paying for the prescription (BASICS Project Trip Report 1995a).

In addition, there are financing constraints related to the organization of joint public-private activities themselves. If providers are to have training, communication activities, and supplies, finding the right formula for cost-sharing between the MOH and the private sector is an important challenge—particularly in the context of the phase-out of USAID funding.

2.3.2 Other Policy Constraints

In addition to limitations on available financing, these specific policy constraints potentially limit the capacity of the private sector to provide FP/MCH services:

1. Advertising is restricted on private health care in general and on drugs in particular. Specific exceptions to this restriction have been allowed for contraceptives and ORS.

   Les Laboratoires ROCHES, after negotiating a waiver with the government, is advertising Supradine on television and intends to advertise more drugs in the future. This experience may well open doors to more regulation changes in that domain.

2. All products considered to be drugs are limited to distribution through pharmacies, including most contraception and public health products such as vaccines. There is no over-the-counter (OTC) classification—all drugs require a prescription in principle.

2.3.3 Organizational and Institutional Constraints

1. No clear intermediary exists between the public and private sectors for coordination and regulation. In general, there is little regulation of the quality of care in the private sector, and there is not much information available about the types and quantity of services provided by private doctors.

2. Private sector GPs typically have individual practices and are not organized in service-delivery partnerships that would allow them to cover broader segments of the population and to interact more efficiently with the MOH and with third-party payment systems.

3. EXPERIENCE TO DATE—WORKING WITH THE PRIVATE SECTOR UNDER THE PHASE V FP/MCH PROJECT

Partnerships for Health

USAID has been the primary donor to the GOM FP/MCH program since the program's inception. The bulk of the assistance was provided through the public sector, but USAID has progressively introduced the provision of FP products and services through the private sector. Approaches were tested during Phase V in the private sector because the MOH was relatively inexperienced in dealing with those issues and because there was a lack of any mechanism to ensure collaboration. Recognizing the potential of the private sector, the MOH started a focused private-sector strategy, called "partnerships for health," with support from USAID through the Phase V FP/MCH Project. The objectives of the strategy were as follows:

1. Increase availability of basic health products and services to urban and peri-urban households through the private sector.

2. Improve the efficiency and effectiveness of services provided.

3. Enhance the quality of health services.

4. Ensure the financial sustainability of the service delivery network.

Initially, both FP and child survival services were part of a package of care envisioned as part of this strategy that would include a broad spectrum of the private sector: doctors, pharmacists, nurses, midwives, private clinics, nongovernmental organizations (NGOs), professional associations, local collectives, and private industries. As the complexity of working with the private sector became apparent, the focus was shifted to just FP. The original implementation procedure—small grants to specific private sector organizations—proved to be administratively awkward and subject to delays. Thus it was dropped in 1996.

One of the projects that was funded through this process was to provide training to workers from the member organizations of the *Fédération des Industries des Produits de la Mer* (FIPROMER). Many of the members of FIPROMER are fishing canneries, and these canneries have an estimated total of 50,000 workers. Because much of the work is seasonal, workers often have a temporary status and are disproportionately female, making them a good target audience for FP/MCH training. FIPROMER's interest was that hygiene topics be included in the training. In May 1998, selected female workers from cannery factories were trained with assistance from the Phase V Project. The intent was for those women to return to their factories and organize further training or communication sessions for female workers at the factories. Thus far, it does not appear that this "second-level" training has generally taken place. The main reasons given are that there are

administrative delays related to the organization of the original training and insufficient resources available for the second-level training.

After an initial 2-year period, the private sector partnership focused its attention on GPs, who were the most numerous physicians in the country. They were trained in FP with a special emphasis on the IUD (in support of the GOM strategy of encouraging the use of long-term methods). Partnerships were established with groups that represent doctors and pharmacists, namely the CNSMP and the *Fédération Nationale des Syndicats des Pharmaciens* (FNSP). Those activities have helped to sensitize the private sector to provide FP services and have identified mechanisms that can be used in the future to help accelerate progress.

The training of GPs was initially done in Sale for 96 physicians and then extended to cover 650 GPs throughout the country. Training in IUD insertions was provided through three training centers in Rabat and Casablanca (two at *Centre Hospitalier Universitaire* and one at *Maternité Souissi*). The training program will be evaluated in September, and efforts are under way to gather service statistics on the numbers of IUDs that have actually been inserted. The GPs see the addition of FP services as good for their business, though there is still significant competition from the public sector. More demand generation is needed for the IUD, both in terms of client education and in terms of advertisement through the mass media.

Despite Phase V's shift in emphasis to provide FP services, several activities that are either directly or indirectly related to health care provision were implemented. These activities include the following:

- The *Service de Collaboration Intersectorielle* was established within the *Direction de la Population* in the MOH.

- Together with the SMSM, a module was developed for training private doctors on how to establish a private clinic (Ktiri 1997).

- Phase V targeted vaccination for children who are older than 18 months and who fall outside of the package of vaccines effectively offered by the MOH. In April 1997, a *Conférence de Consensus* harmonized the vaccination calendars between public and private sectors, which was an example of the type of collaboration possible between the MOH, the SMSM, the regional *Syndicats des Médecins Privés*, and the national level CNSMP.

- Under Phase V, revisions of FP/MCH topics in the medical school curricula were made (e.g., participatory teaching methods, practicums). Given the large numbers of doctors entering private practice each year directly from medical schools, this curricula revision is a particularly important accomplishment.

The Partnerships for Health Reform (PHR) Project is tasked with some of the important policy and regulatory issues that need to be resolved for the private health sector to offer comprehensive family health care. Those issues include the reduction of taxes on the purchase and importation of contraception and other essential products, plus a review of legislation governing physician and paramedical practice. The work of PHR should help to set the stage for two key strategies recommended in this report: institutional and organizational strengthening, and policy and financing reform.

Social Marketing

The social marketing of contraceptives program was initiated during Phase III by The Futures Group International's Social Marketing of Contraceptives Project (SOMARC) with the introduction in the market of the Protex brand condom in 1989. The program extended its product range to include OCs (1993), the injectable (1996), and the IUD (1997). The introduction of Protex in 1989 helped create a new market for the condom in Morocco. Protex became self-sufficient in 1993, and management was transferred to a private pharmaceutical distributor, PROMAPHARM. While total condom sales have increased, Protex's share of the market has declined as it has faced competition from cheaper black market products that do not need to pay the 20 percent value-added tax (VAT). With the introduction of the pill (Kinat Al Hilal), the Al Hilal brand name was introduced and was used to market the injectable and the IUD. As in other countries, this range of methods approach has the potential to encourage informed consumer choice. In the case of Kinat Al Hilal, sales volume reached a high enough level to justify complete self-sufficiency for the product in January 1997, 4 years after its introduction. The Moroccan contraceptive market is nearly 70 percent pill, which helped make this achievement possible. Sales figures for Kinat Al Hilal show that nearly one-third of users were former pill users in the public sector. This result is strong evidence that consumers can be shifted from the public sector to the private sector if they are provided with affordable but reliable products and services. As products graduate, manufacturers and distributors provide fewer client materials and promotions to the consumer. In the case of the Kinat Al Hilal, a return-to-project fund (a contribution agreed to by the pharmaceutical industry) provides partial funding for purchasing airtime to advertise the product on Moroccan television.

High-quality technical assistance, as well as strong funding levels from USAID, have driven the excellent levels of sales of certain contraceptive products. Another contributing factor was the involvement in the program of pharmacists from the outset. The Futures Group International is investigating the establishment of a local nonprofit organization that will take over the current role of The Futures Group International in managing the Al Hilal product line and in nurturing individual products through to graduation. The local organization may also have a mandate to take on new products. This organization will require technical assistance and funding support in order to become operational within 2 years.

As the social marketing project has matured and turned its attention to the longer-term methods, which are heavily provider dependent, the needed synergy between product marketing and service delivery has become a stronger feature of the USAID program. GPs trained through the John Snow Inc. (JSI) project are provided with the Al Hilal logo, and an affordable IUD is made available through the private sector either directly to doctors or through pharmacies. While the Al Hilal logo can help position private sector doctors as high-quality providers of FP services, the value added for them at present is not entirely clear. In some cases, people might perceive Al Hilal as part of the public sector, and because government regulations prohibit advertising for doctors, the perception might limit any benefits from a logo. In addition, quality standards and monitoring need to be introduced to ensure that Al Hilal maintains its reputation for quality. JSI has provided some client counseling materials (method-specific fiches) that doctors can use in their consultations with clients and that will supplement the social marketing effort. More effort appears to be needed to help the GPs generate demand for FP methods from their client base and, specifically, for the more affordable Al Hilal IUD. The Al Hilal IUD package (including client card, insertion, and follow-up visit) is available for 250 MDH.

Population Services International (PSI) has promoted an ORS brand, Biosel, that is currently manufactured in Morocco by Cooper Maroc. Distribution of Biosel, either through the MOH or through sale in pharmacies, is currently approximately 700,000 sachets per year. But the product remains subsidized, and Morocco needs sustainable strategies for ORS supply. Those strategies are discussed in Section 4 of this report.

Other Donors to the Private Sector

While there are many donors to the health sector in Morocco, few besides USAID have been providing assistance to build service delivery and health products in the private sector. Donors in the health sector generally include the European Union, UNICEF, the World Bank, UNFPA, WHO, French Cooperation, Germany, Belgium, Spain, and Japan.

The European Union has expressed an interest in working in the field of social marketing, thereby extending the current range of products to the smaller cities and peri-urban areas.

UNICEF has provided some funding for social marketing of ORS through provision of raw materials, but ceased its assistance in 1997. UNICEF has also provided equipment and materials to iodize salt in the private sector, but has also ceased this assistance. UNICEF introduced both iodized salt and ORS to the market and nurtured them to the point where they should now be self-sustaining. UNICEF recognizes that additional marketing efforts may be needed.

There has been some limited success in leveraging corporate funding for health activities. PSI has had limited success in promoting the socially marketed ORS product, Biosel. Of the more than 30,000 NGOs in the country, only a few have been successful in leveraging private sector funding for limited discrete campaigns in the social field. There is an indication that these resources might

grow in the future. Organizations use the funds raised for both service delivery and high-level national advocacy for health programs.

The World Bank is preparing a health reform project that has broad components related to health financing and could have a major impact on financing available for the private health sector—both in terms of the amount of financing available for the sector and in terms of the mechanisms adopted. USAID can successfully leverage its own resources in this area by coordinating closely with the World Bank project, which contains four major areas, each with specific goals for the year 2002:

1. Reform health insurance.

2. Create a financing mechanism for those unable to pay.

3. Reform the MOH hospital payment and reimbursement systems.

4. Re-deploy MOH personnel to under-served provinces.

4. PROPOSED STRATEGY

The main strategy proposed for the private sector is to build up a network of private sector providers who offer a range of preventive care to their existing clients and are in effect "family health providers." The main points of this strategy are set out in Section 4.1. To achieve its maximum effectiveness, this strategy will depend on a number of supporting strategies that are set out in Sections 4.2 to 4.6. The estimated human and financial resources are set out in Section 5. An overview of the strategies, as well as policy constraints, is presented in a table format as Appendix D.

