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Report No: PAD5318

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
PROGRAM APPRAISAL DOCUMENT
ON A

PROPOSED LOAN

IN THE AMOUNT OF EUR 409.8 MILLION
(US$450 MILLION EQUIVALENT)

TO THE

KINGDOM OF MOROCCO

FOR A

MOROCCO HEALTH REFORM PROGRAM-FOR-RESULTS

MAY 24, 2023

Health, Nutrition & Population Global Practice
Middle East And North Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2023)

Currency Unit =	Moroccan Dirhams (MAD)
MAD 11.07 =	EUR1
EUR 0.91=	US$1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Ferid Belhaj
Acting Regional Director:	Nadir Mohammed
Country Director:	Jesko S. Hentschel
Practice Manager:	Rekha Menon
Task Team Leader(s):	Denizhan Duran

ABBREVIATIONS AND ACRONYMS

AFD	French Development Agency (Agence Française de Développement)
AfDB	African Development Bank
AMO	Mandatory Health Insurance (Assurance Maladie Obligatoire)
ANEP	National Agency for Public Equipment (Agence Nationale des Equipements Publics)
CH	Congenital Hypothyroidism
CHU	Central University Hospital (Centre Hospitalier Universitaire)
CNOPS	National Fund for Social Welfare Organizations (Caisse Nationale des Organismes de Prévoyance Sociale)
CNSS	National Social Security Fund (Caisse Nationale de Sécurité Sociale)
CPF	Country Partnership Framework
CPI	Consumer Price Index
DAMPS	Medicines and Health Product Procurement Division *(Division de l'Approvisionnement* en médicaments et produits de santé)
DELM	Directorate of Epidemiology and Disease Control (Direction de l'Epidemiologie et de la Lutte Contre les Maladies)
DEM	Equipment and Maintenance Directorate (Direction des Equipements et de la Maintenance)
DHSA	Hospital and Outpatient Care Directorate (Direction des Hôpitaux et des Soins Ambulatoires)
DIM	Division of Information Systems and Methods (Division de l'Informatique et Des Méthodes)
DLI	Disbursement-Linked Indicator
DEP	Directorate of Public Establishments (Direction des Etablissement Publics)
DP	Population Directorate (Direction de la Population)
DPF	Development Policy Financing
DPRF	Planning and Financial Resources Directorate (Direction de la Planification et Des Ressources Financières)
DRS	Regional Health Directorate (Direction Régionale de la Santé)
E&S	Environmental and Social
EIA	Environmental Impact Assessments
ESMP	Environment and Social Management Plan
ESSA	Environmental and Social Systems Assessment
ESSP	Primary Health Care Centers (Etablissements de soins de santé primaires)
EU	European Union
FM	Financial Management
GBV	Gender-Based Violence
GCRF	Global Crisis Response Framework
GDP	Gross Domestic Product

GID	Integrated Management System of Expenditure (Gestion Intégrée de la Dépense)
GOM	Government of Morocco
GRS	Grievance Redress System
GST	Territorial Health Groups (Groupements Sanitaires Territoriaux)
HAS	High Authority for Health (Haute Autorité de la Santé)
HCI	Human Capital Index
HRH	Human Resources for Health
HCP	High Commissioner for Planning (Haut Commissariat au Plan)
ICR	Implementation Completion and Results
IFSA	Integrated Fiduciary Systems Assessment
IG	General Inspection for the Ministry of Health and Social Protection (Inspection Générale du Ministère de la Santé et de la Protection Sociale)
ISPITS	Higher Institutes of Nursing Professions and Health Techniques (Institut Supérieur des Professions Infirmières et Techniques de Santé)
JICA	Japan International Cooperation Agency
LMIC	Low Middle Income Country
M&E	Monitoring and Evaluation
MENA	Middle East and North Africa
MHSP	Ministry of Health and Social Protection
NCD	Non-Communicable Diseases
NDM	New Development Model
OPRC	Operations Procurement Review Committee
PAD	Project Appraisal Document
PAP	Program Action Plan
PBT	Triennial Budget Programming (Programmation Budgétaire Triennale)
PFM	Public Financial Management
PDO	Program Development Objective
PEFA	Public Expenditure and Financial Accountability
PforR	Program for Results
PHC	Primary Health Care
PMR	Regional Medical Program (Programme Médical Régional)
RAMED	Medical Assistance Scheme (Régime d'Assistance Médicale)
RTCM	Thermal Building Regulations in Morocco (Réglement Thermique de Construction au Maroc)
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SEGMA	Autonomously Managed State Services (Services de l'Etat Gérés de Manière Autonome)
SSDMAR	Maternal Death Surveillance, Neonatal Death Audit and Response System (Système de Surveillance des Décès Maternels, Audit des Décès Néonatals et Riposte)
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Morocco	Morocco Health Reform Program	
Project ID	**Financing Instrument**	**Does this operation have an IPF component?**
P179014	Program-for-Results Financing	No

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Fragile State(s)
[ ] Contingent Emergency Response Component (CERC)	[ ] Fragile within a non-fragile Country
[ ] Small State(s)	[ ] Conflict
[ ] Alternate Procurement Arrangements (APA)	[ ] Responding to Natural or Man-made Disaster
[ ] Hands-on Enhanced Implementation Support (HEIS)	

Expected Project Approval Date	Expected Closing Date
15-Jun-2023	30-Sep-2028

Bank/IFC Collaboration

No

Proposed Program Development Objective(s)

To strengthen institutional capacity and governance for improved provision of quality public health services in the Program Area

Organizations

Borrower :	The Kingdom of Morocco
Implementing Agency :	Ministry of Health and Social Protection
Contact:	Abdelouahab Belmadani

Title:	Director of Planification and Financial Resources
Telephone No:	212537761675
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COST & FINANCING

SUMMARY

Government program Cost	1,294.93
Total Operation Cost	1,296.06
Total Program Cost	1,294.93
Other Costs	1.13
Total Financing	1,296.06
Financing Gap	0.00

Financing (USD Millions)

Counterpart Funding	**846.06**
Borrower/Recipient	846.06
International Bank for Reconstruction and Development (IBRD)	**450.00**

Expected Disbursements (USD Millions)

Fiscal Year	2023	2024	2025	2026	2027	2028	2029
Absolute	0.00	99.00	99.38	89.63	80.25	81.75	0.00
Cumulative	0.00	99.00	198.38	288.00	368.25	450.00	450.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Substantial
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Substantial
8. Stakeholders	Substantial
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

Does the program depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the program require any waivers of Bank policies?

[ ] Yes [✓] No

Legal Operational Policies

	Triggered
Projects on International Waterways OP/BP 7.50	No
Projects in Disputed Areas OP/BP 7.60	No

Legal Covenants

Sections and Description
Section I.A.1(b) of Schedule 2:
The MHSP (through its Planning and Financial Resources Directorate ("DPRF") shall, no later than four (4) months after the Effective Date, or such later date as agreed by the Bank, establish, and thereafter maintain throughout the implementation of the Program, a Steering Committee responsible for overall oversight and strategic guidance of the Program, with composition and roles and responsibilities as set forth in the POM.

Sections and Description
Section I.A.1(c) of Schedule 2:
The MHSP (through its Planning and Financial Resources Directorate ("DPRF") shall, no later than four (4) months after the Effective Date, or such later date as agreed by the Bank, establish, and thereafter maintain throughout the implementation of the Program, a Technical Committee responsible for assisting the MSPS on the technical aspects of the implementation of the Program, with composition and roles and responsibilities as set forth in the POM.

Sections and Description
Section I.A.2 of schedule 2:
The Borrower shall, through the DPRF, not later than four (4) months after the Effective Date, prepare and adopt a Program operational manual, in form and substance acceptable to the Bank ("Program Operational Manual" or "POM").

Conditions

Type	Financing source	Description
Disbursement	IBRD/IDA	Section III.B.1(a) and (b) of Schedule 2:

		1. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (a) on the basis of DLRs achieved prior to the Signature Date; (b) for any DLR under Categories (1) to (9) until and unless the Borrower has furnished evidence satisfactory to the Bank that said DLR has been achieved.

I. STRATEGIC CONTEXT

1. **This Program-for-Results (PforR) operation aims to support the Government of Morocco (GOM) in strengthening the institutional capacity and governance for improved provision of quality public health services in the Program Area.** This will be achieved by supporting the implementation of the first three pillars of the Government health system redesign program, each of which correspond to result areas for the Program. The first result area supports strengthened institutional capacity through the new deconcentrated governance system, through the rollout of the new deconcentrated governance system including a focus on improved administrative capacity, gender and climate-sensitive health planning; improved content, quality, and accessibility of health data; and mechanisms to improve information exchange between central and regional entities, as well as collect information on patient satisfaction. Through its second result area, the Program seeks to improve the availability, motivation and competence of human resources for health (HRH), particularly through interventions improving training capacity for nurses and health technicians by over 50 percent, supporting curriculum reforms, and operationalizing the new health service to improve the quality of service delivery. The third result area supports the reorganization of health services through rehabilitation of public primary health care (PHC) facilities to address climate vulnerabilities, the institutionalization of quality evaluation and improvement in public health facilities, and strengthening of epidemiological surveillance capacity including for climate change related health issues. Through three result areas, the Program incentivizes catalytic results to build the foundation for a health system which will continuously measure and improve quality of care and improve health outcomes, as well as improve its resilience against climate change and reduce its gender gaps, in line with international evidence. Key expected outcomes include: (i) 100 percent of the Territorial Health Groups (GST) in Program Area have established a regional health map, (ii) 100 percent of GST have increased their human resource capacity by 50 percent with respect to identified gaps in 2023, to ensure an equitable distribution, (iii) 100 percent of GST have produced a quality evaluation report and adopted a quality improvement plan for public hospitals and public PHC facilities; and (iv) 90 percent of public PHC facilities in Program Area have essential health service package.

A. Country Context

2. **Morocco had achieved substantial economic and development gains in the past two decades**. The Kingdom has made significant social and economic progress since 2000, aided by political stability, large public investments as well as institutional and sector reforms. Accelerated economic growth led to a sharp decline in the national poverty rate (extreme poverty was close to be eradicated in 2019, with a national poverty rate of 1.7 percent[1]), increased life expectancy, greater access to basic public services, and significant public infrastructure development. The 2011 Constitution provided further reform impetus, including measures to make public spending more equal and expand protection of citizens against several risks. Most petroleum price subsidies, which had largely benefited the better-off in society, were phased out between 2012 and 2015, one of the most successful reforms in the Middle East and North Africa (MENA) region, resulting in a fiscal savings of about 4.5 percent of Gross Domestic Product (GDP).[2]

3. **The COVID-19 pandemic, climate-related shocks, and various crises have all had significant impacts on**

[1] Official rate from the Haut-Commissariat au Plan (HCP), based on the 2019 National Survey of Income Sources (Enquête Nationale sur les Sources de Revenu, ENSR). World Bank calculations based on data from the HCP's 2013/14 Household Consumption and Expenditure Survey and updated using quintile growth from the 2019 ENSR indicate a rate of 3 percent

[2] A Phased Approach to Energy Subsidy Reform: Morocco Experience. Bousselmame, 2017

the Moroccan economy, hampering its recovery following a recession in 2020. The pandemic led to reduced economic activity, disrupted supply chains, and decreased demand for Moroccan goods and services, particularly in tourism. Climate-related shocks, in particular droughts, have also affected the agricultural sector, leading to reduced productivity and higher production costs. Furthermore, consecutive crises have impacted global energy prices affecting Morocco's energy imports and increasing its energy costs. All these factors have contributed to the slowdown of Morocco's economic recovery, creating challenges for reducing poverty in the country. After a sharp drop in economic activity in 2020 (-7.2 percent), real GDP rebounded strongly in 2021 (7.9 percent) but dropped sharply to an estimated 1.2 percent in 2022. Hopes for a more robust economic performance in 2023 have recently been dampened given the impact the continued drought might have on agricultural production, yet again.

4. **These consecutive shocks may threaten shared prosperity in Morocco and may exacerbate pre-existing vulnerabilities.** After several years of declines, the poverty rate (US$3.2 purchasing power parity - international poverty line) is estimated to have increased from 5.4 percent in 2019 to 6.6 percent in 2020, an increase that could have been larger, if it had not been for the cash transfer programs which supported vulnerable households. In addition, poor, vulnerable and rural households are disproportionately suffering from the impact of the inflationary surge. The annual inflation may be 30 percent higher for the poorer decile of the income distribution than for the wealthier one. These inflation differentials are mostly due to the impact of food price increases, which represent a higher share of poorer households' consumption baskets.[3] An adaptative and a better targeted social protection system will constitute a more cost-effective tool to mitigate the impacts of these supply shocks.

5. **Morocco is highly vulnerable to climate variability and change.** Morocco is facing different challenges pertaining to climate-induced hazards and health conditions, with coastal regions more exposed to flooding and sea-level rise, while others to drought, heat waves, sandstorms or other climate-induced shocks. The country is one of the most water-scarce countries in the world, and expectations of increasing frequency and intensity of droughts for the country are particularly alarming for the agricultural sector and will affect both rural livelihoods and the economy.[4] The increasing incidence and severity of droughts is already a major source of macroeconomic volatility, and a threat to food security. With a longer-term perspective, the reduction in water availability and the drop in crop yields due to climate change could reduce GDP by up to 6.5 percent. Rainfed agriculture, which represents 80 percent of the country's cultivated area and employs most of the agricultural workforce, is particularly vulnerable to both droughts and water scarcity[5], increasing the risk of crop failures, food insecurity, and malnutrition. Floods are the most frequent climate-related natural hazards in Morocco, causing average direct losses estimated at US$450 million per year, with a disproportionate impact on vulnerable households. Increased floods due to climate change will also cause extensive direct and indirect health effects, including impacts on food production, water provision, ecosystem disruption, infectious disease outbreak and vector distribution, as well as longer term effects such as post-traumatic stress and population displacement. In addition, given that more than 65 percent of the population and 90 percent of industry is concentrated on the country´s coastline, sea-level rise constitutes another long-term stressor, especially for low-lying areas that will contribute to exacerbating the risk of floods. [6]

[3] Morocco Economic Monitor, World Bank 2023.
[4] Climate Risk Country Profile, World Bank, 2021
[5] Morocco Country Climate and Development report, World Bank, October 2022
[6] Morocco Country Climate and Development report, World Bank, October 2022

6. **The GOM recognizes weak human capital as a binding constraint to economic growth, and the New Development Model[7] (NDM) is focused on strengthening human capital as a key driver of inclusive economic development.** Morocco's Human Capital Index (HCI) in 2020 was 0.50, indicating that a child born today would only be 50 percent as productive as if they had access to full education and full health, by age 18. This is lower than the average for the MENA region (0.56), but higher than the average for Low-Middle Income Countries (LMIC, 0.48). On May 2021, the Government announced the ambitious and comprehensive NDM, charting a path towards sustainable and inclusive growth, and defining key priorities through 2035. The model is focused on strengthening human capital as a key driver of inclusive economic development. The report sets several objectives to be achieved by 2035, including: i) achieving an average annual growth rate of 6.8 percent over the period 2021-2035; ii) reducing the poverty rate and closing the gap between the richest and poorest regions; and iii) improving access to healthcare for all citizens and reducing infant and maternal mortality. The NDM sets ambitious targets of improving the HCI from 0.50 to 0.75, reaching universal health coverage through the universalization of health insurance, reducing out-of-pocket expenditures from 47 percent to 30 percent of current health expenditures, and improving the density of health workers from 1.65 per 1,000 population to 4.50, by the end of 2035.[8]

B. Sectoral (or Multi-Sectoral) and Institutional Context

7. **Morocco has made substantial progress in health outcomes over the past decade, but geographic inequalities persist.** Between 2010 and 2017, the maternal mortality ratio declined by over one-third, from 112 to 73 maternal deaths per 100,000 live births.[9] The rural maternal mortality ratio also declined significantly, from 148 to 111 maternal deaths per 100,000 live births. Yet, regional disparities persist across maternal and child health indicators: in 1992, the rural maternal mortality rate was 1.27 times that of the urban maternal mortality rate; in 2018, however, it was 2.47 times that of the urban maternal mortality rate. Coverage of key health interventions differs by region: while, in 2018, 94 percent of deliveries in the regions of Casablanca-Settat, and Rabat-Salé-Kénitra regions were attended by skilled personnel, the same figure was only 67 percent in Draa-Tafilalet. The rural-urban coverage of key health interventions also differs: 38.5 percent of women in rural areas have completed four or more antenatal care visits, compared to 65.6 percent of women in urban areas.[10] Similar inequalities across regions are seen for other key maternal, neonatal, and child health indicators, as well as across urban and rural areas.[11]

8. **While most of the disease burden in Morocco is due to non-communicable diseases (NCD), their diagnosis, treatment, and control rates remain low.** High blood pressure, high body mass index, and high blood sugar constituted the top three NCD risk factors in 2019.[12] In 2018, 38 percent of overall mortality was due to

[7] The NDM's three goals for health sector reform include: i) improvement of financial protection; ii) significant strengthening of availability and quality of care, particularly for human resources for health; and iii) improvement of quality and efficiency of care. The first priority is operationalized by the ongoing implementation of the scaling up of health insurance coverage, as stipulated by the Framework Law 09-21, and the second and third priorities are operationalized by the Framework Law 06-22. *La commission spéciale sur le modèle de développement, 2021. « Le nouveau modèle de développement : libérer les énergies et restaurer la confiance pour accélérer la marche vers le progrès et la prospérité pour tous »*

[8] The special commission on the development model, 2021. "The new development model: unleashing energies and restoring confidence to accelerate the march towards progress and prosperity for all"

[9] All data in this paragraph is from the Population and Family Health Survey (ENPSF), 2018

[10] National Population and Family Health Survey (Enquête Nationale sur la Population et la Santé Familiale, ENPSF) - 2018

[11] A detailed assessment of health outcomes across regions, urban, and rural areas is presented in the technical assessment based on latest available data.

[12] Institute for Health Metrics, 2022 (data from 2019) *https://www.healthdata.org/morocco*

cardiovascular diseases, 14 percent due to cancers, and 6 percent due to diabetes.[13] 39 percent of adults above age 18 have never had their blood pressure measured, and 63 percent of adults above age 18 never had their blood sugar measured, indicating low levels of population-level testing despite high prevalence.[14] Effective coverage of both hypertension and diabetes remains low (Table 1). Coverage of key NCD interventions is higher for females, and for those in urban areas.

9. **Morocco's population health is vulnerable to climate variability and projected climate change trends.** Climate change threatens to exacerbate health problems, whilst undermining water and food supplies, infrastructure, health systems and social protection systems. Of the top 10 conditions that cause the most deaths, eight are expected to be exacerbated by climate change, such as cardiovascular conditions and respiratory conditions.[15] About 60 percent of the overall disease burden in Morocco is set to be exacerbated by the impact of climate change.[16] The elderly, children, the chronically ill, the socially isolated and at-risk occupational groups are particularly vulnerable to heat-related conditions. Infants are vulnerable to health conditions which will be exacerbated by climate change, such as diarrheal diseases, and elderly are vulnerable to heat waves, the mortality burden of which is expected to increase by over ten times by 2080.[17] Under a high emissions scenario, and without significant investments in adaptation, some of the main health risks include (i) deaths in children under 15 due to diarrheal diseases attributable to climate change should represent approximately 10.5 percent of the approximately 1,600 deaths due to diarrheal diseases expected in 2030; (ii) vectorial capacity relative for dengue fever transmission is expected to increase, to about 0.33 by 2070 relative to the value of estimated baseline of 0.22; (iii) heat-related deaths in the elderly (65 years and older) are expected to increase to nearly 50 deaths per 100,000 population by 2080, in comparison with the estimated baseline of only less than 5 deaths per 100,000 population per year between 1961 and 1990; and (iv) 187,400 people in average per year are expected to be affected by floods caused by sea level rise between 2070 and 2100.[18] Morocco is likely to face an increased incidence of vector- and water-borne conditions exacerbated by climate change, such as dengue fever, malaria, and schistosomiasis.

10. **In addition to the increases in the disease burden associated with climate change, the health system faces various challenges in responding effectively to the additional burden of disease which will emerge from climate change as well as from increased incidence of climate-induced hazards.** A centralized governance of the health system and low levels of a health workforce which is further inequitably distributed, are among the main binding constraints to the ability of the health system to manage the additional burden of disease emerging from climate change. Health facilities' administrators lack training on climate adaptation and on how to allocate resources to better align with conditions that will be exacerbated by climate change, especially those that currently cause the largest deaths and are expected to become worse, such as ischemic heart disease, strokes, hypertensive heart disease, chronic kidney disease, diabetes, lower respiratory infections, chronic obstructive pulmonary disease, and lung cancer. Further, the service delivery system relies predominantly on hospitals with an outdated epidemiological surveillance system, which poses further constraints on the ability of the health

[13] STEPwise survey, 2017-18
[14] STEPwise survey, 2017-18
[15] *https://www.healthdata.org/morocco*. Climate-linked conditions that currently cause the largest deaths and are expected to become worse include: ischemic heart disease, strokes, hypertensive heart disease, chronic kidney disease, diabetes, lower respiratory infections, COPD, and lung cancer.
[16] IHME Global Burden of Disease data, 2019. This includes: nutritional deficiencies (1%); chronic respiratory diseases (3%); relevant cancers (8%); neglected tropical diseases and malaria (0.25%); sense organ diseases and other non-communicable diseases (10%); skin diseases (1%); respiratory infections and tuberculosis (4%); cardiovascular diseases (26%); and diabetes and kidney diseases (6%).
[17] World Health Organization, 2015. Climate and Health Country Profile for Morocco. *https://www.who.int/publications/i/item/WHO-FWC-PHE-EPE-15.10*
[18]. World Health Organization, 2015. Climate and Health Country Profile for Morocco. *https://www.who.int/publications/i/item/WHO-FWC-PHE-EPE-15.10*

system to manage the additional disease burden due to climate change, particularly at the community levels. It is important to also note the climate vulnerabilities and direct impact of climate change on health infrastructure, notably the damage to primary healthcare facilities due to flooding and droughts.

11. **Substantial improvements have been achieved in the context of limited resources, yet the health system still faces substantial challenges.** As demonstrated in Table 1, Morocco has lower government health expenditures, as well as lower levels of physical and human resources capacity, than middle-income countries or MENA averages, even as its average outcomes are like comparator countries, implying that the health sector is performing near its efficiency frontier. At the same time, Morocco's effective coverage index score at 58 percent, which is lower than other Maghreb countries and the average for the MENA region.[19]

Table 1: Key health system indicators for Morocco, lower-middle income, and MENA countries, latest available year

Indicator	Morocco	MENA average+	Lower-middle income average
Key health outcome indicators			
Death caused by non-communicable diseases (% of total)*	84	79	6
Life expectancy at birth*	77	74	69
Maternal mortality (/100,000 live births)*	70	57	253
Under-5 mortality (/1,000 live births)*	19	21	45
Hypertension prevalence, %***	35	38	N/A
Hypertension control, %***	10	22	N/A
Pregnant women receiving prenatal care, %*	89	84	86
Skilled birth attendance, %*	87	81	78
Diabetes prevalence, % (ages 20-79)*	9.1	12.9	10.5
Prevalence of stunting, % of children under 5*	12.9	17	28.7
Key health financing indicators			
Current health expenditure per capita, constant US$**	$174	$277	$97
of which, public	40%	47%	39%
of which, out-of-pocket	47%	44%	48%
General government expenditure on health, % of general government expenditure	7.10%	N/A	5.53%
Key service delivery indicators			
Hospital beds per 1,000 population *	1	1.4	2.3
Physicians per 1,000 population *	0.7	1.1	0.8
Nurses per 1,000 population *	1.4	1.9	2.3
Surgeons per 100,000 population *	4	20	10

MENA average excludes high-income MENA countries.
*Source: Indicators with a * are from World Development Indicators, latest available year; indicators with a ** are from WHO, 2019; and indicators with a *** are from the NCDi-RISC, 2021 database.*

[19] Effective coverage is defined as intervention coverage adjusted by need, use, and quality, capturing the proportion of health gain that could be potentially received from the intervention relative to what is experienced. Data here comes from the Institute for Health Metrics and Evaluation, 2019 *https://www.healthdata.org/morocco*

12. **There is substantial regional variation in disease burden, health needs, and health system performance, yet the governance of the health system remains centralized, with constraints regarding the production and use of data.** A centralized governance system with limited use of health information systems limits responsiveness at local levels, and the absence of a performance-based management system provides a binding constraint to expanding the availability and quality of health services. Despite the adoption of regionalization and 'deconcentration'[20] reforms since 2011[21], the health sector has remained largely centralized, with limited autonomy for deconcentrated structures at the regional and provincial/prefectoral levels. The health system is currently organized along vertical lines of governance, with a central administration (the Ministry of Health and Social Protection, MHSP), regional health directorates *(Directions régionales de la santé, DRS),* and provincial/prefectoral health delegations *(Délégations provincials de la santé*).[22] Managerial autonomy at the regional levels remains limited, with all governance functions remaining at the centralized MHSP. Other than university hospitals *(Centre Hospitalier Universitaire, CHU)*, health facilities have limited scope to no financial or managerial autonomy, with primary health care (PHC) facilities (*Etablissements de soins de santé primaires,* ESSP) having no financial and managerial autonomy, under the jurisdiction of DRS. Secondary-level hospitals benefit from the status of the Autonomously Managed State Services *(Services de l'Etat Gérés de Manière Autonome,* SEGMA) with no distinct legal character but some levels of financial autonomy, including for revenue generation. Tertiary CHU hospitals have full public establishment status, which entails full financial and decision-making autonomy, with a direct reporting to the Ministry of Economy and Finance's (MEF) Directorate of Public Establishments (Direction des Entreprises Publiques et de la Privatisation, DEPP)[23]. In addition to the overly centralized system, the lack of an integrated patient-level electronic medical records system, as well as the unavailability of timely health data, constrain evidence-based decision-making.[24]

13. **Over the past three years, Morocco has embarked on a comprehensive health financing reform process, strengthening revenue raising, harmonizing pooling, and rationalizing purchasing arrangements.** Prior to the launch of the health financing reform process, the Moroccan health financing system was characterized by low levels of government health spending; fragmented across three purchasers and with low levels of financial risk protection, with a third of the population lacking any form of financial risk protection. Current modalities of passive purchasing systems prohibit the utilization of financial incentives to leverage desired quantity or quality of health services. Following the launch of the social protection reform, there are three main purchasers of services from the public sector: i) MHSP, which purchases services for interventions offered free of charge at public facilities within the benefits package; ii) the National Social Security Fund (*Caisse Nationale de Sécurité Sociale*, CNSS), which purchases services for those under the Mandatory Health Insurance (*Assurance Maladie Obligatoire*, AMO)-CNSS and AMO-Tadamon schemes; and iii) the National Fund for Social Welfare Organizations (*Caisse Nationale des Organismes de Prévoyance Sociale*, CNOPS), which purchases services for those under the

[20] 'Deconcentration' in the Moroccan context refers to the devolution of various limited responsibility and decision-making roles to territorial entities. Decentralization refers to the complete or near-complete transfer of power, responsibilities and competencies to local collectivities which have moral personality and an autonomous budget. There are three dimensions of decentralization in this context: political, fiscal, and administrative. In the current Moroccan reform context, which is described in the further sections, the first step is to strengthen institutional capacity for strong implementation of deconcentrated arrangements, which is within the context of the current phase of the reform, paving the way towards a more decentralized system.
[21] 2015 Organic Law on Regionalization, 2018 Charter on 'Deconcentration'.
[22] In addition: 76 hospital centers scattered throughout the territory, in addition to 7 higher institutes of nursing professions and health techniques with their 16 annexes.
[23] This is also the case for the regional blood transfusion center-Casablanca; the Medicines and Pharmacy Department; the National School of Public Health; the National Center for Blood Transfusion and Hematology - National Institute of Hygiene; and the National Center for Radiation Protection.
[24] As of March 2023, the latest survey focusing on NCD is from 2017, the latest household survey is from 2018, the latest health sector administrative data report is from 2020, and the latest information on physical and human resource capacity is from 2021.

AMO-CNOPS scheme.[25] There is currently limited budgetary autonomy and financial management (FM) capacity within public PHC facilities and secondary hospitals, which are mostly paid through global budgets by the MHSP, whereas CHU resources are subsidized through a mix of global budgets, fee-for-service, and case-based payments. Recently, a convention has been signed between MHSP, MEF, and CNSS to arrange for the payment of public PHC facilities through monthly capitation payments from CNSS to the general government budget for AMO-Tadamon beneficiaries' outpatient visits. For inpatient and chronic conditions, health facilities would be billing CNSS directly, based on an existing national price reference list, which is in the process of being updated. Government expenditures on health has been increasing by almost 10 percent annually since the launch of the reform in 2022, and the government has universalized the mandatory health insurance to enroll previously ineligible population groups, with the aim of reaching 100 percent coverage by 2025. As discussed in in the "Program Description" (section II), the government is currently in the process of aligning health financing arrangements with the supply-side health system redesign program.

14. **Constraints in the availability, distribution, and performance management of the health workforce pose one of the most substantial bottlenecks to the delivery of quality health services in Morocco.** There are currently about 27,881 doctors in Morocco[26] (13,682 and 14,199 respectively in the public and private sectors) and a total of 35,789 nurses and health technicians (including 15,772 general nurses and 5,757 midwives) at PHC level. The number of physicians per 1,000 population in Morocco stands at 0.7, a measure below the LMIC average of 0.9 physician per 1,000 population and below some comparator countries in the region.[27] Similarly, the number of nurses and midwives per 1,000 population in Morocco stands at 0.9; below the LMIC average of 2.3 per 1,000 population, and below comparator countries in the region. This deficit is further aggravated by regional inequalities with about half of the doctors concentrated in the regions of Rabat-Salé-Kénitra and Casablanca-Settat.[28] The density of health care personnel per population is not equitable and decreases with the regions and provinces' remoteness, with some provinces being under-resourced in terms of doctors, nurses, and health technicians. The region of Casablanca-Settat has the most physicians available per population with 1 physician available for 951 persons, whereas Drâa-Tafilalet has the lowest, with 1 physician available for 3,176 persons. Similarly, nurses and midwives are also inequitably distributed, with Oriental region having the highest ratio (1.13 nurses and midwives per 1,000 population) and Casablanca-Settat region having the worst ratio (0.67 nurses and midwives per 1,000 population). The government estimates a need for an additional 32,000 doctors and 65,000 nurses to comply with the World Health Organization (WHO) requirements, which is substantially above the current available capacity. Recruitment, accountability, and performance management for human resources for health is managed at central and regional levels, with limited redistribution and performance management for staff at health facilities. Limited mobility to high-need areas, and performance management challenges further pose constraints to effective human resources for health management.[29]

15. **Patient pathways are well defined but not respected.** In addition, the absence of the implementation of an institutionalized quality evaluation system, as well as low levels of structural quality in public PHC facilities, constrain effective public service delivery. Government health facilities are organized in a pyramidal structure, with primary care facilities forming the entry point to secondary and tertiary levels of care. Given the limited

[25] Amongst these schemes, AMO-CNSS covers salaried workers in the private sector as well as non-salaried workers who are mandated to enroll based on their professional associations. AMO-CNOPS covers salaried workers in the public sector. AMO-Tadamon covers poor and vulnerable households whose eligibility is determined based on the unified social registry. The three schemes combined cover about 70 percent of the population.
[26] http://cartesanitaire.sante.gov.ma/dashboard/pages2/index_2021.html
[27] World Bank. (2021). World Development Indicators – Based on latest available year data
[28] The effectiveness of the right to health. Challenges, issues and ways to strengthen. National Human Rights Council, February 2022
[29] WHO, 2017. Labor market assessment for human resources for health in Morocco

implementation of a referral system as well as the limitation of the benefit package offered at primary health care centers, most patients seek services directly at the hospital level, resulting in overwhelmed facilities which already face staffing shortages. At the same time, despite various initiatives, including the initial institutionalization of quality assessments by law 34-09 followed by Framework Law 06-22, these evaluations are not yet implemented at central or regional levels. The MHSP conducted seven rounds of a quality competition (*concours qualité*) between 2007-2018, ranking health centers and hospitals across domains including accessibility, competency, management, and patient satisfaction. The last round of the competition conducted in 2018 demonstrated substantial variation in performance, as well as substantial inequalities within and across regions. Hospitals, on average, scored lowest on patient satisfaction (38 percent) and health worker technical competency (44 percent), whereas health centers scored lowest on community engagement (33 percent). The results of the assessment have been utilized to develop regional quality improvement strategies; however, in the absence of autonomy at the regional, territorial, and health care facility levels, the ability of decision-makers and providers to implement these strategies has been limited. No assessments have been conducted in the last five years at the level of public PHC facilities, even as the evaluation of hospitals with new guidelines has started. An assessment in 2018 of maternal health service delivery quality in hospitals demonstrated similar constraints, with 91 percent of sampled regional hospitals not complying with structural and organizational norms, 50 percent of sampled health facilities not implementing clinical audits, and 80 percent of sampled health facilities not implementing targeted in-service training.[30] In addition to system-wide governance constraints, the health system also suffers from a wider range of binding constraints with regards to quality of care, including (i) limited performance management of the health workforce; (ii) limited availability and use of data for effective decision-making; (iii) low levels of patient satisfaction, despite lack of data on the granular drivers; (iv) fragmented health service delivery without a focus on patient pathways and experience; and (v) a disconnect between health financing arrangements and service delivery, resulting in limited resource availability at the facility level to deliver quality services.[31]

16. **Building on this momentum and responding to the limitation of the health system, the government launched a comprehensive social protection reform process in July 2018, with substantial political will, commitment and engagement for its effective implementation.** His Majesty, the King Mohammed VI, announced the reform of the social protection system on July 29, 2018, during his annual speech on the anniversary of his accession to the throne. The implementation of the reform was accelerated due to the COVID-19 pandemic and took on a substantial focus on redesigning the health sector, as reinforced by the King's speech on July 29, 2020. The social protection reform, including the health system redesign, was integrated into the NDM and the current government's program in 2021. The reform seeks to improve the quality, equity, and resiliency of the health system. On the demand side, the reform aims to extend health insurance to add 11 million uninsured people to reach 100 percent coverage, through gradually enrolling non-salaried workers and their households based on occupation groups, as well as expanding eligibility for the 11 million poor and vulnerable individuals who were previously covered in the medical assistance scheme (*Régime d'assistance médicale,* RAMED) into the Mandatory Health Insurance scheme AMO by 2025. On the supply side, described in more detail under "Program Description" (Section II-C), the Framework Law 06-22 was adopted and published in the Official

[30] Ministère de la santé, 2018. Rapport de l'enquête nationale d'évaluation de la qualité des soins et des services des maternités hospitalières et des unités de néonatologie au niveau des hôpitaux régionaux au Maroc

[31] World Bank, 2021. "Towards a high-quality health system in Morocco" & "Policy note: Maximizing the impact of health reform by putting quality at its center" Both notes are summarized in the technical assessment for this PforR.

Gazette No.7151, dated December 9, 2022,[32] introducing substantial changes across all health system functions, with the intention of improving the quality and availability of health services and engendering a health system redesign. Since the King's Speech in 2020, the royal priority of health sector redesign has been one of the top priorities of the government, and it is integrated into key reports such as the NDM and the new government's program (as of 2021), as well as the legislative framework, as described in Section II.