4.1 Building a Network of Family Health Providers

For the health system in Morocco to continue to provide high-quality products and services after the withdrawal of USAID and other donors, the private sector will have to take on an increasing share of the delivery of FP and maternal health services. According to the World Bank, Morocco's better-off citizens receive 40 percent of the budget of the MOH, while the poorest receive less than 20 percent (World Bank 1996). This fact is particularly important because the private sector is rapidly increasing in size. (Currently more than 50 percent of the population seeks care in the private sector; by the year 2007, as much as 57 percent of the population will seek care at one of what could be as many as 10,000 private doctors.) As the private sector takes on that portion of the population that can afford to pay (primarily in urban areas), resources will be freed up that the MOH can target to meet the needs of the rural areas and the urban poor. In this way, the MOH can further accelerate the progress that is being reported in the rural areas (PAPCHILD 1997). While increase in the use of contraceptives in rural areas has been faster than in the urban areas from 1992 to 1997, the actual CPR is equivalent to that in the urban areas in 1987. In addition, the MOH can help meet the unmet demand for IUDs in urban areas (Market Segmentation Study 1998). Through training and promotion as part of a high-quality network, private doctors can help meet the twin goals of tripling the private sector's delivery of contraception (increasing the market share from 37 to 56 percent of total CPR) and shifting to more cost-effective, long-term methods, which are especially provider dependent (e.g., IUDs and voluntary surgical contraception [VSC]).

During the transition period, USAID should help develop a network of comprehensive health providers who provide a high-quality yet affordable package of reproductive and preventive health services to the growing numbers of urban Moroccans who can afford to pay. Investments have already been made in identifying and training GPs in FP. Further investments are proposed so that the GP becomes a family health provider offering a range of care to his or her patients, including the affordable package of reproductive and preventive health care. Initially, this package would include FP, vaccination, and prenatal care. Other elements could be added, if funding were available.

For the GPs to become true family health providers, a number of other things need to happen. First, the GPs must be provided with technical training, and their skills in marketing and management must be improved. Second, institutional mechanisms need to be in place to apply standards of care and to monitor quality. Third, a range of high-quality, socially marketed products should be available in the market. Fourth, demand for services needs to be generated through mass media and client education. Fifth, changes in regulations and improvements in financing are needed to ensure that GPs can provide the full health care package to a growing number of potential clients. The principal goal of establishing a network of respected, high-quality private, family health care providers lies at the center of the approach that is being recommended. But this goal depends on each of the supporting strategies—training doctors, organizational strengthening for quality assurance, making products available at reasonable prices through social marketing, demand generation, and policy change. These strategies are mutually reinforcing and together would create the needed synergy to accelerate progress in the private sector in Morocco.

The proposed strategy would build on the private sector–public sector partnership created in Morocco during Phase V. The MOH would contribute in establishing quality standards and mechanisms to monitor service delivery, and it might also contribute to training or information education and communication (IEC) materials development. Private doctors would be expected to contribute to the local costs of the training and to pay for some of the materials that they would receive. This network of family health providers should be linked together in terms of the services that it offers, and how it is presented to the public. The network could be linked to the highly successful social marketing effort of Al Hilal, though the network should not necessarily use the same logo and denomination because it will provide more than just FP services. The social marketing effort should broaden its effort from the existing highly successful range of contraceptives to other health products, including iron supplements and vaccines. Cold chain equipment could also be made available to private doctors at affordable prices. Point-of-sale materials could be provided through the pharmaceutical industry (production could be subcontracted by the FNSP) with the MOH ensuring message consistency. Media campaigns that promote the package and the doctors could be supported through a local version of the Advertising Council that would ensure sustained promotional efforts for the family health provider network, as well as for other health programs in the future.

4.2 Training of General Practitioners

4.2.1 Background

For the GPs to be able to provide a package of quality services in the area of MCH and FP, they need both technical training and better skills in managing and in generating demand for their practices. There are reasons to believe that many small practices in Morocco are facing difficulty in being profitable. Helping doctors to balance supply and demand will help them to provide preventive services to that portion of the clientele that is able to pay. Private GPs have a need for management and marketing skills that could help them to run their clinics more efficiently and to

communicate more effectively with their clients. (For example, GPs do not effectively use the space where patients wait—space that could contain written materials or other material promoting the clinic and providing useful public health information.)

Training of the GPs in FP, with a special emphasis on the IUD, is being done under the Phase V bilateral program. To date, 650 GPs have been trained, and plans are to train at least 70 percent of the GPs in Morocco. This training creates a pool or critical mass of doctors who are now able to offer FP services to their patients. An affordable IUD has been made available in the market as the Al Hilal IUD, and doctors can purchase it for 50 MDH. (Pharmacists buy it at 35 MDH and sell it at 60). Other IUDs in the market sell for up to 380 MDH, but the price does not include the cost of insertion.

Since the training was started in 1997, there are indications from a small number of providers that the trained providers have inserted limited numbers of IUDs. An evaluation will be undertaken in September 1998 to determine the impact that the training has had. This evaluation will also provide data on the actual number of IUDs that doctors have inserted.

Private doctors are interested in adding preventive services to the range of care that they can provide to their clients. They see preventive services as potentially helping them to provide better care to their existing clients and to become family doctors. Providing better service to their existing patients will help them get other clients as well.

A recent decree requires couples who are getting married to have a physical exam before marriage in order to get a *certificat médical pre-nuptial*. While it may take some time for this practice to become widespread, this meeting between physicians and young couples offers an excellent opportunity for doctors to provide the essential elements of FP and reproductive health. Physicians should be trained not only to conduct the exam effectively but also to provide counseling to the couple.

4.2.2 Main Points of the Strategy

Doctors will be trained in a package of reproductive and preventive health services that includes vaccination, safe motherhood, nutrition, and oral rehydration therapy (ORT). In this way doctors can provide those services to existing patients that come for curative care. Training would be done in short weekend courses that can attract doctors and would combine management and marketing with technical skills.

Doctors should also receive training in the management of their practice and in how to better market their services. Doctors who successfully complete the training will receive a certificate from a recognized institution, such as the *Centre National de Formation en Reproduction Humaine* (CNFRH) or the SMSM, and will benefit from a distinctive marketing symbol that could be developed, building on the existing experience with logos and slogans. This network of doctors would agree to charge affordable fees for preventive services, would be trained, and must be able

to be advertised (as a network) through mass media advertising. These campaigns would be funded through the demand-generation mechanism that is outlined in Section 4.5.

During the transition phase, training would be conducted in the Casablanca-Rabat-Kenitra corridor (where the bulk of private doctors practice) and in one other medium-sized city. Criteria for selection of the city would include the existence of significant numbers of doctors already trained under the Phase V private sector program. Private doctors would contribute to the costs of the training, thereby defraying some of the costs. Those contributions would be channeled through the syndicates or the SMSM and should be linked to accreditation.

The training would involve the following:

1. Instruction for GPs in the management of a private clinic, including communication and promotion strategies. The SMSM has developed a guide titled *Guide d'Installation du Médecin* (Ktiri 1997). The guide covers marketing, MOH prevention programs, and a minimal kit for guaranteeing quality of care. This guide would provide the foundation for a one-half or 1-day training course, which would include an emphasis on counseling techniques and skills. The SMSM and the *syndicats* should be closely involved in the training, with the SMSM organizing the training.

2. Training for private doctors in the pilot area in specific MCH topics, including nutrition, Control of Diarrheal Diseases (CDD), and safe motherhood.

3. Preparation of a module and conducting training for doctors administering the *certificat médical pre-nuptial*—including reproductive health, FP, and safe motherhood, with a strong emphasis on counseling.

As part of the strategy, doctors will be encouraged to use the waiting room to promote the health care package, as well as to educate clients. Training will be provided to those nurse-assistants who want it (in conjunction with training sales staff at pharmacies) in basic notions of counseling and information for clients. This training will facilitate the passage of information to prospective FP clients. Nurses and assistants would also provide simple, easy-to-read client materials (e.g., brochures on methods or on preventive health) to patients when they visit. The materials would be provided by the FNSP. (See Section 4.5.)

4.2.3 Advantages and Possible Disadvantages

Advantages of the strategy are as follow:

- Training would give private GPs more tools to interact effectively with patients, thereby helping the transition of paying clients from the public sector to the private sector.

- The project would set an example for other parts of the country and for the national level concerning how to institutionalize public-private collaboration and quality control mechanisms.

- It would help shift clients who can pay from the public sector to the private sector by helping the private sector not only to add to the range of care that it provides, but also to better manage and market existing services.

- The unmet demand for FP from that portion of the population that uses the private sector for curative services will be reduced.

- If the GPs were to use the Al Hilal logo, they would take advantage of a symbol of quality in which an investment has already been made through heavy media exposure.

Possible disadvantages and drawbacks to the strategy are the following:

- If the GPs were to use the Al Hilal logo, it would mean that the success of many components are interlinked, and failure in one area could have an impact on the other. In addition, Al Hilal logo positioning needs to be assessed. There is also the danger that GPs will provide only Al Hilal products, crowding out other products in the market and stifling competition in the marketplace.

- The strategy greatly depends on people's willingness and ability to pay. Issues like insurance coverage and free supply of contraceptives in the public sector might influence this strategy as well.

4.2.4 Illustrative Implementation Plan

Year 1

Note: These activities might also be undertaken in fiscal year 1999 if funds and time permit (in which case the training in the regions could start in Year 1, and other activities would be moved forward accordingly.)

- Conduct a study to identify how the family doctor should be positioned.
- Establish coordinating mechanisms.
- Identify specific areas in which training will take place.
- Select participants.
- Begin work to remove policy barriers in the areas of the promotion of doctors' networks through study visits and through identifying key actors in the process.
- Develop curricula for GPs in the area of marketing and management of a private practice, and update the curriculum on the reproductive health package.

- Develop updated curriculum for nurses and assistants and for salespersons in pharmacies on the subject of counseling clients.

Year 2

- Conduct training courses for both GPs and nurses and assistants.
- Begin to organize demand-generation activities for the family doctor network, using both mass media and local mobilization.
- Establish standards of care.

Year 3

- Monitor quality.
- Establish a roll-out plan to other regions.
- Create a sustainability plan.
- Continue demand-generation campaigns.

4.3 Institutional and Organizational Strengthening

4.3.1 Background

The sustainability of collaborative efforts between the public sector and private doctors depends to a large extent on the development of appropriate institutional mechanisms for collaboration and for sharing information. Currently, these mechanisms do not exist, and the public-private collaboration that has taken place has depended on individual dynamism and relationships. Without these mechanisms, collaboration with GPs is unlikely to produce a sustained increase in the delivery of quality FP/MCH services in the private sector.

Specifically, there is a need to develop mechanisms for the following:

- Coordinated follow-up to the training of GPs to resolve technical and supply problems related to incorporating the FP/MCH services into the GPs' routine activities.

- Quality assurance of FP/MCH services offered in the private sector, as well as for feedback to the public sector of information concerning services delivered by the GPs. Regulation of the quality of care in the private sector is currently minimal. Serious problems or complaints are brought to the attention of the *Conseil de l'Ordre des Médecins*, usually at the regional level.

  In the MOH, the *Direction de la Réglementation et des Contentieux* enforces standards concerning hygiene and physical space for private providers. But there is

no mechanism for quality assurance or for collecting information concerning the quantity and type of services provided in the private sector.

- Cost-sharing of specific activities, such as training and the production of communication materials, between the public and private sectors.

- A system of continuing, in-service training for private doctors linked to accreditation and the updating of the license to practice. Currently, once a physician is granted a license to practice by the *Conseil de l'Ordre des Médecins*, there is no requirement for the physician to ever update it. The SMSM is involved in a study of continuing medical education.

A related point is that private GPs are themselves not well organized to provide comprehensive family health care. They typically work in individual practices, and it is difficult for them to meet equipment and overhead costs. Operating in partnerships, GPs would be able to achieve economies of scale and ultimately to cover a higher percentage of the population.

4.3.2 Main Points of the Strategy

1. Set up a quality assurance and feedback mechanism within existing institutions in the same geographic areas where the training of private doctors will have taken place. After the FP/MCH service delivery and management training for the GPs (described in Section 4.2), participants should work with the regional representation of the MOH, the regional *Syndicats des Médecins Privés*, the regional *Conseil de l'Ordre de Médecins*, and the regional SMSM to set up a forum for collaboration and information exchange. One of the priority functions of this group would be to collect information from its members (private sector GPs) concerning FP/MCH service delivery and forward this information to the MOH. The information collection could most easily be done through the monthly or bimonthly distribution, collection, and compilation of forms containing basic statistics on FP/MCH services.

   As part of this forum, a quality assurance mechanism will be implemented emphasizing peer review and incorporating established standards for FP/MCH programs.[4] This quality assurance mechanism would be based on exchanges between private doctors living in the same area, with additional visits made by members of the SMSM. The visits would be systematic and coordinated by the

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[4] In fact, such standards already exist and would need to be adapted and recognized as appropriate standards for private sector GPs. MOH standards for maternity and neonatal care, developed with WHO and UNICEF, were published in 1996. Standards for the treatment of diarrheal disease in the context of the CDD program were established by the MOH in 1992, and ARI standards were published in 1993. FP standards also exist. Clinical service standards for voluntary surgical contraception, IUDs, and injectable contraceptives have been recently developed by the MOH (PHR 1998).

forum referred to above. The essential idea is that physicians can exchange experiences and, when standards are not being met, one doctor can help another to improve practices. The visits would be voluntary and informal. Standards would be jointly established by the SMSM, CNOM, and the MOH, with input from the *syndicats* and with new standards based on existing standards for FP/MCH programs.

The peer review quality control mechanism should be explicitly linked to a logo or other mechanism used to identify a network of providers as quality providers of FP/MCH services. The peer review mechanism should be completely self-sustaining by the end of the transition period. Funding requirements will be minimal, since doctors will contribute their time as part of their commitment to the network. Belonging to the network and being able to display the logo will provide strong incentives for private doctors both to meet the quality assurance standards and to contribute time to the peer review system.

2. At the national level, work with the CNSMP, SMSM, CNOM, and the FNSP to institutionalize continuous training and accreditation mechanisms. Currently, there is no need for private physicians to update their licenses once they are registered with the *Conseil National de l'Ordre des Médecins*. A system of accreditation, based on continuous training, would provide a large incentive for private doctors to attend training courses. Such a system would also provide an incentive for the *syndicats* to finance training.

   The Secretary General of the CNOM has expressed an interest in developing an accreditation system based on continuing education. The SMSM, financed by the contributions of its members, is now involved in a study of the feasibility and legal framework of accreditation that would be based on continuing training. Even before accreditation becomes the norm, the SMSM can and should play a central role in training private sector doctors by designing training curricula and granting certificates to physicians who complete the training.

   The specific actions to be funded as part of this activity depend on how the accreditation process develops. It would make sense for USAID to support additional studies by the SMSM or other institutions, including an international study of accreditation mechanisms that would help put the findings of the current SMSM study into a wider context. Such a study would include experiences from different countries, with pros and cons of different accreditation mechanisms from a financial, public health, and regulatory point of view.

3. Organize study tours of quality management in the context of private health care service delivery. Potential countries to visit include France, Canada, Egypt, and

Chile. The study tour should include representatives of the *syndicats*, the CNOM, the SMSM, and the MOH.

4.3.3 Advantages and Possible Disadvantages

Advantages

- There is currently no mechanism for quality control of FP/MCH services in the private sector and for the feedback of information concerning service delivery to public health authorities.

- More organized group practice would help to resolve problems of the potential over-supply of physicians and the high costs of entry into the field. Clinics with several members would be better able to offer family health care to clients.

- Institutionalizing continuing education and accreditation of doctors would greatly contribute to quality control.

- Having a mechanism or forum for public-private collaboration would help to resolve regulatory issues as they come up in the future and would also provide a forum for the coordination of coverage for FP/MCH services between the public and private sectors.

- Self-regulation through peer review within the *syndicats* and in coordination with the SMSM and CNOM creates ownership on the part of those institutions and will not require additional USAID financial inputs after 3 years.

Possible Disadvantages

- Self-financing from the syndicats for peer review is not guaranteed. Arguments for this type of peer review will have to be convincingly made.

- The success of a project in one area of the country can depend on the personality of a few individuals and can be difficult to replicate and institutionalize nationwide.

- Private physicians are unfamiliar with a group practice model and may not welcome or accept the idea of forming group practices.

4.3.4 Illustrative Implementation Plan

This strategy will clearly require the presence of a full-time person, probably a local hire who will simultaneously be engaged in the other principal strategies and who can work with the various partners (the *syndicats,* SMSM, CNOM, and MOH) on a daily basis. In addition, technical

assistance will be required for the management training and other collaborative activities (6 months of technical assistance and six trips between Morocco and the United States). USAID should pay the start-up costs associated with exchange visits between clinics and by members of the SMSM to clinics. Local costs for training and logistics related to the start-up of the quality control network will also be included.

Year 1

- Set up quality assurance mechanism.
- Work with MOH, CNOM, SMSM, and CNSMP to establish an accreditation system.
- Develop standards based on existing MOH policies for the FP/MCH programs.
- Conduct training.

Year 2

- Work with MOH, CNOM, SMSM, and CNSMP to establish an accreditation system.
- Start visits as part of a mechanism of quality assurance using peer reviews.
- Organize study tours of quality management in the context of delivering organized, private health care service.

Year 3

- Continue visits within the mechanism of peer review quality assurance.

4.4 Expansion of Social Marketing

4.4.1 Background

Social marketing of contraceptives has been very successful in Morocco. Two products have reached a level of financial sustainability where they are produced, sold, and managed by the private sector without subsidization—a concept known as "graduation." These products are Protex, a socially marketed condom launched in 1989, and Kinat Al Hilal, two socially marketed OCs that are produced by Wyeth and Scherring Labs and that were launched in 1993. As a result, affordable contraceptives are available through the market system.

The Futures Group International, which has supported the social marketing of contraceptive products in Morocco through the SOMARC Project, has more recently turned its attention to the marketing of injectables and IUDs. That group is now helping to establish a national nonprofit organization that will progressively take over the role of product manager that has been played first by a subcontractor (up to 1997) and then directly by The Futures Group International. It is proposed that the social marketing NGO be called the *Agence Al Hilal*, taking its name from the brand name used for the oral contraceptives, the IUD, and the injectable.

USAID will invest in capacity building for the proposed social marketing NGO over the next 2 years with the support of a resident advisor. The EC is interested in funding the NGO through The Futures Group International (based in the United Kingdom) to extend the current socially marketed products to smaller cities in Morocco. There are no plans to extend these products to rural areas because most people believe that rural groups cannot afford to pay for contraceptives and because the network of pharmacies being used probably could not reach rural areas in Morocco.

It would be difficult to introduce new contraceptives to the Al Hilal line during the transition phase. There are limits on the numbers of trained practitioners for voluntary surgical contraception, and the introduction of Norplant® has gone slowly. In addition, graduating the IUD will be more difficult to achieve than graduating the OCs, even if the number of providers who can perform insertions increases through the private sector training program. Extending the social marketing effort to rural areas would seem to offer less potential benefit for the investment that would be made.

The considerable social marketing experience, channels, and expertise gained through contraceptive social marketing can, therefore, be turned to the social marketing of health products and can link those to developing the concept of the family doctor. Specifically, there is considerable potential for the social marketing of ORS, vaccines, iron supplements, and antibiotics for the treatment of sexually transmitted diseases (STDs).

Iron deficiency affects more than 30 percent of women and children in the country (Schlossman 1998). The MOH has begun to address this problem. Iron supplementation for pregnant years of

age is standard policy in MOH facilities. But not all pregnant women are covered—the 1997 PAPCHILD survey shows that only 42 percent of pregnant women had at least one prenatal visit. This number is much higher in urban areas (69 percent), and private doctors could, in fact, cover many of those women, thus reducing the financial strain for the MOH of purchasing iron supplements.

Likewise, the government faces financing constraints related to purchase of vaccines (see Section 2.3.1). Eighty-nine percent of children aged 12 to 23 months are completely vaccinated, and those high rates have been achieved almost exclusively through the public sector. There is increasing interest on the part of both private providers and the MOH to have private physicians administer more vaccines. For the private GP, providing vaccines is a way of strengthening relationships with patients as a family doctor.

With respect to ORS, USAID has already supported the Biosel brand, which has achieved fairly wide distribution. But Biosel continues to be subsidized and has contributed to the gradual disappearance of the only other affordable commercial brand on the market (Diarit), also manufactured by Cooper Maroc. Sales of both Diarit and Biosel have also been adversely affected by widespread free distribution of ORS in MOH facilities. UNICEF donated an average of 3 million sachets a year to the MOH during 1990–1995.

The following estimated figures document the distribution of Biosel ORS in MOH facilities (most of which has been donated by UNICEF), and of Diarit:[5]

Estimated Distribution by Year

Year	Biosel	ORS in MOH Facilities	Diarit
1989	n/a	1,585,000	190,000
1990	300,000	2,452,000	213,600
1991	680,000	2,032,000	129,600
1992	373,000	3,500,000	110,100
1993	223,000	3,162,000	186,600
1994	530,000	3,415,000	103,800
1995	381,000	3,100,000	75,000
1996	363,000	n/a	suspended
1997	620,000	n/a	suspended

5 Sources: BASICS Project trip reports, 1995 and 1996; conversations with Mohammed Jebbor, PSI.

UNICEF is no longer donating ORS to the MOH, which has changed its policy for giving out ORS.[6] Biosel is now sold in pharmacies at a price of 9 dirhams for a pack of three sachets. The estimated sustainable price of Biosel is 11 or 12 dirhams for the three-sachet packet—including materials but still without promotional costs (personal communications with Mohammed Jebbor, PSI). Currently, Biosel is subsidized in two ways: the raw materials used have been donated by UNICEF, and promotional activities are carried out by PSI. In 1996, UNICEF contributed raw materials for 1,770,000 sachets. In 1998, PSI and Cooper Maroc sold 285,000 sachets to the MOH.