17. **The effective response to COVID-19 has contributed to limit the impact of the pandemic, improve the public's perception of the health system and represents an opportunity to continue improving perceived public satisfaction.** Despite health system constraints, Morocco implemented effective and consistent public health measures, and communicated them effectively to the public to garner trust and reduce the spread of COVID-19. With significant increases to the health budget and a focus on service continuity, impact on essential health services was reduced and the system responded to surges in severe cases. An early commitment to vaccine procurement gave Morocco one of the highest vaccination rates across LMIC, putting it on a path to reopen safely and quickly. This has resulted in lower per capita case and death rates compared to other countries in the MENA region. Effective response has also been reflected in population satisfaction, with 86 percent of the population being satisfied with the country's performance in responding to the pandemic in April 2021[33] This is promising, given that there was a reported 82 percent dissatisfaction with the health system in 2018.[34] While there are platforms for the population to express their grievances or challenges with the health system, such as the *Chikaya.ma* citizen engagement and grievance management platform, there are no institutionalized structures for effective grievance management.

C. Relationship to the CPS/CPF and Rationale for Use of Instrument

18. **The Program is aligned with the overall objective of Morocco's Country Partnership Framework (CPF) 2019-2024 (Report No. 131039-MA) discussed by the Executive Directors on February 19, 2019, to help Morocco promote social cohesion by transforming and protecting human capital and promoting inclusive and resilient territorial development.** Three strategic focus areas form a foundation for the CPF: (i) Promoting Job Creation by the Private Sector; (ii) Transforming and Protecting Human Capital; and (iii) Promoting Inclusive and Resilient Territorial Development. The Program directly supports the second and third focus areas of the CPF and will contribute to the Objective 6 "Improve the quality and efficiency of health service delivery systems", and Objective 7 "Strengthen social protection for the poor and vulnerable" by strengthening the quality and efficiency of the health system delivery to meet the Moroccan population's expectations through equitable access and quality of care. A Performance and Learning Review of the CPF is being prepared to be distributed to the Board before end FY23, maintaining the focus on human capital development and the support for health reforms.

19. **The Program is aligned with the World Bank Group's Global Crisis Response Framework (GCRF), Pillar 3 "Strengthening Resilience" and Pillar 4 "Strengthening Policies, Institutions and Investments for Rebuilding Better**". The Program will support the government in implementing the new deconcentrated governance system, strengthening policies and management of deconcentrated entities, including to mitigate climate risks, reforms

[32] The new framework law 06-22 enables upgrading the supply of health services, creating the family and community medicine system, establishing the obligation to respect the primary level as entry point to coordinated care pathways, and deconcentrating health service delivery to regional health networks (GSTs).
[33] Latest available Arab Barometer report for Morocco, 2021 *https://www.arabbarometer.org/wp-content/uploads/Morocco_ArabBarometer_Public-Opinion_2021_En-1.pdf*
[34] Arab Barometer surveys, 2021 and 2018

to the health financing system, digitizing the health information system to improve the content, quality, and availability of data, including for climate sensitive health conditions (pillars 3 and 4). The Program is aligned with Pillar 3 through (i) supporting the rehabilitation of public PHC facilities with the intent to address climate vulnerabilities outlined in the country and sectoral contexts while complying with the country's energy and thermal efficiency criteria, (ii) strengthening the epidemiological surveillance capacity including for climate sensitive health conditions[35]; (iii) and contributing to strengthening climate resilience. The Program will support draft Law no. 09-22[36] on the operationalization of the health service to define health worker entitlements and to improve the quality-of-service delivery. The Program will also support the organization of exchange and coordination platforms between central and regional entities, strengthen policies and institutions (Pillar 4).

20. **The Program contributes to the achievement of the World Bank Group's strategic goals to end extreme poverty and promote shared prosperity in a sustainable manner, and is also aligned with the Health, Nutrition, and Population (HNP) Global Practice goals and the MENA Regional Strategy.** The Program will contribute to the objective of reaching universal health coverage, in alignment with the HNP Global Practice goals of ensuring access to health services and financial protection (against catastrophic out-of- pocket expenditures) for everyone by 2030. With a focus on improved access to quality of public health services and on enhanced governance mechanisms, the Program is aligned with Pillar II of the 2015 MENA Strategy "Renewing the Social Contract." It also contributes to the expanded MENA Strategy (March 2019) pillar on "Building Human Capital", which places a greater focus on harnessing human capital and the World Bank Group Gender Strategy (FY16-23) by increasing women's access to health services.

21. **The Program builds on the World Bank's deepening engagement in the Moroccan health sector since 2015.** The previous health operation in Morocco, Improving Primary Health in Rural Areas Program for Results (US$135 million, P148017), including additional financing for COVID-19 response (P173944), became effective in 2015 and closed on September 30, 2021. The operation was fully disbursed, and according to its Implementation Completion and Results Report (ICR)[37], it was successful in strengthening primary health service delivery in rural areas by enabling a shift in the system's focus toward NCDs. It also supported (i) an expansion in the coverage of maternal and child health services; (ii) strengthened health information systems; (iii) measurement of different dimensions of quality of care through the quality competition (*concours qualité*); and (iv) expansion of surge capacity for COVID-19 response. Since 2018, the World Bank has been substantially engaged in the health financing reform process (see Box 1). In close collaboration with the government, a comprehensive health financing diagnostic has been conducted, which led to the development of a roadmap regarding the integration of different financial risk protection schemes, as well as the analysis of costs of service delivery at primary health facilities to inform contracting. In addition, the World Bank is supporting the design of the financial and operational model for Territorial Health Groups (*Groupements sanitaires territoriaux*, GSTs) in selected regions, which is one of the key aspects of the government's health system redesign program. The World Bank is also supporting a Climate Health Vulnerability Assessment and a carbon foot-print assessment, both at the level of health facilities and for the health sector overall. Based on these assessments, the World Bank will support the development of an action plan to reduce health system carbon emissions and make the system more resilient to climate change.

[35] This includes both communicable and non-communicable diseases, as highlighted in paragraph 8.
[36] The special status relates in particular to the essential guarantees granted to human resources for health.

[37] *Morocco - Health Sector Support Project (English).* Washington, D.C. : World Bank Group. *http://documents.worldbank.org/curated/en/998811657067132849/Morocco-Health-Sector-Support-Project*

Box 1: Health financing reform and the World Bank Development Policy Financing (DPF) Series

In 2021, the Government of Morocco launched the royal priority of the social protection reform, with the intention of covering 22 million Moroccans who are not under the AMO schemes, through integrating 11 million non-contributory beneficiaries who were previously in the RAMED scheme into the AMO, as well as enabling another 11 million non-salaried workers to enroll in the AMO scheme. The World Bank is supporting this reform through a *Strengthening Human Capital for a Resilient Morocco* DPF series (P176937, P178382), the development objective of which is to improve protection against health risks, human capital losses during childhood and poverty in old age and to improve climate risk management and resilience against catastrophic events. The DPF series includes various prior actions and triggers pertaining to the promulgation of laws and application decrees for the implementation of the reform. The DPF series also includes prior actions and triggers on the completion of a climate vulnerability evaluation and the adoption of a roadmap for the reduction of greenhouse gas emissions for health facilities. This PforR builds on these initiatives through indicators set to incentivize the timely and quality implementation of the legislative framework pertaining to the health system redesign program.

22. **The World Bank PforR financing instrument will support the implementation of the government program.** PforR financing mechanism, using Disbursement-Linked Indicators (DLIs) is appropriate for this context given the presence of a strong government program, experience with the PforR instrument, and an orientation of the government program towards results. Within each of these elements, the PforR is designed to add value by supporting the implementation of the health system redesign program, as described below:

- Strong, well-defined, and interlinked government program: The PforR supports the implementation of the health system redesign program by linking disbursements to results. The reform adopts a whole-of-sector approach to strengthening governance while aligning incentives across all levels of the health system. In this context, the Program seeks to support the reform, with a focus on areas where impact can be catalyzed to improve the quality and availability of health services.

- Experience with PforR and implementation capacity: While the previous health PforR faced implementation challenges during early stages of implementation, it resulted in stronger MHSP implementation capacity through targeted support. Beyond the MHSP, the Government of Morocco has utilized the PforR instrument extensively in sectors ranging from agriculture to education, early childhood development, blue economy and urban development. This consolidates the government's experience in managing for results in line with the organic law no. 130-13 published in July 2015 in relation to the finance law.

II. PROGRAM DESCRIPTION

A. Government Program

23. **The government program ("p") supported by this PforR seeks to redesign the health system to improve the quality and availability of health services.** The comprehensive health sector reform seeks to improve the

quality, equity, and resiliency of the health system through two components: i) demand-side financial protection reform; and ii) supply-side health system redesign program. On the demand side, the reform aims to achieve effective health coverage of 100 percent by 2025, by extending health insurance coverage to 11 million uninsured people, corresponding to self-employed workers and their households based on professional groups, as well as switching of 11 million poor and vulnerable people who were previously covered by the medical assistance scheme (RAMED) to the compulsory health insurance scheme (AMO). The demand-side reform is already underway and is being supported by a series of World Bank DPFs (see box 1) and other complementary partner investments. This PforR is supporting the government's supply-side health system redesign program, which is based on two sets of foundational documents: a) Framework Laws 06-22 and draft Laws 07-22, 08-22, 09-22, 10-22 and 11-22[38], which set forth the principles and domains of the health system redesign; and b) the three-year government's Triennial Budget Programming (*Programmation Budgétaire Triennale* (PBT), 2023-2025) (Figure 2). The PBT incorporates aspects of the reform, as well as other recurrent activities for the operation of the health sector, across five programs, with annual performance targets.[39]

24. **Through four pillars, the Framework Law, and five draft Laws introduce a substantial shift in every function of the health system.** The government's health system redesign program seeks to improve the health system across the four pillars below:

i. Strengthening organizational and institutional capacity for health system governance: To improve responsiveness and enable improving quality of care, Framework Law 06-22 and draft Laws 07-22 and 08-22 introduce radical changes to the governance of the health system at all levels. At the central level, a new, fully independent and autonomous High Authority for Health (*Haute Autorité de la Santé*, HAS) will be instituted for the supervision of health insurance, definition of quality standards, and the implementation of accreditation (draft Law 07-22). The government will strengthen the 'deconcentration' of the governance of the health sector through the introduction of the GSTs, which are going to serve as institutional and operational structures responsible for ensuring the provision of public health services within a region. As deconcentrated entities and public establishments with full managerial and financial autonomy across health system functions, the GSTs will ensure the complementarity and coordination of health facilities and services and will allow to tailor the supply of services to the specificities of the region: once effective, PHC centers, secondary and tertiary hospitals will all be integrated under the GSTs. This organizational integration will allow the GSTs to deliver integrated health services based on a Regional Medical Program *(Programme Médical Régional, PMR*), which covers public facilities and patient pathways within the public sector. It will also allow the GSTs to strengthen physical and human resources through the elaboration of a regional health map, which includes both public and private facilities and seeks to meet the specific needs of the population while maximizing quality and efficiency. Coordination of health services across levels of care will be ensured within each GST, with the primary health center within a GST forming the entry point to care-seeking,

[38] Framework Law 06-22 was adopted by the Council of Ministers on July 13, 2022, and by the House of Councilors at the Parliament on October 11, 2022. It was promulgated on December 2, 2022 through Dahir n° 1-22-77 and published on the Official Gazette (issue 7151) on December 9, 2022. Draft Laws 08-22, 09-22, 10-22 and 11-22 were approved by the Chamber of representatives on April 26, 2023. Draft Law 07-22was approved by the Government Council on December 21, 2022 and will be discussed by the Parliament in the June or October 2023 session. All draft Laws are expected to be promulgated by the end of 2023 following these discussions.

[39] PBT is updated every year for the subsequent three years. The current PBT covers 2022-2025, and does not include activities specific to the Framework Law 06-22. The programs in the PBT are further described in the figure on Program boundary and the section on expenditure framework, and include human resources for health; planning, programming, and coordination; reproductive, maternal, newborn and child health; epidemiological surveillance; service delivery at primary, secondary, and tertiary levels; and upgrading of health infrastructure and medical equipment. Each of the programs have annual results indicators and targets.

and primary and secondary services being organized around regional hospitals through a referral system. As such, GST will integrate service delivery while taking on functions across governance (i.e. developing the epidemiological regional health profile and managing service delivery capacity for both public and private sectors) and financing (i.e. defining financing needs and revenue collection particularly for investment and infrastructure budget). GST would also purchase health services from AMO, and allocate these resources for service delivery with facility and health workforce payment modalities to be designed based on various elements including quality of care. Strong implementation of deconcentrated service delivery and decision-making is expected to contribute to improved health outcomes in Morocco, particularly for conditions which require sustained engagement and follow-up such as maternal, newborn, child health, and NCDs, resulting in improved health sector responsiveness to health needs due to climate shocks. Improvements in governance will be accelerated by the digitalization of the health system, with the launch of an integrated health information system (across public and private sectors, as well as across service delivery and billing for insurance purposes), and patient-level electronic medical records.

ii. Improved availability and competence of human resources for health: To reduce the shortage of human resources for health, alleviate territorial disparities, and improve clinical quality, Framework Law 06-22 and draft Law 09-22 allow health workers to be paid based on performance, as well as incentivize the recruitment of foreign doctors. The laws designate GSTs with the responsibility to manage health worker performance. It provides GSTs with the authority to move health workers within their region to close gaps in high-need areas. This includes the definition of performance payment modalities based on quality and other factors for health workers. In addition, the laws prioritize the expansion of capacity building, particularly for priority cadres that face substantial shortages, and open new training programs for specialists. To improve clinical competency, the laws include measures to update training curricula and scale up continuous in-service training.

iii. Reorganized health service delivery: A substantial reorganization of the health service delivery system is needed to: (i) rectify insufficient physical resource capacity, (ii) improve spatial and gender equity of health outcomes; and (iii) improve the quality of health services. Framework Law 06-22 and Law 08-22 do so through four levers. First, the laws stipulate care pathways within a GST including that patients can only seek services at the hospital level if they first seek services at their public PHC facilities and receive a referral. Second, they stipulate the rehabilitation and upgrading of both public PHC facilities and public hospitals for the improvement of their structural quality, which will result in improved climate resilience and conformity with energy and thermic standards. Third, the laws seek to institutionalize quality evaluation and improvement processes at the GST level, in addition to the accreditation arrangements stipulated at the central level. Fourth, the legislative framework as well as the PBT include priority activities to strengthen health prevention and promotion, combatting stigmatization of individuals due to their health status, as well as epidemiological surveillance capacity. While the legislative framework stipulates improved coordination between public and private sectors. The details of how the private sector will be contracted or deliver services under the redesign are yet to be defined.

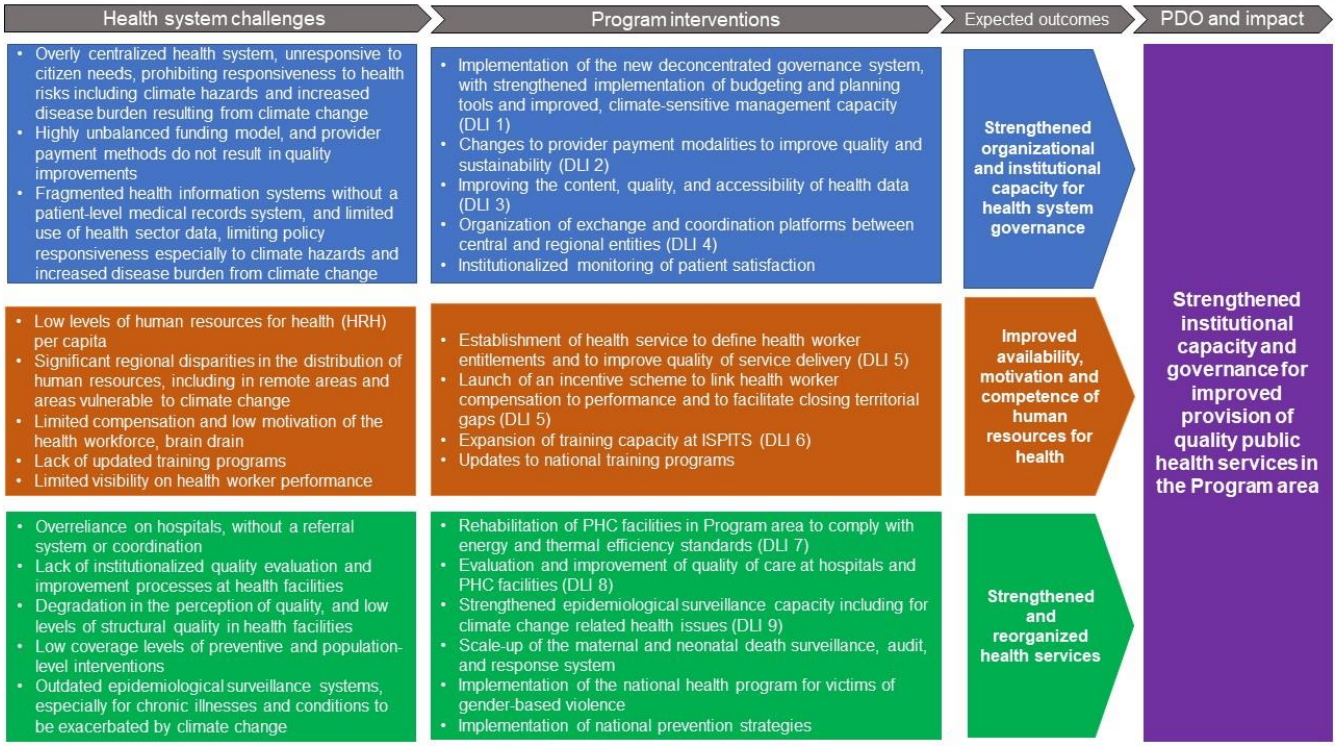
iv. Strengthened pharmaceutical regulatory and production capacity: To improve Morocco's self-sufficiency and capacity to respond to potential supply-side shocks with regards to pharmaceuticals and other health commodities, Framework Law 06-22 and draft Laws 10-22 and 11-22 include measures to ensure quality control and regulation for pharmaceuticals, to support the development of a local pharmaceutical

industry, and to prepare, implement, track, and evaluate blood policy to ensure a reliable supply and quality.

B. Theory of Change

25. **The World Bank PforR ("P") seeks to strengthen institutional capacity and governance for improved provision of quality public health services in the Program area.** Figure 1 Figure 1 shows the Program theory of change, with specific interventions supported by the Program within the context of the government's health system redesign program across three results areas which are aligned with the pillars of the government program. Given the fact that the reform is in early stages of implementation, Program interventions focus on ensuring strong implementation of the key building blocks of the government's health system reform, including on 'deconcentration', provider payment modalities, health information system, knowledge exchange platforms, strengthening HRH availability and motivation, strengthening structural quality, implementing quality evaluations, and strengthening preventive and surveillance platforms. Across each of the result areas, the Program strengthens the health system's capacity to address climate vulnerability, resulting in improved adaptation of the health system to climate hazards and conditions that are set to be exacerbated by climate change, and mitigation to reduce the health sector's carbon footprint.

Figure 1 Program Theory of Change



C. PforR Program Scope

26. **The World Bank Program ("P") supports the achievement of results in Program area within the supply-side health system redesign program to be implemented in the next five years by the MHSP.** Given the fact that this PforR will be implemented in the early stages of the reform, interventions will prioritize the establishment of building blocks and incentive mechanisms for its successful implementation. This will enable the reform to improve the availability of high-quality health services, deliver competent care, and strengthen the health system through interventions to improve governance, health workforce, and service delivery capacity. While the legislative framework and the strategic vision for the reform are established through the publication of Framework Law 06-22 in December 2022, there remains a degree of uncertainty with regards to the timeline in which various key institutions that are a part of the reform but outside of the scope of the MHSP would be established. As such, interventions pertaining to the scope of these institutions are out of the Program scope, which includes the establishment of HAS, Moroccan Agency for Pharmaceuticals, and the Moroccan Agency for Blood and Blood Products. Further certainty on the implementation of the reform will be ascertained through the publication of implementation decrees for each of the Laws, as well as the promulgation of draft Laws 08-22 (on GST) and 09-22 (on HRH) which were adopted on April 26, 2023 by the parliament. The Program is entirely based on Framework Law 06-22, as demonstrated in Table 2 and Figure 2. In addition, activities within the PBT that are essential for achieving the Program Development Objective (PDO) and the objectives of the reform are also included in the Program scope. This includes programs pertaining to training, planning, programming, coordination; strengthened delivery of maternal, newborn, and child health services; improved epidemiological surveillance; service delivery at primary, secondary, and tertiary levels; climate-resilient rehabilitation of public PHC facilities; and upgrading of medical equipment. Investments with potential to cause significant adverse impact on the environment and/or affected people as defined in the World Bank Policy and Directive on PforR financing, as well as investments involving works, goods, and consultancy contracts above the World Bank thresholds, are excluded. Finally, the implementation of the activities is restricted to the Program area, which will be further defined in the Program Operations Manual (POM). This Program area comprises the Borrower's regions and provinces as defined in the POM. As described further in the expenditure framework section and in Table 8, the program will be financed for a total of US$ 1.296 billion, including an IBRD loan of US$ 450 million (34.72 percent of total program financing) and by the Government.

27. **While Morocco's health financing and social protection reform is supported by other development partner projects, including the World Bank through budget support (Box 1), this is the first operation focusing on the health system redesign program.** While other development partners are providing financing support for different aspects of the health sector, including the social protection reform, most are not related to the health system redesign program which is supported by this PforR. The main partners supporting health sector include the French Development Agency (AFD), European Union (EU), African Development Bank (AfDB), and Japan International Cooperation Agency (JICA). While this PforR builds on these investments, none of the investments from these partners are directly within the scope of the health system redesign program and, as such, partners' funding are excluded from the Program financing table.[40] However, a number of partner organizations are

[40] Relevant financing from AFD (150 million EUR, 2021-2023) in the context of the health system redesign program include the passage of legislation for the implementation of GST, implementation of a mental health and NCD strategy, as well as the renovation of ESSP from previous years. Relevant

providing TA which is geared to support the achievement of results identified in this PforR operation, such as by the European Union to strengthen management capacity for GST.

Figure 2 Scope of government program ("p") and Program ("P") supported by the PforR
Boxes in dark blue are included in the Program, whereas boxes in light blue are excluded

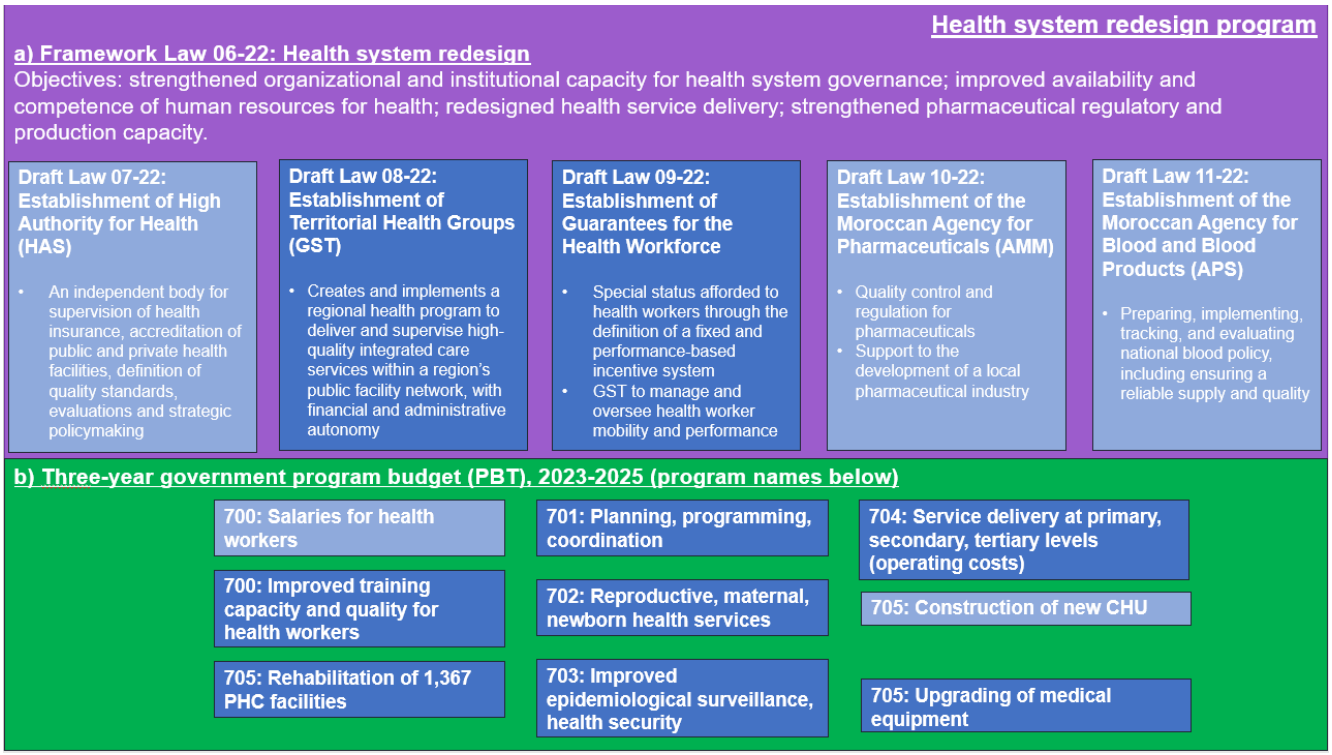


Table 2 Pillars and activities described in Framework Law 06-22 for health system redesign program, and corresponding Program indicators

Pillar	Activities
Strengthened organizational and institutional capacity for health system governance (articles 15-17, 21-22, 28-29, 32)	• Launch of an integrated health information system where all public and private health institution data is integrated with patient-level electronic medical records, including protection of personal data **(DLI 3).** • Establishment of a High Authority for Health for technical supervision of mandatory health insurance, assessment of quality of services, and informing definition of public health policies • Establishment of GST to implement government health policy in regional and territorial levels, with each GST including all public facilities within the region **(DLI 1, DLI 4).**

financing from JICA include interventions to support the development of a previous evaluation on maternal and newborn deaths, changes to training curricula, and development of progress reports for DELM (through the end of 2023). Relevant financing from EU through the PASS III involves support to the development of quality evaluation standards for health facilities, and proportion of ESSP ensuring continuity of care. AfDB financing pertains to supporting hospitals as well as the deployment of health information systems in hospitals.

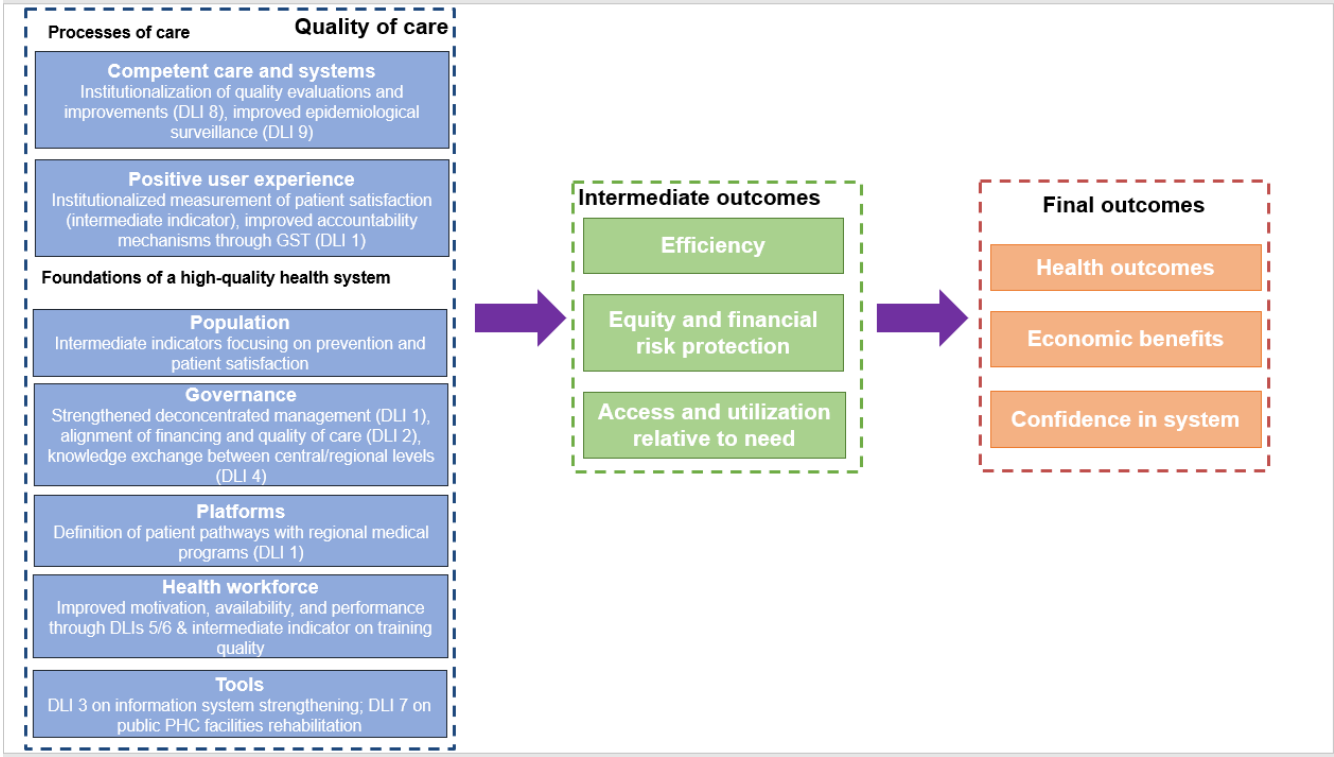
	• GST to have independent financing and managed by performance contracts with the MHSP **(DLI 2).** • Development of a health map defining distribution of treatments, and development of regional health maps by GST, including a comprehensive inventory of public and private sectors, with the GST having the responsibility to close gaps in health infrastructure **(DLI 1).**
Improved availability and competence of human resources for health (articles 17, 23-27)	• Establishment of a health service to define health worker entitlements and to improve the quality-of-service delivery **(DLI 5).** • Scaling up of health worker enrollment and graduation from the Higher Institutes of Nursing Professions and Health Techniques (*Institut Supérieur des Professions Infirmières et Techniques de Santé*, ISPITS) and other training institutions **(DLI 6).** • Update to the curricula for pre-service training and in-service training **(Intermediate Outcome indicator)** • Recruitment of foreign doctors. • Strengthening of pre-service and in-service training **(Intermediate Outcome indicator).**
Reorganized health service delivery (articles 2, 3, 5, 6, 8, 9, 10-14, 18-20, 30-31)	• Rehabilitation of primary healthcare facilities to improve their physical capacity and to comply with energy and thermal efficiency standards to address climate vulnerabilities **(DLI 7).** • Reorganization of care pathways to introduce gatekeeping (primary health care institutions for public sector; generalist or attending physician for the private sector) **(PDO indicator).** • Definition of quality standard and specifications, safety standards, clinical guidelines, and launch of accreditation to ensure continuous improvement of quality and safety of health services **(DLI 8).** • Reduction of inequalities and scale up investments in medical equipment, beds, facilities **(DLI 7).** • Strengthening health surveillance to reach WHO approved standards, and to respond to health threats in an integrated manner **(DLI 9).** • Informing population of health risks, behaviors, and measures, and precautions to be taken for its prevention, and ensuring access to preventive services **(Intermediate Outcome indicator).**
Strengthening pharmaceutical regulatory and production capacity (article 7) (outside Program scope)	• Promotion of the development of a local pharmaceutical industry and encouraging the development of generic medicines. • Determining safety and quality rules in the field of manufacturing and importing medicines, as well as their export, distribution, and delivery. • Encouraging scientific research. • Launch of two institutions (one on medicines and the other on blood products) to strengthen governance.

28. **Through three results areas, the Program incentivizes catalytic results to build the foundation for a health system which will continuously measure and improve quality of care and improve health outcomes, in line with international evidence.** The government's health system redesign program seeks to introduce a high-quality health system; one that "optimizes health in a given context by consistently delivering care that improves or maintains health outcomes, by being valued and trusted by all people, and responding to changing population needs."[41] As demonstrated in Figure 3, the Program design mirrors the pillars of the health system redesign

[41] Kruk, M.E., et al, 2018. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health 6, e1196–e1252. https://doi.org/10.1016/S2214-109X(18)30386-3

reform, with interventions that are specifically selected and defined to improve quality of care on the basis of country context and good international practices. A high-quality health system has three aspects, which are targeted by the redesign program: i) foundations of a high-quality health system, which include aspects pertaining to the population, governance, platforms; health workforce, and tools; ii) processes of care, which include competent care and systems and positive user experience; and iii) quality impacts, which include health outcomes, economic benefits, and confidence in system. [42] All these aspects are supported by the Program through DLIs and other indicators in the results framework.

Figure 3 Program activities within the context of a high-quality health system[43]



Result Area #1: Strengthened organizational and institutional capacity for health system governance

29. **Given the essential role of strengthened governance in improving the quality and availability of health services, the Program supports aspects of the health system redesign program which are going to be implemented in the next five years, as outlined in Framework Law 06-22 and Draft Law 08-22 as well as the PBT.** Strengthened governance at every level of the health system, or governing for quality, is a prerequisite for improved availability and quality of health services. Recent work points to the role of poor-quality care resulting in high mortality and morbidity, demonstrating that system-wide, "macro" reforms are more effective in

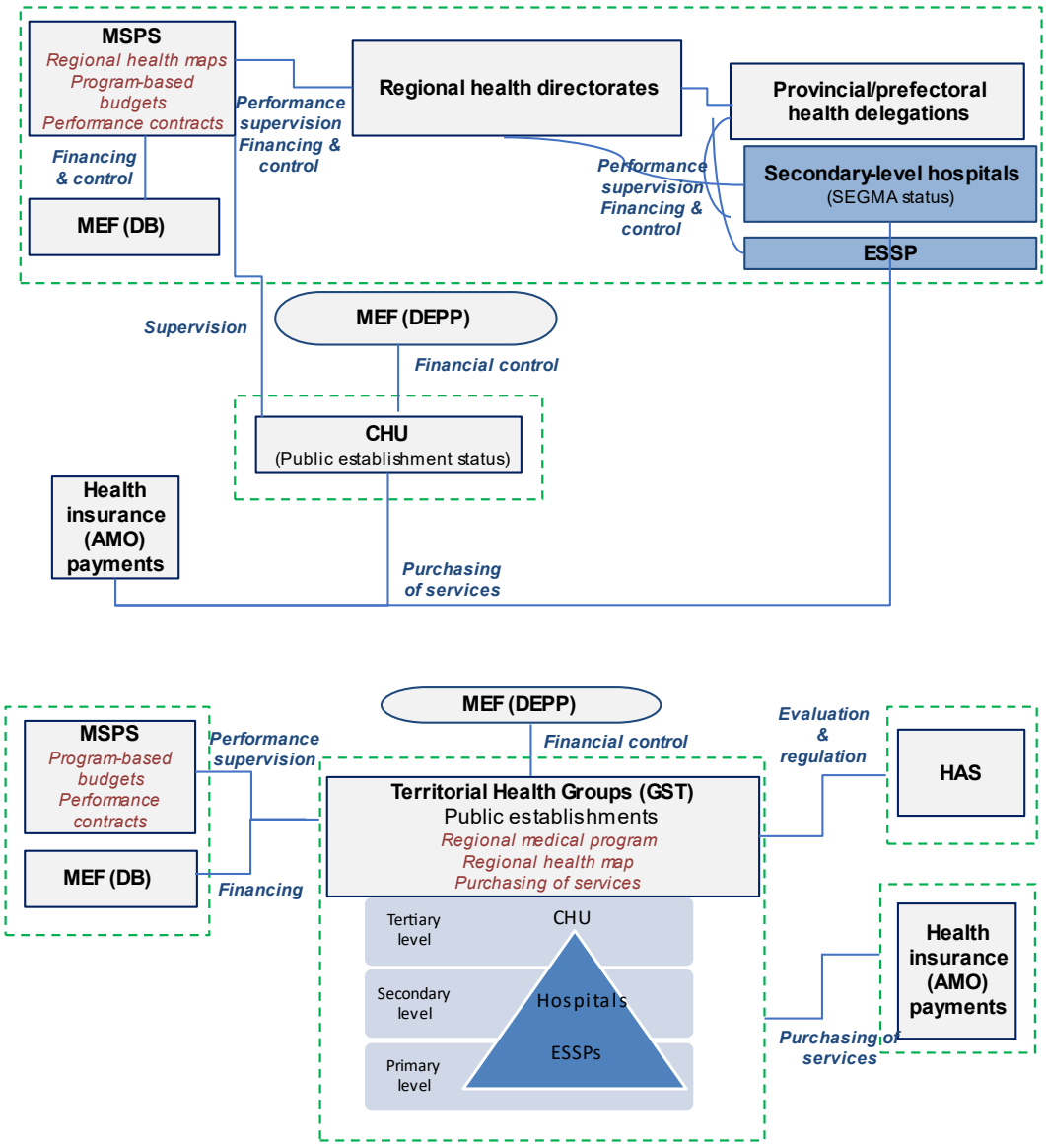
[42] ibid
[43] ibid

improving quality and averting deaths than “meso” or “micro” interventions. [44] Governing for quality includes several elements: (i) adopting and implementing a quality policy and strategy; (ii) improving capacity for management at all levels of the health system; (iii) strengthening regulation and accountability, and (iv) collecting and learning from health system data, all of which are reflected in the design of the first result area.

30. **The health system redesign program introduces a full reorganization of institutional roles and responsibilities in the health sector.** Figure 4 summarizes the anticipated changes as a part of the health system redesign program through the establishment of new institutions. The current governance structure results in limited autonomy, strategic planning and accountability at the regional, provincial, and facility levels, with minimal incentives or decision space to be able to take decisions to improve the availability or quality of health services. While the health sector has deconcentrated in recent years, this has taken place without substantial autonomy for deconcentrated entities. The supported reforms are expected to improve the enforceability and scope of performance-based management and decision-making space for regions, as they shift from being deconcentrated entities without autonomy, towards public establishments with increased managerial and financial autonomy. As such, these entities will be able to take decisions and implement interventions to improve availability and quality of services. Once established as financially autonomous structures, GSTs will receive funding mainly through the services they receive as AMO payments, as well as through direct transfers from the MHSP, which they will then allocate to the health facilities within their jurisdiction: this transition is expected to take place gradually, with the goal being full GST financing through AMO payments. Given the current limited use of planning and budgeting tools under the deconcentrated system, strengthened implementation of this modality with the introduction of GSTs as public establishments entails a substantial shift and will need to be accompanied with a proactive focus on trainings and capacity building, as well as the strengthening of control and accountability measures. The current legislative context indicates that all GSTs will be established at the same time, with the promulgation of Law 08-22, as well as relevant application decrees, by the end of 2023.

[44] Kruk, M.E., et al, 2018. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health 6, e1196–e1252. https://doi.org/10.1016/S2214-109X(18)30386-3

Figure 4 Governance of the health sector current (top) and post health system redesign (bottom)



Blue text: responsibility; red text: planning and accountability tools[45]

31. **The Program supports the establishment and implementation of key institutional functions and planning tools for GSTs, which will also strengthen climate resilience.** Strong implementation of 'deconcentration' has the potential to improve equity, efficiency, and resilience of the health system, developing a strong institutional framework for quality improvements, through three pathways: i) bringing governance closer to people and allowing for the use of local initiatives and local feedback mechanisms, as well as improving

[45] Compiled by authors based on the current legislative frameworks. ESSP: primary health centers; HAS: High Authority for Health; CNSS: National Social Security Fund. Secondary-level hospitals include proximity, provincial, regional, and inter-regional hospitals.

responsiveness particularly in areas with poorer health outcomes; ii) distributing people and resources to improve outcomes; and iii) institutionalizing mutual accountability and support between different levels of government and community.[46] In this context, a key tenet of the health system redesign program is to establish GSTs as autonomous public establishments governed by a Board of Directors and managed by a Director[47], combining the existing regional directorate and CHU structures. Based on Moroccan and international experiences, strengthened implementation of these arrangements takes a considerable period of time to be implemented successfully: as such, the Program supports the initial and essential building blocks for successful deployment of new institutional arrangements, with a focus on the two following domains:

(i) The establishment of functional internal governance mechanisms, including the Board of Directors, and the adoption of an organigram to delineate the territorial and institutional organization of GSTs. The Program will support the adoption of basic management tools such as the definition of a Board of Directors, an organogram, status of the personnel and internal regulations, which will enable the codification of roles and responsibilities. The procedure manual will include further details on fiduciary arrangements within the GST. These mechanisms will enable successful roll-out of 'deconcentration' as a first stage, and pave the way for increased autonomy at a second stage, which would include the adoption of additional management tools focusing on financial accountability, procurement, and program contracts between MHSP and GSTs. The publication of internal regulations will set the stage for strengthened FM and procurement capacity of GSTs.
(ii) The development of essential data and planning functions and tools at the regional level through two tools: the PMR and the regional health map, which will enable proactive planning and reallocation of health sector resources – financial, physical, and human – to respond more equitably and proactively to population demands and expectations, therefore providing a concrete pathway to quality-of-care improvements.

- The PMR would be determining the epidemiological profile of each region, and defining patient care pathways within the primary, secondary, and tertiary facilities of GSTs for each of the priority epidemiological conditions, including a focus on adapting and mitigating to climate change through focusing on climate-sensitive conditions and bringing health services closer to the population, mitigating gender inequalities, and strengthening care pathways for women and children survivors of violence. PMR would only cover public facilities within the GST.
- The regional health map would cover all public and private facilities within the GST, provide an inventory of healthcare services to respond appropriately to the needs of the population and serve as a unified planning tool for physical and human resources, with the intention of informing an equitable distribution of resources within a GST. The regional health map will provide a substantial lever for the reorganization of service delivery including for health conditions that will be exacerbated by the impact of climate change, enabling proactive deployment of financial, physical, and human resources. In particular, the regional health map will form the basis for the

[46] Abimbola, S., Baatiema, L., & Bigdeli, M. (2019). The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence. *Health policy and planning*, *34*(8), 605-617.
[47] The Board of Directors, which has a wide and diversified representation, will include among its essential missions the approval of the annual program, the regional health map, the organizational structure, the status of civil servants, and the group's internal regulations. The Board is expected to meet at least twice a year to take stock of achievements and set the provisional budget for the following year. The Director of the GST has, for his part, broad prerogatives, as manager of the group. It executes the decisions of the Board and prepares the projects submitted to it, including the group's annual workplan, the regional health map, the regional medical program, the group's annual program and its organizational chart. It ensures the management of all the structures of the group and the health establishments that compose it, as well as the coordination of their activities.

distribution of the health workforce within a GST, with the definition and implementation of incentive structures to enable the movement of staff to high-need areas, as described under the second result area.

32. **The Program will strengthen management capacity of deconcentrated entities through the development and deployment of a comprehensive training plan, fostering the health system's adaptation to climate change.** The role of strong managerial capacity across all levels of the health system is a key enabler to improvements in quality of care, with managerial training interventions proven to be substantially impactful across a wide range of contexts.[48,49] This is particularly important for the Moroccan context, given the substantial changes that will be introduced with the roll-out of the GST model across all governance functions, including strategic planning, policymaking and coordination, public financial management, communication, and performance management. In this context, the Program will support the development and implementation of a comprehensive training plan at the GST level. These trainings will be an opportunity to better understand gender gaps and include potential activities related to improved integration of gender in the budgeting as well as the importance of collecting and reporting gender disaggregated data. In a context of increased vulnerability to climate change and in line with government priorities, the training plan will include a substantial focus on improving the resilience of the health system to climate change, through enabling the development of specific interventions and their integration into PMR, supporting adaptation to the risks of climate change as trained GST staff will be able to integrate adaptation considerations into PMR, as well as strengthening preventive and curative care around health conditions exacerbated by the impact of climate change, such as cardiovascular and respiratory diseases. With deconcentrated governance and human resources management, GST administrators will oversee financial, physical, and human resource allocation, within their respective regions. The knowledge gained through the training on climate change impacts on health, in terms of both specific conditions exacerbated by climate change as well as adaptation measures, will allow GST administrators to make resource distribution and other decisions with the intent of addressing climate risks and vulnerabilities, strengthening the preparedness and resilience of the healthcare system, and more generally attending to the most vulnerable populations and most at risk in the face of climate shocks. The training program will also include a focus on preventing and responding to Gender-Based Violence (GBV), ensuring strong health system responsiveness to a national priority.

33. **The implementation of demand – and supply – side health sector reforms will require updates to current provider payment modalities, and the Program will support the transition towards a strategic purchasing system.** The implementation of the health system redesign program will entail a substantial shift in purchasing arrangements, with the GST unifying the totality of service delivery under a single entity and billing the institutions managing AMO (such as CNSS and CNOPS) collectively for services delivered at public facilities within its integrated network. Provider payment arrangements between the institutions managing AMO and GST, as well as from the GST to the individual facilities within the network, are yet to be defined. A range of options, such as capitation for public PHC facilities and diagnosis-related groupings for secondary and tertiary hospitals, are being considered. The Program will accompany the transition toward a system where GST budgets are fully financed from AMO payments, enabling financial sustainability and alignment of financial incentives for quality service delivery. The integration of the purchasing function has the potential to improve efficiency, through

[48] Bradley, E. H., Taylor, L. A., & Cuellar, C. J. (2015). Management matters: a leverage point for health systems strengthening in global health. *International Journal of Health Policy and Management*, 4(12), 411-415.;
[49] Lega, F., Prenestini, A., & Spurgeon, P. (2013). Is management essential to improving the performance and sustainability of health care systems and organizations? A systematic review and a roadmap for future studies. *Value in Health*, *16*(1), S46-S51

higher visibility by the purchaser on service utilization and productivity patterns and conditioning payments on a range of modalities. The Program will support the development of a roadmap for the progressive financing of GST by the AMO, including the interoperability of the billing system with the CNSS. It will also support the development of a roadmap for choosing provider payment methods for GST, which will enable a transition towards strategic purchasing, one of the key enablers of a high-quality health system. The roadmap would diagnose the current provider payment modalities, and propose a new modality to improve the quality, efficiency, and equity of payments from the institutions managing AMO to GST and from GST to health facilities, likely focusing on a range of methods such as capitation, fee-for-service, or global budgets. The roadmap would also include specifications on related implementation modalities, and how the proposed payment modality would ensure improved quality of care as well as health facility productivity.

34. **The Program will support the third and final phase of the government's roll-out of an integrated, digitalized health management information system at public PHC facilities in Program Area.** The deployment of integrated patient-level electronic medical records is the prerequisite to enabling coordination between providers, improving the availability of health sector data, and transitioning towards a learning health system.[50] Over the past decade, Morocco has made substantial progress, first having developed a detailed strategy and rolled out facility-level information systems at hospitals, and second, having phased this in public PHC facilities in selected regions while launching integrated patient-level electronic medical records at the hospital level. The Program supports the third and final phase through the finalization of the deployment of integrated patient-level electronic medical records in the remaining GSTs in Program Area; and publication of an annual health sector report including data on effective coverage indicators and other quality metrics, disaggregated by GST and gender, at most a year after the generation of the data. The government has allocated the required budget for the implementation of this initiative and started the procurement processes, ensuring sustainable implementation of the integrated health information system. The information system would include detailed patient-level information on demographics, conditions, and treatments, with coding mechanisms developed to bill the CNSS and with interoperability across providers and payers. The rollout of facility-based health information systems and gender disaggregated data collection will allow to capture gender gaps and regional disparities in health service delivery and facilitate decision making at lower levels. Through dematerialization of data, the integrated health information system will contribute to climate change mitigation by reducing the carbon footprint associated with paper health registers. The integrated health information system would also serve as a mechanism to improve data availability during climate shocks, through both remote access to data as well as by preventing possible loss of paper health registers during floods or wildfires and would enable timely publication of an annual health sector report including actionable information on climate exacerbated conditions and diseases. As 60 percent of the disease burden in Morocco is attributable to conditions that are set to be impacted by climate change[51], the deployment of a patient-level medical records system will enable the health system to adapt to the conditions that are caused by climate change, through enabling evidence-based planning across regions and seasons.

35. **Supporting a transition towards a learning health system, the Program incentivizes the institutionalization of an information and policy exchange and coordination platform between all stakeholders in the health sector, and supports routine data collection on patient satisfaction indicators.** The health system

[50] Kruk et al (2018).
[51] IHME Global Burden of Disease data, 2019. This includes nutritional deficiencies (1%); chronic respiratory diseases (3%); relevant cancers (8%); neglected tropical diseases and malaria (0.25%); sense organ diseases and other non-communicable diseases (10%); skin diseases (1%); respiratory infections and tuberculosis (4%); cardiovascular diseases (26%); and diabetes and kidney diseases (6%).

redesign program touches every health system function and involves every stakeholder in the system, and is being implemented in the context of low rates of patient satisfaction with the health system. This demonstrates the substantial need to organize both horizontal and vertical information sharing platforms, which are associated with improvements in health sector quality through increased accountability and a transition towards a learning health system.[52] The Program will support the development of a digitalized information exchange and coordination platform for information sharing and learning between central and regional entities. The new platform, which will be in the format of a discussion forum, will institutionalize such information sharing, and enable constant exchange and coordination between stakeholders at the MHSP, HAS, Moroccan Agency for Medicines, all the GSTs which will be established, as well as health facilities. The exchange will therefore strengthen feedback loops between facilities, GSTs, and the central government. Implementation of this platform will complement the integrated patient-level electronic medical records system and the *Chikaya.ma* citizen engagement and grievance management system. Enabling a platform between health system decision-makers will help in acknowledging and addressing health system challenges faced by citizens. At the same time, given the substantial changes expected with the health system redesign program, it is essential to track feedback from patients, particularly given the absence of an institutionalized modality to regularly track aggregate levels of patient feedback. MHSP is planning to design and implement annual rounds of patient satisfaction surveys both centrally and through the GST, through a range of rapid survey methods. The Program will support these activities which seek to institutionalize a learning health system across all levels.

36. **This result area is supported by four DLIs and two intermediate results indicators.** The Program supports the achievement of results pertaining to each of the dimensions of this approach, and will enable a transition towards governing for quality, through supporting the achievement of the following results: DLI 1 (US$75 million, also a PDO indicator), strengthened institutional capacity through the new deconcentrated governance system; DLI 2 (US$28.875[53] million), health financing system reformed to reflect the context of the reform and improve quality of service delivery; DLI 3 (US$37.5 million), improved content, quality, accessibility and utilization of health data; and DLI 4 (US$30 million, also an intermediate result indicator), exchange and coordination platforms organized between central and regional entities. An additional intermediate result indicator will measure the improvement in patient satisfaction.

Result Area #2: Improved availability, motivation and competence of human resources for health

37. **To rectify the challenges in the availability, distribution, and performance of the health workforce in Morocco, the health system redesign program seeks to improve the availability, motivation and quality of the health workforce.** Framework Law 06-22 and Draft Law 09-22 seek to improve the availability, motivation, and performance of the health workforce through five actions: (i) improving the availability of the health workforce, through improved training capacity ; (ii) tasking GST with recruiting and managing the performance of the health workforce in their respective catchment areas; (iii) improving the compensation of the human resources working in the health sector by establishing the health service to define health worker entitlements and to improve the quality of service delivery; (iv) improving the distribution of the health workforce through the operationalization of the human resources for health information system to allow for up-to-date data; and (v) strengthening the quality of pre- and in-service training for health workers at both training institutions and regional levels.

[52] Witter, S., Sheikh, K., Schleiff, M., 2022. Learning health systems in low-income and middle-income countries: exploring evidence and expert insights. BMJ Glob Health 7, e008115. *https://doi.org/10.1136/bmjgh-2021-008115*

[53] Front-end fee of 0.25 percent of total amount has been subtracted from DLR 2.1 (originally US$7,500,000; new amount US$6,375,000) under this DLI.

38. **The Program will improve the quality of health services through incentivizing the design and implementation of a new financial incentive structure and improving the distribution of the health workforce.** Draft Law 09-22 has been adopted by the council of government in December 2022, and by the parliament on April 26, 2023, building on the decree 2.22.682 to change the salary structure of the health workforce and introduce a variable component in the compensation based on performance including on quality. The incentive model will outline the adaptation of the payment model, through the introduction of differing coefficients of medical procedures within regions, and through mechanisms to measure performance of health workers and teams through a focus on both productivity and quality. The financial incentive structure will be implemented in addition to the base salary of health workers, and the payment would come from the AMO payments received by the GST, within a range considering the health and economic context of the region. This structure will be codified through one of the implementation decrees of the Draft Law 09-22. Through introducing a financial incentive to improve performance, which can incentivize reduced absenteeism or increased adherence to clinical guidelines, the Program will support improvements in provider motivation, helping close the know/do gap and strengthen quality of care. Considering the higher representation of women in the health sector, the Program will also support the definition of performance criteria through a gender lens, ensuring that they take gender equality into account, benefiting labor perspectives and conditions for women especially as they move to harder-to-reach areas. Given the role of GST in managing the health workforce within a region, performance payments will also be used for ensuring mobility within a GST, through incentivizing health workers to provide services not only in urban areas but also in underserved rural areas within a particular region. Particular attention will be given to preventing over-treatment and unnecessary care which could be unintended consequences of fee for service or volume-based incentives, through the integration of quality of health care delivery in the definition of the human resources incentive model. Financial incentives have the potential to improve quality and motivation, if they incorporate metrics based on context. These incentives can also be leveraged for improving healthcare worker retention in rural and remote areas.[54] International experience demonstrates that performance defined as productivity or volume of services, without accounting for quality, can result in overprovision of certain services: unless payment systems at both individual and facility levels are carefully calibrated, there is a high risk of unnecessary and potentially harmful use of drugs, diagnostics, and interventions.[55] The World Bank will seek opportunities to mobilize technical assistance to support the collation of relevant global experience as well as the development of policy options for the development of this payment modality.

39. **The Program supports the establishment of building blocks for the deployment of health workforce to reduce regional inequalities.** The finalization of the human resources health information system and its deployment by all GSTs will allow for instant tracking of filled/vacant positions and continuous monitoring of human resources gaps and needs. This administrative reform, combined with the human resources incentive model, would contribute to a better availability of human resources, particularly in the provinces and municipalities that are currently under-resourced in terms of doctors, nurses, and technical health staff, therefore improving quality of care, particularly in rural areas, including the ones most vulnerable to climate change risks. Leveraging information from the climate health vulnerability assessment to identify climate vulnerable facilities, the human resources for health information system will help anticipate needs in the most underserved facilities and those most vulnerable to climate change, and therefore address shortage through

[54] World Health Organization. (2021). *WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas*. World Health Organization. *https://www.ncbi.nlm.nih.gov/books/NBK570763/pdf/Bookshelf_NBK570763.pdf*

[55] Josephson, E., Gergen, J., Coe, M., Ski, S., Madhavan, S., Bauhoff, S., 2017. How do performance-based financing programmes measure quality of care? A descriptive analysis of 68 quality checklists from 28 low- and middle-income countries. Health Policy and Planning 32, 1120–1126. *https://doi.org/10.1093/heapol/czx053*

improved distribution adapted to the increased demand. Once GSTs have operationalized the human resources health information system and implemented the human resources incentive model, they would be able to increase the percentage of vacancies filled in provinces and communes with current insufficient health workforce.

40. **Improving the availability of human resources for health and the quality of the health system is not possible without increased training capacity and quality, which is supported by this Program.** To rectify the low levels and inequitable distribution of the health workforce, the MHSP, the MEF and the Ministry of Higher Education and the Scientific Research and Innovation have signed a framework agreement to increase the training of health professionals, improve the availability of specialized training programs, and improve the quality of training content by 2030. With an objective of having a workforce of 177,000 health professionals by 2030, the MHSP has developed an action plan to train 64,000 nurses and health technicians. In this context, the Program will support improved training capacity for nurses and health technicians at the ISPITS. In addition to improved training capacity, the Program will support the improved quality of the pre-service and in-service training curricula for nurses and health technicians, both in terms of the introduction of new specialties as well as ensuring alignment with the current epidemiological context and the health system redesign program. Together with financial incentives, these updates to training curricula will ensure improved relevance and quality of the health workforce.

41. **This result area is supported by two DLIs and an intermediate results indicator.** DLI 5 supports the operationalization of the health service to define health worker entitlements and to improve the quality of service delivery, specifically through an increased share of GSTs in Program Area that have increased and equitably distributed their human resource capacity (US$45 million). DLI 6 supports increased training capacity in ISPITS (US$45 million, also an intermediate results indicator). An additional intermediate results indicator measures updates to training curricula for nurses and technical staff at both central (pre-service training) and regional (in-service training) levels.

Result Area #3: Strengthened and reorganized health services

42. **This result area of the Program supports the third pillar of the health system redesign program, upgrading health infrastructure and reorganizing health service delivery.** A substantial reorganization of the health service delivery system is going to be implemented to (i) rectify the insufficient physical resource capacity; (ii) improve spatial and gender equity in health outcomes; (iii) address climate vulnerabilities of health infrastructure; and (iv) improve the quality of health services. Framework Law 06-22 and Draft Law 08-22 address this through several components, including the reorganization of care pathways to introduce gatekeeping (primary health care institutions for public sector, generalist or attending physician for the private sector); institutionalizing of quality evaluation and improvement modalities; and the rehabilitation and upgrading of public primary health facilities and public hospitals to improve their structural quality.

43. **This result area supports the reorganization of service delivery to improve quality of care through strengthening referral systems, strengthening climate resilience, institutionalizing quality improvements, and enabling timely action to current and emerging health risks.** The Program specifically supports the achievement of results related to (i) rehabilitation of public PHC facilities to comply with energy and thermal efficiency standards and address climate vulnerabilities; (ii) development and implementation of recommendations by the GST on improving quality of care at hospitals and public PHC facilities; (iii) strengthened epidemiological

surveillance capacity including for climate change related health issues; (iv) scale-up of the maternal and neonatal death surveillance, audit, and response system; (v) strengthening of treatment for women and children survivors of GBV; and (vi) the implementation of priority prevention strategies including for congenital hypothyroidism screening.

44. **Rehabilitation of public PHC facilities is a crucial enabler of service delivery reorganization and climate change adaptation.** A key aspect of the GST reform is the establishment of integrated care networks within each region, with public PHC facilities serving a gatekeeper role such that patients can only access higher level facilities with a referral from them, with the exceptions of emergency care and specialized care such as gynecology. Bringing services closer to the beneficiaries represents an opportunity to narrow the gap in access to health services between urban and rural women as well as between male and female-headed households. Public PHC facility rehabilitation, among other things, includes easy physical accessibility, especially for people with reduced mobility and special needs. Public PHC facilities' rehabilitation is a key lever of climate change adaptation through improving service delivery for the most vulnerable populations, including those living in rural and hard to reach areas and in areas most vulnerable to climate change. Strengthened health service delivery in these areas will further improve the emergency preparedness and responsiveness of the health system against climate-induced hazards and the increased disease burden, as public PHC facilities form a key aspect of health sector response against health conditions that are to be exacerbated by climate change. Currently, many public PHC facilities lack the basic medical equipment and sufficient infrastructure to respond to patient needs. Further, there are various constraints at the PHC level regarding the implementation of national guidelines on health security for medical and pharmaceutical waste management, which poses an environmental concern.[56] At the same time, in line with government guidelines, there is a substantial need to reinforce the climate resilience and energy efficiency of all public infrastructure, including public PHC facilities. The rehabilitations, which include minor civil works together with the purchase of corresponding medical equipment, will be conducted according to specifications agreed upon with the contractors, in accordance with the guide of the National Agency for Public Equipment, (*Agence Nationale des Equipements Publics,* ANEP) on energy efficiency of public equipment and the guide for sustainable construction, as well as government guidelines to address identified climate vulnerabilities and implement both adaptation and mitigation measures. This includes strengthening thermal regulations in buildings aligned with national standards (*Règlementation Thermique de Construction du Maroc*, RTCM) adopted in 2014 to rationalize the energy consumption of buildings, by setting thermal requirements and energy performance. Rehabilitations will target facilities that will bring services closer to climate vulnerable populations, provide workarounds around climatic patterns, maximization of natural ventilation and minimization of heat exposure, especially during hot periods. In terms of mitigation against climate change, rehabilitations will also focus on thermal and energy efficiency regulations, thermal insulation, choice of construction products, materials and technical equipment with low energy consumption (e.g., heating and cooling equipment, smart Light Emitting Diode (LED) light fixtures, energy efficient sanitary appliances, biomedical equipment) as well as introduction of renewable energy solutions with solar hot water. All climate adaptation and mitigation measures are expected to go beyond business as usual and are explicitly designed with the intent to address assessed climate risks on health of the population.

45. **Institutionalized quality evaluations at the GST level will improve the responsiveness of the health system.** While the HAS will have the role of defining accreditation guidelines with a focus on quality of care, each of the GST have the role of continuous quality of care evaluations as well as supervising and supporting the

[56] Sécurité Sanitaire des Établissements de Soins de Santé Primaires, Guide du Professionnel, 2021

development and implementation of quality improvement strategies for health facilities, within the scope of the PMR. Strengthened 'deconcentration' provides an opportunity to define and implement quality improvements, given the fact that authorities and providers who are closest to the public will be trained to act on challenges and respond to population expectations. Recent research highlights the inclusion of district-level initiatives, such as quality improvement collaboratives, in any comprehensive strategy to sustainably improve service quality, through setting up a platform for learning on processes.[57,58] The MHSP has already been delivering on its responsibility of technical planning to improve quality of care, through the quality competition (*concours qualité*) which it has been organizing. The competition has had seven rounds between 2007-2018 and ranks participating health centers and hospitals across domains of accessibility, security, satisfaction, ethics, rational resource use, improvements, technical competency, leadership, and community engagement (only for public PHC facilities). At the same time, the MHSP has developed quality standards for hospitals and has started to implement them. These comprehensive guidelines assess the management, information systems, quality evaluation, patient records, organization of delivery, structural quality, hygiene and security, infrastructure, and external services of hospitals. Leveraging this groundwork, the MHSP will develop quality evaluation tools for primary health care facilities. Through the establishment of a quality assessment structure at the GST level, GST will oversee quality evaluation and improvement at hospitals and primary health care facilities, ultimately leading to the development and implementation of quality improvement action plans for hospitals and primary health care facilities according to adopted quality evaluation and improvement roadmaps.

46. **The strengthening of epidemiological surveillance capacity based on the priority areas will include a deliberate focus on climate change related health issues.** The epidemiological surveillance system in Morocco includes both passive surveillance involving routine data collection on notifiable diseases from health facilities and laboratories, and active surveillance involving targeted data collection for specific diseases or outbreaks. The surveillance system aims to detect and respond to disease outbreaks in a timely manner to prevent their spread and protect public health[59], and is based on several key principles, including timely detection, rapid response, and the use of reliable and standardized surveillance methods. The system monitors a range of infectious and non-infectious diseases, including respiratory infections, diarrheal diseases, vaccine-preventable diseases, and sexually transmitted infections. To strengthen the disease surveillance system and ensure improved disease control and management, the MHSP, through the Directorate of Epidemiology and Disease Control (Direction de l'Epidémiologie et la Lutte Contre les Maladies, DELM), has signed performance contracts with the DRS focusing on epidemiological surveillance, monitoring and health safety, prevention and disease control, for a humanized, secure and quality care for the citizen. The performance budget program 703 aims at supporting the deconcentrated services to achieve performance objectives for better disease control and management, notably through a better match between regional needs and centrally available resources available, management based on accountability and responsibility, and improved resources and management tools.[60] A study was recently conducted to assess epidemiological surveillance capabilities and the Program will ensure the DELM has defined,

[57] Rowe, A. K., Rowe, S. Y., Peters, D. H., Holloway, K. A., Chalker, J., & Ross-Degnan, D. (2018). Effectiveness of strategies to improve health-care provider practices in low-income and middle-income countries: A systematic review. *The Lancet Global Health*, *6*(11), e1163–e1175. https://doi.org/10.1016/S2214-109X(18)30398-X

[58] Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., Doubova, S. V., English, M., García-Elorrio, E., Guanais, F., Gureje, O., Hirschhorn, L. R., Jiang, L., Kelley, E., Lemango, E. T., Liljestrand, J., … Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: Time for a revolution. *The Lancet Global Health*, *6*(11), e1196–e1252. https://doi.org/10.1016/S2214-109X(18)30386-3

[59] Ministry of Health, Epidemiology and Disease Control Directorate (2019). Strategic Plan for Surveillance of Communicable Diseases and Pandemics. http://www.sante.gov.ma/Publications/Plans_strategiques/PSSRMEP-2019-2023.pdf

[60] Performance Contract between the Epidemiology and Disease Control Directorate and Regional Health Directorate of Rabat-Sale-Kenitra. December 2021.

adopted and validated a roadmap for the restructuring of epidemiological surveillance capacity based on the priority areas highlighted by the study results, focusing on regulations, revision of epidemiological standards, laboratories, digitalization and training. As climate change continues to be a threat to the health of the population in an already climate vulnerable country, especially for the most vulnerable populations including children and the elderly, the Program will ensure epidemiological surveillance addresses adaptation to climate change, and will support the inclusion of climate change related emerging and re-emerging diseases to the list of notifiable diseases, such as asthma crisis due to air pollution, vector- and water-borne conditions like malaria or diarrhea, and NCDs notably strokes, cardiac and respiratory conditions. This focus on climate change related health issues on the epidemiological surveillance will facilitate access to data on climate-change induced health impacts, which can ultimately be used for targeted assistance programs during climate-related emergencies.

47. **Scaling-up maternal and neonatal death surveillance, audit, and response system will be of critical importance to reduce regional disparities and improve maternal and neonatal health outcomes**. Despite recent declines, Morocco still has a high maternal mortality rate, especially in rural areas. As part of the 2008-2012 action plan for the reduction of maternal mortality, the MHSP established the first Maternal Mortality Surveillance System (MMSS) in 2009, with the objective of monitoring and reducing maternal deaths in the country. The MMSS, coordinated by the DELM, is a component of the health information system and aims to provide reliable and timely data on maternal deaths, identify the causes of these deaths, and monitor trends over time. The system collects information on maternal deaths from multiple sources, including hospitals, health centers, and community health workers. It uses a standardized maternal death notification form to capture data on the demographic characteristics of the deceased woman, the circumstances surrounding her death, and any contributing factors. The form also includes questions to help determine the cause of death and identify opportunities for prevention. Data collected through the MMSS is analyzed at the regional and central levels to identify patterns and trends in maternal mortality. The findings are used to inform policies and programs aimed at reducing maternal deaths and improving the quality of maternal health care in Morocco, as well as develop targeted interventions to improve the quality of care for newborns, which range from improving skills of health workers in neonatal care, strengthening referral systems, and providing equipment and supplies to health facilities. The MMSS has provided a basis for conducting surveys and monitoring maternal mortality and its causes; a survey on maternal deaths and causes was conducted in 2015 and, as part of the survey's recommendations, the maternal death surveillance, neonatal death audit and response system (SSDMAR) was developed to identify the reasons behind maternal and neonatal deaths. The SSDMAR is currently allowing for surveillance of maternal mortality in 7 regions. The Program will support the SSDMAR scale-up in Program area by 2026, as well as the integration of neonatal death audit into the existing system. On this basis, the Program will also support the production of complete maternal and neonatal death audit reports by GST through an intermediate results indicator.

48. **Health prevention and promotion are crucial for the success of the health system redesign program, and the PforR focuses on strengthening prevention capacity for priority conditions.** The MHSP is currently implementing a strategy for congenital hypothyroidism (CH), screening. The CH is a national priority condition as hypothyroidism is the most common endocrinopathy in Morocco, after diabetes, with a prevalence of 1 per 1,950 live births.[61] The CH is a serious disease with complicated consequences not only on the health of the individual but also by the social support of the handicap that it generates.[62] In the absence of early diagnosis and rapid

[61] A pilot study on congenital hypothyroidism conducted in Fes between 2001 and 2003, involving a sample of 15,000 newborns, showed a frequency of one case of congenital hypothyroidism per 1952 births. Dépistage Néonatal de l'Hypothyroïdie Congénitale
[62] Dépistage Néonatal de l'Hypothyroïdie Congénitale, Guide à l'usage des professionnels de santé, 2016

treatment, newborns are exposed to mental and growth disabilities, but the condition remains preventable with timely diagnosis. As clinical signs are often invisible at birth, systematic and generalized neonatal screening for all newborns will allow early CH diagnosis and the provision of child adapted therapy. Early diagnosis and treatment will allow to avoid certain secondary handicaps due to late diagnosis and the absence of early treatment. The introduction of CH neonatal screening in the health care system as part of the MHSP 2012-2016 action plan resulted in the creation of specialized diagnosis centers for CH in five regions in Morocco, and the adoption of a specific pathway for the diagnosis and therapeutic management of confirmed cases. The Program will support the implementation monitoring and scale-up of CH neonatal screening through an intermediate results indicator.

49. **The reform will enhance the health sector's focus on gender equity, including prevention and response to GBV, as well as violence against children.** According to the 2019 National Survey on Violence against Women and Men, carried by the Higher Planning Commission in Morocco (Haut Commissariat au Plan, HCP), out of a population of 13.4 million women and girls aged 15-74, more than 8 out of 10 have experienced at least one form of violence in their lives (82.6 percent). In the 12 months preceding the survey, more than 7.6 million women aged 15 to 74 years old, or 57.1 percent, experienced an act of violence, this prevalence being the highest among girls and women under 50 years of age, for young people aged 15-19 (70.7 percent) and 20-24 (65.8 percent). With a prevalence of 46.1 percent (5.3 million women), the marital context remains the most marked by violence in both urban and rural settings. The educational environment ranks second, where 22.4 percent (20.7 percent in urban areas and 31.2 percent in rural areas) of students have experienced violence.[63] The prevalence of economic and sexual violence has increased sharply between 2009 and 2019, with economic violence increasing from 8 to 15 percent and sexual violence from 9 percent to 14 percent. GBV remains significantly underreported in Morocco (and globally) due to a host of overlapping factors (for example, stigma, social and gender norms, lack of knowledge and/or access to services). Training and curriculum content on GBV care for the frontline health workforce can ensure that current and future generations of the health workforce are equipped to provide empathic, high-quality care to those subjected to or affected by violence. Public authorities have adopted several consecutive strategies, programs and plans to combat violence against women and girls over the past two decades. Law No. 103-13 on combating violence against women became effective in 2018. Response to violence against women and children is among the top policy priorities of the MHSP, as reflected by the 2017-2021 strategic action plan for the health program for the care of women and children victims of violence. Through 'deconcentration', the Program aims to expand the reach of the program, notably by increasing the number of women and children survivors of GBV treated in integrated units for women and children survivors of violence in public health facilities (currently 113 at hospital level). To ensure greater understanding and quality care for women and children survivors of GBV, the Program will also support integration of GBV in both in-service and pre-service training, through training of trainers to improve service providers' ability to identify, refer and care for women and children survivors of GBV, as well as through the integration of a human rights and gender component, including GBV, in the ISPITS pre-service training.

50. **This result area is supported by three DLIs and three intermediate result indicators.** DLI 7 (US$75 million) supports the rehabilitation of 395 public PHC facilities to comply with energy and thermal efficiency standards green building criteria to address climate vulnerabilities. DLI 8 (US$45 million, also a PDO indicator) incentivizes the evaluation and improvement of quality of care at public hospitals and public PHC facilities in Program Area. DLI 9 (US$67.5 million, also an intermediate result indicator) supports the strengthening of

[63] Rapport sur les violences faites aux femmes et aux filles. Enquête Nationale sur la Violence à l'encontre des Femmes et des Hommes, HCP, 2019

epidemiological surveillance capacity including for climate change related health issues. An intermediate results indicator supports the scaling up of the maternal and neonatal death surveillance, audit, and response system; and a second one supports the strengthening of the governance and organization of preventive health services for screening of CH. Another intermediate results indicator will capture the percentage of pregnant women in Program Area who have completed four antenatal care visits.