Cooper Maroc does not promote the product. Although the raw materials donated by UNICEF will soon be exhausted, there is a possibility that the Government of Japan may provide financing for additional raw materials.

As with vaccines, contraceptives, iron supplements, and other essential health products, the MOH faces funding constraints for the purchase of ORS. A major issue for ORS, as with other socially marketed health products, is that commercial sale is currently limited to pharmacies. An earlier proposal for social marketing of Biosel suggested a partnership between the MOH and Cooper Maroc in cooperation with rural-focused social marketing and promotion (BASICS trip report 1996). At that time, the pharmaceutical industry was opposed to marketing ORS outside the pharmacy network.

Another important issue is that ORS has not yet been fully accepted either by private physicians—many of whom still over-prescribe antibiotics and antidiarrheal drugs—or by pharmacists, who are resistant to ORS as a standard treatment because of its low profit margin. Successful promotion of ORS must, therefore, include activities targeted to those two groups.

4.4.2 Main Points of the Strategy

1. USAID should provide technical assistance through field support to promote Biosel in the private sector and to introduce vaccines, iron supplements, and antibiotics for STDs to the line of socially marketed products to be managed by the proposed social marketing NGO. The association should be encouraged and supported to develop a separate health product line with a distinct image from the Al Hilal brand, which is currently very focused on FP and should remain that way.

2. Work with the MOH, the *syndicats*, and the FNSP to change regulations and practices restricting the commercial sale of such products to pharmacies (see Section 4.6). Technical assistance and support will be needed to help develop the product line and to strengthen the proposed social marketing NGO to promote health products through pharmacies.

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[6] The current practice is to provide 1 sachet for Plan A cases and 2 sachets for Plan B cases—compared to a previous practice of 3 sachets for all cases.

3. With respect to ORS, the main strategy for the transition phase should be to promote ORS to doctors and pharmacists, building on networks already established for the promotion of the Al Hilal contraceptive products (including the IUD, which has been promoted directly to physicians). It will also be important to generate overall demand for ORS through a communications campaign for ORS and ORT, either through the proposed social marketing NGO or through a subcontracting arrangement with PSI.

   Before any ORS social marketing begins, USAID should support market research to assess the image of Biosel in the eyes of pharmacists, physicians, and the general public. If the image of the product is one of low quality (possibly linked to free distribution in public facilities), then it may make sense to change the name. If the name Biosel is retained, then it will be necessary to reach an agreement among the various parties involved (PSI, Cooper Maroc, the MOH, and USAID) concerning ownership of the name. In the future, the name should be transferred to Cooper Maroc so that the product graduates and becomes truly sustainable.

   The market research, which would be qualitative and limited in scope, would also help to inform the subsequent promotion efforts. A marketing strategy for ORS should be well prepared in advance, with separate strategies to target pharmacists, physicians, and the general public. Once the advertising council is operational (see Section 4.5), ORS could be one of the first products to benefit from a media campaign. Alternatively, USAID could directly fund a media campaign.

   Additional justification for a communications campaign could come from a USAID-supported study of the causes of infant mortality that is currently under way. The last such study, completed in 1990, showed that diarrheal disease was the leading cause of child deaths. Diarrhea and dysentery accounted for 36 percent of the causes of deaths of children aged from 1 month to 4 years (Royaume 1990).

   After 2 years of ORS promotion to physicians, pharmacists, and the general public, the Biosel brand should have sufficient brand recognition to be financially self-sustaining in the private sector. USAID would *not* be involved during this time in the production or distribution of Biosel; those activities would remain the responsibility of Cooper Maroc and PSI.

   As part of the social marketing arrangements for Biosel, there should be clear agreement that the product will be sold at its financially self-sustaining price by the end of the transition period. At the same time, Biosel should *not* be distributed in MOH facilities at no cost; such a practice can only adversely affect the image and sustainability of the product. The MOH should be encouraged to buy locally produced ORS, but if the ORS is to be given away, it should be under a different name.

4. For the social marketing of other health products, including vaccines, iron supplements, and antibiotics for STDs, the principal target audience will be doctors, with a secondary target of pharmacists. This strategy of targeting the doctor for these socially marketed products will help to increase the viability of the private GP as a family doctor and will reduce some of the financial pressure on the public sector to provide such products.

   The company Reacting has already established distribution channels directly to general practitioners , and additional products could be added to this network. For pharmacists, the channels of distribution developed by the Al Hilal contraceptive products should also be used for vaccines, iron supplements, and antibiotics. For those products, USAID should assist in identifying suppliers on the international market—again, similar to the experience of the IUD now distributed by Reacting.

   As noted above, the successful social marketing of health products to doctors will require changes in the laws that regulate the distribution of medicalized products. Strategies to promote those changes are discussed in Section 4.6. Other options may also be available. For example, doctors could maintain vaccines, syringes, and refrigerators in their offices, and could include the price of the vaccine in their charge for vaccinations, rather than charging separately for the vaccine product. Many doctors already have refrigerators in their clinics. Syringes should be marketed and distributed to doctors together with the vaccines.

4.4.3 Advantages and Possible Disadvantages

Advantages

- Vaccination can be the entry point for establishing a stronger GP-family relationship. Provision of iron, ORS, and antibiotics for STDs will strengthen this relationship.
- If the proposed Al Hilal NGO were to become the social marketing NGO and the main vehicle for the social marketing of health products, that would build on established marketing experience and distribution channels.
- Using Al Hilal also precludes the need to create another institution while broadening the scope of the Al Hilal effort and diversifying its product line, leading to a more stable organization.

Possible Disadvantages

- Direct provision of vaccines, ORS, antibiotics, and iron by GPs depends on policy changes.
- The cost/profitability margins for vaccines, iron, ORS, and antibiotics may make some or all of these products inappropriate for social marketing.

- Al Hilal itself may take up to 2 years to be fully operational and another 3 years to be self-sustaining. Adding new products will lengthen the time it will take for the association to become independent of donor assistance.

4.4.4 Illustrative Implementation Plan

Year 1

- Conduct market research for ORS and Biosel.
- Identify suppliers for vaccines, iron, and antibiotics for STDs, as well as the appropriate local organization for distributing such products.
- Develop promotional and market segmentation strategies for all health products.
- Begin promotion of ORS to physicians, pharmacists, and the general public.

Year 2

- Continue ORS promotion.
- Begin promotion and distribution of vaccines, iron, and antibiotics.

Year 3

- Phase out ORS promotion.
- Continue promotion and distribution of vaccines, iron, and antibiotics.

4.5 Demand Generation and Client Information Materials

4.5.1 Background

If the private sector is to assume a growing share of the burden for FP and delivery of MCH services, through the network of family doctors, then continuing investments will need to be made to sustain client education and to generate demand for services and products. GPs now have access to limited materials (for use in counseling clients about FP) and have few waiting room materials that clients can take with them on FP methods and the health package. In pharmacies, the availability of these types of materials is even more limited. The current line of socially marketed products contains package inserts, which are relatively user-unfriendly. With the current high rate of discontinuation of all methods, the proper use of those methods and a good understanding of their side effects are important issues for the Moroccan FP program. The goal of the FP program is to increase IUD use and simultaneously to shift users from the public sector to the private sector. The area of client education has the potential either to accelerate this process, or, in the negative, to hamper its progress.

The public sector has developed a strong IEC program and has produced materials of high quality on issues such as safe motherhood and client counseling. The MOH itself cannot fund and

produce either mass media campaigns or client materials for use by private doctors. The private sector needs to develop sustainable mechanisms that can produce both of these and can leverage private sector funding for them.

Demand for either socially marketed products or for the services of family doctors can be generated in a number of ways: through pricing, positioning, and also through promotion. Up to now, USAID has been the main donor in the health field that has funded promotional activities primarily through the SOMARC project. This project has included production as well as airtime. A return-to-project funds (a portion of the gross sales of contraceptives that are channeled back to SOMARC from the contraceptive manufacturers) is currently used to fund airtime for the Kinat Al Hilal line of oral contraceptives. In one case, those funds covered only 2 months of airtime for the product.

There is no assurance that the manufacturers would continue to make such contributions once the proposed NGO is established as a Moroccan Social Marketing Organization. In addition, even if they did so, the contributions would not cover the associated costs of marketing communication research, which can be quite high in Morocco (for instance, the cost of including one question in an ongoing omnibus survey is US$750). For example, Promopharm, the distributor of Protex spends nearly 30 percent of its gross sales on its advertising campaign, which uses only radio. Radio costs are, on average, one-tenth of television costs. Purchasing airtime is relatively expensive in Morocco (about US$1,000 per 20-second TV spot). The prospect for a return-to-project funds for the IUD (Lawlab Al Hilal) are less encouraging than for the oral contraceptives. At the same time, the marketing of the IUD will require more varied and intensive promotional activities (once the problem of supply is addressed through training).

Morocco has a growing body of experience in the past 5 years in private sector fundraising for socially oriented campaigns. This fundraising has included both MOH initiatives, as well as other nonhealth causes. Some examples include the following:

- The work that the *Banque Morocaine du Commerce Extérieure* (BMCE) did to help protect the environment through AFAK, headed by the former Minister of Health, Dr. Harouchi

- The campaign that SAGA advertising agency, the makers of Always sanitary napkins, and the Ministry of Education conducted on school-based puberty education for adolescents

- The partnership between the MOH and Proctor and Gamble on the safe uses of chlorine bleach

This increase in the number of commercial sponsorships is the result of a growing interest in the private commercial sector in sponsoring social causes. While the exact motives for each activity are different, there is an indication that Moroccan business is concerned about developing a

favorable corporate image in addition to obtaining tax deductions. Although this concern is true of only a small group at present, well-placed Moroccan observers indicate that this positive social behavior will grow in Morocco. A growing number of key personalities are driving this process. These personalities include Noureddine Ayouch from SHEMS, who is also founder of the Zakoura Foundation for Micro Credit; Dr. Harouchi, who heads AFAK; and Ms. Himmich, who created the *Association de Lutte Contre le SIDA*. They have the ability and the credibility to leverage private sector resources, and they have helped drive the process.