D. Program Development Objective(s) (PDO) and PDO Level Results Indicators

51. **The PDO is to strengthen the Borrower's institutional capacity and governance for improved provision of quality public health services in the Program Area.** The PDO will be achieved by supporting the implementation of the first three pillars of the government health system redesign program, through a combination of system and policy strengthening interventions focusing on governance, human resources for health, and service delivery. Table 3 demonstrates the PDO-level results indicators.

Table 3 PDO-level results indicators

PDO-Level Results Indicators	Strengthened institutional capacity and governance	Improved provision of public health services	Improved quality of public health services
Strengthened institutional capacity through the new deconcentrated governance system (DLI 1)	x		
Health service operationalized to define health worker entitlements and to improve the quality of service delivery (DLI 5)	x	x	x
Quality of care at public hospitals and public PHC facilities evaluated and improved (DLI 8)		x	x
Availability of essential health service package at public PHC facilities[64]		x	

E. Disbursement Linked Indicators and Verification Protocols

52. **Nine disbursement-linked indicators are included based on their relevance.** The DLIs set actionable

[64] This indicator captures the improvements to service delivery capacity at the primary care level: through the introduction of a gatekeeping modality, ESSP will be the first point of contact between the population and the health system.

targets for the achievement of results within the first five years of the health system redesign program implementation, and address all functions of the health system, as does the government's health system redesign program. The achievement of DLIs will be verified by the General Inspection (Inspection Générale, IG) of MHSP with technical expertise before disbursement of funds and will be tracked through measuring achievement against Disbursement-Linked Results (DLRs), each of which will be independently verified prior to disbursements being made against each DLR. The verification protocols for DLIs/DLRs are described in detail in Annex 2, and will be finalized in the POM.

53. **Across the three result areas, complementary DLIs ensure strengthened institutional capacity and governance to enable improvements in quality of care (Table 4).** One of the main objectives of the health system redesign program is to improve quality of care through a focus on each of the components of a high-quality health system. In the first result area, DLI 1 and 2 target the governance and platforms components, both of which form the foundations of a high-quality health system, through enabling improved measurement, responsiveness, and decision-making to improve quality of care at all levels of the health system. DLI 4 enables improvements to positive user experience, one of the key dimensions of processes of care. Under the second result area, DLI 5 seeks to motivate the health workforce to improve the know-do gap as well as improve the distribution of qualified health workforce. Under the third result area, DLI 8 institutionalizes quality evaluation mechanisms at health facilities and GST, enabling an improvement of competent care and systems, a key tenet of high-quality processes of care.

Table 4 Disbursement-linked indicators, allocation, and justification*

Result area	Disbursement-linked indicators and allocation	Justification for DLI selection
Result area 1: Strengthened organizational and institutional capacity for health system governance	**DLI 1:** Strengthened institutional capacity through the new deconcentrated governance system (US$75 million)	• Health system redesign program entails a substantial shift towards a deconcentrated governance model, with the introduction of management, planning, and budgeting tools for GST to fulfill their responsibilities. • This DLI incentivizes the development of key management inputs, such as Board of Directors, organogram, status of personnel, and internal regulations as well as key planning tools, such as the regional medical program and the health map. Evidence from other sectors demonstrates challenges in institutionalizing 'deconcentration' arrangements, and the DLI will incentivize accelerated implementation. • The deconcentration's governance also implies a substantial need to strengthen the capacity of personnel working in GST, and this DLI also incentivizes the development and implementation of a comprehensive training program for relevant staff in GST. • Training, as well as the establishment of the deconcentrated system, will enable a focus on planning and implementing interventions within GST to adapt to the health impacts of climate change, including the eight climate-exacerbated condition and adaptation measures. GST will be able to respond to changing

		population disease burden needs faster with increased autonomy, enabling rapid allocation of financial, physical, and human resources to adapt to the increased disease burden due to climate hazards. These interventions address system-wide binding constraints for improved responsiveness to the health impact of climate change at deconcentrated levels, which is especially important given the differential impact of climate change. • It is estimated that about two-thirds of resources allocated to this DLI will directly contribute to improved responsiveness for preventive and curative care of climate-exacerbated conditions, through the establishment of GST as well as the training of administrative personnel.
	DLI 2: Health financing system reformed to reflect the context of the reform and improve quality of service delivery (US$28.875 million)[65]	• Provider payment modalities will shift drastically, with additional responsibilities to GST to purchase services from the integrated network of health facilities within their jurisdiction, as well as bill AMO management entities for delivered services, including for climate induced health conditions.[66] • This DLI incentivizes the finalization of a roadmap to define provider payment modalities within GSTs and includes targets on the share of hospital financing that would be coming through AMO financing as a metric for improved financial sustainability.
	DLI 3: Improved content, quality, accessibility and use of health data (US$37.5 million) [67]	• The government is in the process of deploying an integrated digital health information system at all health facilities, with deployment at public PHC facilities being the only remaining phase. • This DLI incentivizes the finalization of the deployment of integrated health information systems, as well as timely use of data, through targets on the finalization of an annual health sector report including quality of care indicators (e.g., effective coverage) becoming available a year after the availability of data. • The integrated health information system is also a mechanism to improve data availability during climate shocks and decrease carbon footprint through minimizing paper-based health registers and paper waste. Improved availability of data will ensure enhanced responsiveness to climate-induced conditions and enable the targeting of climate vulnerable populations through enabling evidence-based planning, and the timely publication of an annual health sector report will provide timely information on climate exacerbated conditions and diseases. • Given the share of the disease burden that is set to be impacted

[65] Front-end fee of 0.25 percent of total amount has been subtracted from DLR 2.1 (originally US$7,500,000; new amount US$6,375,000) under this DLI.
[66] *https://www.healthdata.org/morocco*. Climate-linked conditions that currently cause the largest deaths and are expected to become worse include ischemic heart disease, strokes, hypertensive heart disease, chronic kidney disease, diabetes, lower respiratory infections, COPD, and lung cancer.
[67] It is estimated that 60 percent of the resources allocated to this DLI will enable the government to adapt to climate change.

		by climate change, it is estimated that 60 percent of the resources allocated to this DLI will enable the government to adapt to climate change[68], given the fact that the improved content and quality of the health information system will enhance responsiveness to these conditions.
	DLI 4: Exchange and coordination platforms between central and regional entities organized (US$30 million)[69]	• Given the substantial nature of changes and the increase in the number of stakeholders with the health sector reform, it is essential to institutionalize knowledge exchange and coordination platforms to improve the responsiveness of the health system. • This DLI incentivizes the implementation of a systematic platform to facilitate these exchanges, which will provide a crucial platform for change management, citizen engagement, and a modality to institutionalize learning. The exchanges would focus on the experience of implementing different aspects of the regional medical program, including experiences on improved health system responsiveness to climate induced health conditions.
Result area 2: Improved availability, motivation and competence of human resources for health	**DLI 5:** Health service operationalized to define health worker entitlements and to improve the quality of service delivery (US$45 million)[70]	• Human resources for health are inequitably distributed across the regions and provinces, with some areas being critically under-resourced; there are no financial incentives for health workers to enable deployment to hard-to-reach areas or to improve their performance. The operationalization of the health service, through the design of a new payment modality, will allow to improve the motivation and distribution of the health workforce, encouraging deployment in under-resourced regions and provinces through a system of coefficients of medical procedures by regions, including incorporating conditions of distributions of the labor force through a gender lens. • The DLI will incentivize the integration of well-defined measures on quality and performance into the payment of health workers, with the intention of motivating health workers to close the know/do gap and to work in hard-to-reach areas, including areas most vulnerable to climate change, leveraging information from the climate health vulnerability assessment to identify climate vulnerable facilities. This will also ensure bringing services closer to the population, with increased availability of health services at the regional level, therefore resulting in a lower carbon footprint for the health sector through reduced mobility to seek health services.
	DLI 6: Improved training capacity in ISPITS (US$45	• The government estimates a need for an additional 32,000 doctors and 65,000 nurses. Improving the availability of human

[68] IHME Global Burden of Disease data, 2019.
[69] In alignment with the disease burden and the scope of regional medical programs that would be a part of the platform, it is estimated that 30% of this DLI contributes to enabling adaptation to climate change.
[70] Through the pathway on bringing services closer to the population, as a share of staff that can be reallocated within a region, it is estimated that about 30% of this DLI contributes to enabling adaptation to climate change.

	million) [71]	resources for health and in turn the quality of health service delivery is not possible without increased training capacity. • This expansion in capacity will be supported by DLI #6, which includes annual targets for the number of educational openings for nurses and health technicians at the ISPITS.
Result area 3: Strengthened and reorganized health services	**DLI 7:** Number of public PHC facilities rehabilitated in Program area to comply with energy and thermal efficiency standards to address climate vulnerabilities (US$75 million)	• Rehabilitation of public PHC facilities is a crucial enabler of service delivery reorganization, as they will form the entry point to integrated care pathways within a GST. At the same time, in line with government guidelines, there is a substantial need to reinforce the climate change resilience and energy efficiency of all public infrastructure, including public PHC facilities. • This DLI ensures that the energy and thermal efficiency standards, as specified in the contract specifications and scope of work, are effectively met as 395 public PHC facilities are renovated in accordance with ANEP's guide on energy efficiency of public equipment and ANEP's sustainable guide for construction. • The entirety of the amount associated with this DLI is expected to contribute to enabling mitigation to climate change, given adoption of energy and thermal efficiency measures in operational aspects of public PHC facilities according to the above mentioned ANEP's guides, particularly on energy efficiency related to heating and cooling equipment and systems and lighting systems and consumption, and the use of renewable energy with solar hot water. • On climate adaptation, rehabilitation of health facilities will enable bringing services closer to (climate) vulnerable populations, workarounds climatic patterns, maximization of natural ventilation and minimization of heat exposure, especially during hot periods.[72]
	DLI 8: Quality of care at hospitals and public PHC facilities evaluated and improved (US$45 million)	• The 'deconcentration' provides an opportunity to incentivize and institutionalize quality improvements at the facility level. • This DLI includes a phased approach for the institutionalization of quality evaluations at the GST level, starting with the establishment of a quality assessment structure at the GST level, then the development and adoption of quality evaluation tools for public PHC facilities. The last two annual targets will focus on

[71] Through the pathway on bringing services closer to the population, as a share of staff that is being trained, it is estimated that about 30% of this DLI contributes to enabling adaptation to climate change.

[72] This could potentially include, when applicable, the use of durable/climate resilient materials in the building envelope and grids (water, electricity), materials and passive design elements that improve thermal insulation of buildings, reduce heat accumulation during heat waves, use of "nature-based" passive design solutions (trees) and topography features to manage heat exposure of buildings and reduce demand for HVAC systems, use optimal amount of natural light, inclusion of evacuation exits and place in visible locations emergency evacuation plans for emergency events, backup energy supply for disaster-related energy supply service interruptions can where feasible can utilize renewable/solar generation and batteries. This could also potentially include topography features or built elements to improve stormwater drainage during storm events to ensure that uninterrupted access to/exit from buildings is available, including for vulnerable populations, such as the immobilized or partially immobilized, children, pregnant women, and elderly.

		the development and adoption of a quality evaluation and improvement roadmap, then on the production of a quality evaluation report and adoption of a quality improvement plan for hospitals and public PHC facilities.
	DLI 9: Epidemiological surveillance capacity strengthened including for climate change related health issues (US$67.5 million)	• Epidemiological surveillance capacity is a key health system function, especially as the health risks from climate change become more imminent; MHSP is in the process of restructuring epidemiological surveillance capacity. • This DLI incentivizes the government to implement this restructuring process to strengthen surveillance capacity, starting with the definition of a roadmap in the first year, followed by the adoption and validation of the structure of the epidemiological surveillance in the second year, and the update and adoption of regulations in the third year. This DLI has a focus on climate change adaptation and will include the inclusion of climate change related diseases in the updated list of notifiable diseases in the third year. The fourth- and fifth-year targets will ensure that GSTs publish epidemiological bulletins based on new regulations. • 60 percent of the amount associated with this DLI is expected to contribute to enabling adaptation to climate change for the health system, based on the disease burden impacted by climate change.

* *DLI 1 supports GCRF pillars 3 and 4; DLI 2 supports GCRF pillar 4; DLI 3 supports GCRF pillars 3 and 4; DLI 4 supports GCRF pillar 4; DLI 5 supports GCRF pillar 4; DLIs 7 supports GCRF pillar 3; DLI 8 supports GCRF pillar; DLI 9 supports GCRF pillars 3.*

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

54. **The MHSP will be the implementing agency for the Program, with the involvement of GSTs in Program Area, and MHSP directorates (**Table 5**).** Within the MHSP, the Planning and Financial Resources Directorate (DPRF) will be the implementation focal point for various activities, and will also oversee coordination, through the Cooperation Division. This division has implemented this role effectively in the previous World Bank Improving Primary Health in Rural Areas PforR (P148017) without the need for an additional Project Management Unit, and the same arrangements will be preserved, with a focus on the implementation of technical, fiduciary, environmental and social capacity enhancement activities outlined in the Program Action Plan (PAP). In addition to the DPRF, seven other directorates are tasked with implementation of activities, focusing on strengthening health information systems, reinforcing human resources for health, quality evaluations and rehabilitation of

primary health centers. GSTs, which will be under the oversight of the MHSP with public establishment status, will also be implementing activities. As in the previous PforR, a steering committee will be constituted through the secretariat of the Cooperation Division within the DPRF and meet regularly for strategic guidance and overall oversight of the Program, namely activity implementation progress, with representatives from directorates as well as GST. The steering committee would include not only MHSP stakeholders, but also the HAS to advise on quality-of-care related areas, as well as the CNSS to advise on provider payment-related areas. Prior to the establishment of the GST, stakeholders from CHU and regional directorates will be involved in Program management. An additional technical committee will also be established and will be responsible for assisting the MHSP on the technical aspects of the implementation of the Program. Given the implications of the comprehensive health sector reform, various roles and responsibilities are expected to change during Program implementation, and the POM would be updated to reflect these arrangements, including the roles and responsibilities of MHSP, GST, and other entities in the health sector as a result of the redesign. Verification processes from the previous Improving Primary Health in Rural Areas PforR (P148017) will be retained, with independent verification and auditing ensured by the IG of the MHSP, utilizing the extensive verification protocols and infrastructure which has been developed with World Bank technical assistance. The Program will benefit from the fact that the implementation of the health system redesign program is one of the top royal and government priorities, and that MHSP has prior substantial experience implementing a successful PforR.

Table 5 Summary of Roles and Responsibilities with respect to DLI and Program Functions

DLI & Program Function	Responsible Directorates and Institutions
Disbursement-Linked Indicators and PDO Indicators	
DLI 1: Strengthened institutional capacity through the new deconcentrated governance system	• Each *Groupements sanitaires territoriaux* (Territorial Health Groups – **GST**) • Coordination at the central level with the *Direction de la planification et des ressources financieres* (Planning and Financial Resources Directorate – **DPRF**) and its divisions pertaining to different management functions, as well as with the *Direction des ressources humaines* (Human Resources Directorate – **DRH**) regarding the development and implementation of training curricula
DLI 2: Health financing system reformed to reflect the context of the reform and improve quality of service delivery	**DPRF**
DLI 3: Improved content, quality, accessibility and use of health data	*Division de l'informatique et des méthodes* (Division of Information Systems and Methods – **DIM**)
DLI 4: Exchange and coordination platforms organized between central and regional entities	**DIM** *Division de la communication* (Division of Communication – **DICom**)
DLI 5: Health service operationalized to define health worker entitlements and to improve the quality of service delivery	***Direction des Ressources Humaines*** **(Division of Human Resources - DRH)**
DLI 6: Improved training capacity at ISPITS	**DRH**
DLI 7: Number of public PHC facilities rehabilitated in Program Area to comply with energy and thermal efficiency standards to	*Direction des Equipements et de la Maintenance* (Equipment and Maintenance Directorate – **DEM**)

address climate vulnerabilities	
DLI 8: Quality of care at public hospitals and public PHC facilities evaluated and improved	**DPRF** Each **GST**
DLI 9: Epidemiological surveillance capacity strengthened including for climate change related health issues	*Direction de l'Epidemiologie et de Lutte contre les maladies* (Epidemiology and Disease Control Directorate **– DELM**)
Program Implementation	
Steering, Coordination, Reporting	**DPRF** (through the Cooperation Division)
Environmental and Social Focal Points	**Environmental: DEM** **Social: DRH**
Fiduciary Focal Points	**Financial Management: DPRF** **Procurement:** *Division de l'Approvisionnement* en médicaments et produits de santé (Medicine and Health Product Procurement Division – **DAMPS**)
Verification	*Inspection Générale du Ministère de la santé et la protection sociale* (General Inspection Directorate for the Ministry of Health and Social Protection – *IG*)

B. Results Monitoring and Evaluation

55. **MHSP, through DPRF, will be responsible for collecting all the data and documentation necessary for monitoring, verification, and evaluation**. MHSP will bear the responsibility for monitoring overall progress toward achievement of the Program's results, as well as for ensuring timely collection and provision of monitoring data and verification documents for the World Bank and the MEF. The World Bank will provide implementation support based on the detailed Implementation Support Plan (Annex 3), whose focus would be on timely implementation of the agreed PAP (Annex 6), provision of necessary technical support, conducting of fiduciary reviews, and monitoring and evaluation activities. These would be done as part of regular implementation support visits and through reviews of data and documents, discussions with government and non-government counterparts and relevant partners, and visits to Program sites and facilities, as needed. Regarding monitoring and evaluation, the World Bank will pay particular attention to reviewing the monitoring data and verification documentation for the Program's results and DLIs submitted by the MHSP, retaining the right to make the final decision, for disbursement purposes, on whether the agreed DLIs have been achieved.

56. **The Program will support substantial improvements in the availability and use of health sector data.** As identified in the ICR[73] of previous Program, the Improving Primary Health in Rural Areas Program for Results (P148017), there are challenges with the availability of on-time, quality health data in Morocco, constraining evidence-based decision-making. The Program focuses on supporting the improved availability of routine, and reliable health information.

[73] *Morocco - Health Sector Support Project (English).* Washington, D.C. World Bank Group. *http://documents.worldbank.org/curated/en/998811657067132849/Morocco-Health-Sector-Support-Project*

C. Disbursement Arrangements

57. **The Program's funding will be disbursed based on the achievement of DLI targets as certified in accordance with the independent verification protocol.** The project is planned to be implemented over a five-year period from the effectiveness date with a closing date of September 30, 2028, using PforR financing of US$450 million provided under IBRD terms. The total amount of the loan proceeds will be disbursed through 9 DLIs under the Program. Disbursement will be made upon achievement of the targets and verified by the independent entity as per the agreed verification protocols. The financing amount for each DLI is further broken down into sub allocations, corresponding to years and sub-targets. Scalable disbursement will be applied to specific yearly targets for various DLI.

58. **The government can request advances up to 25 percent of the financing allocated to DLIs that have not yet been achieved by following the relevant procedures.** This will ensure that the government has the funds required to fulfill the intermediate operational requirements, leading to the achievement of the disbursement linked results. When the DLR against which an advance has been disbursed is achieved, the amount of the advance will be deducted from the total amount due to be disbursed under that DLR. The World Bank will record the amount disbursed to achieve a disbursement linked result ("recovered") after it has notified the Borrower of its acceptance of the evidence of achievement of the result.

59. **The verification of progress towards achievement of the Program's objectives will be based on an annual technical audit that will be carried out by the IG of the MHSP**. IG reports will be submitted directly to the MHSP, who ensures its independence vis-à vis MHSP services and enables IG to access information and data. The PforR-financed results areas are embedded in the budget and expenditure management processes of the country system. Program funds will be entirely reflected within the participating entities' budget. All payments of the Program will be made through the centralized Treasury Bank accounts held at the Central Bank (Bank Al-Maghrib). The GOM, through its budget, will transfer the funds to the MHSP based on the expenditure framework and activities to be executed by the directorates and agencies involved in the program and thus prefinance the expenditure. The Public Accountant (comptables publics) of each participating agency oversees making the payments. For advances, prior results and achieved results, the funds will be disbursed to the GOM's Treasury Single Account (TSA) at the Bank Al-Maghrib. The disbursements under the DLIs would be compared with Program expenditures incurred to achieved DLIs over the Program entire implementation period.

D. Capacity Building

60. **Capacity building is an integral part of the Program and will be supported directly through DLIs 1, 4, 6 and 8, as well as ongoing policy dialogue and technical assistance.** Through DLI 1 which focuses on the training of GST managerial staff, DLI 6 which focuses on improved training output, and DLI 8 which focuses on institutionalizing quality evaluations at facility and GST levels, the Program focuses on capacity building across a range of health system functions. The development of a training protocol under DLI 1 on performance-based management, FM, and health sector resilience to climate change, and the development of the capacity of quality evaluators under DLI 8, are also examples of capacity building. The implementation of a knowledge-sharing platform across all stakeholders of the health system, as supported by DLI 4, is a key example of the integration of capacity building into Program design. In addition to the DLI, the World Bank will also seek to mobilize technical assistance to provide inputs to the implementation of the health system redesign program. Table 6 demonstrates

potential technical assistance domains and status based on the context of the health system redesign and World Bank engagement.

61. **Given the substantial nature of the health system redesign program, ongoing capacity building and policy dialogue will also focus on change management.** The Program introduces a substantial change in the roles and responsibilities of stakeholders across all levels of the health system, and a paradigm shift will be required to operate in this context, particularly regarding the improved role of deconcentrated entities, and the institutionalization of performance both in terms of personnel compensation and facility quality evaluations. The World Bank will provide ongoing support and technical assistance with a focus on change management and health system redesign reform implementation, in addition to the aforementioned areas of technical assistance.

Table 6 Potential technical assistance domains and status for the first two years of Program implementation

Technical Assistance Domain	Status
Definition of epidemiological profiles, development of patient pathways, and development of organizational and financial models for GST	Ongoing World Bank support (Maghreb health monitoring, P179683), as well as ongoing support from the EU and the WHO
Inputs for training of GST staff in integrating gender and climate considerations for service delivery planning	Potential area identified given the context of the reform and relevant World Bank expertise. Discussions are ongoing to define scope
Change management and cross-cutting implementation support for governance and 'deconcentration' reforms	Potential domain identified given the context of the reform and relevant World Bank expertise, ongoing discussions to define scope
Support on fiscal 'deconcentration' and public financial management	Potential domain identified given the context of the reform and relevant World Bank expertise, ongoing discussions to define scope
Supporting the definition of an incentive modality for health workers	Requested from World Bank, ongoing work to define terms of reference and scope of work, to be financed by ongoing World Bank support (P179783) at the first stage
Monitoring and evaluation of health insurance scheme	Ongoing World Bank and WHO engagement on health financing, ongoing discussions to define scope
Development of policy options for a transition towards strategic purchasing	Ongoing World Bank and WHO engagement on health financing; ongoing World Bank work to define terms of reference and scope of work
Development of policy options on quality-of-care improvements	Ongoing World Bank, WHO, and AFD engagement; ongoing World Bank work to define terms of reference to scope of work to support the development of quality improvement platforms at the GST level
Development of a roadmap to strengthen epidemiological surveillance, including climate-related risks	Requested from World Bank, ongoing work to define terms of reference and scope of work; ongoing support from the European Union
Strengthening the care of gender-based violence survivors	Requested from World Bank, ongoing work to define terms of reference and scope of work
Support to update pre- and in-service training curricula with a focus on priority gender areas	Priority domain identified by the MHSP, ongoing discussions to define scope; ongoing JICA engagement

ESSP liquid waste management assessment: Support for conduct a diagnosis for ESSP liquid waste management system to identify ESSPs that require improvement to their liquid sanitation system.	Requested from the World Bank, ongoing discussions to define the terms of reference and scope of work

IV. ASSESSMENT SUMMARY

A. Technical (including program economic evaluation)

62. **The Program has been designed to contribute substantially to attain the objectives of the health system redesign program of the government, of improving the availability and quality of services.** As described in the detailed technical assessment[74], Program interventions tackle the binding constraints faced by the Moroccan health system in terms of improving quality of care.

63. **The success of the health system redesign program, as measured by its impact on health outcomes, is contingent upon the extent to which they will be able to strengthen quality of care.** While access to health care cannot prevent all mortality, evidence shows that Morocco has a higher share of mortality due to low quality of care than lack of utilization. According to a cross-country study from 2018, 55 percent of all amenable deaths[75] in Morocco were due to poor quality: there were 22,005 deaths that were preventable by population-level interventions, and 34,996 amenable to health care; of the deaths amenable to health care, 19,241 were due to poor quality and 15,755 due to non-utilization, demonstrating that poor quality is a more significant[76] driver of mortality in Morocco as opposed to non-utilization. The designed reform initiatives seek to strengthen the foundations of a high-quality health system through specific interventions to strengthen the governance, platforms, health workforce, and tools of a high-quality health system. These links indicate that the current reforms have the potential to strengthen quality of care and thus health outcomes, through strengthened financing arrangements, governance, and investments in improving health system capacity. For example, introduction of performance-based contracts for primary care, coupled with the empanelment of the population to a family medicine system such that individuals will have easier access to a generalist to consult as needed, has the potential to result in a patient-centered system which focuses on prevention as well as timely access to care.

64. **A detailed assessment of the context, international experience, and soundness of each of the Program interventions as provided in the standalone technical assessment document.** These interventions include strengthening of governance of deconcentrated entities; implementation of strategic purchasing; development of financial incentives; improvement of training capacity; implementation of patient pathways and integrated care; improvements to quality of care at health facilities and deconcentrated levels, as well as epidemiological surveillance and early warning systems.

Economic Analysis

[74] A full standalone technical assessment attached to the package will be disclosed at the same time as the Project Appraisal Document (PAD).
[75] Amenable deaths are defined as deaths which would have been prevented in the presence of access to quality health services.
[76] There were 56 deaths per 100,000 in Morocco due to poor quality; Kruk, M.E., Gage, A.D., Joseph, N.T., Danaei, G., García-Saisó, S., Salomon, J.A., 2018. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. The Lancet 392, 2203–2212. *https://doi.org/10.1016/S0140-6736(18)31668-4*

65. **This Program is expected to lead to substantial health and economic benefits in the Moroccan health sector, estimated to reach US$18.5 billion over a 10-year period.** Given the difficulty of attributing the impact of individual health system reform interventions on the reduction of mortality or quantifiable economic benefits, this economic analysis adopts a holistic approach to estimate the health and economic benefits of health system reform program interventions supported by the Program. Based on the literature reviewed in the technical assessment, this quantifies the economic impact of four pathways: a) investing in quality of care; b) investing in maternal and neonatal care; c) investing in primary health care strengthening through rehabilitation and definition of care pathways; and d) investing in epidemiological surveillance systems. The US$18.5 billion amount is based on the lower end of the estimates presented in the paragraphs below,and entails potential double-count between the overall economic benefits emerging from quality improvements, as well as the specific improvements from the remaining three pathways; however, given the relatively low percentage benefits assumed for the quality of care improvements, this double count should be minimal.

Program Expenditure Framework

66. **Morocco's health budget for 2023 is MAD 28.1 billion (US$2.7 billion)[77], reflecting recent growth to account for investments associated with the health sector reform.** This constitutes about 7 percent of the general government budget. The government health budget grew by 19.5 percent compared to 2022 to account for additional recruitment and investments to strengthen the health system for the reform, and the PBT for 2023 through 2025 assumes an annual nominal growth rate of 8 percent for this period, demonstrating funding predictability, commitment and sustainability[78]. Additional information on the macro-fiscal context is included in the technical assessment, demonstrating an improved commitment to the success of a comprehensive health and social reform agenda.

67. **The expenditure framework of the Program includes relevant line items from the MHSP budget, with the exclusion of large-scale civil works, lines outside of the scope of the Program, and contracting of activities that exceed World Bank thresholds.** The expenditure framework is based on the relevant budget lines for the MHSP across each of the six programs and activities in the program-based budget. Relevant lines and the expenditure framework are summarized in Table 7, primarily including investments on health information systems, epidemiological surveillance, operating budgets for training institutions, and service delivery related costs such as procurement of medicines and consumables. The expenditures included for individual activities are commensurate with their scale and complexity, and facilitate efficient execution. The expenditure framework strikes a balance between operating costs, procurable items, and non-procurable items. Investments with potential to cause significant adverse impact on the environment and/or affected people as defined in the World Bank Policy and Directive on PforR financing, as well as investments involving works, goods, and consultancy contracts above the World Bank thresholds, are excluded. As such, construction and major rehabilitation works were excluded. The budgets of tertiary- and secondary-level hospitals, as well as that of other SEGMA institutions, have been excluded given the difficulty of tracking them as well as given the fact that they will no longer exist as independent institutions following the launch of GSTs.

Table 7 Summary of Program expenditure framework

[77] The amount excludes the budgets of five Central University Hospitals (CHU). Throughout this section, an exchange rate of US$/MAD of 1/10.32 is used.
[78] This rate is based on the average growth rate of the MSPS budget from 2023-2025, based on the PBT.

Results Area	Budget Category	Program Budget	Activity	Total for 2023
1	Investment	705	Health information systems	MAD 500,000,000
1	Operating budget	701	Surveillance, health information systems, and other interventions	MAD 300,000,000
2	Investment budget	705	Operating and investment budgets of ISPITS	MAD 107,000,000
3	Investment budget	705	Rehabilitation of primary care facilities	MAD 71,245,623
3	Special accounts	702	Purchase of medicines and consumables	MAD 1,287,785,505
			Total, 1 year, MAD	**2,266,031,128**
			Total, 1 year, US$	**217,469,398**
			Total, 5 years, US$	**1,296,056,624**

68. **Based on the expenditure framework, a 5-year cost for the Program was estimated, with various assumptions (Table 8).** The overall expenditure framework of the Program is estimated at US$1.296 billion, out of which the World Bank is financing US$450 million, or 34.72 percent. Given the uncertainty associated with various dimensions of the reform, the five-year Program cost was calculated based on the average year-on-year growth rate of 8.79 percent from 2023-2025, and this figure was used for the remaining duration of the Program. Risks to the Program Expenditure Framework arising out of budget constraints are low as the Program expenditure constitutes a small portion of the overall program cost, and as the Moroccan macroeconomic framework remains strong, with sufficient predictability with high budget execution rates. Further, the Program is fully aligned with government priorities, and only provides a sub-set of a comprehensive and ambitious government program, which is reflected in the continuity of health budgets providing space for increased expenditures.

Table 8 Program financing

Source	Amount (US$, million)	% of Total
Government financing	846.06	65.28%
PforR IBRD financing	450.00	34.72%
Other development partners	0	0.00%
Total Program costs	1,296.06	100.00%

B. Fiduciary

69. **As part of the Program preparation, the World Bank task team carried out an Integrated Fiduciary Systems Assessment (IFSA) of the Program in accordance with the World Bank Policy on PforR Financing.** The objective of the assessment was to examine whether Program systems provide reasonable assurance that the financing proceeds will be used for the intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability. Based on the Program boundaries and expenditure framework, the IFSA covered the MHSP mainly through the DPRF and the technical directorates, which are substantially involved in the coordination of the Program**.** The IFSA was conducted based on the financial sector

evaluation (FSA) team knowledge of the country public financial management (PFM) systems applicable to this program, the documents and data provided by the MHSP, and the experiences derived from closed and on-going PforR operations in the sector and in the country.

70. **The IFSA concluded that the Program's fiduciary systems, with the implementation of the proposed mitigating measures and actions included in the PAP, meet World Bank Policy Program-for-Results Financing requirements, and provide reasonable assurance that financing proceeds will be used for intended purposes with the objective of supporting achievement of Program objectives**. Morocco's PFM systems are acceptable to the Bank and meet the requirements for the implementation of a PforR. Specifically, MHSP is familiar with the PforR financing instrument, as it is the second PforR it would be implementing, in addition to ongoing operations funded by other development partners using similar financing instruments. The fiduciary team of the DPRF is familiar with the country's PFM systems including sector-level PFM performance and World Bank's fiduciary requirements. The performance of the MHSP in the budget execution of the general budget appropriations of the programs supported by the PforR was judged to be satisfactory, with rates above 85 percent in the years 2020 and 2021. The internal audit and management control function has been introduced in the MHSP in May 2018. The new decree on the internal audit will help to speed up the operationalization of this function in the MHSP. This was done through a phased approach, and before its generalization to all directorates and entities covered by the MHSP, a review of the implementation of the pilot phase will have to be done, which can be supported by the Program. MHSP's Inspectorate General (IG) carries out missions that cover both technical and financial aspects divided into four functions: inspections, audits, investigations, and support. The assessment of the internal control system is covered in the audit and inspection missions conducted by the IG. The IG overall performance is deemed satisfactory as shown in the 2021 and 2022 activity reports. Additionally, the Government of Morocco has recently adopted a new national public procurement decree (PPD) No2-22-431, the scope of which is now enlarged to include public entities besides ministries and local governments. The new decree includes several enhancements such as the introduction of rated criteria, the selection of the most advantageous bid, competitive dialogue, and establishment of an observatory for public procurement. The implementation of the new decree is expected to achieve better value for money with adequate levels of transparency, competitiveness, efficiency, and fairness by all entities involved in the Program. The Program's procurement system governed by the new decree is therefore considered adequate to meet the requirements of the World Bank Policy and Bank Directive for Program-for-Results.

71. **The Program presents opportunities to strengthen budget execution including procurement planning, execution and contract management, financial reporting, internal audit function and anti-corruption mechanisms.** A detailed description of the fiduciary risks and weaknesses is provided in Section V-Risks. The risks associated with procurement are multifaceted, including: (i) weaknesses in capacity for procurement planning and execution, (ii) challenges in operationalizing the new procurement decree, (iii) an inadequate procurement complaint handling system, (iv) a lack of procurement performance reporting mechanisms, and (v) a lack of suspension and debarment check mechanism which may result in awarding a contract to firms and/or individuals debarred or suspended by the Bank. FM risks are related to: (i) Timely implementation of the internal audit function; (ii) Audit recommendations follow up; (iii) Reconciliation of Program expenditure framework; and (iv) Reporting of fraud and corruption cases. To ensure adequate implementation, the systems will require capacity and systems strengthening activities as described below in the risks mitigation measures and PAP.

72. **Based on the fiduciary context and assessment, the overall residual fiduciary risk of the Program is Substantial, and the PAP includes specific, time-bound actions to mitigate these risks**. These measures aim to

ensure adequate budget and procurement execution of the Program Expenditure Framework (PEF), effective accountability and transparency mechanisms, and achievement of expected results. In particular, the procurement-related risks will be addressed through the following key actions: (i) ensure that procurement plans are prepared and implemented in accordance with existing regulations, particularly at the deconcentrated level; (ii) develop and implement a program to enhance capacity-building on the new procurement decree; (iii) Implement a semi-annual reporting mechanism on tenders and procurement-related complaints through the minutes of technical committees; and (iv) include in the bidding documents an eligibility check clause requiring implementing agencies to ensure that any person or entity debarred or suspended by the Bank is not awarded a contract, or otherwise allowed to participate in or benefit from the Program during the period of such debarment or suspension by the Bank. The FM-related risks will be addressed through the following key actions: ; (ii) Deploy a performance management mechanism through monitoring of key fiduciary performance indicators of the Program results framework; (ii) Strengthen coordination between implementing entities through the appointment of fiduciary focal point in each entity (e.g. it will be a matter of identifying existing staff of the directorates who will be entrusted with the responsibility of collecting and transmitting the financial data of their directorate) and develop tools for collecting budget execution and accounting data at the level of each implementing entity in addition to capacity building activities to be supported by the World Bank team; (iii) Develop the tools and procedures including the entity responsible for collection, consolidation, and reporting cases of fraud and corruption, in the POM. The MHSP will execute the activities in accordance with the World Bank's "Guidelines on Preventing and Combating Fraud and Corruption in Program-for-Results Financing", dated February 1, 2012, and revised July 10, 2015. The Program ex ante and ex post arrangements were found adequate to address the risk of fraud and corruption. The DPRF will: (i) collect, with support from the MHSP's GI, and share information with the World Bank regarding all allegations of fraud and corruption in connection with the Program in the periodic progress reports, investigate all credible allegations received, report to the World Bank on actions taken, and cooperate in any inquiry that may be conducted by the World Bank into allegations or other indications of fraud and corruption in connection with the Program; and (ii) monitor and abide by the World Bank's list of debarred/suspended firms. Measures have been proposed in the PAP to address the risk of lack of reporting of cases of fraud and corruption.

73. **The Program's FM arrangements will be similar to that of the PforR operations (P148017 & P173944) that closed in 2021 with measures to strengthen the Program's fiduciary performance**. The Program's budget execution will be done following the public expenditure chain with the financial control provisions in place in Morocco and used by several PforR operations financed by the World Bank. The FM team of the DPRF that participated in the execution of the previous World Bank-financed Program is still in place. The closed PforR operations faced challenges including delays in preparing annual financial statements due to lack of coordination between the DPRF and the directorates. Measures including the designation of FM focal points in the directorates involved in the Program have been proposed to ensure timely collection of financial information and facilitate the preparation of the Program's financial statements. The program will be subject to external audits of the consolidated financial statements prepared under the responsibility of the DPRF.

74. **Summary of procurement arrangements**. With the enactment of the new procurement decree No.2-22-431, effective September 1st, 2023, the existing public procurement decree No.2-12-349 dated March 20, 2013, will be replaced, and its scope will be extended to public entities and establishments in addition to ministries and deconcentrated regional entities. Consequently, the Program's procurement, to be carried out by MHSP will be fully governed by this new decree. It is important to note that procurement of medicines and pharmaceutical products at the central level is exclusively the responsibility of the Directorate of Pharmaceutical and Health

Products' Procurement. Moreover, local procurement of medicines and pharmaceutical products through purchase orders (PO) according to the public procurement decree is subject to the Minister of Health Order/Circular No. 10/DHSA dated January 30, 2019[79], which sets out local procurement procedures (PO) for medicines and other pharmaceutical products. Procurement of goods, services and works is the mandate of the DEM. In accordance with the MEF Order No. 1982-21 dated December 21, 2021, on the digitalization of public procurement procedures and financial guarantees, MHSP are required to comply with full digitalization of electronic submissions and bid securities. This order has progressively introduced the obligation to electronic submission of bids, electronic bid opening, and electronic bid securities effective from November 1st, 2022. On the institutional level, the Moroccan public procurement system has been strengthened with the adoption of Decree No. 2-14-867 dated September 21, 2015, which established the National Public Procurement Commission (Commission Nationale de la Commande Publique, CNCP). The CNCP's main mission involves professionalizing public procurement, ensuring compliance with the principles of transparency, efficiency, economy, and fairness, handling procurement-related complaints from bidders, and treating requests for opinions from public buyers. More details on procurement arrangements for the program are detailed in Annex 4. Based on the PEF, 100 percent of the Program expenditures under the three results areas are procurable and can be grouped under four (4) main procurement categories as follows: (1) Goods (59 percent), (2) Information systems (35.3 percent), (3) Works (4.3 percent) and (4) consulting services (1.4 percent) which in total represents 100 percent of the PEF. The procurement will cover strengthening and upgrading of information systems under Results Area1; procurement of goods, works and consulting services for the strengthening of the ISPITS under Results Area 2 and purchase of medicines and consumables under Results Area 3. It was confirmed with the MHSP that the Program doesn't include any activities that involve high-value contract exceeding the World Bank threshold value that would qualify for procurement exclusions.[80]

C. Environmental and Social

75. **An Environmental and Social Systems Assessment (ESSA) has been conducted to inform the preparation of the Program.** The ESSA examines the Environmental and Social (E&S) systems applicable to the Program to evaluate compliance with the provisions of the World Bank Policy and Directive on PforR financing and ensure that the E&S risks of the Program are well managed. Overall, environmental and social benefits of the Program stem from addressing bottlenecks in health sector development. The Program will enable a transition through strengthening all aspects of the health system, with a focus on governance, human resources for health, and service delivery. Social benefits of the Program come from the inclusion of women and youth, potential job and skills creation, the promotion of sustainable livelihoods, and citizen and community participation. The ESSA has been publicly disclosed on the World Bank Website on April 11, 2023 and submitted for public consultation on April 17, 2023, and its executive summary is in Annex 5.

[79] The order/circular outlines guidelines for the purchase of essential pharmaceutical products and medical products in the decentralized services of the Ministry of Health and Social Protection through purchase orders (Pos) and in compliance with the Public Procurement Decree. To control State spending, all purchases must comply with legislative and regulatory provisions and can only be made through authorized pharmaceutical establishments. Hospitals must adhere to a decision-making tree and purchase directly from authorized establishments using POs. The circular emphasizes the importance of reinforcing the safety of care provided to citizens in public health structures by ensuring that medical products and essential reagents are exclusively and obligatorily sourced from authorized establishments with a certified registration certificate, according to relevant laws.

80 The program procurement risk being assessed as Substantial, OPRC thresholds are as follows: (a) works, estimated to cost US$75,000,000 equivalent or more per contract; (b) goods, estimated to cost US$50,000,000 equivalent or more per contract; (c) non-consulting services, estimated to cost US$50,000,000 equivalent or more per contract; or (d) consultant services, estimated to cost US$20,000,000 equivalent or more per contract.

76. **Potential negative environmental effects of the Program activities are moderate.** Activities with the potential to generate moderate environmental risks mainly relate to rehabilitation of public PHC facilities. For structural activities with moderate environmental effects, mitigation measures have been defined to complement the existing systems. Program activities were assessed for E&S risks based on the PforR eligibility criteria which exclude high-risks interventions. Each implementing agency will conduct a screening to confirm risk levels, prepare management instruments, identify adequate social and environmental mitigation measures, and prepare corresponding action plans. An increase in medical and pharmaceutical waste as well as liquid waste is anticipated following the improvement of access to care services and the improvement of care structures (primary health care and primary health care establishment facilities). The management of waste will hence be improved through the implementation of the Drugs and Pharmacy Directorate (Direction des Médicaments et de la Pharmacie, DMP) management plans, and the diagnosis of liquid waste generated by public PHC facilities. The results of these 2 actions, which are included in the ESSA action plan, will contribute to meeting the requirements of the law in terms of i) Incorporating the necessary measures to fight against the dangers that affect health within the framework of an integrated, complementary and shared policy between the sectors and in coordination with all the stakeholders (Article 8 of Law 06-22) and ii) taking into account the organization and management of healthcare establishments' principles of user safety, quality specifications and rules of cleanliness and preservation of health (Article 8).

77. **The analysis of the regulatory and institutional frameworks that constitute the environmental management system has shown their adequacy with the PforR policy.** The scope, procedures, and principles of the Environmental Impact Assessments (EIAs) in Morocco are generally in line with international practices. Environmental management and EIA procedures are both clear at the technical level and sound at the institutional level. The main gaps identified are (a) limited integration of social aspects in impact assessment studies; (b) gaps in implementation of public consultations involving the parties affected by the Program; and (c) constraints regarding integration of Environment and Social Management Plans (ESMPs) in impact assessment studies, including documented mitigation measures. Capacity strengthening is needed for the various institutions responsible for managing E&S aspects of program activities. Aiming to fill the gaps identified in the ESSA, the Program will support specific measures to strengthen the performance of the environmental management system stakeholders involved with the operation, especially through Monitoring and Evaluation (M&E) and E&S management capacities.

78. **There are various social risks associated with the implementation of the Program.** The main risks are related to social inclusion, particularly the risk of (i) gender discrimination in the recruitment process and during performance evaluations that eventually affect salaries and bonuses, (ii) racial discrimination when recruiting foreign staff, especially given that the Moroccan Labor Code does not provide a strong legal framework to protect foreigners from any act based on racism, (iii) social exclusion of people with disabilities especially if the law on the protection of people with disabilities is not incorporated into the MHSP's Human Resources and patient access measures; and (iv) sexual exploitation and abuse (SEA) between health care staff and patients and sexual harassment (SH) risks between health care coworkers that could possibly be exacerbated by the increase in the number of male and female employees as well as the number of patients treated. The risk of SEA/SH can increase if the measures in place are not sufficient to address abuse in its different forms (staff-on-staff harassment, staff-on-patient violence and violence perpetrated by patients and their visiting guests against medical staff).

79. **The analysis of the regulatory and institutional frameworks that constitute the social risk management**

system has identified considerable gaps with the PforR policy. The systems currently in place to mitigate these risks are not well developed. The action plan included in the ESSA (Annex 5) presents the recommended steps required to strengthen human resources systems, manage social risks associated to construction/rehabilitation, as well as guidelines to prevent and mitigate the risk of sexual harassment and sexual exploitation and abuse amongst health workers as well as between health workers and patients/community members in the context of the program. The actions also focus on engagement through i) technical assistance towards strengthening the quality of the available response services for women and children who have experienced violence, ii) regular collaboration with stakeholders of the program, and iii) through the enhancement of grievance redress mechanisms.

80. **When combined, the overall environmental and social risk is Substantial.** The rating can also be justified by the experience with the previous health PforR, where there were delays in the designation of environmental and social focal points at the central and regional levels, limiting the dissemination of environmental and social management procedures and the implementation of the ESSA action plan. The risk rating will be revisited during implementation, and capacity building efforts will be prioritized in line with the PAP.

D. Corporate Requirements

Gender

81. **The Program seeks to address gender gaps in access to health services (Figure 5, Table 9).** These gaps exist primarily through three pathways: i) overall gaps between females and males; ii) gaps between urban and rural women; and iii) gaps between women in different regions and at different income levels, notably in regions most vulnerable to natural disasters and climate risks. According to a joint Morocco High Commission of Planning and the United Nations Women report, 62 percent of male-headed households had access to medical care for common medical illnesses, compared to 52 percent of female-headed households. For reproductive health services, the access rate was 67 percent for male-headed households and 59.2 percent for female-headed households.[81] Furthermore, utilization of maternal health services is lower in rural areas: only 38.5 percent of rural females had four or more antenatal care visits during their pregnancy compared to 65.9 percent of females based in urban areas, due among other factors to lack of awareness on the benefits of delivering in a health facility, lower decision-making power, and common barriers such as lack of transportation.[82] As depicted in Figure 5 and Table 10, the Program will contribute to closing the female urban and rural divide and regional disparities in access to quality health services through revamping the supply of health services and increasing the availability of health workers, notably through more equitable distribution. The redesigned service delivery and deconcentrated governance structures, especially at the primary healthcare level, will contribute to closing the gender gap in access to health services as they are expected to improve the quality and availability of public health services in the Program area, and will particularly benefit women in rural areas and those in the poorest quintile who are currently the most underserved group. Through DLIs 1, 3, 5, and 6, as well as through two intermediate results indicators, the Program incentivizes closing the gender gap in the health sector with a focus on the governance, human resources for health, and service delivery functions.

82. **The Program is also expected to have a positive impact on the labor force participation for women.**

[81] Gender analysis of the impact of the coronavirus on households' economic, social and psychological situation, 2021.
[82] UNESCWA. Arab Gender Gap Report, 2020.

Although Morocco has a low female labor force participation rate, according to the 2018 Labor Force Survey, women are overrepresented in medical/health degrees: 60 percent of medical doctors in the public sector are women. HRH is at the center of the health system redesign program and constitutes an important results area under the Program. The expansion of training and the introduction of financial incentives for health workers will improve their skills and competence, while improving employment perspectives and conditions particularly for women.[83]

83. **The Program will support the strengthening of the health program for the care and treatment of women and children who are survivors of violence**. GBV and violence against women and children are significant public health problems posing challenges to the health sector. In Morocco, 13.4 million women and girls aged 15-74 (82.6 percent) have experienced at least one form of violence in their lives. In 2018 alone, more than 7.6 million women aged 15 to 74 years old, or 57.1 percent, experienced an act of violence.[84] In response, in line with the national health program for the care and treatment of women and children victims of violence, hospitals have set up integrated units of care for women and children who are survivors of violence (113 integrated units as of 2018). Consequently, the number of women and children survivors of violence, who have been cared for and treated at public health facilities, has steadily increased over the last 10 years; 24,444 women survivors of violence were treated in 2021 compared to 8,355 in 2012; for children, this number increased from 1,814 in 2012 to 7,786 in 2021.[85] While these results are encouraging, the proportion of women and children survivors of violence cared for and treated remains significantly below the actual needs. The Program will further support the government's efforts in the implementation of this program, including through improved learning and capacity building of nurses about GBV, with the objective of improving identification, referral and empathetic, high-quality care/treatment of women and children survivors of violence, ultimately leading to an increased number of women and children survivors of violence being cared for and treated.

[83] World Bank. Morocco Jobs Landscape
[84] Rapport sur les violences faites aux femmes et aux filles. Enquête Nationale sur la Violence à l'encontre des Femmes et des Hommes, HCP, 2019
[85] Le Programme National de la Santé pour la Prise en charge des Femmes et des Enfants Victimes de Violence: Bilan des Performances des UIPFEVV

Figure 5 Program's gender theory of change

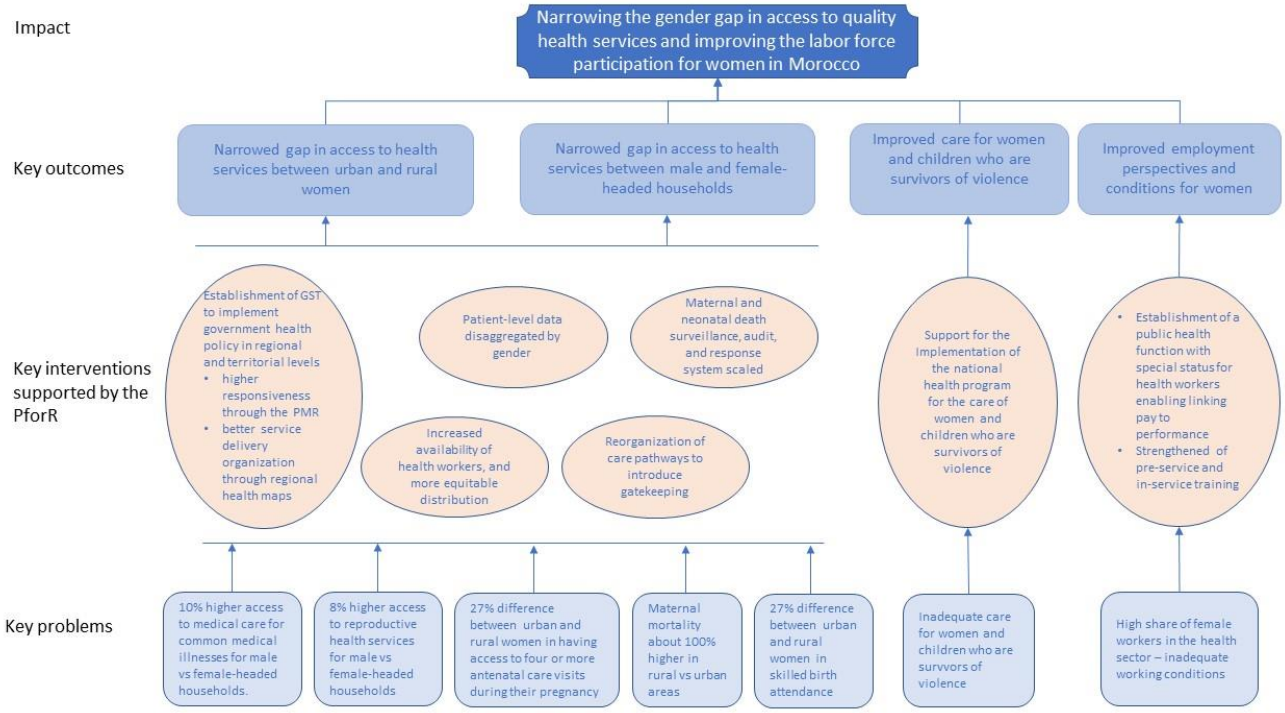


Table 9 Gender theory of change, related interventions and outcomes

Gender Gap	Intervention and Program indicator	Key/intermediate outcomes
10% higher access to medical care for male vs female-headed households	▪ Establishment of GST to implement government health policy in regional and territorial levels, with each GST including all public facilities within the region (DLI 1, DLI 4) ▪ Development of regional health maps defining distribution of treatments, and development of regional health maps by GST, including a comprehensive inventory of public and private sectors, with the GST having the responsibility to close gaps in health infrastructure (DLI 1) ▪ Reorganization of care pathways to introduce gatekeeping (primary health care institutions for public sector; generalist or attending physician for the private sector) (Law 08-22 on Establishment of Territorial Health Groups – GST)	Narrowed gap in access to health services between urban and rural women Narrowed gap in access to health services between male and female-headed households
8% higher access to reproductive health services for male vs female-headed households		
27% difference between urban and rural women in having access to four or more antenatal care visits during their pregnancy		

27% difference between urban and rural women in skilled birth attendance Maternal mortality about 100% higher in rural vs urban areas	(PDO indicator) ▪ Improved training capacity in ISPITS (DLI 6) ▪ Reduction of inequalities and scale up investments in medical equipment, beds, facilities (DLI 7) ▪ Maternal and neonatal death surveillance, audit, and response system scaled (Intermediate Outcome indicator) ▪ Improved percentage of pregnant women in Program area who have completed 4 antenatal care visits (Intermediate Outcome indicator)	
Insufficient care for women and children who are survivors of violence	▪ Training of GST administrative staff to better organize service delivery to respond to GBV survivors' needs (DLI 1); strengthened health information system to improve reporting for GBV service utilization (DLI 3); updates to training curricula including for GBV interventions (intermediate outcome indicator)	Improved care for women and children who are survivor of violence by providers with knowledge and skills on addressing GBV.
High share of female workers in the health sector – inadequate working conditions	▪ Health service operationalized to define health worker entitlements and to improve the quality of service delivery (DLI 5) ▪ Strengthening of pre-service and in-service training (Intermediate Outcome indicator)	Improved employment perspectives and conditions for women

Table 10 Gender results indicators

Gender Gap	Results Indicators	Baseline (%)	Target (%)
Urban/Rural gap in access to and quality of maternal health services	Percentage of pregnant women in rural areas who completed 4 ANC visits	38.5	47
	Percentage of pregnant women in urban areas that completed 4 ANC visits	65.6	70
	Maternal and neonatal death surveillance, audit, and response system scaled up	70% of GST in Program area use the maternal death surveillance system	100% of GST integrated maternal and neonatal death audits/50% of GST in Program area have validated maternal and neonatal death audits
Inadequate care for women and children who are survivors of violence	Update of training curricula for nurses and health technicians to reflect the health system redesign program, with the incorporation of rights to health and gender, including gender-based violence (GBV)	Training curricula not updated to reflect health system redesign program with the integration of rights to health and gender	100% of GST in Program area have implemented the updated in-service training curricula for nurses and technical staff

Climate Change

84. **Climate change threatens shared prosperity in Morocco and may exacerbate pre-existing vulnerabilities.** Morocco is classified as one of the world's climate hotspots. Average temperatures have increased by almost 1.36°C between the 1970s and the 2010s (0.34°C per decade), recording nine of the ten warmest years recorded in the country's history have taken place in the 21st century. Moreover, precipitation

patterns have been very erratic with frequent and intense droughts as well as severe rain events and flooding. Rising temperatures and erratic rainfall have reduced river flows and increased evaporation and siltation of storage dams, leading to a 20 percent reduction in overall water resources in the last 30 years, exacerbating the problem of water scarcity generated by non-climate stressors such as population growth in the north, irrigation expansion, as well as urban, industrial and tourism development. This places Morocco in a situation of structural water stress. Since the 1980s, cold spells and heavy snowfall have particularly affected the High and Middle Atlas areas, isolating the localities affected and making them inaccessible for periods ranging from a few days to over a month. Low-income, marginalized populations – particularly women, youth, rural populations – lack the resources to adapt to climate-induced shocks such as floods, landslides, droughts, and heat waves, to which Morocco has been and will continue to be highly exposed. Poor households suffer the highest economic losses from extreme weather events, whether direct or indirect through adverse health impacts. In addition, those working in sectors which require them to spend large amounts of time outdoors such as agriculture and the large tourism sector are particularly vulnerable to impacts of exposure to heat and the sun as well as respiratory health risks due to dust caused by climate-related events. Public health impacts include a 10-fold increase in heat-related mortality, a higher incidence of skin cancer, respiratory illnesses, and cardiovascular disease, an increase in diarrheal deaths linked to climate change, an expansion of dengue fever transmission vectors and other vector-borne diseases, and declines in outdoor labor productivity.

85. **The Program will provide substantial support to climate adaptation, which is a priority for the Moroccan health sector.** Guiding documents include the 2010 Health Sector Adaptation Strategy to Climate Change, and the 2017-2021 operational action plan. The strategy focuses on the protection of population health with specific emphasis towards the reduction of health risk inequalities, an improved epidemiological surveillance system, strengthening health facilities resilience to extreme events, improved preparation and implementation of emergency and response plans, and the promotion of research focused on the impacts of climate change on health.

86. **The Program intends to address climate vulnerabilities through DLIs that directly support the Moroccan health system's adaptation to and mitigation of the risks posed by climate change.** As demonstrated in Table 11, Program design integrates climate change considerations in a cross-cutting manner, demonstrating that the health system redesign program improves the climate resilience of the health sector. Adaptation and mitigation measures will be informed by ANEP's guide for energy efficiency of public equipment, ANEP's guide for sustainable construction and the government's thermal construction regulation (Reglement Thermique de Construction au Maroc - RTCM). ANEP's guide for energy efficiency of public equipment specifies parameters to reduce energy consumption and optimize natural conditions. These include: 1) thermal insulation requirements by Morocco's six sub climate zones for walls, roofs, floors, and glazing of windows; 2)control of thermal bridges according to ISO standard 14683, to reduce heating and cooling needs for buildings, improve building conditions with no heat or air conditioning, energy efficient use of heating and cooling equipment, reduce mold and deterioration of paint; 3) efficient performance of air-conditioning and cooling equipment to reduce consumption, reduce GHG emissions, and comply with national and international energy efficiency standards; 4) efficient performance of heating equipment to reduce consumption and GHG emissions, improve production and distribution of hot water, and comply with national and international energy efficiency standards; 5) efficient performance of clean hot water equipment to reduce production relative to consumption of hot water, reduce GHG emissions, and comply with national and international efficiency standards; and 6) lighting standards and lighting equipment specifications to reduce consumption, reduce GHG emissions, comply with national standards and specifications, and reduce air conditioning use and costs.

87. **Sections of the ANEP's guide for sustainable construction will be used to inform the rehabilitation of public PHC facilities**. The guide provides parameters on 1) climate conditions for a building including the orientation (exposure to sunlight and dominant winds), considerations for natural ventilation and natural light; 2) exterior design including green spaces, compliance thermal building regulations, insulation parameters, use of renewable energy resources, heating and cooling techniques, hot water management, lighting equipment choices according to energy use, 3) construction materials, 4) water and sanitation management and equipment for enhanced water conservation, water preservation and harvesting, 5) air quality including adherence in accordance with GOM's decree number 2-09-286, ventilation, and guidance on pollutants and product labels to mitigate air quality pollution; and 6) green construction management including responsible management of waste and responsible handover once construction is concluded.

Table 11 Climate Actions in the Program

DLI and Climate Financing	**Climate Action**
DLI 1: Strengthened institutional capacity through the new deconcentrated governance system (US$75 million total, US$37.5 million to administrative staff training including on health sector resilience to climate change)	Administrative staff will be trained in improving health sector resilience to climate change, resulting in improved responsiveness to climate change-related diseases, particularly in regions worst impacted by heat and drought. Strengthened deconcentrated governance, combined with improved knowledge on health resilience and adaptation to climate change, will allow GST to plan and distribute staff across zones impacted by climate shocks. **(adaptation)**
DLI 3: Improved content, quality, accessibility and use of health data (US$37.5million total, all climate-change related)	Improved availability of data will ensure enhanced responsiveness to climate-induced conditions and enable the targeting of climate vulnerable populations through enabling evidence-based planning, and the health sector report will provide timely information on climate exacerbated conditions and diseases. **(adaptation)** Also, the integrated health information system is a mechanism to improve data availability during climate shocks **(adaptation)**. The integrated health information system will help decrease carbon footprint through minimizing paper-based health registers and paper waste **(mitigation).**
DLI 7: Number of public PHC facilities rehabilitated in Program area to comply with energy and thermal efficiency standards to address climate vulnerabilities (US$75 million total, all climate-change related)	The GoM made a formal commitment to the Presidency of COP 26 on November 12, 2021, to gradually reduce greenhouse gas emissions from health facilities to zero by 2050. In this framework, and through DLI 7, the Program will tackle climate change mitigation and adaptation measures through ensuring that climate change readiness and energy efficiency are reinforced in public PHC facilities to reduce their carbon emissions. As part of its service delivery reorganization, the

	government has targeted the rehabilitation of 1367 public PHC facilities. Energy efficiency standards will be used to ensure that the health facilities will produce low greenhouse gas emissions, contributing to the country's low carbon emission pathway. The GoM will apply ANEP's sustainable construction guide and GoM's regulation on thermal construction and building regulations, to ensure that rehabilitation activities follow specifications related to, energy efficiency, thermal insulation requirements, energy reduced construction materials, water and sanitation management, measures to improve air quality inside buildings, and equipment specifications to reduce air pollution. **(mitigation).** Energy Efficient standards will be used, and equipment will be purchased in line with ANEPs guide to energy efficiency in public equipment which includes measures for heating and cooling of buildings, standards for heaters and air conditioners, use of thermal bridges in buildings; and improving the operational energy efficiency of buildings including the energy performance of equipment used to generate clean hot water and the use of energy efficient lighting and equipment. ISO Standard 8995-1 will be used for parameters on lighting requirements for specific health service resource areas. ISO Standard 14683 will be used for thermal bridges. General electrical equipment such as LED lights will use the Energy Star Efficiency Criteria. The introduction of renewable energy solutions with solar hot water will further contribute to reducing greenhouse gas emissions **(mitigation).** To support the health facilities' adaptation to climate shocks, measures to help facilities adapt to Morocco's climate risks will be incorporated into health facilities, these include passive cooling measures through reflective paint and ventilation designed to lower temperatures as well as measures to reduce risks of extreme floods, beyond those integrated in standard practice **(adaptation).**
DLI 9: Epidemiological surveillance capacity strengthened including for climate change related health issues (US$67.5 million total, US$40.5 million associated with mitigating climate change)	Through DLI 9, the Program will strengthen epidemiological surveillance capacity and integrate conditions that will be exacerbated by climate change to the list of notifiable conditions, such as asthma, dengue fever, malaria, skin cancer, etc. Strengthening of health information systems, including improved epidemiological monitoring and surveillance system, will support early warning systems, as well as detection and

	rapid action, with respect to climate change-related diseases. **(adaptation).**

Citizen Engagement

88. **Strengthened deconcentration, improved health information system data, and institutionalized rapid surveys to measure patient satisfaction are the three main pathways through which the Program will foster citizen engagement.** One of the main objectives of the government's health system redesign program is to improve patient experience and satisfaction. As captured in DLI 1, the government seeks through the 'decontration' to bring health services closer to the population, improving accountability and responsiveness as well as providing a specific pathway to improving trust. This is also captured in DLI 4, which institutionalizes information sharing platforms and knowledge exchange mechanisms between different levels of the health system, further improving accountability and responsiveness. Through improvements in health information systems, supported by DLI 3, these accountability mechanisms are further reinforced, particularly with improved collection and publication of health system performance data, and the ability of patients to easily access their own health information. Finally, through the incorporation of an intermediate outcome indicator which seeks to institutionalize rapid assessment of patient experience and satisfaction at central and regional levels, the Program will incorporate the routine measurement and tracking of patient satisfaction for the first time in the Moroccan health system.

89. **Grievance Redress.** Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance mechanism or the Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address pertinent concerns. Project affected communities and individuals may submit their complaint to the Bank's independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted at any time after concerns have been brought directly to the Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's GRS, please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the Bank's Accountability Mechanism, please visit https://accountability.worldbank.org.

90. Morocco has numerous institutions with a mandate to hear and decide on grievances and claims related to activities supported by the proposed PforR. The existence of grievance and appeal mechanisms and their recent promotion to the constitutional level provide them with the necessary independence and financial autonomy, as well as expanded powers for self-referral.[86] The World Bank's GRS system does not minimize the value of the Moroccan system of grievance management.

[86] *https://www.chikaya.ma/*

V. RISK

91. **The overall risk rating for the proposed operation is Substantial** due to macroeconomic, sector strategies and policies, institutional capacity for implementation and sustainability, stakeholders, fiduciary, and environmental and social risks, which are all rated Substantial.

92. **The macroeconomic risk is rated as Substantial.** Global market conditions and frequent droughts due to climate change may continue to put pressure on commodity prices and adversely affect the post-COVID-19 recovery. Further downturn in the global economic outlook could reduce exports, tourism receipts, and foreign direct investment. Inflationary pressures remain strong, eroding household's purchasing power and thus consumption, while the monetary policy tightening has increased the sovereign's domestic borrowing costs. This could reduce the Government's ability to reverse the upward trajectory of the debt-to-GDP ratio over the medium term. In addition, the resulting accumulation of debt globally could trigger an episode of international financial instability, affecting Morocco's ability to access external finance and/or increasing the cost of covering its financial needs, as well as reducing the potential for increased public spending. The New Development Model and the reform agenda engaged by the government's would improve the attractiveness of Morocco for private investment, especially in promising sectors with high value-added and mitigate the impact of these potential risks. The International Monetary Fund has recently approved a precautionary Flexible Credit Line, which will ensure continued sustainable financing for the health system reform, which is already reflected in the government's three-year budget.

93. **Sector strategies and policies, institutional capacity for implementation and sustainability, and stakeholders risks are Substantial.** These risks stem primarily from the high level of ambition of the reform and its incipient and evolving nature. The reform entails fundamental changes to the governance of the health sector with the introduction of an array of new governance bodies, institutional arrangements, and legislative and regulatory texts. While bold legislative reforms have been adopted, many critical elements of reform design are still to be defined through the application decrees as well as the dissemination of Laws 08-22 and 09-22. This is likely to impact institutional coordination among key stakeholders at different governance levels (ranging from central levels to regional, and public hospital/public PHC facilities) and across different institutions (for example between the MHSP and the HAS). High level of political commitment by the Government has been mobilizing the needed financial, human, and technical resources to support the reform. While this Program is entirely based on elements that are described under the Framework Law 06-22, which has already been promulgated, the promulgation of related Laws 08-22 and 09-22 are included as prior actions in a World Bank DPF under preparation, which contributes to reducing the legislative uncertainty. The World Bank together with other development partners, such as the EU, WHO, AFD, and JICA, is also supporting capacity development through technical assistance on important aspects of the reform including roadmap for strategic purchasing, evaluation of the epidemiological surveillance system, and support on gender-based violence aspects.

94. **The residual environmental and social risk is Substantial.** This is due to the potential delay in the designation of environmental and social focal points at the central and regional levels, limiting the dissemination of environmental and social management procedures and the implementation of the ESSA action plan. On the social side, the Program's main risks would be the risk of exclusion of vulnerable groups from quality service provision, for example for survivors of GBV, people with disabilities and rural women (with low levels of literacy), including *intersectionalitie*s amongst these vulnerable groups. In addition, health workers can face abuse from

those in power within the health system, and also at times from patients, and vice versa. The ESSA includes an assessment of systems of response to GBV and identifies strengthening mechanisms. The Program has also a potential to not only mitigate these risks but also to mainstream upstream actions to increase duty bearers' capacity and systems on prevention and response to GBV in Morocco in general.

95. **Residual fiduciary risk is rated Substantial**. While the PFM and procurement country systems at the national level are deemed acceptable to the World Bank and broadly meet the requirements for the implementation of a PforR, there are several identified risks: (i) weaknesses in capacity for procurement planning, execution and performance reporting and lack of complaints' tracking, suspension and debarment check mechanism; (ii) challenges in operationalizing the new public procurement decree; iii) delays in implementing audit recommendations and/or failure to systematically report on the status of the implementation of audit recommendations; (iv) delay in deployment of Internal Audit and Management Control Units; (v) multiplicity of executing directorates combined with weak coordination mechanisms; (vi) quality and timeliness of submission of consolidated financial statements; and (vii) ineffectiveness or absence of mechanisms for the collection, consolidation, and periodic reporting of cases of fraud and corruption or whistleblowing. Fiduciary risk mitigation measures have been embedded to ensure adequate and timely budget planning and execution, effective accountability and transparency mechanisms, and achievement of expected results, as detailed in the PAP and the fiduciary assessment annex. Mitigation measures include: (i) ensuring that annual procurement plans are published no later than the end of the first quarter of each fiscal year and implemented in accordance with existing regulations, particularly at deconcentrated levels; (ii) developing and implementing a program to enhance capacity-building on the new procurement decree; (iii) implementing a semi-annual reporting mechanism on tenders and procurement-related complaints; (iv) including an eligibility check clause in the bidding documents to eliminate debarred and suspended firms/individuals by the Bank; (v) assigning fiduciary focal points to strengthen coordination between implementing entities and developing tools for collecting budget execution and accounting data; (vi) developing in the POM tools and procedures for collection, consolidation, and reporting on cases of fraud and corruption. Successful implementation of the deconcentration, with strengthened management and fiduciary capacity of deconcentrated entities, is a core piece of this Program as supported by DLI 1, and presents opportunities for mitigating the identified risks and ensuring a successful implementation of the PAP.