4.5.2 Main Points of the Strategy

Generating Demand for Services

The USAID special objective for the period 2000–2005 is to institutionalize key interventions, which will facilitate sustainability of population, health, and nutrition programs. As a means of sustaining demand for products and service in the private sector, USAID and the MOH should pursue the policy agenda of obtaining free airtime for public service campaigns. This effort, however, may not yield the desired result. When airtime is completely free, the sponsor loses the ability to place the ad during the time when most of the audience is watching or listening. An alternative solution is to create a mechanism by which airtime can be paid for by commercial sponsors who are interested in identifying their products with the family health doctors or with a socially marketed ORS. It would be possible for USAID to create such a mechanism in Morocco.

Ideally, this sponsorship structure should be in the form of an association of advertising agencies, sponsors, credible personalities from civil society, and the MOH in a technical role. The reason for such a structure is that the existing advertising association lacks credibility. The functions could be included in the mandate of the proposed NGO. This mechanism would be a cost-effective way to promote private sector–public sector partnerships similar to those that have worked in the United States, such as the Partnership for a Drug Free America and the fight against AIDS.

Senior Moroccan observers have indicated that such an association could be self-supporting after a few years if USAID (with the support of a U.S. foundation) could provide initial support. During the transition phase, funding would be needed for the structure's personnel and its training. Costs for activities (production, airtime, etc.) would all be contributed by the private sector, which Noureddine Ayouch, head of SHEMS, one of the oldest and most respected agencies, has confirmed. During the 3-year period, the newly created association would assume a greater burden of its structural costs to the point where, at the end of the 3-year period, the organization would be self-sustaining, covering both its recurrent costs as well as the funding of the campaigns. Part of this process would include the development of a mechanism so that companies can contribute on a regular basis to the costs of the association. A board of directors (including a representative of the government) would determine priorities for funding and channel resources. These campaigns could include the Al Hilal products, the private sector family doctor, Biosel, or any other product or service that has a positive social value. Such a structure would

help USAID to sustain gains that have been made in the past and to consolidate past investments. USAID funding could be used to leverage additional support from a U.S.-based foundation, such as the Rockefeller Foundation, and to provide initial technical assistance through a U.S.-based contractor who has expertise in organizing social campaigns and working with advertising agencies.

Such an agency could leverage creative resources of the advertising industry as well as the growing market research industry and could provide the costs for airtime for private sector family doctors and for socially marketed products. This funding method could generate as much as US$250,000 for airtime.

An alternative would be to include the functions of the proposed advertising council in the mandate of the proposed social marketing NGO. The advantage of such an approach is that USAID invests in the development of one association and thus creates a stronger link between the services and products and the demand-generation activity. The possible disadvantage is that a very single-issue-oriented agency (such as the proposed NGO) might not mobilize the interest and energy of the broader sector of the advertising industry and the commercial sponsors.

Producing Client Materials

To deal with producing client materials, USAID could build capacity within the FNSP. This group already produces materials for pharmacists, including a magazine, *Caduce*, that covers a number of topics of interest to pharmacists. The FNSP, with some technical assistance, has the potential to subcontract the production of high-quality materials that can be distributed through pharmacists and private doctors and given to clients. The FNSP would need to staff its office with an additional person to handle this function and to help develop a client focus for materials. USAID would need to encourage the FNSP to take on this role by helping to establish a documentation center and a website that could be used by the pharmacists to exchange materials on FP and other elements of the package of services. USAID would need to fund an initial set of client materials that the *Féderation* could use as a way of interesting the private sector in sponsoring this type of material. The technical materials review would need to be included in the mandate of the private sector–public sector mechanisms that should be set up to make this happen (see Section 4.3).

4.5.3 Advantages and Possible Disadvantages

The advantages of creating an association that is the equivalent of an ad council are as follows.

- A Moroccan institution would be created that would leverage private sector support well into the future.
- It would encourage a more efficient use of resources and give the MOH a role in establishing priorities, as well as in providing sanction for activities and technical inputs.

- This organization (if not too associated with one donor) could help channel other donors' funds through UNICEF or the European Union for campaigns that are needed in areas such as salt iodization.
- The neutral character of the organization would help leverage non–FP resources. It would harness the creativity of the private sector advertising industry for the social sector to produce high-quality materials with little cost after an initial investment.

The advantages of developing capacity for the pharmacists' organization to develop materials are as follows:

- Developing this capacity would create ownership for the materials (and therefore greater impact) and piggyback on an existing distribution mechanism. The MOH involvement can help ensure message consistency. The content of the materials should also be linked to the training activities through a possible participation of the SMSM in reviewing the content of the materials.
- The more that materials are available, the more likely that pharmacists will generate more demand for preventive services.
- In addition, the materials will be used in GPs waiting rooms and will help market FP to existing clients.

Among some constraints for the creation of the association are the following:

- Creating the association requires the expansion of a corporate behavior as well as a consumer behavior that will be favorable to generating sales through sponsorship. It requires setting up a new association from the ground up and an investment over a 3-year period.

- The role of the MOH needs to be clearly defined as one that facilitates and encourages, but that allows the private sector a sense of ownership.

- The strategy very much depends on the people who are now in positions of leadership and who have an interest and commitment. The people could obviously change.

4.5.4 Illustrative Implementation Plan

In terms of implementation, the following steps should be considered:

Year 1

- Hold an informal meeting with interested parties to discuss a mission statement and to develop a detailed proposal.
- Identify a U.S. partner and foundation.

- Establish a mechanism for public sector–private sector coordination.
- Staff the association and carry out a pilot campaign for one product.
- Establish a capacity for materials production and train staff members in the materials development process.
- Produce an initial set of client materials.
- Identify companies that are willing to sponsor client materials.

Year 2

- Carry out two campaigns per year for 2 years (for private sector doctors, Al Hilal, and health products).
- Produce client materials for FP/MCH.

Year 3

- Carry out two campaigns per year for 2 years (for private sector doctors, Al Hilal, and health products).
- Produce client materials for FP/MCH.

4.6 Policy and Financing Reform

4.6.1 Background

Section 2.3 of this report describes the policy constraints that negatively affect the ability of the private sector to provide effective FP/MCH services. Resolving these constraints is crucial for the success of the overall strategy proposed in this document. The constraints include the following:

1. An advertising restriction on private health care in general and drugs in particular

2. A limitation to distribute only through pharmacies those products considered as drugs, including most contraception and public health products such as ORS, vaccines, and vitamin supplements

3. Taxation on contraceptives and other essential FP/MCH products

4. A lack of viable third-party financing.

Each of these constraints affects the overall strategy proposed in this document, to make private sector GPs into viable providers of high-quality, comprehensive FP/MCH care to the segment of the population that can pay for this care. The advertising restriction limits the potential to promote a network of doctors identified by a logo and clearly restricts the promotion of health products directly to the population through advertising. Taxes and duties on FP/MCH products

make such products more expensive for pharmacists, physicians, and the general public, thereby reducing the already limited amount of funding for health care available in the private sector.

No clear figures are available concerning the financing constraints faced by private doctors, but interviews suggest that the problem is a serious one and that a significant number of private clinics are being driven out of business (Gingembre 1996a). A lack of viable third-party financing was nearly universally identified as a problem by the small sample of private doctors interviewed for this report.

CNOPS covers about 11 percent of the population (approximately 3 million people) and is made up of nine *mutuelles* of public sector employees. Without more widely available insurance, the use of private health services by Morocco's working class will certainly remain restricted. For private GPs to successfully offer a package of family-oriented health care, health insurance will need not only to be more widely available, but also to cover FP/MCH services.

Meanwhile, market forces are creating change in the health insurance market. Agreements between insurers and providers set prices and establish norms for reimbursement. One example is the recent agreement between *l'Association Nationale des Cliniques Privées* (ANCP) and the *Fédération Marocaine des Sociétés d'Assurances et de Réassurances* (*l'Economiste* 1998). Unfortunately, those agreements cover only a small, relatively well-off segment of the population. Public third-party financing and public-private collaboration for third-party financing remain inadequate, and this situation is a serious obstacle to meeting the private sector's potential. Moreover, the government is not taking advantage of the current opportunity to regulate the quality and composition of health services covered by insurance.

There is a consensus in the MOH that reform of health insurance is a priority issue. The CNOM has been involved in facilitating arrangements (*conventions*) between providers' groups and insurers, and it is likely to continue to play an active role in this area. USAID has experience working on health reform and policy issues in other countries, and it is in a good position to share this information and to help Morocco to collect further information necessary for policy formulation.

4.6.2 Main Points of the Strategy

USAID should strengthen the ability of the MOH to identify and quantify the impact of key policy barriers, including taxation and import duties on key FP/MCH products, the ability of doctors to distribute vaccines and ORS directly, the ability of doctors to organize (to increase coverage), and the ability of physicians to advertise services and products. USAID should support the plans of the government, in collaboration with the World Bank and the European Commission (EC), to expand the coverage of health insurance systems and to include preventive and FP/MCH care in insurance reimbursement packages.

The implementation of this strategy should strongly emphasize capacity building for the parts of the MOH that conduct research, propose policies, and advocate with the government on behalf of public health interests. Wherever possible, implementation should also be in collaboration with the SMSM, CNSMP, and the CNOM. Wherever external technical assistance is used, it should be for the transfer of skills to Moroccan counterparts.

1. Support research in collaboration with the MOH and with local institutions. USAID has a successful track record in supporting research in key policy areas in Morocco and in other countries. In 1994, USAID supported a review of the legal, institutional, and organizational framework pertaining to provision of FP services, which included recommended changes in these areas (Royaume 1994; Bowen 1994).

   The PHR Project is now working with the MOH on a similar effort aimed at revising key aspects of paramedical practice. In the fall of 1998, PHR will be helping the government to carry out a survey of national health accounts (NHA), which will show the expenditure flows in the health sector from various sources, including government, households, private providers, and insurance.

   USAID should continue to support useful studies to help resolve unanswered questions related to the private sector's provision of FP/MCH services, including the following:

   - International comparisons of different third-party payment systems and their advantages and disadvantages in the context of Morocco
   - Options for the regulation of quality and the feedback of service delivery information in the context of third-party payment systems
   - The ability of different segments of the population to pay for health care (to help establish reasonable reimbursement rates)
   - A survey of providers' prices
   - An analysis of medical demography to estimate future supply
   - Research to quantify the impact on service delivery of key policy barriers: taxation and import duties, restriction of vaccines and other products such as ORS to pharmaceutical distribution channels, and ability to advertise private health services and products

2. Continue to support the capacity of the MOH to lobby for reduced duties and lower taxes on essential contraceptives and other products through research (related to Point 1, above) and through advocacy training (related to Point 5, below).

   Expensive import duties and taxes on essential FP/MCH products present a considerable obstacle to the financial sustainability of the strategies described in

this document. Total taxes can be as high as 57 percent, including a 25 percent import duty, 12–15 percent for the *prélèvement fiscal à l'importation* (PFI), and 20 percent for the *taxe sur la valeur ajoutée* (TVA).

There are successful examples of reducing these taxes. In July 1997 the government sharply lowered taxes on vaccines by lowering the TVA (or VAT) by eliminating the PFI. But taxes on other products, particularly contraceptives, still present a financial problem. PHR is now finalizing a multicountry survey on tax waivers and contraceptives, with specific application to Morocco, which should help to present policy options for reducing the tax burden.