ANNEX 1. RESULTS FRAMEWORK MATRIX

Results Framework
COUNTRY: Morocco
Morocco Health Reform Program

Program Development Objective(s)

To strengthen institutional capacity and governance for improved provision of quality public health services in the Program Area

Program Development Objective Indicators by Objectives/Outcomes

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Strengthened organizational and institutional capacity for health system governance							
Strengthened institutional capacity through the new deconcentrated governance system (Text)	DLI 1	Legal framework for the establishment of territorial health groups (GST) established through publication of Framework Law 06-22. Training programs for relevant staff do not include the current decentralization arrangements.	100 percent of GST in Program area established and defined their governance framework including: i) an executive board; ii) an organogram; iii) the status of personnel; and iv) internal regulations	Development of a training program by the MHSP for relevant GST staff in Program area in performance-management, financial management, gender approach (including GBV), and health sector resilience to climate change	100 percent of GST in Program area have developed and validated their regional medical program, including a focus on gender-sensitive service delivery and services for GBV survivors	100 percent of GST in Program area have trained relevant staff in performance-based management, financial management, gender approach (including GBV), and health sector resilience to climate change	100 percent of GST in Program area have established a regional health map
Improved availability, motivation and competence of human resources for health							

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Health service operationalized to define health worker entitlements and to improve the quality of service delivery (Text)	DLI 5	The distribution of human resources across regions and provinces is not equitable, and some provinces do not have sufficient staffing of doctors, nurses and technical health staff		Adoption by decree of a financial incentive model for human resources including elements on (i) regional characteristics; (ii) performance of health workers (including quality of care)	100 percent of GST in Program area have operationalized the human resources information system	100 percent of GST in Program area have implemented the human resources incentive model	100 percent of GST in Program area have increased their human resource capacity by 50 percent with respect to identified gaps in 2023 to ensure an equitable distribution, particularly at the level of under-resourced provinces
Strengthened and reorganized health services							
Quality of care at public hospitals and public PHC facilities evaluated and improved (Text)	DLI 8	Development of quality standards and ongoing quality evaluation of public hospitals.		100% of GST in Program area have a quality management structure in place	Development and adoption of quality evaluation tools for public PHC facilities	100 percent of GST in Program area have adopted a quality evaluation and improvement roadmap	100 percent of GST in Program area have produced a quality evaluation report and adopted a quality improvement plan for public hospitals and public PHC facilities
Availability of essential health service package at public PHC facilities (Text)		72% of public PHC facilities in Program area have essential health service package			85% of public PHC facilities in Program area have essential health service package		90% of public PHC facilities in Program area have essential health service package

Intermediate Results Indicator by Results Areas

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Strengthened organizational and institutional capacity for health system governance							
Exchange and coordination platforms organized between central and regional entities (Text)	DLI 4	Communication focal points at the regional health directorate level, informal communication networks between the regions and the central level		Validation of terms of reference and deployment roadmap for the exchange and coordination platform	33 percent of GST in Program area have deployed the exchange and coordination platform and published a report on the main learnings	55 percent of GST in Program area have deployed the exchange and coordination platform and published a report on the main learnings	100 percent of GST in Program area have published a report on key discussion areas from the platform and have integrated suggestions emerging from the exchange and coordination platform
Improved patient satisfaction (Text)		No systematized tracking of patient satisfaction	Survey tool developed for collecting routine and rapid patient satisfaction data	First round of patient satisfaction survey implemented; baseline established	5 percentage point increase compared to baseline established in year 2	10 percentage point increase compared to baseline established in year 2	15 percentage point increase compared to baseline established in year 2
Improved availability, motivation and competence of human resources for health							
Update of training curricula for nurses and health technicians to reflect the health system redesign program, with the incorporation of rights to health and gender, including GBV (Text)		Training curricula not updated to reflect the health system redesign program with the integration of rights to health and gender	Adoption of a new set of national educational standards manual (cahier des normes pedagogiques nationales, CNPN) specific to health worker training	Pre-service training curricula for nurses and health technicians have been updated to reflect the health system redesign program, with the incorporation of rights to health and gender, including GBV	100% of ISPITS in Program area implementing new CNPN and new ISPITS training curricula	100% of GST in Program area have finalized an update to their in-service training curricula for nurses and technical staff	100% of GST in Program area have implemented the updated in-service training curricula for nurses and technical staff
Improved training capacity for ISPITS (Number)		7,500.00	9,100.00	10,900.00	10,900.00	11,100.00	11,600.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Strengthened and reorganized health services							
Strengthened epidemiological surveillance capacity including for climate change related health issues (Text)	DLI 9	A study was conducted to assess epidemiological surveillance capabilities	Adoption of a roadmap by the MHSP for the restructuring of epidemiological surveillance capacity based on priority areas	Adoption of the new epidemiological surveillance system by MHSP	Adoption of updated epidemiological surveillance regulations, and adoption of the updated list of notifiable diseases including those related to climate change, by MHSP		100 percent of GST in Program area published epidemiological bulletins based on approved revised surveillance regulations
Strengthening of the governance and organization of preventive health services for screening for congenital hypothyroidism (Text)		Screening for congenital hypothyroidism available in 56 percent of GST/regions in Program area	Screening for congenital hypothyroidism available in 67 percent of GST/regions in Program area	Screening for congenital hypothyroidism available in 78 percent of GST/regions in Program area	Screening for congenital hypothyroidism available in 78 percent of GST/regions in Program area	Screening for congenital hypothyroidism available in 89 percent of GST/regions in Program area	Screening for congenital hypothyroidism available in 100 percent of GST/regions in Program area
Maternal and neonatal death surveillance, audit, and response system scaled up (Text)		70% of GST in Program area use the maternal death surveillance system	80% of GST in Program Area using the upgraded maternal death surveillance system (SSDMAR)	100% of GST in Program Area using the upgraded maternal death surveillance system (SSDMAR)	50% of GST in Program Area having integrated neonatal death audit into the SSDMAR	100% of GST in Program Area having integrated neonatal death audit into the SSDMAR	50% of GST in Program area have completed maternal and neonatal death audit reports
Percentage of pregnant women in Program area who have completed 4 antenatal care visits (Text)		Rural: 38.5% (2018) Urban: 65.6% (2018)					Rural: 47% Urban: 70%
Percentage of pregnant women in Program area who have completed 4 antenatal care visits in rural areas (Text)		38.50		47.00			47.00
Percentage of pregnant women in Program area		65.60		70.00			70.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
who have completed 4 antenatal care visits in urban areas (Text)							

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Strengthened institutional capacity through the new deconcentrated governance system	• Health system redesign program entails a substantial shift towards a decentralized governance model, with the introduction of many management, planning, and budgeting tools for GST to fulfill their responsibilities. • This indicator/DLI incentivizes the development of key management inputs, such as executive board, organogram, and status of personnel, as well as key planning tools, such as the regional medical program and the health map. Evidence from other sectors demonstrates challenges in institutionalizing decentralized arrangements, and the DLI will accelerate this implementation. This also implies a substantial need	Annually	MHSP	First year – Verification of 2 published legislative decrees (on executive board, organizational structure, personnel structure) and official regulation upon receipt by the Inspection General (IG) of the MHSP Second year - Receipt of an internal signed MHSP letter confirming the establishment (adoption) of the training program and its communication to GST Third year - Desk review of (i) elaborated, validated regional medical program with contents according to standards defined in the POM and (ii) receipt of the validated (through signatures and internal communication) regional medical program by the	MHSP

	to strengthen the capacity of relevant personnel working in GST, with training serving as the first step for personnel to be able to strengthen institutional capacity. This indicator/DLI also incentivizes the development and implementation of a comprehensive training program for GST, including a focus on planning and implementing interventions within GST to support victims of GBV and to adapt to the health impacts of climate change.			IG Fourth year - (i) Desk review of the list of relevant staff who completed training and the training meeting minutes (ii) verification via telephone of a random 1% subset of staff who completed training Fifth year - Desk review of (i) regional health map according to standards defined in the POM by the IG	
Health service operationalized to define health worker entitlements and to improve the quality of service delivery	• Human resources for health are inequitably distributed across the regions and provinces, with some areas being critically under-resourced; there are no financial incentives for health workers to enable deployment to hard-to-reach areas or to improve their performance. The operationalization of the health service, through the	Annually	MHSP	Year 2 - Official publication of decree within Law 09-22 on the performance-based health worker payment modality, including the quality component Year 3 - Validation of the functionality of the information system at each GST by the IG according to standards defined in the POM,	MHSP

	design of a new payment modality, will allow to improve the motivation and distribution of the health workforce, encouraging deployment in under-resourced regions and provinces through a system of coefficients of medical procedures by regions, including incorporating conditions of distributions of the labor force through a gender lens. • The DLI will incentivize the integration of well-defined measures on quality and performance into the payment of health workers, with the intention of motivating health workers to close the know/do gap and to work in hard-to-reach areas, including areas most vulnerable to climate change, leveraging information from the climate health vulnerability assessment to identify climate vulnerable			through a reception of an official letter from each GST Year 4 -- Official communication received by the IG from the GST indicating the implementation of the performance payment modality aligned with the decree adopted in/before year 2 Year 5 - (i) Communication signed by GST board with a list of health workers who have been deployed to close health workforce inequalities between provinces within the GST, as defined and stipulated in the POM	

	facilities. This will also ensure bringing services closer to the population, with increased availability of health services at the regional level, therefore resulting in a lower carbon footprint for the health sector through reduced mobility to seek health services.				
Quality of care at public hospitals and public PHC facilities evaluated and improved	• Deconcentration provides an opportunity to incentivize and institutionalize quality improvements at the facility level. • This DLI includes a phased approach for the institutionalization of quality evaluations at the GST level, starting with the establishment of a quality assessment structure at the GST level, then the development and adoption of quality evaluation tools for public PHC facilities. The last two annual targets will focus on the development and adoption of a quality evaluation and	Annually	MHSP	Year 2 - Receipt of signed and validated terms of reference by the IG of a quality of care management unit within each GST that has become operational Year 3 - Adoption of PHC center quality evaluation tools to be validated by through the reception with signature by the IG Year 4 - Formal adoption of quality assessment and improvement roadmap for hospitals and PHC for each GST, through the receipt of an internal letter by the IG for	MHSP

	improvement roadmap, then on the production of a quality evaluation report and adoption of a quality improvement plan for hospitals and public PHC facilities.			validation, in compliance with the criteria indicated in the POM Year 5 - Receipt of validated (through signature and endorsement by each GST executive board) quality evaluation report and improvement roadmap for hospitals and PHC facilities within the GST by the IG for validation in compliance with the criteria indicated in the POM	
Availability of essential health service package at public PHC facilities	MHSP has an essential health service package for primary care levels which differs according to the level of the public PHC facility. A survey was conducted by the MSPS among a purposive sample of about 446 PHCs (considered as chief health district or circle) in the Program area, to assess the availability of the essential health services package at the PHC level. This survey captured a range of	Year 3 and 5	MHSP	Data on the availability and structural quality of the essential package of health services in the sample of 446 PHC facilities in the Program Area will be collected through an evaluation survey to see the impact of the outreach measures put in place following the 2021 survey, and to measure the progress in the availability of the essential package of	MHSP

	elements pertaining to structural quality of health facilities, including the availability of staff, availability of medicines, and availability of medical equipment to enable effective screening and treatment of maternal and newborn health conditions, as well as non-communicable diseases. The results of the survey led to the implementation of a series of improvement measures.			health services in this sample of PHC facilities covered by the initial survey. This indicator provides a percentage of the overall availability of the essential health service package interventions at PHC facilities, based on the survey.	

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Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Exchange and coordination platforms organized between central and regional entities	Given the substantial nature of changes and the increase in the number of stakeholders with the health sector reform, it is essential to institutionalize knowledge exchange and coordination platforms to improve the responsiveness of the health system. • This Indicator/DLI incentivizes the implementation of a systematic platform to facilitate these exchanges, which will provide a crucial platform for change management, citizen engagement, and a modality to institutionalize learning.	Annually	MHSP	Year 2 - Desk review of the final terms of reference and roadmap for the deployment of a platform, with contents according to standards defined in the POM, and receipt of an official letter from the Communication Division of the MHSP to IG highlighting the adoption of the terms of reference and roadmap for the deployment Year 3-4 - Assessment of the deployment of the platform in each region, with the methodology and assessment report	MHSP
Improved patient satisfaction	Given the substantial changes expected with the health system redesign program, it is essential to track the feedback from patients. There is currently no systematized modality	Annually	MHSP	The development of the survey tool, as well as the results from the annual surveys, will be submitted by the MHSP (Communication Directorate) to the	MHSP

	to regularly track patient feedback. In this context, this indicator measures the establishment of a standardized process to measure patient satisfaction, and its implementation to track improvements as a result of the successful implementation of the reform.			World Bank through the routine supervision reports of the Program.	
Update of training curricula for nurses and health technicians to reflect the health system redesign program, with the incorporation of rights to health and gender, including GBV	Health system redesign program will entail substantial changes to service delivery, through reorganization of service delivery, definition of pathways, increased autonomy and accountability with performance / quality payments for health workers. In addition, there is a renewed focus on various priority epidemiological conditions, such as chronic diseases and the care of gender-based violence survivors. This necessitates an overhaul of pre-service	Annually	MHSP	Each yearly outcome will be verified through a review of documents produced by the MSPS (HRD) as part of overall supervision.	MHSP

	training curricula at ISPITS and in-service training curricula at the GST level, which will contribute to improved quality of service delivery. This indicator captures the updates to these training curricula as well as their implementation for pre-service training at ISPITS, and in-service training at the GST level, with the incorporation of rights to health and gender, including gender-based violence.				
Improved training capacity for ISPITS	• The Ministry of Health and Social Protection developed an action plan to train of 64,000 nurses, and this expansion in capacity will be supported by the DLI, which includes annual cumulative end targets of 11,600 for the number of enrollees from ISPITS from a baseline of 7,500 ISPITS enrolled.	Annually	MHSP	Every year: (i) Desk review of proofs of enrollees as received in official communication from ISPITS to IG for a given academic year and (ii) verification via phone call to a random subset of 5% of students enrolled from that given year.	MHSP
Strengthened epidemiological surveillance capacity including for climate change related health issues	• Epidemiological surveillance capacity is a key health system function,	Annually	MHSP	Year 1 - Desk review of (i) the roadmap with contents satisfying	MHSP

	especially as the health risks from climate change become more imminent; MHSP is in the process of restructuring epidemiological surveillance capacity. • This indicator/DLI incentivizes the government to implement this restructuring process to strengthen surveillance capacity, starting with the definition of a roadmap in the first year, followed by the adoption and validation of the structure of the epidemiological surveillance in the second year, and the update and adoption of regulations in the third year. This indicator/DLI has a focus on climate change adaptation and will include the inclusion of climate change related diseases in the updated list of notifiable diseases in the third year. The fourth and fifth years will ensure that GSTs publish			standards defined in the POM and (ii) proofs of its formal adoption (meeting minutes signed by all directorates in the meeting adopting the roadmap submitted to the IG) Year 2 - Desk review of (i) the structure of the epidemiological surveillance system and (ii) proofs of its formal adoption (official circular) received and validated by the IG Year 3 - Desk review of (i) adopted new surveillance regulations satisfying standards defined in the POM, (ii) updated list of notifiable diseases satisfying standards defined in the POM (official ministerial decree) received and validated by the IG Year 5 - Desk review of the published regional epidemiological bulletins officially approved by	

	epidemiological bulletins based on new regulations.			the GST board of directors and received and validated by the IG	
Strengthening of the governance and organization of preventive health services for screening for congenital hypothyroidism	Within the framework of the government's strategy to strengthen prevention of health services, the governance and organization of preventive services for congenital hypothyrodism (CH) is a signiifcant priority, and strengthened prevention for this condition is a cost-effective way to reduce the burden of physical and mental health conditions. This indicator captures the progressive implementation of the government's strategy to reduce this burden and also provide a blueprint for the prevention of other priority health conditions, serving as a proxy for the government's scale up of preventive services through the health system redesign program.	Annually	MHSP	The targets for the indicator are to be validated through desk review, and include the progressive scale-up of congenital hypothroidism screening and diagnosis capacity.	MHSP
Maternal and neonatal death surveillance, audit, and response system scaled up	Maternal and neonatal mortality in Morocco	Annually	MHSP	Receipt of reports by the World Bank from the	MHSP

	continues to remain high, and maternal and neonatal death surveillance, audit, and response system is critical to decrease the number of avoidable deaths. • This Indicator incentivizes the accelerated scale-up of the maternal surveillance system in the first year, the integration of neonatal death audit in the second and third years, and the development and implementation of recommendations to reduce maternal and neonatal deaths in the fourth and fifth years.			MHSP which detail the progress made with the extension of the system and the production of death audit reports, within the annual Program progress reports	
Percentage of pregnant women in Program area who have completed 4 antenatal care visits	There is a substantial gender gap between the coverage of the required four antenatal care visits between women living in urban and rural areas, which is a key health indicator for maternal health. Most women end up seeking care antenatal care services at the PHC level, and the health system redesign is	Year 2 and 5	Survery by the Population and Family Health Survey (ENPSF),	Data comes from the Population and Family Health Survey (ENPSF), which was last conducted in 2018 and will next be conducted in 2024-2025, which is the midpoint target. The final target will be confrimed on the basis of the results of the 2024-25 survey	MHSP

	expected to increase utilization of these services.				
Percentage of pregnant women in Program area who have completed 4 antenatal care visits in rural areas					
Percentage of pregnant women in Program area who have completed 4 antenatal care visits in urban areas					

ANNEX 2. DISBURSEMENT LINKED INDICATORS, DISBURSEMENT ARRANGEMENTS AND VERIFICATION PROTOCOLS

Disbursement Linked Indicators Matrix				
DLI 1	Strengthened institutional capacity through the new deconcentrated governance system			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	75,000,000.00	16.67
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Legal framework for the establishment of territorial health groups (GST) established through publication of Framework Law 06-22. Training programs for relevant staff do not include the current decentralization arrangements.			
2024	100 percent of GST in Program area established and have defined their governance framework including: i) an executive board; ii) an organogram; iii) the status of personnel; and iv) internal regulations		22,500,000.00	US$2,500,000 for each 11% of GST in Program area established with executive board, organogram, personnel, internal regulations
2025	Development of a training program by the MHSP for relevant GST staff in Program area in performance- management, financial management, gender approach (including gender-based violence - GBV) and health sector resilience to climate change		15,000,000.00	US$15 million per the adoption of a training program according to standards defined in the POM

2026	100 percent of GST in Program area have developed and validated their regional medical program, including a focus on gender-sensitive service delivery, and services for GBV survivors	7,500,000.00	US$833,333 to be disbursed for 11% of GST in Program area which have elaborated and validated a regional medical program
2027	100 percent of GST in Program area have trained relevant staff in performance-based management, financial management, gender approach (including GBV) and health sector resilience to climate change	22,500,000.00	US$2,500,000 to be disbursed per 11% of GST in Program area which have trained at least 50% of their relevant staff
2028	100 percent of GST in Program area have established a regional health map	7,500,000.00	US$833,333 to be disbursed for 11% of GST in Program area which have delivered a regional health map

DLI 2	Health financing system reformed to reflect the context of the reform and improve quality of service delivery			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	28,875,000.00	6.42
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Public hospitals constitute 10 percent of Mandatory Health Insurance third party payments			
2024	Roadmap adopted by the MHSP for the progressive financing of GST by AMO payments, including the interoperability of the billing system with the CNSS in Program area		6,375,000.00	US$6,375,000 upon verification of adopted roadmap
2025	-		0.00	-

2026	Roadmap adopted by MHSP on the financing modalities of public health facilities within each GST of Program area	7,500,000.00	US$7,500,000 upon adoption of roadmap
2027	40 percent of total GST budgets in Program area are from AMO payments	7,500,000.00	US$187,500 for each 1% of total GST budgets coming from AMO payments
2028	70 percent of GST budgets in Program area are from AMO payments	7,500,000.00	US$250,000 for each additional 1% of total GST budgets coming from AMO payments

DLI 3	Improved content, quality, accessibility, and use of health data			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	37,500,000.00	8.33
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Integrated and digitalized health information system deployed at hospitals, and deployment began in PHC centers			
2024	33 percent of GST in Program area have deployed the integrated and digitalized health information system at public PHC facilities		13,500,000.00	US$4,500,000 for each 11 percent of GST in Program area which have deployed the integrated and digitalized HIS at PHCC
2025	56 percent of GST in Program area have deployed the integrated and digitalized health information system at public PHC facilities		6,000,000.00	US$3,000,000 for each additional 11 percent of GST in Program area which have deployed the integrated and digitalized HIS at PHCC

2026	78 percent of GST in Program area have deployed the integrated and digitalized health information system at public PHC facilities	6,000,000.00	US$3,000,000 for each additional 11 percent of GST in Program area which have deployed the integrated and digitalized HIS at PHCC
2027	100 percent of GST in Program area have deployed the integrated and digitalized health information system at public PHC facilities	6,000,000.00	US$3,000,000 for each additional 11 percent of GST in Program area which have deployed the integrated and digitalized HIS at PHCC
2028	Publication of an annual health sector report in Program area on health programs with an emphasis on quality indicators	6,000,000.00	US$6,000,000 for the publication of an annual health sector report including data on quality in Program area

DLI 4	Exchange and coordination platforms organized between central and regional entities			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	30,000,000.00	6.67
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Communication focal points at the regional health directorate level, informal communication networks between the regions and the central level			
2024	-		0.00	-
2025	Validation of terms of reference and deployment roadmap for the exchange and coordination platform by the MHSP		7,500,000.00	US$7,500,000 for the validation of final terms of reference and deployemnt roadmap for the

			exchange and coordination platform
2026	33 percent of GST in Program area have deployed the exchange and coordination platform and published a report on the lessons learned	9,000,000.00	US$3,000,000 per 11% of GST that has deployed the exchange and coordination platform
2027	55 percent of GST in Program area have deployed the exchange and coordination platform and published a report on the lessons learned	6,000,000.00	US$3,000,000 per 11% of GST that has deployed the exchange and coordination platform (in addition to those in preceding year)
2028	100 percent of GST in Program area have published a report on key discussion areas from the platform and have incorporated suggestions from the exchange and coordination platform	7,500,000.00	US$1,875,000 per 11% of GST which has published a report incorporating platform suggestions

DLI 5	Health service operationalized to define health worker entitlements and to improve the quality of service delivery			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	45,000,000.00	10.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	The distribution of human resources across regions and provinces is not equitable, and some provinces do not have sufficient staffing of doctors, nurses and technical health staff			
2024	-		0.00	-
2025	Adoption by a decree of a financial incentive model for human resources, including (i) regional characteristics; (ii) performance of health		15,000,000.00	US$15,000,000 for verification of the decree for the adoption of the new financial incentive model

	workers (including quality of care)		
2026	100 percent of GST in Program area have operationalized the human resources for health information system	11,250,000.00	US$1,250 per 11% of GST that have fully operationalized the human resources health information system
2027	100 percent of GST in Program area have implemented the financial incentive model for human resources	6,750,000.00	US$750,000 per 11% of GST that implements the human resource incentive model
2028	100 percent of GST in Program area have increased their human resource capacity by 50% relative to the gap identified in 2023 to ensure equitable distribution, particularly for understaffed provinces	12,000,000.00	US$1,333,333 per 11% of GST which closes more than 50% of the human resource for health gap identified in CY2023

DLI 6	Improved training capacity at ISPITS			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Number	45,000,000.00	10.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	7,500.00			
2024	9,100.00		12,000,000.00	US$1,097,561 for each 100 openings for nurses and health technicians to enroll in ISPITS
2025	10,900.00		10,500,000.00	US$1,097,561 for each 100 openings for nurses and health technicians to enroll in ISPITS

2026	10,900.00	7,500,000.00	US$1,097,561 for each 100 openings for nurses and health technicians to enroll in ISPITS
2027	11,100.00	7,500,000.00	US$1,097,561 for each 100 openings for nurses and health technicians to enroll in ISPITS
2028	11,600.00	7,500,000.00	US$1,097,561 for each 100 openings for nurses and health technicians to enroll in ISPITS

DLI 7	Number of public PHC facilities in Program area rehabilitated to comply with energy and thermal efficiency standards to address climate vulnerabilities			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Number	75,000,000.00	17.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
2024	100.00		30,000,000.00	US$189,873 for each additional public PHC facility renovated to meet energy and thermal efficiency standards
2025	200.00		15,000,000.00	US$189,873 for each additional public PHC facility renovated to meet energy and thermal efficiency standards

2026	300.00	15,000,000.00	US$189,873 for each additional public PHC facility renovated to meet energy and thermal efficiency standards
2027	395.00	15,000,000.00	US$189,873 for each additional public PHC facility renovated to meet energy and thermal efficiency standards
2028	395.00	0.00	-

DLI 8	Quality of care at public hospitals and public PHC facilities evaluated and improved			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	45,000,000.00	10.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Development of quality standards and ongoing quality evaluation of public hospitals			
2024	-		0.00	-
2025	100% of GST in Program area have established a quality management structure		13,500,000.00	US$1,500,000 per the verification of the quality management structure at 11% of GST in Program area
2026	Development and adoption of quality evaluation tools for public PHC facilities		9,000,000.00	US$9,000,000 for the adoption of quality evaluation tools for PHC facilities

2027	100 percent of GST in Program area have adopted a quality evaluation and improvement roadmap	9,000,000.00	US$1,000,000 for each 11% of GST in Program area have adopted a quality assessment and improvement roadmap as verified by circulars
2028	100 percent of GST in Program area have produced a quality evaluation report and adopted a quality improvement plan for public hospitals and public PHC facilities	13,500,000.00	US$1,500,000 for each 11% of GST in Program area produced quality evaluation report and adopted a quality improvement plan

DLI 9	Strengthened epidemiological surveillance capacity including for climate change related health issues			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	67,500,000.00	15.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	A study was conducted to assess epidemiological surveillance capabilities			
2024	Adoption of a roadmap by the MHSP for the restructuring of epidemiological surveillance capacity based on priority areas		13,500,000.00	US$13,500,000 for the roadmap for the restructuring of epidemiological surveillance capacity based on priority areas
2025	Adoption by the MHSP of the new epidemiological surveillance system		16,875,000.00	US$16,875,000 for the adoption of the structure of the epidemiological surveillance system, through a ministerial circular
2026	Adoption of updated epidemiological surveillance regulations, and adoption of the updated list of		16,875,000.00	US$16,875,000 for adoption of regulations and updating the list of

	notifiable diseases including those related to climate change, by MHSP		notifiable diseases including climate change through a decree
2027	-	0.00	-
2028	100 percent of GST in Program area published epidemiological bulletins based on approved revised surveillance regulations	20,250,000.00	US$2,250,000 for each 11% of GST in Program area have published an epidemiological bulletin based on new regulations

Verification Protocol Table: Disbursement Linked Indicators	
DLI 1	Strengthened institutional capacity through the new deconcentrated governance system
Description	• Health system redesign program entails a substantial shift towards a decentralized governance model, with the introduction of many management, planning, and budgeting tools for GST to fulfill their responsibilities. • This DLI incentivizes the development of key management inputs, such as executive board, organogram, and status of personnel, as well as key planning tools, such as the regional medical program and the health map. Evidence from other sectors demonstrates challenges in institutionalizing decentralized arrangements, and the DLI will accelerate this implementation. This also implies a substantial need to strengthen the capacity of relevant personnel working in GST, with training serving as the first step for personnel to be able to strengthen institutional capacity. This DLI also incentivizes the development and implementation of a comprehensive training program for GST, including a focus on planning and implementing interventions within GST to support survivors of GBV and to adapt to the health impacts of climate change.
Data source/ Agency	MHSP
Verification Entity	Inspection General of the MHSP
Procedure	First year – Verification of 2 published legislative decrees and other regulatory acts upon receipt by the Inspection General (IG) of MHSP Second year - Receipt of an internal MHSP letter confirming the development (adoption) of the training program and its communication to GST by IG of MHSP Third year - Desk review of (i) developed, validated regional medical program with contents according to standards defined in the POM and (ii) receipt of the validated (through signatures and internal communication) regional medical program by the IG Fourth year - (i) Desk review of the list of relevant staff who completed training and the training meeting minutes (ii) verification via telephone of a random 1% subset of staff who completed training by the IG of MHSP Fifth year - Desk review of regional health map according to standards defined in the POM by the IG of MHSP
DLI 2	Health financing system reformed to reflect the context of the reform and improve quality of service delivery
Description	• Provider payment modalities will shift drastically, with additional responsibilities to GST to purchase services from the integrated network of health facilities within their jurisdiction, as well as bill CNSS and CNOPS for delivered services. • This DLI incentivizes the finalization of a roadmap to define provider payment modalities within GST and includes targets on the

	share of hospital financing that would be coming through AMO financing as a metric for improved financial sustainability.
Data source/ Agency	MHSP
Verification Entity	Inspection General of MHSP
Procedure	For years 1 and 3: receipt of validated roadmap with an internal letter signed by the Minister of Health For years 4 and 5, submission of reports from each of the GST regarding financial flows
DLI 3	Improved content, quality, accessibility, and use of health data
Description	• The government is in the process of finalizing the infrastructure for the deployment of patient-level electronic medical records, with deployment at PHC facilities the only remaining phase. • This DLI incentivizes the finalization of the deployment of integrated health information systems, as well as timely use of this data, through targets on the finalization of an annual health sector report including quality of care indicators (across structure, process, and outcomes) becoming available a year after the availability of data.
Data source/ Agency	MHSP
Verification Entity	Inspection General of MHSP
Procedure	Years 1 – 4: Report from the Information Systems Directorate (DIM) proving the implementation of the health information system at GST in Program area Year 5 - Report from DIM demonstrating the scale up of the information system at all GST and receipt of the report for verification
DLI 4	Exchange and coordination platforms organized between central and regional entities
Description	• Given the substantial nature of changes and the increase in the number of stakeholders with the health sector reform, it is essential to institutionalize knowledge exchange and coordination platforms to improve the responsiveness of the health system. • This DLI incentivizes the implementation of a systematic platform to facilitate these exchanges, which will provide a crucial platform for change management, citizen engagement, and a modality to institutionalize learning.
Data source/ Agency	MHSP
Verification Entity	Inspection General of MHSP

Procedure	Year 2 - Desk review of the final terms of reference and roadmap for the deployment of a platform, with contents according to standards defined in the POM, and receipt of an official letter from the Communication Division of the MHSP to IG highlighting the adoption of the terms of reference and roadmap for the deployment Year 3-4 - A report of the deployment of the platform in each region, with the methodology and assessment report according to standards defined in the POM, through a signed letter from the Communication Division of the MHSP to the IG Year 5 - Desk review of (i) the annual report which is officially received by the IG from the MHSP with an official letter by the Information Systems Directorate; ii) meeting minutes and attendance list of the national workshop signed by the Information Systems Directorate and submitted to IG where the discussions were conducted on the learnings from the platform
DLI 5	Health service operationalized to define health worker entitlements and to improve the quality of service delivery
Description	• Human resources for health are inequitably distributed across the regions and provinces, with some areas being critically under-resourced; there are no financial incentives for health workers to enable deployment to hard-to-reach areas or to improve their performance. The special status for health workers, notably through the design of a new payment modality, will allow to improve the motivation and distribution of the health workforce, encouraging deployment in under-resourced regions and provinces through a system of coefficients of medical procedures by regions. The new payment modality will also have a quality component. • The DLI will incentivize the integration of well-defined measures on quality and performance into the payment of health workers, with the intention of motivating health workers to close the know/do gap and to work in hard-to-reach areas.
Data source/ Agency	MHSP
Verification Entity	Inspection General of MHSP
Procedure	Year 2 - Official publication of decree within Law 09-22 on the performance-based health worker payment modality, including the quality component Year 3 - Validation of the functionality of the information system at each GST by the IG according to standards defined in the POM, through a reception of an official letter from each GST Year 4 -- Official communication received by the IG from the GST indicating the implementation of the performance payment modality aligned with the decree adopted in/before year 2 Year 5 - (i) Communication signed by GST board with a list of health workers who have been deployed to close health workforce inequalities between provinces within the GST, as defined and stipulated in the POM

DLI 6	Improved training capacity at ISPITS
Description	• The Ministry of Health and Social Protection developed an action plan to train of 64,000 nurses, and this expansion in capacity will be supported by the DLI, which includes annual cumulative end targets of 11,600 for the number of enrollees from ISPITS from a baseline of 7,500 ISPITS enrolled . • For disbursement purpose, only end targets are considered.
Data source/ Agency	MHSP
Verification Entity	Inspection General of MHSP
Procedure	Every year: (i) Desk review of proofs of enrollees as received in official communication from from the Human Resources Directorate of the MHSP to IG for a given academic year Loan Agreement for this indicator shows cumulative targets and amounts with scalability formula.
DLI 7	Number of public PHC facilities in Program area rehabilitated to comply with energy and thermal efficiency standards to address climate vulnerabilities
Description	• Rehabilitation of primary health centers (PHC facilities) is a crucial enabler of service delivery reorganization, as they will form the entry point to integrated care pathways within a GST. At the same time, in line with the government guidelines, there is a substantial need to reinforce the climate change resilience and energy efficiency of all public infrastructure, including PHC facilities. • This DLI ensures that the energy and thermal efficiency standards, as specified in the contract specifications and scope of work, are effectively met as PHC facilities are renovated. • For disbursement purpose, only end targets are considered.
Data source/ Agency	MHSP
Verification Entity	Inspection General of MHSP
Procedure	For each year: (i) Receipt of official documentation indicating the rehabilitation has been completed in line with criteria specified in the POM by the IG Loan Agreement for this indicator shows cumulative targets and amounts with scalability formula.
DLI 8	Quality of care at public hospitals and public PHC facilities evaluated and improved
Description	• Decentralization provides an opportunity to incentivize and institutionalize quality improvements at the facility level. • This DLI includes a phased approach for the institutionalization of quality evaluations at the GST level, starting with the establishment of a quality assessment structure at the GST level incorporated to regional medical programs.

Data source/ Agency	MHSP
Verification Entity	Inspection General of MHSP
Procedure	Year 2 - Receipt of signed and validated terms of reference by the IG of a quality of care management unit within each GST that has become operational Year 3 - Adoption of public PHC center quality evaluation tools to be validated by through the reception with signature by the IG Year 4 - Formal adoption of quality assessment and improvement roadmap for public hospitals and public PHC centers for each GST, through the receipt of an internal letter by the IG for validation, in compliance with the criteria indicated in the POM Year 5 - Receipt of validated (through signature and endorsement by each GST executive board) quality evaluation report and improvement roadmap for public hospitals and public PHC facilities within the GST by the IG for validation in compliance with the criteria indicated in the POM
DLI 9	Strengthened epidemiological surveillance capacity including for climate change related health issues
Description	• Epidemiological surveillance capacity is a key health system function, especially as the health risks from climate change become more imminent; MHSP is in the process of restructuring epidemiological surveillance capacity. • This DLI incentivizes the government to implement this restructuring process to strengthen surveillance capacity, starting with the definition of a roadmap in the first year, followed by the adoption and validation of the structure of the epidemiological surveillance in the second year, and the update and adoption of regulations in the third year. • This DLI has a focus on climate change adaptation and will include the inclusion of climate change related diseases in the updated list of notifiable diseases in the third year. The fourth and fifth years will ensure that GSTs publish epidemiological bulletins based on new regulations.
Data source/ Agency	MHSP
Verification Entity	Inspection General of MHSP
Procedure	Year 1 - Desk review of (i) the roadmap with contents satisfying standards defined in the POM and (ii) proofs of its formal adoption (meeting minutes signed by all directorates in the meeting adopting the roadmap submitted to the IG) Year 2 - Desk review of (i) the structure of the epidemiological surveillance system and (ii) proofs of its formal adoption (official internal letter) received by the IG

	Year 3 - Desk review of (i) adopted new surveillance regulations satisfying standards defined in the POM, (ii) updated list of notifiable diseases satisfying standards defined in the POM (official regulatory document) received by the IG Year 5 - Desk review of the published regional epidemiological bulletins officially approved by the GST board of directors and received by the IG

ANNEX 3. IMPLEMENTATION SUPPORT PLAN

Focus of Implementation Support

1. The Implementation Arrangements and Support Plan will be conducted in line with the World Bank's implementation support guidelines for PforR operations and will be adapted to the design and risk profile of the Program and lessons learned from the past World Bank operations. While the borrower is responsible for the Program's overall implementation, including its technical aspects, the basic mandate of the World Bank for its implementation support includes the following: (a) review implementation progress, including the PAP and the achievement of program results and DLIs; (b) provide support for resolving emerging Program implementation issues and bottlenecks; (c) provide technical and institutional capacity-building support to the Government for the implementation of the PAP, the achievement of DLIs, and other Program results; (d) monitor the adequacy of systems' performance (for example, through monitoring reports, audit reports, and field visits) as well as compliance with legal agreements and, as needed, the PAP; and (e) support the Government in monitoring and managing changes in the various types of risks.

2. The Program will require well-coordinated technical support from the World Bank, particularly during the early stages of implementation. Implementation support will be provided by the World Bank team comprising a core group of technical specialists to provide regular guidance and implementation support to the entities involved in Program implementation. This includes staff with relevant competencies in health systems, health financing, public health, quality of care, operations, procurement, finance, and E&S safeguards. The World Bank team will undertake periodic field missions throughout the Program's implementation, as required. While results and DLIs will be assessed as completed annually, implementation support missions will be conducted every four- to six-months to ensure strong implementation. In addition, a number of technical specialists are based in the region and country office, which will allow timely follow-up on specific issues and/or areas of concern if needed.

3. Program implementation will be coordinated by the MHSP through the DPRF and involve the intervention of GSTs. The DPRF will be responsible for the work related to the three results areas and deliver on the results framework indicators including DLIs and Program action Plan. A Program Steering Committee, which will be constituted of high-level officials from MHSP, and other stakeholders will guide and monitor Program implementation and accountability.

Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate
First 12 months	Support the establishment of the Program implementation arrangements including PIP and POM	Technical and Operational specialists	3 implementation support missions
	E&S monitoring and reporting on actions included in the PAP	Social and environmental specialists	
	Fiduciary monitoring and reporting on actions included in the PAP	Fiduciary specialists	
13–60 months	Support to Technical Assistance areas	Technical experts in Health Financing, Human Resources for Health Quality of care epidemiological surveillance and GBV	2 implementation support mission per year including midterm review
	E&S capacity building	Social and environmental specialists	
	Fiduciary capacity building	Fiduciary specialist	

ANNEX 4. (SUMMARY) FIDUCIARY SYSTEMS ASSESSMENT

A. Objective, methodology and scope of the FSA

1. **The integrated Fiduciary Systems Assessment (FSA) of the MHSP was carried out by the World Bank, as part of the Program preparation, based on the requirements of the World Bank policy and procedures for the PforR.** Based on the analysis of available documents and working sessions with the key stakeholders, the FSA considers whether the Program's fiduciary systems provide reasonable assurance that the financing proceeds will be used for intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability. It covers the Program's institutional arrangements, financial management and procurement systems, and governance systems.

2. **Data collection and methodology: The FSA team focused on the following sources of information:** (i) the team's knowledge of Morocco's public procurement and PFM systems in the current context; (ii) the Court of Auditors' report dated March 2023; (iii) the MHSP's performance Audit reports for 2020 and 2021; (iv) the 2020 and 2021 audit reports and fiduciary supervision mission reports of the Bank and other development partners closed or active operations; (v) Finance bills for the years 2020 to 2023; (vi) the fiduciary data available on the electronic government public procurement portal (PMMP); and (vii) various reports issued by the oversight bodies including Inspectorate General of MHSP (IG).

3. **Based on the Program boundaries and expenditure framework, the IFSA covered MHSP through the DPRF and participating directorates, substantially involved in the coordination of the Program and implementation of its RAs:** The overall implementation and supervision of this Program will be under the responsibility of the MHSP, through the Division of Cooperation within the DPRF. The DPRF is responsible for: (i) coordinating the department's action in the budgetary field by finalizing, based on the proposals of the directorates and delegations, the department's draft budgetary laws; (ii) implementing appropriations by delegating them to and by keeping the department's accounts; (iii) playing the role of resource observatory, by monitoring the use of budgetary and extra-budgetary resources in relation to the physical achievements of the department. Most of the directorates / implementing entities were involved in Bank-financed operations (Improving Primary Health in Rural Areas and Responding to COVID-19 Pandemic Emergency PforR (P148017 & P173944).

4. **The Kingdom of Morocco and specifically the PFM and procurement country systems at the national level are deemed acceptable to the Bank and broadly meet the requirements for the implementation of a PforR**. There are strong legal and institutional frameworks; governance and oversight institutions, effective PFM planning and budget system; and strong internal control system with clear and relevant segregations of duties at each step of the budget execution. Budget execution and internal control systems are computerized and inter-linked with treasury systems. As to procurement, the Government of Morocco has recently adopted a new national public procurement decree (PPD) No2-22-431, the scope of which is now enlarged to include public entities besides ministries and local governments. The new decree includes several enhancements e.g., introduction of rated criteria, most advantageous bid, competitive dialogue, and establishment of an Observatory for public procurement. The implementation of new decree is expected to achieve better value for money with adequate levels of transparency, competitiveness, efficiency, and fairness by the program implementing agency (MHSP).

However, at the sectoral level (MHSP), while the MHSP's fiduciary system is broadly aligned to the national one, the FSA assessment has revealed some key weaknesses and risks that require to be addressed through a number of actions that are detailed in the **Program Systems and Capacity Improvements** section below.

5. **The Program will finance approximately 34.72 percent of the GOM's supported Program expenditures (US$ 1,296.06 million):** The government program is formalized through the aggregation of five programs of the 2023-25 program-based budget. The World Bank reviewed the government four (4) programs at the MHSP, and subprograms extracted from the General budget of the State (P700; P701; P702; and P705) following the performance-based nomenclature set by the 2015 LOF and reflected in the PPs of the MHSP.

Risk assessment

6. The overall residual Fiduciary risk of the program is assessed to be **substantial**. The FSA concludes that only upon implementation of the agreed fiduciary mitigation measures, will the Program's fiduciary systems provide reasonable assurance that the financing proceeds will be used for intended purposes. A detailed description of fiduciary risks is presented in Section V of the PAD "Risk".

B. Program Description, Institutional Arrangements, and Expenditure Framework

(i) Program Description

7. The PforR has three results areas: (a) Strengthened organizational and institutional capacity for health system governance; (b) Improved availability, motivation and competence of human resources for health and (c) Strengthened and reorganized health services. The Program has nine DLIs and will be executed during the period (2023-2028). DLI 1 focuses on strengthening institutional capacity through the new deconcentrated governance system with the introduction of management, planning, and budgeting tools for GST to fulfill their responsibilities as well as the development of key management inputs, such as the Board of Directors, organogram, and status of personnel; it also includes measures to strengthen the management capacity of these deconcentrated entities. The Program supports activities across six programs in the PBT of the MHSP: (i) P700: Human resources and health system capacity building; (ii) P701: Planning, programming, coordination and support of health system missions; (iii) P702: Reproductive health maternal, child, youth and special needs populations; (iv) P703: Epidemiological surveillance, health monitoring and safety, disease prevention and control; (v) P704: Primary, pre-hospital and hospital care delivery actions ; and (vi) P705: Strengthening, upgrading and preservation of infrastructure and equipment.

(ii) Institutional Fiduciary Arrangements

8. **The Planning and Financial Resources Directorate (DPRF) within the MHSP will be the World Bank fiduciary Focal point for the PforR operation:** The PMU established within MHSP's Planning and Financial Resources Directorate *(Direction de la planification et des Ressources financières – DPRF)* through the Cooperation Division is familiar with World Bank requirements and will be the World Bank fiduciary focal point. The DPRF will have the overall fiduciary responsibility of the World Bank-funded PforR in terms of procurement and financial reporting and annual external audit. Although it is not mandatory, in order to anticipate the preparation of the consolidated annual financial statements, the

program will prepare financial information similar to that of the consolidated unaudited interim financial report (IFRs) and will be integrated with the biannual Program report. Furthermore, the audit reports, prepared by the IGF, of the consolidated annual financial statements of the program will be submitted to the World Bank within nine months following the end of each calendar year. The participating entities involved in the program will have to prepare and submit to the Cooperation Division within the DPRF—for consolidation—individual budget execution report related to expenditures executed from the PEF. Similarly, the DPRF will be in charge of collecting and consolidating semi-annual procurement performance reports along with key procurement performance indicators and share them with the World Bank.

(iii) Expenditure Framework

9. The PforR will finance approximately 34.72 percent of the GOM's supported program expenditures. Specifically, the program will be financed over four years (2023–2028) for a total of US$ 1,296.06 million, including an IBRD loan of US$ 450 million. The distribution of this funding is as follows:

Table A4.1: Program costs and source of financing (US$ 1,296.06 million)

Source	Amount	% of Total
Borrower	846.06	65.28
IBRD	450	34.72
Total	**1,296.06**	**100**

10. **Based on the PEF, 100 percent of the Program expenditures under the three results areas are procurable and can be grouped under four (4) main procurement categories** as follows: (1) Goods (59 percent), (2) Information systems (35.3 percent), (3) Works (4.3 percent) and (4) consulting services (1.4 percent) which in total represents 100 percent of the PEF. The procurement will cover reinforcement and upgrading of information systems under RA#1; procurement of goods, works and consulting services for the reinforcement of the Higher Institutes of Nursing Professions and Health Techniques (*Institut Supérieur des Professions Infirmières et Techniques de Santé*, ISPITS) under RA#2 and purchase of medicines and consumables under RA#3. Table A4.2 below summarizes the breakdown of the PEF into procurement categories per Result Area.

Table A4.2. PEF by procurement category

Results Area	Implementing Entity	Goods and services (US$ million)	Information Systems (US$ million)	Works (US$ million)	Consulting Services (US$ million)	Annual (US$ million)	Total (US$ million)
Result Area #1: Strengthened organizational and institutional capacity for health system governance	MHSP	0%	91.512(100%)	0%	0%	91.512	457.560
Result Area #2: Improved availability, motivation and competence of human resources for health	MHSP	0.428(3.5%)	0%	11.150(91.1 %)	0.661(5.4%)	12.240	61.199
Result Area #3: Strengthened and reorganized health services	MHSP	155.460(100 %)	0%	0%	0%	155.460	777.298
Total		**155.888 (35.3%)**	**91.512 (59%)**	**11.150 (4.3%)**	**0.661 (1.4%)**	**259.212**	**1,296.06**

11. **The program expenditure framework (PEF) includes relevant lines items from the MHSP with exclusion of salaries, large-scale civil works, lines outside of the scope the Program, and contracting of activities that exceed OPRC thresholds**.

12. **Investments with potential significant impact on the environment and/or affected people as defined in the World Bank Policy and Directive on PforR financing, as well as investments involving works, goods, and consultancy contracts above the Operations Procurement Review Committee (OPRC) thresholds, are excluded**. As such, construction and major rehabilitation works were excluded. In addition, salaries for health workers are excluded. SEGMA budgets (which include ANAM, blood transfusion centers, and secondary-level hospitals) and CHU budgets were also excluded.

13. The PforR supports a portion of the Government program. The expenditure framework arrangements are based on the country PFM Organic Act adopted in June 2015 and on the new national public procurement decree (PPD) No2-22-431.

14. Measures related to fiduciary aspects in place by the government have been assessed by the Bank fiduciary team and found acceptable. The Royal General Treasury (TGR), from the MEF, generates a

monthly report on State budget execution (*bulletin de statistiques des finances publiques*), as well as special funds. The report is available on TGR website.[87] However, the financial information provided by TGR is global and doesn't detail expenditures by beneficiary sectors and items procured. Additionally, the Moroccan Public procurement Portal (www.marchespublics.gov.ma) is the One Stop Shop for the State and Local Governments Public Procurement activities where, among others, annual procurement plans, contract award information, bid opening and evaluation minutes, procurement audit reports (for large contracts) and debarred firmed are published. However, information published by public buyers, including the MHSP, on the eGP portal is incomplete.

C. Legal and Institutional PFM Framework in Morocco applicable to the PforR

15. **The legal and institutional PFM framework is acceptable for the PforR:** The Moroccan public finance system is governed by a legal and regulatory framework that is in line with international standards. Morocco's compliance with rules and regulations and existing accountability arrangements provides an adequate framework for the use of public funds, and PFM is considered broadly transparent.

16. Specifically, the Organic Law No. 130-13 relating to the Finance Laws (OLFL) promulgated on June 2, 2015, introduced the three-year budget program in its article 5 and the program budgeting, which uses statements of missions, goals, and objectives to explain how the money is spent. Overall, the planning and budgeting of all central entities involved in the program follow a structured, timely, and disciplined process, which is consistent with the country's PFM cycle and ensures that allocations fit within the available budget envelope. The 2017 PEFA assesses the country's planning and budgeting procedures as satisfactory (rated A). The ongoing PEFA assessment will provide updates on the performance of the country's PFM systems used by the directorates the MHSP.

17. **The Program procurement will be executed in accordance with the GOM's procurement procedures and regulatory framework.** Procurement and award of contracts for MHSP will be governed by the new Public Procurement Decree (PPD)# 2-22-431[88], approved by the Council of Government on December 29, 2022, and published in the Official Bulletin #7176 dated March 9, 2023. This New Decree will come into effect and replace the existing one (#2-12-349 dated March 20, 2013) as of September 1st, 2023. The new procurement decree is largely in line with international best practices of economy, efficiency, fairness and integrity.

Program Planning, Budgeting, and Transparency

18. The overall costs of the supported Program including the portion financed by the World Bank are expected to be integrated into the budget laws 2023-2028. Planning and budgeting related to this

[87] *https://www.tgr.gov.ma/wps/wcm/connect/665c9aa6-9d96-4bd2-8fc5-242d23ae932b/BSFP+Mars+2020_2.pdf?MOD=AJPERES&CACHEID=665c9aa6-9d96-4bd2-8fc5-242d23ae932b*

[88] On December 29, a new procurement decree, decree# 2.22.431, was adopted by the Moroccan government in response to the recommendations of the special commission for the New Development Model and was published in the Official Bulletin No. 7176 dated 9 March 2023. The new decree aims to consolidate the public procurement system to provide more clarity to economic actors and improve the business climate. It also seeks to open opportunities for innovation, for new procurement features and approaches such as competitive dialogue and for small businesses and self-employed individuals (self-entrepreneurs) and establish a national preference for domestic products. Furthermore, the new procurement decree includes provisions to strengthen transparency, fight corruption, promote data analytics through the establishment of a procurement observatory and to promote sustainable development. Notably, the new decree includes a scoring system (rated criteria) that considers factors beyond price, such as an enterprise's ability to deliver a project on time and environmental criteria.

Program will follow the national procedures. Based on budget instructions/circulars, the teams of the MHSP will prepare the budget of the Program considering the limits of allocations set by the Government. The total amount allocated to the Program during years 2023-27 according to the operation document should be reflected in the 2023-27 budget Laws.

19. **The sustainability of the expenditure framework is ensured by the existence of several tools.** First, the three-year budget programming developed in the context of the Public Finance Act. The current three-year budget programming covers the period from 2023-2025 and is annually updated through the Finance Act. Second, the annual performance plan endorsed by Parliament which describes the key programs, the associated budget and performance indicators. Third, the annual performance report which summarizes the results achieved and the budget executed for a given year. The Program is well included and articulated with the above-mentioned tools.

20. **Funding predictability**. Overall, the predictability of the GoM's expenditures is robust with timely release of the budget's appropriations to the budget holders. The expenditures of the Program are already planned as part of the Government program as mentioned above and are therefore included in the three-year programming of the Finance Act. The expenditures planned for 2023 are programmed in detail in the Budget Law. The Bank fiduciary and task teams will ensure close monitoring of budget programming of this program year by year with the MEF to avoid any incoherence between the Program expenses and the disbursement rate. No specific issue related to funding predictability as well as budget allocation release was identified in the execution of the programs as well as for the ongoing PforR operations in Morocco. No delays were observed in payment of public administration (directorates) expenses. Furthermore, the government has set up a platform "MASSAR" on the MEF website to monitor payment durations of companies and public establishments. All establishments are required to provide payment execution times on a quarterly basis. The table below shows the evolution of the MHSP budget allocations and confirms the increase in allocations in the sector; this guarantees the predictability and sustainability of the program in terms of financing. Budget allocations in the sector increased by more than 26 percent between 2020 and 2022; capital budget allocation in the sector doubled during the same period.

Table A4.3. MHSP budget evolution

	Evolution of the budget of the MHSP 2020-2022 (MDH)					
Chapter	**FL 2020**	**Evolution**	**FL 2021**	**Evolution**	**FL 2022**	**Evolution**
Capital budget	3,350.0	3.08%	4,200.0	25.37%	6,900.0	64.29%
Operating budget	15,334.6	17.23%	15,574.1	1.56%	16,642.6	6.86%
Personnel	10,908.5	27.12%	10,431.1	-4.38%	11,367.6	8.98%
Materials & DD	4,426.1	-1.64%	5,143.0	16.20%	5,275.0	2.57%
TOTAL	**18,684.6**	**14.41%**	**19,774.1**	**5.83%**	**23,542.6**	**19.06%**

21. **Budget structure.** The General Budget of the State is the source of funding of this Budget Program. Its budget structure is conformed with the international budget classification (Classification of the Functions of Government – COFOG) as confirmed by last PEFA report (rated A). The ongoing PEFA will provide update on the country overall PFM system performance. Expenditure will be subject to procurement following the country public procurement decree (No. 2-12-349 of March 20, 2013). This

procurement decree and directives are deemed adequate and are in line with international standards. They have been used for all the ongoing PforR operations in Morocco. No specific activity or expenditure has been identified as high-risk activity.

22. **Procurement planning.** MHSP is required to publish an Annual Procurement Plan (APP) in a nationally distributed newspaper and on the electronic government procurement (eGP) portal before the end of the first quarter of the fiscal year. APP can be searched through the search engine of the eGP portal[89]. However, a recent assessment of the Moroccan eGP by the World Bank using the Multilateral Development Banks (MDBs') e-GP readiness Guidelines, has revealed that APP is not interoperable with the e-bidding process. The APP is created separately. Different public entities create the plan in different formats, and Invitation to Bids don't link or refer to the procurement item in the APP, so the procurement plan and procurement process are not interoperable. The APP is also required to be displayed in the MHSP premises for at least 30 days no later than the end of the first quarter of the fiscal year. As an example, the DPRF APP for 2023 that is currently published on the eGP portal is summarized in the table below**:**

Category	Description	Place of Performance/Delivery	Procurement Method	Tentative date for Invitation to Bid	Contacts of the concerned Department	This Contract is reserved to SMEs (Yes/No)
Services	Selection of a service provider for the provision of air medical transport services on behalf of the MHSP as part of its emergency medical assistance service (as a single lot)	**MHSP**	Open Competitive Bidding	S1 of 2023	Ministère de la Santé et de la Protection Sociale, 335 avenue Mohammed V Rabat (entrée rue Larache) Tel: 0537 76 51 54 Fax : 0537 76 94 80	No
	Supply, installation, and implementation of a geolocation system on behalf of the MHSP, as well as related training and maintenance services	**MHSP**	Open Competitive Bidding	S2 of 2023	Ministère de la Santé et de la Protection Sociale, 335 avenue Mohammed V Rabat (entrée rue Larache) Tel : 0537 76 51 54 Fax : 0537 76 94 80	No

[89] Searchable here: https://www.marchespublics.gov.ma/index.php?page=entreprise.ListePPs

Goods	Purchase of computer supplies for the DPRF.	**DPRF**	Open Competitive Bidding	S2 of 2023	Ministère de la Santé et de la Protection Sociale, 335 avenue Mohammed V Rabat (entrée rue Larache) Tel : 0537 76 51 54 Fax : 0537 76 94 80	Yes
	Purchase of computer equipment for the DPRF."	**DPRF**	Open Competitive Bidding	S2 of 2023	Ministère de la Santé et de la Protection Sociale, 335 avenue Mohammed V Rabat (entrée rue Larache) Tel : 0537 76 51 54 Fax : 0537 76 94 80	No

23. **Procurement profile of the Program**. According to the Program Expenditure Framework (PEF), all Program expenditures falling under the three results areas are considered procurable and can be categorized into four primary procurement categories, which are as follows: Goods (59 percent), Information Systems (35.3 percent), Works (4.3 percent), and Consulting Services (1.4 percent %), representing a total of 100 percent % of the PEF. Procurement activities will involve the reinforcement and upgrading of information systems under Result Area #1, procurement of goods, works, and consulting services for the reinforcement ISPITS under Result Area #2, and the acquisition of medicines and consumables under Result Area #3. The MHSP is expected to leverage the new procurement decree and utilize its new features such as rated criteria, competitive dialogue, and international competitive bidding, among others, as deemed necessary. To estimate the average contract value, we analyzed a sample of data provided by DEM regarding its procurement activities from 2020-2022, primarily focused on central equipment and works activities. For the procurement of medicines and health products, since the 2020 and 2021 CAS-Compte d'Affectation Speciale (Account for Special Assignment) performance reports did not include the number of contracts, we used the data available in the 2021 audit report of the previous PforRs implemented by MHSP (Improving Primary Health in Rural Areas and Responding to COVID-19 Pandemic Emergency PforR (P148017 & P173944) about the sample of 2020 and 2021 contracts reviewed by the Inspectorate General of Finance (IGF) as a proxy. The table below summarizes the average contract size per type of purchase, specifically equipment and works (DEM) and medicines and other health products (Procurement Division).

Year	2020			2021			2022		
Type of purchases	**# of committed contracts**	**Total amount (MAD)**	**Average contract amount (MAD)**	**# of committed contracts**	**Total amount**	**Average contract amount**	**# of committed contracts**	**Total amount**	**Average contract amount**
1- Equipment and Works (DEM)	33	238,280,852.250	**7,220,631.886**	65	239,178,109.970	**3,679,663.230**	64	156,204,609.610	**2,440,697.025**
2- Medicines and other Health products (Procurement division)	6	69,940,098.850	29,554,581 (largest contract)	4	70,970,754	29,156,065.54 (largest contract)			

24. The information presented in the aforementioned table validates that the program's procurement activities do not entail high-value contracts surpassing the OPRC threshold value that would make them eligible for procurement exclusions. Regarding procurement capacity, multiple documents reviewed by the fiduciary team have identified several key and persistent shortcomings. The table presented below summarizes these weaknesses with regards to procurement capacity.

Source of information/Report reviewed by the FSA Team	Key procurement capacity-related weakness (s)
2021 CAS-Compte d'Affectation Speciale (Account for Special Assignment) performance reports	Procurement delays at the local level for purchasing emergency services equipment (SAMU - service d'assistance médicale urgente).
the Court of Auditors' report dated March 2023	Inefficient management and monitoring of some medicine procurement contracts due to unrealistic planning and delays.
the 2021 audit report of the previous PforRs implemented by MHSP (*Improving Primary Health in*	Irregularities in executing three contracts for technical and medical equipment/accessories ($0.8 million)

Rural Areas and Responding to COVID-19 Pandemic Emergency PforR (P148017 & P173944))	
The IGF report on the 2021 Performance Assessment of MHSP's 700 and 703 programs	Inadequate approach to translating MHSP's programs into projects.

25. **Budget execution.** The monitoring of budget execution is ensured through the Performance Reports (Rapports de Performance RoP) which trace the results achieved and analyzes the discrepancies between the forecast established in Performance Projects (PdP) and the budget execution. The RoPs of ministerial departments or institutions are consolidated in the Annual Performance Report. This report has been audited by the IGF since the year 2020. The table below demonstrates the commitment and payment rates for the supported programs during 2020 and 2021. These programs were executed by the directorates of the centrale administration of the MHSP involved in the program. The DPRF is responsible for : (i) coordinating the department's action in the budgetary field by finalizing, based on the proposals of the directorates and delegations, the department's draft budgetary laws; (ii) implementing appropriations by delegating them to sub-ordinators and by keeping the department's accounts; and (iii) playing the role of resource observatory, by monitoring the use of budgetary and extra-budgetary resources in relation to the physical achievements of the department.

26. **Overall, the directorates and entities involved in the Program have had acceptable performance in terms of budget commitments and execution in 2020 and 2021:** Morocco scored A for PI-1 of PEFA 2016. Table 12 describes the strong performance of budget commitments and execution of the MHSP involved in the program. Specifically, the directorates of the centrale administration budget execution rate exceeds 85 percent in 2020 and 2021. Budget execution performance is deemed satisfactory.

Commitment and payments rates (MDH)

Budget execution of general budget (GB) appropriations by program - MDH

Programs	Year 2020			Year 2021		
	Commitment	Payment	Rate	Commitment	Payment	Rate
700	11,028.8	10,478.4	95.0%	10,525.6	10,507.5	99.8%
701	3,632.6	3,565.9	98.2%	3,034.9	2,971.5	97.9%
702	464.6	417.2	89.8%	497.8	384.0	77.1%
703	161.7	132.1	81.7%	160.3	132.0	82.3%
704	3,346.9	3,308.7	98.9%	3,789.0	3,718.2	98.1%
705	4,623.8	2,013.6	43.5%	5,370.9	2,797.3	52.1%
Total	**23,258.4**	**19,915.9**	**85.6%**	**23,378.5**	**20,510.5**	**87.7%**

27. **The overall commitment and payment rates in 2020 and 2021 for all six programs were satisfactory overall, except for program 705:** the overall execution rate (payment) of the budget is 85.6

percent in 2020 and 87.7 percent in 2021. However, the payment rates of the program 705 was low at 43.5 percent in 2020 and 52.1 percent in 2021 mainly due to the COVID-19 pandemic as all contracts were committed by the end of December 2020. The analysis of the MHSP 2020 and 2021 budget documents revealed the following: (i) about 56 percent of the ministry's general budget is executed at the level of the central directorates (common services), compared to 44 percent in the regions, with payment rates of around 77 percent each; (ii) the rate of budget execution (payments) made for the personnel and the operating expenditure is deemed satisfactory and was respectively above 98 percent, while the investment budget is 54 percent; and (iii) the budget execution rate at region levels varies from 41 percent (lowest in 2020) to 80 percent (highest in 2021).

Budget execution of CAS appropriations by program - (MDH)

Programs	Year 2020			Year 2021		
	Commitment	**Payment**	**Rate**	**Commitment**	**Payment**	**Rate**
701	48.1	34.5	71.7%	181.9	141.3	77.7%
702	139.6	38.4	27.5%	514.0	405.7	78.9%
703	922.6	558.7	60.6%	538.1	375.6	69.8%
704	3,495.1	2561.3	73.3%	3,031.1	2,023.0	66.7%
Total	**4,605.4**	**3,192.9**	**69.3%**	**4,265.1**	**2,945.6**	**69.1%**

28. **The overall execution rate of the CAS (Compte d'Affectation Special) budget is considered satisfactory at around 69 percent in 2020 and 2021**. The low budget execution rate in 2020 of the program 702 is linked to the contracts related to COVID-19.

29. **Procurement processes and procedures.** With the enactment of the new procurement decree No.2-22-431, effective September 1st, 2023, the existing public procurement decree No.2-12-349 dated March 20, 2013, will be replaced, and its scope will be extended to public entities and establishments in addition to ministries and deconcentrated regional entities. Consequently, the Program's procurement, to be carried out by MHSP will be fully governed by this new decree. The new procurement decree includes several enhancements e.g. introduction of rated criteria, most advantageous bid, Competitive dialogue, and establishment of an Observatory for public procurement. The implementation of new decree is, therefore, expected to achieve better value for money with adequate levels of transparency, competitiveness, efficiency, and fairness by MHSP. The implementing agencies' procurement systems adhere to the rules of good governance and provide for sustainable procurement. Bidding documents are overall based on the guidance note[90] and the standard bidding documents[91] that were issued by TGR in 2015. Procedures for bid submission, receipt and opening are clearly described in the document called "Consultation Regulations- *Règlement de consultation*" which is part of the bidding documents. The qualification, evaluation and award criteria are clearly defined in the bidding documents and are complied with during evaluation. Based on the published Annual Procurement Plan of MHSP for 2023, open tendering is the default method of procurement. It is important to note that procurement of medicines

[90] Available here : https://www.marchespublics.gov.ma/pmmp/IMG/pdf/note_relative_aux_documents_type_des_marches_publics.pdf

[91] Available here : https://www.marchespublics.gov.ma/pmmp/spip.php?article122&lang=fr

and pharmaceutical products at the central level is exclusively the responsibility of the *DAMPS*. DAMPS is newly created by Decree No.2-22-811 dated 24 January 2023 and has replaced the previous Procurement Division created in 1994. MHSP has, since 2013, a Guide for the organization and operation of the hospital pharmacy[92] which describes, among others, the procurement procedures to be followed for the purchasing of medicines and health products. Moreover, local procurement of medicines and pharmaceutical products is subject to the Minister of Health Order No. 10/DHSA dated January 30, 2019, which sets out local procurement procedures for medicines and other pharmaceutical products. Procurement of goods, services and works is the mandate of the DEM.

30. **Record Keeping and Document Management Systems**. The contracting authorities are required to keep records of all procurement transactions for at least five (5) years, and these records must include all documents related to the procurement process, such as the procurement plan, specifications, invitations to bid, bid evaluation reports, contracts, invoices, payment records, and any other relevant documents. The contracting authorities are also required to ensure that these records are organized and kept in a way that ensures their accessibility, reliability, and integrity. Additionally, with the generalization of electronic submission, contracting authorities must establish an electronic procurement record management system that complies with the technical and legal requirements established by the Ministry in charge of finance. While the MHSP didn't provide details about the way record keeping is being implemented, this requirement is generally complied with given the robust audit institutions and legal framework in Morocco.

31. **Controls, oversight of procurement and audits.** In Morocco, public procurement oversight during the procurement and contract award process is mainly performed by the TGR for the MHSP. While MHSP conducts its own procurements, the TGR oversees a network of "public comptrollers," who sit on evaluation panels and monitor procurement process throughout both the local and national governments. These controllers have the authority to stop procurements if serious violations are found in the implementation of the tenders. Furthermore, the TGR has implemented: (1) the Moroccan Public Procurement Portal (e-procurement), (2) integrated systems to track and implement budget spending and to process payments (GID), and (3) the e-invoicing in public procurement[93] . In addition to TGR, the Court of Accounts (CoA) conducts post-audits of procurements and issues reports identifying weaknesses or irregularities that are shared with the public. The CoA's jurisdiction covers all government acquisitions including those implemented by local governments and state-owned entities. The CoA audits are conducted on a systematic basis and are not done randomly. While the CoA does not have a specialized task force for procurement, it has many technical experts who have specialized knowledge of each of the sectors covered by the CoA. Additionally, as per article 165 of the existing procurement decree (#2-12-349), all contracts whose value is MAD 5 million and higher for contracts awarded through open competitive bidding process and MAD 1 million and higher for direct contracts are subject to a systematic procurement audit. While these reports are searchable on the Moroccan Procurement Portal (here: *https://www.marchespublics.gov.ma/index.php?page=entreprise.ListeSRA*), the documents published are not necessarily related to procurement audit. They sometimes include the procurement plan and other types of documents. Therefore, to strengthen the program's procurement oversight and audit, the

[92] The Guide is available here: https://remed.org/wp-content/uploads/2017/03/Guide-dorganisation-et-de-fonctionnement-de-la-pharmacie-hospitali%C3%A8re.pdf
[93] See guide here: http://communaute-fournisseurs.gid.gov.ma/assets/files/Guide%20DEF%20VF3-04062019-rectifier-et-valider.pdf

implementing agencies will be required to timely and accurately publish all procurement audit reports under the program on the public procurement portal.

32. **e-Procurement**. In accordance with the Minister of Economy and Finance Order No. 1982-21 dated December 21, 2021, on the digitalization of public procurement procedures and financial guarantees, MHSP is required to comply with full digitalization of electronic submissions and bid securities. This order has progressively introduced the obligation to electronic submission of bids, electronic bid opening, and electronic bid securities effective from November 1, 2022. Public Procurement plays an important role in the national economy of Morocco. In 2022, the Moroccan Government spent MAD 245 billion(~US$25 billion) which is almost 20 percent of the total GDP. This important activity inspired the government to prioritize modernizing public procurement. In 2007, the TGR launched a basic form of e-Government Procurement (e-GP) and developed its features over the years, culminating in 2022 when it became mandatory for all public entities to use. As of 2021, 35,000 invitations to bid have been published through the e-GP portal and generated more than 84,000 electronic submissions for a total estimated contracts' cost of MAD 126 billion, representing more than 50 percent of that year's total procurement. Currently, 4,400 public entities, 600 public companies, and 28,000 providers and suppliers are registered on the system; 1,826 being foreign (6.5 percent). MHSP is using e-GP. The recent assessment of the GOM's eGP system by the World Bank has concluded that the system is generally compliant with Multilateral Development Banks' e-GP Guidelines, and the Bank will gradually start accepting the e-GP system in Bank financed contracts under IPF Operations.

33. **The public procurement decree has a complaints' handling mechanism.** A bidder can file a complaint no later than the fifth day after the publication of the provisional contract award results on the public procurement portal. If so, there will be up to 15 days of a standstill period. During this time, complaints can be filed, and decisions received. If not satisfied with the decision made, the bidder may file the complaint again. The 1st and 2nd appeals should be resolved within 15 days. After 15 days, if the dispute is not resolved, the bidder can appeal to the minister. The minister can order the contracting authority to stop the procurement process up to 10 days. A bidder can go for an administrative appeal to the CNCP and court at any time. The complainant may get compensation if the decision is made in favor of the complainant. According to the Ministry's Inspectorate General (IG) activity report for 2022, IGM received and treated 12 procurement-related complaints out of 144 complaints received in total, which represented 8.3 percent. The complaint handling mechanism is expected to be strengthened with the entry into force of the new procurement decree that introduced a strengthened redressal mechanism. Additionally, based on the information published in the CNCP's opinions, in 2022, 32 complaints were received. On average, CNCP makes its decision in about 103 working days which is much higher than the 30 working days period set forth in the decree establishing CNCP[94]. Therefore, there is a need to strengthen the program's procurement-related complaints handling mechanism. As to the possibility of filing a complaint electronically, the institutional portal of TGR has a space with a dedicated page and form

[94] As per Article 32 of Decree No. 2-14-867 of 7 Hijra 1436 (September 21, 2015) establishing the National Public Procurement Commission, the handling of complaints shall be carried out by the competent bodies of the commission in accordance with a maximum period of fifteen (15) working days from the date of receipt of the complaint letter. This period may be extended for a period of fifteen (15) working days by a reasoned decision of the president of the commission, which shall be notified to the interested parties.

of complaint where bidders could submit complaints[95]. Complaints about public procurement could be selected among a drop-down menu of Category of common complaints.

34. **Additionally, there is a blacklist in the e-GP System**. If the scope of abuse is limited to the single department, the minister will sign the decision placing the company in blacklist. The second case is a broader exclusion, the bidder is excluded from all public procurement processes, and this needs the approval of the head of the government. The blacklist is publicly available and can be found by using the search engine of the portal[96]. Some blacklists are temporary, and some are definitive. The list shows the reason for blacklisting, the beginning and end date of blacklisting, type of blacklisting: partial (only within a department) or total. The decision document is uploaded and accessible to the public.

35. **The program's procurement processes and procedures are evaluated to be inclusive, transparent, and fair, with open competition being the default procurement method.** The bidding documents establish qualification, evaluation, and award criteria, which are generally followed during the evaluation process. The procurement approaches employed aim to ensure that appropriate bidders participate and that the best-suited bidder is selected. While a mechanism for handling procurement-related grievances exists, it needs further improvement to become more efficient. Furthermore, there is a need to enhance MHSP's procurement planning and execution to prevent delays that have been identified in various recent reports.

36. **Contract management.** The TGR has established functional systems for budget tracking, payment processing (GID), and e-invoicing in public procurement, which MHSP is using. However, according to the IGF report on MHSP's 700 and 703 programs' performance, there is no appropriate approach to translate programs into projects, resulting in poor visibility of project-level contract execution at the deconcentrated level. To improve the procurement of medicines and strengthen the management of contracts for this critical category, the newly established DAMPS will create a digital platform. This is intended to address weaknesses in medicine contract management identified in recent audit reports.