3. Provide key decision makers in the government with international comparisons of different third-party payment systems, the advantages and disadvantages of those systems in the context of Morocco, and options for regulating quality and for giving feedback about service delivery information in the context of such systems. These decision makers include the Prime Minister's Office and, in the MOH, the *Direction de la Population,* the *Direction de la Planification,* and the *Direction de la Réglementation et des Contentieux*.

4. Support the plans of the government to reform health insurance to (1) increase coverage, and (2) increase services covered, adding FP/MCH services. The importance of insurance reform is described above.

   USAID can play a pivotal role by working proactively with the MOH, CNOPS, the CNOM, private insurers, the World Bank, and the EC to identify the specific information, research, and policy points that need to be addressed, including documentation of the advantages and disadvantages of different policy options, along with international comparisons pertinent for Morocco. USAID can also fund research related to health insurance, as described above. Some progress has already been made in this area, as some private insurance companies have started to reimburse the IUD insertion package at the price of 150–250 MDH (Laasri, Bezad, Tyane, and Lippeveld 1998).[7]

5. Provide training to MOH officials concerning advocacy and the use of data for lobbying for public health interests.

6. Conduct study tours for key government, insurance, and CNOM officials to provide Moroccan decision makers with examples of how other countries have

[7] A USAID-supported study concludes that insurance companies will be willing to cover the cost of the IUD but that without insurance reform OCs and female sterilization are currently too expensive to be widely reimbursed (Alternative Consultants and Guedira 1996).

dealt with the issues of taxation and regulation of FP/MCH products and health insurance reform.

4.6.3 Potential Impact—Advantages and Possible Disadvantages

Advantages

- Helping to change key policy barriers can have enormous impact on the sustainability of FP/MCH care in the private sector. Without policy reforms, the other investments of USAID may be lost. Lack of adequate third-party financing is possibly the single biggest barrier to the successful expansion of the private sector in delivering FP/MCH service.

- If taxes can be significantly lowered on contraceptives and other essential products, such as ORS, that are being socially marketed, the prospects for the financial sustainability of those products will be considerably enhanced. Additionally, private physicians will be more able to procure those products.

- Involvement in policy in general, and in insurance reform in particular, would allow USAID to coordinate activities with the World Bank and the European Commission—and would help to ensure that those donors' investments are well targeted in such areas.

- Third-party financing would help to systematize the application and enforcement of quality-of-care standards for FP/MCH, as well as the feedback of service delivery information from private providers to the government.

- There will be a positive synergy between the operational level of the project and the "policy" level of the project. The lessons learned at the operational level can quickly and efficiently be disseminated for input into the national-level policy process.

Possible Disadvantages

- Policy identification, advocacy, and reform depend on the political climate and factors outside the control of USAID—in other words, success is not ensured.

- Decision making for health insurance is now scattered, making it politically sensitive to get involved and potentially difficult to bring the different players together.

4.6.4 Illustrative Implementation Plan

This strategy will require the presence of an individual who is available locally to coordinate on a daily basis with the different players involved in the policy process. This person would not have to be employed full time but would need to be senior enough to have access to senior MOH officials and experienced enough to know the policy issues and process in Morocco. Coordinating with the USAID Health and Population Office, this person would then arrange for prompt technical assistance.

Technical assistance will be required to conduct studies, present options to policy makers, and conduct training in advocacy. Wherever possible local technical assistance should be used. Other studies will be done by local organizations. There will also be local costs for training and study tours.

Years 1–3

- Support research (see Point 2 of the strategy for a full description of topics).
- Support policy making and lobbying for reduced duties and taxes on essential contraceptives and other products.
- Support policy making and lobbying to reform health insurance.
- Provide advocacy training to MOH officials.
- Conduct study tours.

5. HUMAN AND FINANCIAL RESOURCES REQUIRED

If Morocco is to implement this comprehensive package of services in the private sector, technical and financial assistance will be needed in a number of areas. The total financial cost for implementing the package of services is estimated to be US$3.9 million over the 3-year transition period if the idea of the partnership is not adopted. If the partnership is adopted and the ad agencies cover the costs of the campaigns, then the cost would be less, about US$3 million.

5.1 In-Country Staff

A number of local staff members working within Moroccan institutions would be needed to implement the proposed package and to develop a capacity within the organizations to continue after USAID has terminated its funding. A local hire such as a long-term technical assistant (TA) is needed to implement the training and institutional capacity-building activities. This person would work directly with the Moroccan implementation agency (possibly the SMSM) and would help coordinate with the other partners in training and quality control—the MOH, the doctors' syndicates, SMSM, and CNOM. A health product manager should be recruited in the proposed social marketing NGO on a long-term basis to develop the health product line. This position would be phased out in year 3. These two positions could cost US$150,000. If the proposal to create a local equivalent of the Partnership for a Drug Free America is accepted, that program would require investment in local staffing for the first 3 years. The positions needed would include a Secretary General and two professional account managers. The costs for these staff members total approximately US$400,000. If the proposed NGO subsumes the functions of the Partnership, then such positions would not be needed.

5.2 Technical Assistance

Technical assistance could be provided through the field support mechanism with cooperating agencies and centrally funded contracts. The USAID mission in Morocco would be expected to provide overall coordination of technical assistance. A total of 64 months of technical assistance is needed to implement this strategy (32 months of local assistance, and 32 months from the United States). The total cost is estimated at US$725,000. The nature of this technical assistance is shown in Table 1.

Table 1

Technical Assistance

Strategy	Area of Technical Assistance	Number of Months
Training of GPs	Develop the marketing and management curricula and train trainers.	8
Training of GPs	Revise the training curriculum for the courses on preventive health and FP.	2
Institutional and Organizational Strengthening	Create management training and other collaborative activities.	6
Expansion of Social Marketing	Conceptualize promotional strategy and identify product suppliers.	8
Expansion of Social Marketing	Organize vitamin A fortification study and follow-up.	4
Demand Generation and Client Materials	Establish the partnership association.	5
Demand Generation and Client Materials	Assist the *Syndicat des Pharmaciens* to develop technical capacity to produce materials and develop website, etc .	5
Policy and Financing Reform	Coordinate on a daily basis with the different players involved in the policy process.	16
Policy and Financing Reform	Conduct studies, present options to policy makers, and conduct training in advocacy (wherever possible, local technical assistance should be used).	10

5.3 Other Costs (Subcontracts, Study Tours, etc.)

To implement the total package, USAID would need to fund some local costs as follows :

Training costs for GPs would be in the amount of US$500,000. This sum includes training costs, and supervision. The costs of the quality assurance network would be in the order of US$500,000 as well.

In the case where the Partnership solution is adopted for the demand generation, the direct costs for promotional campaigns need not be included. In the case where the proposed NGO subsumes the costs, USAID should foresee a total sum of roughly US$1.3 million over the 3 years. For the clients' materials, USAID's funding for the pharmacists' *syndicat* would be US$100,000 per year, primarily to cover training costs for the staff in materials development and to cover the costs of setting up a national documentation center and a website, as well as an initial set of materials.

A number of studies should be funded by USAID, primarily in the policy area. Those studies need not be considered as direct support to the private sector. In addition, support for study tours should be considered as part of USAID's advocacy of increasing the role of the private sector to implement policy reforms that will accelerate the benefits that can be derived from implementing the package. A total of US$500,000 should be foreseen for such activities.

Study tours and advocacy training would add another US$100,000 to the cost of implementing the strategy.

APPENDICES

APPENDIX A

Scope of Work

Analysis of Private Sector Issues and Potential in Morocco for the Delivery of FP/MCH Services

Background:

Under USAID's FP/MCH Phase IV and V Projects, in-roads have been made in implicating the private, commercial sector in the delivery of family planning and maternal and child health (FP/MCH) services, especially FP services. Morocco's contraceptive social marketing (CSM) program, which began in 1989, has already had two products graduate to sustainability in the private sector, the Protex condom and the Al Hilal pills (Microgynon and Minidril). An injectable (DepoProvera) and an IUD (Copper T380) were launched in late 1996 and 1997 respectively. The training of private sector general practitioners (GPs) in FP methods, with a focus on IUD insertion, began as a pilot effort in 1996, and was expanded to a nation-wide activity based on encouraging results after a year of implementation. In the area of child health, however, repeated attempts to ensure the availability of a low-cost, high-quality and unsubsidized ORS product in the pharmaceutical sector have been less successful.

While there is evidence that training of physicians in areas other than FP is desired by the private sector, due to budgetary, human resource and other constraints, this has not been pursued fully under the USAID projects. Reports done by the Phase V private sector University Research Corporation consultant in 1996 provide valuable insight into the challenges of working with the private medical sector in Morocco. Furthermore, a market segmentation study was undertaken by the POLICY project and will be completed by the time the POPTECH private sector study commences. The market segmentation study will provide additional valuable information and insights concerning FP client preferences and missed opportunities for FP program planners and managers.

USAID's last bilateral health/pop project will end in December 1999. It is anticipated that there will be a modest-scale, post-bilateral USAID assistance program for the health sector between 2000-2003 to further ensure sustainability of the FP/MCH services which USAID has supported throughout the years. A potential area of focus in the post-bilateral period would entail activities designed to strengthen the capacity of the private sector to expand and provide quality FP/MCH services.

Moreover, within the private sector context, the sustainability of the on-going CSM program is of immediate concern. An options study is currently being conducted by a local consulting firm to ascertain the legal ramifications of different management mechanisms for Morocco's CSM program. While the CSM program was initially managed by a local Moroccan firm, SOMARC/The Futures Group took over management of the program when the injectable and

IUD were introduced (1997). At the current time, the intention is to transfer management of the CSM program to a viable local entity, such as an NGO or PVO, a pure private sector entity, a foundation, an association, etc. The study in progress should help CSM program managers and USAID to make a knowledgeable decision concerning future management of the program.

Scope of Work:

The POPTECH consultants will be requested to review the literature available (e.g., studies mentioned above and others, trip reports, USAID project documents, other donor documents) and to interview key knowledgeable persons in both the private and public sectors concerning the private sector's actual and potential contribution to the expansion of quality FP/MCH services in the country, taking into account unmet need statistics and the potential for moving higher-income-level FP clients from the public into the private sector.

USAID/Morocco will be responsible for ensuring that the relevant documents are made available to the consultants upon arrival in country, including FP/MCH background documents (e.g., Demographic and Health Surveys from 1987, 1992, 1995, and PAPCHILD 1997).

The consultants will produce a comprehensive report which:

(1) succinctly characterizes Morocco's experiences since 1994 (beginning of Phase V Project) in implicating the private sector in FP/MCH service delivery (i.e., describe specific activities and their impact to date, including activities with NGOs);

(2) briefly presents other donors' experiences and activities in the private sector health care field over the past 5 years, including activities with NGOs and community organizations;

(3) makes specific recommendations vis-a-vis the future of CSM activities in Morocco, including a discussion of the potential for adding other products to the current line of socially marketed products;

(4) discusses the potential of the private and NGO sectors to become more active in FP/MCH service delivery, in urban as well as rural areas, fully substantiating arguments set forth, and taking into account legal, regulatory and/or social constraints, as well as financial implications for all interested parties;

(5) advises the Mission on alternative strategies and courses of action that could be undertaken during the next 3 years to effectively ensure greater private sector involvement in FP/MCH service delivery (includes a discussion of the pros and cons of each strategy proposed, any policy and regulatory issues involved, and financial and human resource requirements); and,

(6) provides projected timelines, illustrative implementation plans, and potential impact of recommended strategies and activities.

Duration of Assignment and Expertise Required:

POPTECH is requested to field to Morocco, beginning in June or July 1998, 2 experts for a period of 3 weeks (6 day work week is authorized). The consultants should have at least 5 years experience each working with FP/MCH health services in the private sector in developing countries, preferably countries similar to Morocco (lower middle income, relatively well-established private sector). Consultants must be fluent in French, and Arabic is desirable although not required. Familiarity with Morocco or Middle Eastern countries is highly desirable. At least one of the consultants should have a strong financial management background.

Consultants will brief and debrief with USAID/Morocco Population/Health (PH) staff upon arrival and prior to departure from Morocco. During the briefing meeting, USAID PH staff and consultants will discuss expectations of the consultancy, and in particular, the content, form and style of the report to be produced. Consultants will provide a draft report in English in WP5.2 (hard copy and electronic version) to the Mission at least 2 working days prior to departure from Morocco. The final report will be in English; the final report's Executive Summary, and Conclusions & Recommendations sections will be translated into French by Poptech.

APPENDIX B

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APPENDIX C

List of Contacts

Washington, DC

Andrew Boner, Population Services International
Alex Brown, Population Services International
Norine Jewell, The Futures Group International
Jeff Jordan, The Futures Group International
Kathy Krasovec, Partnerships for Health Reform (PHR) Project
Chris McDermott, USAID
Jonathon Ross, BASICS Project
Camille Saadé, BASICS Project
Joseph Sclafani, The Futures Group International

Rabat

Ministère de la Santé

Dr. Mohammed Abou-Ouakil, Chef du Service de la Collaboration et Coordination Inter-sectorielle
Dr. Ali Bensalah, Chef de Service de la Protection de la Santé de la Mère
Dr. Mohamed Bimegdi, IDE Principal, Programme National d'Immunisation
Dr. Hamid Chekli, Chef du Service de la Protection de la Santé Infantile
Dr. Lalla Aïcha Lamrani, Programme de Lutte Contre les Maladies de Carence
Dr. Mostafa Tyane, Directeur, Direction de la Population
Dr. Abdelwahab Zerrari, Chef, Division Santé Maternelle et Infantile

USAID

James Bednar, Director
Abderrahim Bouazza, Economist
Nancy Nolan, TAACS
Helene S. Rippey, Population Fellow

John Snow Inc.

Malika Laasri, Private Sector Program Manager
Dr. Theo Lippeveld, Directeur du Projet
Nicolas de Metz, Conseiller Logistique
Suzanne Reier, Management Specialist

The Futures Group International

Houda Belhaj, Program Manager
Jeanne Brown, Research Director
Don Levy, SOMARC Project Director
Phil Sedlak, Regional Program Manager

Association Marocaine de Planification Familiale

Mohamed Bensehli, Directeur Financier
Mme El Bouhssaini-Sayah Sati, Directrice des Programmes
Abdelkrim Hakam, Directeur Exécutif

Other

Linda Likar, Economiste Principale, Banque Mondiale
Paolo Max Operti, Expert Santé, Délégation de la Commission Européene
Ahmed Serji, Secrétaire Général du Conseil National de l'Ordre National des Médecins
Pascale Slaoui, Directrice, Agence Itissal
Dr. Sergio Soro, Représentant, UNICEF

Agadir

Mehdi Haddi, Président, Syndicats des Médecins Privés, Region du Sud
Bouattaoun El Hassan, l'AMPF Agadir
Boutaam Lahoucine, Médecin Privé
Rajia Meziani, Société Oued Souss Conserves
Malika Ait Youssef, Secrétaire Génerale, FIPROMER
Najib Zougmid, Médecin Privé
Abdel-llah Zyayti, Société Oued Souss Conserves

Casablanca

Ahmed Akhchichine, Léger et Léger
Noureddine Ayouche, SHEMS
Dr. Abdelhadi Benabbou, Confédération des Syndicats des Médecins
Fouad Bouchta, Reacting
Dr. Abdellah Bouras, Confédération des Syndicats des Médecins
Abdenbi Louitri, LMS Marketing
Abdel Kebir Mezouar, LMS Conseil

S. Murnissi, PDG Pharmacom
Najia Rguibi, Vice Présidente, Fédération des Syndicats des Pharmaciens
Hassan Slaoui, SAGA Communication

Tangiers

Dr. Chaoui, Médecin Généraliste
Dr. Mohamed Najib Madidi, Syndicat des Médecins Privés
Dr. Al Maimouni, Médecin Généraliste
Dr. Raoud, Médecin Généraliste

APPENDIX D

Summary of Main Strategies

STRATEGY AND MAIN RECOMMENDATIONS FOR IMPLEMENTATION	JUSTIFICATION AND ADVANTAGES	POSSIBLE DISADVANTAGES AND POLICY CONSTRAINTS	RESOURCES REQUIRED FOR IMPLEMENTATION
4.2 Training of GPs (1) Prepare modules and conduct training for private doctors in pilot regions in specific MCH and reproductive health topics, including vaccination, nutrition, CDD, STD management, and safe motherhood. Provide the trained doctors with a FP/MCH logo. (2) As part of the overall training package, conduct training for GPs in the management of a private clinic, including communication and promotion strategies. (3) Prepare a module and conduct training for doctors administering the *certificat médical pre-nuptial*. (4) Train pharmacy assistants and nurses in counseling skills, in coordination with the *Confédération des Pharmaciens.*	Training would give private GPs tools to manage clinics, communicate effectively with patients, and provide preventive health care, thus helping the transition of paying clients from the public sector to the private. The pilot project would set an example for other parts of the country and for the national level for public-private collaboration and quality control mechanisms. If the GPs use a FP/MCH logo, they can position themselves as high-quality providers.	Training does not directly target assistance to the rural poor, who mostly lack access. The strategy greatly depends on people's willingness and ability to pay. Policy constraints: There is an advertising restriction on private health care (for logo). A lack of viable third-party financing restricts ability to pay for FP/MCH products and services.	A local hire (long-term TA) who would work with the Moroccan implementation agency—possibly the SMSM. This person would organize and coordinate the training and build capacity in the organization. Technical assistance would help develop the marketing and management curricula and train trainers. TA would also be needed to revise the training curriculum for the courses on preventive health and FP. Local costs for training (private sector doctors will be expected to make some contribution).

STRATEGY AND MAIN RECOMMENDATIONS FOR IMPLEMENTATION	JUSTIFICATION AND ADVANTAGES	POSSIBLE DISADVANTAGES AND POLICY CONSTRAINTS	RESOURCES REQUIRED FOR IMPLEMENTATION
4.3 Institutional and Organizational Strengthening (1) Set up a quality assurance and feedback mechanism that is based on peer review within existing institutions in the pilot regions. (2) At the national level, work with the MOH, the *Confédération Nationale des Syndicats des Médecins Privés*, the *Société Marocaine des Sciences Médicales*, the *Conseil National de l'Ordre des Médecins*, and the *Fédération des Pharmaciens* to institutionalize continuous training and accreditation mechanisms. (3) Within the pilot regions, offer GPs a training course related to organization for group practice. (4) Organize study tours of quality management in the context of service delivery of organized private health care.	The sustainability of collaborative efforts between the public sector and private doctors depends on the development of appropriate institutional mechanisms for collaboration, quality assurance, and the sharing of information. Currently, these mechanisms do not exist. More organized group practice would help to resolve problems of the potential over-supply of physicians and the high costs of entry into the field. Clinics with several members would be better able to offer family health care to clients. Institutionalizing the need for continuing education and accreditation of doctors would greatly contribute to quality control. Having a mechanism or forum for public-private collaboration would help to resolve regulatory issues as they come up in the future, and would also provide a forum for the coordination of coverage for FP/MCH services between the public and private sectors. Auto-regulation through peer review within the *syndicats* and in coordination with the SMSM and CNOM creates ownership on the part of these institutions and will not require additional USAID financial inputs after 3 years.	Self-financing from the *syndicats* for peer review is not guaranteed. Arguments for this type of peer review will have to be made convincingly. The success of pilot projects can depend on the personality of a few individuals and can be difficult to replicate and institutionalize.	Will require the presence of a full-time person, a local hire also working on Strategy (2), who can work with the various partners—the *syndicats*, the SMSM, the CNOM, and the MOH—on a daily basis. In addition, technical assistance will be required for the management training and other collaborative activities. Local costs for the start-up of exchange visits between clinics and by members of the SMSM to clinics, and local costs for training and logistics related to the start-up of the quality control network. Study tours.

STRATEGY AND MAIN RECOMMENDATIONS FOR IMPLEMENTATION	JUSTIFICATION AND ADVANTAGES	POSSIBLE DISADVANTAGES AND POLICY CONSTRAINTS	RESOURCES REQUIRED FOR IMPLEMENTATION
4.4 Expansion of Social Marketing The Al Hilal Association should be encouraged and supported to develop a separate health product line: (1) Add ORS, iron supplements, antibiotics for STDs, and vaccines to the line of socially marketed products promoted by Al Hilal. (2) Promote these products directly to doctors and pharmacists, as part of the social marketing effort. (3) Ensure that there is clear agreement that the product will be sold at its financially self-sustaining price by the end of the transition period as part of the social marketing arrangements for Biosel.	For the private GP, providing vaccines, ORS, and nutrition supplements is a way of strengthening relationships with patients as a family doctor. Using the Al Hilal Association precludes the need to create another institution. Provision of these products in the private sector lessens financial pressure on the MOH.	Al Hilal is positioned as a FP organization and does not currently have a capacity to deal with health products. Al Hilal itself may take up to 2 years to be fully operational, and another 3 to be self sustaining. Adding new products will lengthen the time it will take for the association to become independent of donor assistance. Policy constraints: There is an advertising restriction on private health care in general and on drugs in particular. The commercial distribution of all products considered to be drugs is limited to pharmacies. There are high taxation and import duties on contraceptives and other essential FP/MCH products. A lack of viable third-party financing restricts ability to pay for FP/MCH products and services.	Technical assistance: Health brand manager in Al Hilal. Conceptualization of promotional strategy and identification of product suppliers. Vitamin A fortification study and follow-up. Local Costs: Direct support to communication campaigns.

STRATEGY AND MAIN RECOMMENDATIONS FOR IMPLEMENTATION	JUSTIFICATION AND ADVANTAGES	POSSIBLE DISADVANTAGES AND POLICY CONSTRAINTS	RESOURCES REQUIRED FOR IMPLEMENTATION
4.5 Demand Generation and Client Information Materials (1) Help establish a structure to leverage private sector contributions for the promotion of socially marketed products and services in the private sector. Campaigns and causes supported could include the Al Hilal products, the private sector family doctor, and Biosel. (2) With the MOH, pursue the goal of obtaining free airtime for public service campaigns. (3) Seek additional support from a U.S.-based foundation such as the Rockefeller Foundation, and provide initial technical assistance through a U.S.-based contractor. (4) Build capacity within the *Confédération des Pharmaciens* for the production of client materials.	Currently, GPs have limited access to counseling and waiting room materials. In pharmacies, availability of these types of materials is even more limited. A Moroccan institution would be created that would leverage private sector support well into the future. Could help channel other donors' funds for public health campaigns. Would harness the creativity of the advertising industry in the private sector to produce high-quality materials with little cost after an initial investment. Developing materials in coordination with pharmacists would create ownership for the materials (and, therefore, greater impact), and piggyback on an existing distribution mechanism.	Requires the expansion of corporate and consumer behaviors that are favorable to generating sales through sponsorship. Requires setting up a new association, with an investment over a 3-year period. The role of the MOH needs to be clearly defined as facilitating and encouraging, but still allowing the private sector a sense of ownership. The strategy very much depends on the persons who are currently in positions of leadership and who have an interest and commitment. They could change. Policy constraints: There is an advertising restriction on private health care in general and drugs in particular.	Technical assistance would be needed from the United States to establish the association and to help the pharmacists' organization develop technical capacity to produce the materials. USAID would fund local costs for the association over 3 years. The association would provide the funding for production of campaigns and airtime. USAID funding for the pharmacists would cover training costs for the staff in materials development and costs of setting up a national documentation center and a website, as well as an initial set of materials.

STRATEGY AND MAIN RECOMMENDATIONS FOR IMPLEMENTATION	JUSTIFICATION AND ADVANTAGES	POSSIBLE DISADVANTAGES AND POLICY CONSTRAINTS	RESOURCES REQUIRED FOR IMPLEMENTATION
4.6 Policy and Financing Reform (1) USAID should support the ability of the MOH to identify and quantify the impact of key policy barriers. The implementation of this strategy should strongly emphasize capacity building for the MOH. (2) Support research, in collaboration with the MOH and with local institutions. (3) Support the capacity of the MOH to lobby for reduced duties and taxes on essential contraceptives and other products. (4) Support the plans of the government to reform health insurance to (1) increase coverage, and (2) increase services covered, adding FP/MCH services. (5) Provide training to MOH officials on advocacy and the use of data for lobbying for public health interests. (6) Conduct study tours to provide Moroccan decision makers with examples of how other countries have dealt with the issues of taxation and regulation of FP/MCH products and health insurance reform.	Helping to change key policy barriers can have enormous impact on the sustainability of private-sector FP/MCH care. Without policy reforms, the other USAID investments may be lost. For private GPs to successfully offer a package of family-oriented health care, health insurance will need to be more widely available and will also need to cover FP/MCH services. USAID has experience working on health reform and policy issues in other countries and is in a good position to assist Morocco in this area. Lowering taxes on contraceptives and other essential products such as ORS will reinforce the prospects for financial sustainability of these products. Involvement in policy in general, and in insurance reform in particular, would allow USAID to coordinate activities with the World Bank and the European Commission—and would help to ensure that those donors' investments are well targeted. Third-party financing would help to systematize the application and enforcement of FP/MCH quality-of-care standards.	Policy identification, advocacy and reform depends on the political climate and factors outside of the control of USAID—in other words, success is not assured. Decision making for health insurance is currently scattered, making it potentially politically sensitive to get involved and difficult to bring the different players together.	Will require the presence of an individual available locally to coordinate on a daily basis with the different players involved in the policy process. This person would need to be senior enough to have access to senior MOH officials, and experienced enough to know the policy issues and process in Morocco. Additional technical assistance will be required to conduct studies, present options to policy makers, and conduct training in advocacy. Other studies will be done by local organizations. There will also be local costs for training. Study tours.

APPENDIX E

Private Sector Assessment
USAID/Morocco Population/Health Team Comments

General Comments

This document reflects the views expressed by a wide range of actors and decision makers in Morocco, and will be a very useful guide for selecting and implementing future activities regarding private sector implication in population and health programs. It recommends that the main private sector strategy should be to enable private general practitioners (GPs) to function as primary care providers for families who can afford to pay for such services.

The package of products and services proposed to strengthen GPs' capacity to respond to client needs is reasonable and well thought out. However, the potential impact of each of these elements, and of the package as a whole, is not clearly indicated. Thus, the USAID/Morocco PH team will need further analysis of the proposed impact of these strategies, and their feasibility, in order to set priorities for these actions. Analysis is also required to develop more detailed and realistic budgets and timelines for planning and implementing each proposed component or activity.

Executive Summary and Section I

The report mentions financing, policy, and institutional constraints to private sector development, including advertising and distribution restrictions, tax issues, and lack of third-party financing. The problems of private sector development are even more complex than this, as brought out in Claude Gingembre's report of November–December 1996 titled "*La situation de la Médecine au Maroc*." While the Gingembre report does not contradict the overall strategy proposed by the consultants, it may be crucial to consider some of the other problems identified in this report to plan for specific private sector activities.

Section 4

4.1 Building a Network

It is not clear that private providers should be asked to agree to charge the same fees for preventive services to be included in a network. Since market segmentation, competition, etc., are the strong points of the private sector, it may well be inappropriate for all doctors to be asked to charge the same amount for vaccinations if their client populations are very different in income and expectations, and their costs for rent, etc., are different. Therefore, USAID suggests that in developing plans for a provider network, flexibility should be considered, thereby allowing for a range of fees for packages of preventive services.

As stated by the authors, the role of the Ministry of Health (MOH) in this strategy is important, but it also requires careful consideration if program activities are to be sustainable. The MOH is cited as a source of training expertise, but it is costly to pay trainers from, for instance, the Faculty of Medicine. It is difficult to envision a time when the private sector could take on those costs after donor support ends.

Involvement of the MOH in quality control is also important, especially in the development of norms and standards, but if the peer review system is to be functional, the role of the MOH in monitoring quality should probably be at one remove, with the provider network doing the major work of monitoring quality of care.

4.2 Training

This section provides many useful suggestions for training of private physicians, but also raises some concerns about inclusiveness and substainability of the approach. Concerning inclusiveness, there is no mention of a possible role for nurses and midwives in preventive services in the private sector. Since USAID has supported significant efforts by the MOH to increase the pool of qualified paramedical professionals and to expand the range of services they can perform, this important group should be included in this program.

The amount of information and subjects that can be effectively included in one-half day or 1 full day may need more review, as well as a review of the relative weight to be given to technical versus communications versus management training. Particularly important was the lack of training of private GPs in interpersonal communications that was found by Pierre Jean and Ahmed Moussaoui in their GP training evaluation. Jean and Moussaoui advised including a separate module on counseling and IEC, but in this report those subjects would be subsumed within technical training. This report also recommended preparation of a module and training sessions for physicians who deliver the "certificat prenuptial." This recommendation implies extensive training for doctors in this area rather than basic counseling. According to technical advisors here, it would probably be more relevant and useful to develop IEC materials to target this new client

population and to train GPs in use of these materials. Also, the prenuptial exam could become a good opportunity for the private GP to recruit clients.

As discussed above, the role of the MOH in providing training should be carefully reviewed if the ability to train new providers and to provide continuing training to members of the network is accepted as an on-going feature of the program (as would seem likely). Rather than having the MOH provide the training directly, a more private sector approach to the training itself should be considered. For example, in other countries private professional medical associations and universities generate revenue through developing and marketing training programs.

Concerning IEC materials, the role of the MOH and/or the *Syndicat des Pharmaciens* should also be reviewed, because it is unclear who will be responsible for developing and paying for materials. Again, how will the activity be sustainable? Should private physicians pay for these materials? They may find that as a network they can prepare and distribute materials more economically among themselves after the general content is determined in collaboration with the MOH.

The timeline for building a network must be further developed to more adequately track the time and activities needed to establish the network itself. As the timeline is currently written, in the first year the emphasis is on preparation, and in the second year there is suddenly a family doctor network for which demand generation activities should be done. The time and effort needed to create such a network, beyond short courses for individual GPs, is not apparent in the timeline even though this activity is expected to need a full-time local advisor.

4.3 Institutional and Organizational Strengthening

This section probably overemphasizes the role that USAID could play in forming group practices, an idea quite novel to private doctors here. It is difficult to see how a network of private GPs (which many agree is an excellent idea) will be transformed into partnerships and group practice. It is very unclear that private physicians would welcome the idea of forming group practices. The establishment of a peer review system will require a great deal of trust between GPs and should be seen as the first step in a long-term process that may eventually lead to the formation of a few group practices. Setting up a peer review network in the first year (apparently before training of GPs is done) appears unrealistic.

4.4 Expansion of Social Marketing

Adding other preventive products to the range of social marketing products is widely considered to be a good idea among partners, donors, and interest groups in Morocco, but more research is needed to determine which products are feasible for social marketing. As pointed out in the report, the marketing of Biosel is problematic because pharmacists do not feel a sufficient incentive to sell the product. The cost and profitability issues in providing other products are not addressed, so the list of products to be added should be considered as being suggestions that require further market research.

There are also significant institutional issues to be addressed, notably whether, and how, to combine efforts for social marketing of child survival, family planning, and other products. The report points out that Al Hilal is strongly identified with family planning, but it does not seem feasible that several different groups concentrating on different products could each attain institutional sustainability.

4.5 Demand Generation/Client Information Materials

Many interesting ideas are developed in this section, but not all of them are expected to be feasible. In particular, the establishment and support of several different types of associations is a relatively long-term process that may be difficult or impossible to include in a transition strategy.

5.0 Human and Financial Resources Required

This is a very preliminary budget, with little indication of the way budget levels were determined for each element. Detailed budgets will be needed for each element. Because it is probably unrealistic to assume that USAID/M will be able to devote US$3.9 million to this effort, it will be necessary to work with all concerned partners to set priorities, as well as to agree on what would be included in a "scaled-back" scenario, among this array of suggested activities.

Conclusion

The members of the USAID/Morocco Population and Health team appreciate the interest and understanding of private sector issues reflected in this document, and wish to thank the authors for this contribution in preparing for the next phase of USAID assistance to this sector in Morocco. The comments expressed above reflect our shared concern that this critical element of the national program be supported and strengthened in appropriate and sustainable ways. We expect to continue working with partners in the private sector and in the MOH, to ensure that private medical providers in Morocco are able to make a substantial contribution to the reproductive health of the Moroccan population.