37. **Procurement performance**. The 2020 and 2021 audit report of the previous Improving Primary Health in Rural Areas and Responding to COVID-19 Pandemic Emergency PforR (P148017 & AF P173944), revealed irregularities that have affected the execution of the three contracts related to "the purchase of technical and medical equipment and accessories". The cumulative amount of the expenses concerned by these irregularities, was about MAD 8.2 million, representing 21.16 percent of the total amount of the PforR expenditures for the year 2021 but less than 1 percent of overall Program expenditures. This risk is also due to the absence of an integrated fiduciary management system at the central level (DPRF) to monitor the performance of procurement and FM systems at the local and regional level in real-time**.** The table below summarizes the procurement activities of the DEM over the last three years (2020-2022)

[95] Available here https://www.tgr.gov.ma/wps/portal/!ut/p/b1/04_Sj7SwMDEzMDM3t9SP0I_KSyzLTE8syczPS8wB8aPM4i28fc0snAwdDSx8LAwMHAP9nAOC3QKN3QOMgQoigQoMcABHA3z6DUwNofoRClz8QApCAiwcvU0NDIKMibMfjwUE9IfrR6EpwXQBWAE-LxLypJ9Hfm6qfm5UjpubpWeWiaOiIgDg-M1L/dl4/d5/L2dJQSEvUUt3QS80SmtFL1o2XzhLTTY4QjFBMDhMODAwQVFOQ1BTRlEzMkYw/

[96] Available here: https://www.marchespublics.gov.ma/index.php?page=entreprise.EntrepriseRechercherSocietesExclues&search=1`

Procurement Performance Indicators

◈ **2020 :**

Budget	Procurement approach	Number of committed contracts	Total amount MAD	% (out of procurable expenditures)
Investment budget	Direct contracting	33	238,280,852.25	98.71%
	Purchase Order	13	2,344,754.10	0.97%
Operating budget	Purchase Order	14	702,028.85	0.29%
	Common Law contract	02	78,933.52	0.03%

◈ **2021 :**

Budget	Procurement approach	Number of committed contracts	Total amount MAD	% (out of procurable expenditures)
Investment budget	Open competitive bid	65 contracts	239,178,109.97	88.29%
	Direct contracting	11	30,506,817.19	11.26%
Operating budget	Purchase Order	18	893,901.71	0.33%
	Common Law contract	01	11,221.10	0.00%
	Convention	02	99,990.00	0.04%
CAS	Purchase Order	01	199,997.45	0.07%
	Transfer	04	26,776,613.96	

◈ **2022 :**

Budget	Procurement approach	Number of committed contracts	Total amount MAD	% (out of procurable expenditures)
Investment budget	Open competitive bid	64 contracts	156,204,609.61	98.9%
	Purchase Order	10	778,528.20	0.5%
Operating budget	Purchase Order	16	841,350.49	0.5%
	Common Law contract	01	2,173.52	0.0%
	Convention	01	103,080.60	0.1%
	Transfer	01	39,983,234.43	

38. The main points to note from the table are:

- Open competitive bidding is the primary procurement approach used by MHSP, except in 2020 here direct contracting was allowed to quickly respond to COVID-19 needs.
- The size of contracts is small, confirming that the program does not involve high-value contracts that would require procurement exclusions based on OPRC threshold value.

39. **Fraud, corruption, and debarment of Contractors.** Morocco's Constitution, enacted on July 1, 2011, explicitly mentions the need to fight corruption and to ensure good governance and transparency as fundamental tools of public sector management. It also recognizes the right to citizen participation in government decision making and public engagement, as well as the right to access public

information. The 2011 Constitution sets the groundwork for more transparency and the efficient use of public resources, through Title II on conflict of interest, misconduct in public procurement, misuse of public funds, greater transparency, accountability, and fight against fraud and corruption and through Title XII for good governance. The ICPC (Instance centrale de prévention de la corruption) oversees the prevention of corruption. It conducts awareness raising and information campaigns and has set up a database and a whistleblowing system to allow citizens to alert on corruption cases. Furthermore, the client has been sensitized during the preparation phase that it must ensure that any person or entity debarred or suspended by the Bank is not awarded contract under or otherwise allowed to participate in the Program during the period of such debarment or suspension.

Program Accounting and Financial Reporting

40. **Accounting.** Like the Government financial and accounting transactions, the program operations will be accounted for based on the procedures and legal framework applicable to the public-sector described in the public accounting decree no 330-66 du 21/04/1967 (decree on public accounting) which is cash basis. Specifically, DPRF will follow the central Government public-sector accounting standards. Participating entities will use the Integrated Expenditure Management (IEM) system, which is an integrated set of computerized applications developed in-house. Authorizing officers and accounting officers keep administrative and cash accounts separate. The administrative accounts kept by the authorizing and sub-authorizing officers are commitment accounts which clearly show the implementation of the budgetary authorizations recorded in the State budget and in the budget of each of the entities participating in the Program. The accounts of the Treasury record the appropriations and the payment of expenditures. The two accounts are reconciled monthly and then annually to reconcile payment orders paid by the accounting officer. No specific issue has been raised in the audit reports regarding compliance with the prescribed accounting standards by the implementing entities involved in this program. The sub-authorizers and delegated authorizers execute the credits placed at their disposal by the DPRF, which is ultimately responsible for producing the budget execution accounts of the MHSP. To this end, the directorates are required to monitor the budget of the appropriations opened for them and report to the DPRF. In practice, as mentioned in the CoA and IGF report, some directorates have difficulty reporting on their budget execution within the deadlines. As mitigating actions, the semi-annual report (IFR) shows the amount of the budget allocated to each department and the level of commitment and payment/execution. These budget execution reports of each directorate are not published on the website of the MHSP.

41. Specifically, like most of the Bank-financed operations in Morocco, an Excel spreadsheet and data extracted from the national budget execution software “Integrated Expenditure Management System” (*Gestion Intégrée de la Dépense*- GID), will be used to prepare Program’s periodic consolidated budget execution reports and consolidated annual financial statements. The arrangement in place may impact the quality and timeliness in the preparation of those reports and submission of audited financial statements. Detailed actions have been developed (ref. Risk mitigations measures in the Executive Summary of the PAD) to address the issue including assignment of dedicated fiduciary focal point and the development of tools to facilitate the collection on budget execution in each participating directorates and capacity building activities for the entity staff.

Internal Controls and Internal Audit Arrangements

Internal control

42. Law No. 69-00 on the financial control of the State over public enterprises and other organizations describes in its articles 2 and 8, the financial control missions and the financial and accounting organization of public establishments. These provisions are applicable to the state entities of the MHSP (DPRF) involved in the program. The review of the various documents during the evaluation did not reveal any cases of non-compliance or non-application of the provisions of this law.

43. The system of public accounting, as described by Royal Decree No. 330-66 of 21 April 1967, is built around the concept of separation of tasks between authorizing officers and accounting officers. Ex-ante financial control is exercised through expenditure controls in accordance with the procedure for the implementation of the central government budget (Decree n° 2-07-1235 of 4 November 2008). Internal audit. The internal audit and management control function was formally established at the MHSP following a letter from the Minister of Health dated May 30, 2018. The audit firm recruited to support the MHSP has finalized the risk mapping as well as the development of an approach to implement this function. A pilot phase has started with four Divisions including the Finance Division at the DPRF. Some RHD have established internal audit units. However, the operationalization of the circular is still on-going. It was not possible to assess the implementation status of the pilot phase, nor the effectiveness of the units implemented so far in the four Divisions. The report of the last supervision mission of PforR closed in 2021 outlined the need to update the Bank on a regular basis on the progress made in the implementation of the internal audit unit in the MHSP. The new PforR will be an opportunity to support the operationalization of the internal audit and management control function within the central administration directorates, regional health directorates, institutes, centers and national laboratories in line with the Instructions dated on May 30, 2018, and the new decree on the internal audit function. An action will be included in the PAP and will be monitored as part of the program performance indicators. A management control system at the level of the ministerial departments was instituted by decree n°2.22.580. The PAP has planned to operationalize the internal audit and management control function within the MSPS.

inspectorate General of the MHSP (IG)

44. The MHSP's IG is composed of 59 executives, 42 of whom come under the central IG and 17 of whom are made available by the Regional Health Directorates. The IG intervenes in the form of audit, inspection, and investigation missions, but also supports the Ministry's structures, particularly in the preparation of responses to audits carried out by the Court of Accounts and the IGF. The IG of the MHSP has a regional structure called "CRAI" which intervenes jointly with the central level teams or separately on missions. The conclusions of IG auditors confirmed that the procedures for managing and reporting data relating to program indicators are generally complied with, and that the data communicated is reliable. However, they highlighted certain weaknesses, particularly in relation to: (i) the lack of involvement of regional observatories in the monitoring and control of the information system; and (ii) the multitude of information media and the lack of integration in the management and reporting of data relating to the various health programs. In addition to its IVA role, some of IG mandate and missions such as “audits” may overlap with those of the IA units which may lead to some inefficiency in the use of the HR in the institutions of controls. The review of the 2021 and 2022 activity reports prepared by the IG revealed the following as shown in the below table:

Key indicators related to IG activity	2021	2022
Number of missions conducted (all mission categories combined)	227	215
Number of audit missions conducted	56	47
Number of inspection missions conducted	36	35
Number of public entities covered	156	115
Complaints received and handled	535	144
Support to MHSP entities in responding to draft reports of CoA	18	23
Support to MHSP entities in responding to draft reports of IGF	4	7
Coordination and collaboration activities with Ombudsman	62	58
Number of recommendations issued by the IG	367	N/A
Number of recommendations implemented	N/A	N/A

45. A review of the above table reveals the following: (i) the IG conducted 47 audit missions and 35 inspection missions in 2022, compared with 56 audit missions and 36 inspection missions in 2021; (ii) in 2021, audits covered 109 entities included in the program's expenditure framework, compared with 38 for inspections; (iii) 367 recommendations were issued in 2021 by the IG following its missions, of which 237 were made on behalf of the public sector entities covered by the PforR; and (iv) follow-up on the recommendations of the IG's reports or those of other audit bodies has been initiated, but it has not been possible to determine the exact number of recommendations actually implemented for the years 2021 and 2022. The new PforR operation will support the IG as well as other Internal audit units being implemented to strengthen follow up of audit recommendations.

Treasury Management and Funds Flow

46. The budget allocated to line ministries in the Finance law is available and usable as soon as it is promulgated by the parliament. Each ministry is responsible for management or its allocated budget. transfers between budget lines during the year could be proposed by the MHSP and decided at the level of the Directorate of Budget from the MEF and this, according to the Organic Law on the Finance Act (Loi Organique relative à la Loi de Finances, LOLF).

47. **Treasury management and funds flow including disbursement of DLI to the Treasury Bank Account.** The funds flow arrangements for Program implementation are adequate. The Program's funds will be reflected in the Government budget under the MHSP. In fact, the expenditures and revenues of the Program are identified in the State budget through the Budget law and detailed in the annual budgets of the participating entities. The government's treasury single account (TSA) will be used to make payments under the program. Specifically, for the payment of invoices of the activities to be implemented by the participating entities, the funds will flow directly from the TSA to service providers, consultants, and constructors. The GOM's internal institutions of controls will reserve the right to verify the expenditures ex post, and actions might be requested for any noncompliance with the rules. The IFSA team did not identify any wrongdoing during the assessment.

48. For advances, prior results and achieved results, the funds will be disbursed to the Government's Single Treasury Account (STA). Specifically, the GoM would claim disbursements from the World Bank as the DLIs are achieved. All DLIs will be independently verified by the Inspectorate General "IG" of the MHSP, the Independent Verification Agency (IVA). The IVAs will prepare the Results Verification Report, which will be shared with the MHSP, MEF and the World Bank. A key use of the Results Verification Report will be to confirm and certify the technical achievement of the results/indicators. If the World Bank finds that the disbursement request meets the terms of the Financing Agreement, the World Bank will disburse the corresponding funds to the Treasury bank account opened at the Central Bank (Bank Al-Maghrib). The external audit reports will confirm the total expenditures incurred to achieve these DLIs versus the expenditure incurred to achieve these DLI/DLR. The government is expected to use the 25 percent advance, to be reconciled through DLI verification upon achievement of results.

Program's External Audit

49. The arrangements for external audit of the Program consolidated annual financial statements will follow the same arrangements put in place for most Bank-financed operations in Morocco. These arrangements which rely on IGF are deemed adequate with audit reports of good quality. The IGF will audit the consolidated financial statements prepared by the PMU. The IGF will carry out the audits of the Program annual consolidated financial statements based on agreed terms of reference. The audit reports together with detailed management letters will be submitted to the Bank no later than nine (9) months after the closure of accounts. The Program would comply with the World Bank disclosure policy of audit reports within two months of the report being accepted as final by the team and the World Bank. To address the issue of overload of IGF and avoid overdue audit reports, meetings will be planned with the MEF to explore some alternative options including the use of the services of the Court of Accounts to audit Bank-financed operations starting with a pilot.

50. The review of the audit reports of the Bank-funded operation which closed in 2021 revealed some irregularities and internal control weaknesses. The audit reports and Bank supervision missions outlined the delays as well in implementing audit recommendations as the late development of systematic reporting on the status of the implementation of audit recommendations. The audit report of the court of accounts raised some concerns. Appropriate measures have been developed in the risk mitigation section of the PAD as well as in the PAP to address these challenges described above.

51. **Programme Governance and Anticorruption arrangements.** Morocco has a National Anti-Corruption Strategy. The measures foreseen in this strategy cover different aspects of the issue of the fight against corruption, including the upgrading of the institutional and legal aspects, the activation of the prevention and law enforcement dimensions and the intensification of education and awareness-raising activities.

52. The institutional framework is enriched by the National Authority for Probity, Prevention and Fight against Corruption (INPPLC), a constitutional body, which enjoys legal, financial, and administrative autonomy.

53. All these measures have not yet contributed to an effective improvement. Indeed, the score of the Corruption Perceptions Index developed by Transparency International improved from a score of 34/100 in 2011, to 43/100 in 2018 (73rd /180 countries) and regressed in 2022 to a score of 38/100 (94th

/180 countries). In addition, Morocco is ranked 10th out of 54 African countries in 2022 based on the Mo Ibrahim Index of Governance in Africa.

54. The status of actions related to fraud and corruption has not been formally reported for closed and on-going Bank-funded operations. As such, the IFSA team was unable to assess the effectiveness of some institutions in the World Bank portfolio in Morocco, including for the MHSP. This had been previously identified during the implementation of the Bank closed Improving Primary Health in Rural Areas Program for Results, and additional financing for COVID-19 response (P148017 & P173944). Therefore, additional efforts are required and compliance with actions to fraud and corruption as detailed in the paragraph below, and these measures will be monitored over the implementation period. Specifically, the following actions will be required: the development of a framework for collecting and reporting on cases of fraud and corruption and procurement complaints. The frequency and entity responsible for playing this role will be clarified as well. This should be detailed in the POM and monitored as part of the Program performance indicators and included in the PAP.

55. Actions related to fraud and corruption: The Borrower will: (a) take all appropriate measures to ensure that the Program is carried out in accordance with the Bank's Anti-Corruption Guidelines; (b) take all appropriate measures to prevent fraud and corruption in connection with the Program, including (but not limited to) adopting and implementing appropriate fiduciary and administrative practices and institutional arrangements to ensure that the proceeds of the Loan are used only for the purposes for which the Loan was granted; (c) promptly inform the Bank of all credible and material allegations or other indications of fraud and corruption in connection with the Program that come to its attention, together with the investigative and other actions that the Borrower proposes to take with respect thereto; (d) unless otherwise agreed with the Bank with respect to a particular case, take timely and appropriate action to investigate such allegations and indications; report to the Bank on the actions taken in any such investigation, at such intervals as may be agreed between the Borrower and the Bank; and, promptly upon the completion of any such investigation, report to the Bank the findings thereof; (e) if the Borrower or the Bank determines that any person or entity has engaged in fraud and corruption in connection with the Program, take timely and appropriate action, satisfactory to the Bank, to remedy or otherwise address the situation and prevent its recurrence; and (f) ensure that any person or entity debarred or suspended by the Bank is not awarded contract under or otherwise allowed to participate in the Program during the period of such debarment or temporarily suspension. The Bank's debarment list, which is easily accessible, will be checked by all procuring entities before awarding contracts. As regards the list of temporarily suspended firms, each implementing agency will access the same through Client Connection for which one representative from each of the implementing agency shall be nominated for granting access to the Client Connection by the World Bank. The borrower will develop and operationalize the mechanism of enforcing these requirements through the issue of instructions/circular to all the procuring entities requiring the procuring officers to check the eligibility of firms and individuals from the Bank's list of debarred and temporarily suspended firms and record the same in procurement award decision files. The borrower will report compliance with these requirements in annual Program Audit Report.

Evaluation of the Financial Management Risk at the Sector level:

56. There are various areas of improvement for the MHSP, including the implementation of monitoring and evaluation pertaining to following: (i) asset management (assets, equipment, etc.), (ii) management of human resources, (iii) management of stocks of medicines, (iv) internal control systems

complaint with the Committee of Sponsoring Organizations of the Treadway Commission, (v) internal information system to track indicators and prepare consolidated reports and dash boards and (vi) management control system and function in the organigram. These deficiencies remain important fiduciary risk factors. Measures to mitigate these risks will not be fully operational during the PforR period of execution.

57. **Due to these deficiencies, the residual risk of the financial management at the Program level is considered Substantial.**

Financial management performance in the sector and FM arrangements:

58. Most of the directorates / implementing entities were involved in Bank-financed operations. The last supervision missions of the closed operations managed by the MHSP rated the fiduciary performance and risk respectively moderately satisfactory and substantial at closing date. The 2020 and 2021 audit reports on the closed operations identified some procurement irregularities and internal control weaknesses described in detail in the PAD (Section V. Risks). The design of the fiduciary arrangements of this operation will benefit from the lessons learned from the closed Bank's PforR and ongoing development partner operations in the sectors. Furthermore, the 2021 performance audit report of the health sector on programs P700 and 703 prepared by the IGF revealed several areas for improvement, including: (i) the weak implementation of key recommendations from the 2018 to 2020 performance reports; and (ii) the lack of performance indicators for evaluating and monitoring operations with large budget allocations. It is important to remember that during the year 2021, a section was created at the IG level to follow up on the recommendations made during audit missions carried out by the IG as well as those made by other audit and governance institutions. The capacity of the team in charge of audit recommendations follow up will be strengthened during the PforR implementation period.

59. The PforR will be part of the national budget process and will be executed following on existing institutional systems for its implementation. The main arrangements agreed with the Government are:

(i) A program expenditure framework in line with the budget voted under each annual budget law during of the PforR period.
(ii) Government expenditures over its implementation period more than the amount of Bank financing.
(iii) The formal appointment of a steering and a technical committees.
(iv) Compliance with FM requirements including preparation and submission of periodic financial reporting audited financial statements.
(v) Periodic and systematic reporting of cases of fraud and corruption.

60. These arrangements will be detailed in a POM acceptable to the World Bank prior to disbursements against achieved results. This POM should also cover the consistency of the interim financial reports (IFRs), the content of the annual financial statements, the protocol for verification of the DLIs, the disbursement modalities and the terms of reference of the annual audit of the program.

Program Systems and Capacity Improvements.

61. The Fiduciary risk for the health sector PforR is rated “Substantial”.

62. The findings of the fiduciary assessment highlight the risk related to the national fiduciary system itself (budgeting, public procurement, financial management and disbursement) and its environment and those related to the MHPS about its capacity and the way the ministry is organized to implement the Program and carry out fiduciary function. The main risks and proposed mitigating measures are specified in the summary table below. Fiduciary systems also present elements of strengths that will constitute a sound basis for the Program if complemented by measures to strengthen it.

Table A7. PAP Fiduciary Actions to address fiduciary weaknesses

Action Description	Due Date/Schedule	Responsible Party	DLI or Loan Covenant	Completion Measurement
Planning and Budgeting				
Ensure that procurement plans are prepared and implemented in accordance with the existing regulations.	Continuous	DPRF/DEM/DAMPS/GST	N/A	Annual Procurement plans are published no later than the end of Q1 of the fiscal year and are implemented in accordance with the existing regulations.
Budget Execution				
Develop and implement a program to enhance capacity-building on the new procurement decree.	Jan 2024	TGR	N/A	A capacity strengthening program on the new procurement decree.is prepared and implemented
Implement a bi-annual reporting mechanism on: (i)Public Procurement: Tenders and procurement-related complaints (ii) Financial Management: (a) the status of implementation of the program expenditure framework; (b) the amount of commitments and payments made; and (c) the performance indicators as described in the Program Operations Manual (POM).	Continuous Continuous Continuous	DEM/DPRF/DAMPS/GST DPRF DPRF	Semi-annually Semi-annually Semi-annually	A reporting is done through the minutes of technical committees, on a semi-annual basis The status of the program expenditure framework is included in the semi-annual activity report Financial management performance indicators (ref. MOP) are included in the semi-annual program activity report
iInclude in the bidding documents an eligibility check clause	Continuous	MSPS/GST	N/A	An eligibility check clause in included in the bidding documents and implementing agencies are required to ensure that any person or entity debarred or suspended by the Bank is not awarded a contract under the program.

Internal Control and Internal Audit				
Set up the internal audit unit in accordance with the regulations in force (new decree).	Date of publication of the decree	MEF/DPRF	N/A	Application of the decree and operationalization of the internal audit unit within the ministry (internal audit unit with its staff; management tools of the function put in place; number of internal audit mission reports; allocated budget etc.)
Follow up on audits recommendations of the Program	Recurrent	I IGM	N/A	Number of audit recommendations implemented and timely reported in the Program activity reports
External audit				
Fraud & Corruption				
Develop in the program operations manual (POM), the tools and procedures for collection, consolidation, reporting, on fraud and corruption and identify the responsible entity.	Six months following the Program effectiveness / Semi-annual	DPRF	N/A	Number of cases of fraud and corruption systematically reported in Program activity reports
Procurement and FM Capacities				
Strengthen coordination between implementing entities and develop tools for collecting budget execution; and accounting data at the level of each implementing entity and capacity building actions	Six months following the Program effectiveness	WB/DPRF	N/A	Financial and budgetary information is included in the half-yearly activity report and is considered to be acceptable and audited financial statements prepared and submitted on time

Implementation Support

63. **Fiduciary implementation support would include:**

- Monitoring fiduciary implementation progress including reconciliation of execution of the PEF and IBRD disbursements (DLI achieved).
- Support to the borrower to resolve implementation issues and carry out institutional capacity building.
- Compliance with audit reports, including the implementation of the PAP; and
- Monitoring, as relevant, of compliance with the fiduciary provisions of legal covenants.

ANNEX 5. (SUMMARY) ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT

Scope of the Environmental and Social Management System Assessment

1. This assessment examines the extent to which the Moroccan government's existing environmental and social management systems can guide the PforR program's environmental and social impact assessments, mitigation, management, and monitoring of E&S risks. It assesses how the systems incorporate recognized elements of good practice in environmental and social assessment and management, through due diligence, including: (i) early identification of potential impacts; (ii) consideration of policy and technical alternatives (including the "no action" alternative); (iii) explicit assessment of potential induced, cumulative, and transboundary impacts; (iv) identification of measures to mitigate adverse environmental or social risks and impacts that cannot otherwise be avoided or minimized; (v) clear articulation of institutional responsibilities and resources to support implementation of plans; and (vi) responsiveness and accountability through stakeholder consultation, timely dissemination of PforR program information, and accountable complaint handling mechanisms. among others.

Objectives of the environmental and social management system assessment

2. The specific objectives of this evaluation are the following:

- Identification of potential environmental and social impacts/risks applicable to the Program's interventions.
- Review of relevant GoM policy, legal, and regulatory frameworks related to the management of environmental and social risks and impacts through due diligence, in accordance with the six core principles.
- Review of the GoM's proposed due diligence and environmental and social management procedures and institutional responsibilities for the Health Program.
- Assessment of institutional capacity at the level of health sector institutions, focusing on the E&S management of the Program.
- Assessment of the performance of the Program's system against the PforR's core principles and identification of gaps in the Program's performance.
- Recommendations for actions to address the identified gaps that will be integrated into the PAP to strengthen performance against the PforR's core E&S. management principles to ensure sustainable implementation.

Approach to the Environmental and Social Management System Assessment

3. The assessment was prepared by the World Bank team through a combination of detailed reviews of existing program documents, available technical literature including government policies, regulations, guidelines, and sample due diligence and design documents, virtual interviews, and extensive consultations with government staff and sector experts associated with the health sector. The findings, conclusions, and opinions expressed in the ESSA are those of the World Bank based on the analysis conducted.

4. An environmental and social risk review of the proposed activities was undertaken at the design stage to:

- Confirm that no activities meeting the defined exclusion criteria are included in the PforR, as per the Bank's ESSA guidelines; and
- Establish the initial scope of the ESSA. This includes identifying relevant systems within the PforR and relevant stakeholders for engagement and consultation.

5. Following the initial review, the systems review was conducted using the following approach, detailed in the respective chapters[97]:

- The identification of relevant systems for ESSA was done through a review of the program, the country's environmental and social due diligence systems, and the nature of the activities supported by the program.
- In line with the program and proposed interventions, the associated environmental and social risks were identified and are presented in Chapter 2.
- Chapter 3 provides an overview of the country's relevant environmental and social management systems
- The assessment of the client's environmental and social management systems according to the core principles is presented in Chapter 4.
- The environmental and social recommendations that need to be incorporated into the program as due diligence to ensure sound implementation and management with the core principles are presented and addressed in Chapter 5.

Main Activities and Priorities of the Program

6. The Program Development Objective (**PDO**) is to **strengthen institutional capacity and governance for improved provision of quality public health services in Program area**.

7. **Main activities**: The PforR is structured around three result areas that provide a mutually reinforcing set of incentives for the types of activities needed to produce the expected results.

- **Result Area #1**: Strengthening organizational and institutional capacity for health system governance seek to improve the governance capacity at central and deconcentrated levels of the health system. The Program supports activities pertaining to (i) the implementation of the new deconcentrated governance system; (ii) updating of provider payment methods to improve quality of care, (iii) improving the content, quality, accessibility, and utilization of health data, and (iv) organization of exchange and coordination platforms between regions and the central level.
- **Result Area #2**: Improved availability, motivation and competence of human resources for health. The Program supports activities pertaining to (i) establishing a special incentive system for health workers to improve the quality and availability of health service delivery; (ii) administrative reform through shifting to a paperless human resources information system to enable better allocation

[97] The chapter numbers in this summary refer to the longer version of the ESSA that was disclosed on the World Bank website, accessible here: *https://documentsinternal.worldbank.org/Search/34038742*

of the health workforce to high-need areas, and (iii) increasing the number of trained priority health workers.

- **Result Area #3**: Strengthened and reorganized health services. The Program supports activities pertaining to (i) rehabilitation of ESSP to comply with green building criteria to address climate vulnerabilities; (ii) quality of care at hospitals and ESSP evaluated and improved; and (iii) epidemiological surveillance capacity strengthened including for climate change related health issues

Description of Potential Environmental and Social Risks

Summary of potential environmental and social risks:

Environmental

Environmental Effects	Evaluation
Associated or Likely Environmental Effects (This section describes the potential benefits, impacts and risks that are likely to be associated with the Program.) *Environmental effects:* *Potential loss or conversion of natural habitats?* *Potential pollution or other project externalities?* *Changes in land or resource use?*	**The environmental impacts of the Program are not expected to be large scale or irreversible**. The results identified in the project do not require works likely to have significant negative impacts on the environment. The Program is not likely to impact natural terrestrial or marine habitats or create environmental pollution, except for localized temporary impacts of the rehabilitation phase for all proposed infrastructure activities. The PforR is also not likely to cause negative changes in land use and/or resource use. Positive changes in resource use would be fostered by new sustainable management schemes included in this Program. **Risk Assessment: Moderate**
Environmental Context (*This section describes the geographical coverage and the scope of the Program and environmental and social conditions in the Program area that may have significance for Program design and implementation*.) **Environment**: • Does the environmental setting of the Program pose any special challenges that need to be considered? • Program activities in or near sensitive habitat areas? • Potential cumulative or induced	Based on the screening of the activities proposed for this PforR and the Moroccan legislative framework, the activities of the PforR are not likely to affect sensitive natural habitats, such as national parks and terrestrial and marine protected areas. The activities financed under this Program will mainly include capacity and process building actions. The objective is to strengthen the institutional capacity and governance for improved provision of quality and availability of public health services in the Program Area. Given the type and scale of activities supported by this Program, the negative impacts are mainly related to and limited to care activities. They mainly relate to the production of medical and pharmaceutical waste (MPW) as

effects?	well as liquid effluents. As the Program aims to improve access to primary care, the quantities of MPW as well as the volumes of liquid waste should increase. Care centers far from hospitals generally incinerate their medical and pharmaceutical waste (MPW) in the open air. This practice is prohibited by law 28-00 on waste management (article 7). This law also prohibits the disposal by landfilling of MPWs in the sites of their production (article 41). Health centers located in rural municipalities do not have a liquid sewage network. The usual practice for the disposal of wastewater and sewage consists of the construction of cesspools. This system does not ensure the reduction of organic pollution contained in wastewater. It is generally used as a supplement to the treatment resulting from septic tanks The cumulative impacts mainly concern the rehabilitation works of the healthcare centers. Indeed, a target of 395 rehabilitated public PHC facilities at the end of the Program is the subject of DLI#7. Achieving this DLI is partly based on compliance with the environmental clauses specified in the specifications for the rehabilitation works, so the cumulative impacts could be mitigated. **Risk Assessment: Moderate.**
Program Strategy and Sustainability (*This section situates the Program, and its environmental and social management systems, within the country's broader development strategy, with particular emphasis on identification of factors that may impede successful Program management over time.*) 1.Strategic context: What is the long-term vision of this Program in relation to the country's development strategy? 2.Does it include explicit environmental management objectives? 3.Do Program activities commit, constrain or alter decisions of future generations? 4.Are there any potential roadblocks to	The Program is aligned with the overall objective of the Country Partnership Framework (CPF, 2019-2024, Report No. 131039-MA) to help Morocco promote social cohesion by improving the conditions for job creation and reducing social and territorial disparities. The Program directly supports the second and third focus areas of the CPF and will contribute to the Objective 6 "Improve the quality and efficiency of health service delivery systems", and the Objective 7 "Strengthen social protection for the poor and vulnerable" by strengthening the quality and efficiency of the health system delivery to meet the Moroccan population's expectations through equitable access and quality of care. The Program is also in line with the MENA Strategy. With a focus on improved access to quality of public services and on enhanced governance mechanisms, the Program is

ensuring the environmental and social sustainability of the Program after implementation?	aligned with Pillar II of the 2015 MENA Strategy "Renewing the Social Contract". It also contributes to the expanded MENA Strategy (March 2019) pillar on "Building Human Capital", which places a greater focus on harnessing human capital and the World Bank Group Gender Strategy (FY16-23) by contributing to increasing women's access to health. **DLI 7:** Rehabilitation of public PHC facilities in Program Area to comply with green building criteria to address climate vulnerabilities. **DLI 8:** Evaluation of quality of care at hospitals and ESSP (Number of GSTs that have put in place a quality improvement action plan for hospitals and public PHC facilities according to adopted quality evaluation roadmap. The PforR is committed to meeting the needs of future generations. With a strong impact on governance, the PforR will contribute to promoting a model of sustainable management of the health sector. **Risk Assessment: Low**
Institutional Complexity and Capacity (*This section describes organizational, administrative and regulatory structures and practices, as they relate to environmental and social assessment, planning and management*.) 1.Does the Program involve multiple jurisdictions or implementing partners? 2.Capacity or commitment of counterpart to implement regulations and procedures? 3.Is there a track record of commitment and implementation experience on environment and social aspects? 4.Are there any known institutional barriers that would prevent the implementation of this Program? 5.Is there sufficient institutional capacity to address the environmental and social impacts of this Program?	The Program will be implemented by the MHSP. Framework Law 06-22 entails a substantial restructuring of the governance arrangements for the health sector. The exact mandate of these institutions will be determined in the upcoming months, including their roles, responsibilities, composition, and hierarchical structure, as well as linkages with MHSP. The operation will support the program's capacity to identify and screen potential negative effects in advance and implement effective mitigation measures. The main risk identified corresponds to the involvement of several institutions (the introduction of different new governance bodies, institutional arrangements, and relevant legislations which are currently being fleshed out by the government) whose E&S management capacities must be strengthened to allow E&S management of the Program adequate with the requirements of national regulations. The capacity building will target all the counterparts involved in the implementation of the Program. In addition, the assessment of the ESSA's action plan of the

	previous PforR, revealed an important delay in the designation of the environmental and social focal points at the national and regional levels, which limited the dissemination of environmental and social management procedures and the carrying out of actions relating to ESSA action plan. The Sustainable Development Department (DDD) responsible for managing the EIA system has good experience and the necessary skills, particularly in EIA review, project implementation monitoring and environmental monitoring (air, water, soil), through the National Environment Laboratory. The E&S management capacities of Program stakeholders must be developed. The Program is an opportunity to build E&S management capacities and support them in developing their E&S management system. The approach adopted is the one that was used for all the PPRs in the Moroccan portfolio and made it possible to effectively establish the E&S management systems of several institutions (Ministry of the Interior, Directorate General of Territorial Communities, Ministry of Agriculture, Ministry of Employment, Ministry of Equipment, etc.). **Risk Assessment: Substantial**
Reputational and Political Risk Context (*This section describes environmental and social issues, trends or other factors that may cause the program, the country, or the Bank to be exposed to significant reputational or political risk*.) 1.Potential governance or corruption issues 2.Are there any political risks associated with this sector or Program? 3.Is the sector or Program known to be controversial?	The PforR does not present political or reputational risks. 1. The Program's ex-ante and ex-post financial controls have been deemed adequate to address the risk of fraud and corruption. This system includes several effective institutions playing complementary roles: the Office of the Mediator, the Court of Auditors, the IGAT, the CNCP and the IG. 2. There are no political risks associated with the sector and the proposed PforR. 3.No **Risk Assessment: Low**
Overall Assessment: (*This section describes the overall risk profile for the Program, based on the*	The environmental risks potentially associated with Program activities are expected to be moderate. The risk of involving stakeholders whose E&S management

team's subjective weighting and aggregation of all factors identified above. Environmental and social risk factors should be summarized separately). Is the Program suitable for PforR or would it be better suited to a specific investment loan?	capacities need to be strengthened is substantial. **Overall Risk Rating: Substantial**

Social

8. While considering the social risks mentioned below, it is important to bear in mind the inequalities in access to health care between regions, between rural and urban areas, and between social strata. Indeed, human resources for health in Morocco are unevenly distributed and do not match the needs of the population, particularly in rural areas, which could potentially exacerbate social risks and affect their impact and likelihood differently.

Discrimination of vulnerable groups: Substantial

9. There is a potential risk of discrimination across gender, racial, and disabilities in the context of human resources for health reform:

- Gender discrimination – Substantial- a potential risk that can arise during the recruitment process, training, as well as during performance evaluations that eventually affect salaries and bonuses. Moreover, the socially assigned household responsibilities could affect the work/life balance for women and might impact their performance and evaluation which could lead to exclusion based on gender hence the need for accommodation measures and more inclusive structures.
- Racial discrimination – Low– to avoid racial tension or human rights violations, it is necessary to highlight the risk of racial discrimination, especially when recruiting foreign staff. Given that the Moroccan Labor Code does not provide a strong legal framework to protect foreigners from any act based on racial discrimination, it was deemed necessary to highlight this gap and potential risk to ensure its mitigation.
- Social exclusion of people with disabilities – Substantial- a risk that could arise if the articles of the law on the protection of people with disabilities are not incorporated into the Client's HR and patient access measures.

Gender-based violence and harassment: Substantial

10. Based on DLI 5 and 6, an expansion of the health workforce is expected. Given the anticipated increase in the number of male and female employees as well as the number of patients treated, the risk of sexual harassment and sexual assault will likely increase if the measures in place are not sufficient to address it.

11. To design appropriate measures and policies, it is particularly important to highlight the different contexts in which SEA/SH can occur:

- Staff-on-staff violence
- Staff-on-patient violence
- Violence by patients or family members against staff

Data Privacy Risks: Low

12. National law supports data privacy, which includes individuals seeking reproductive health care. Given the emphasis on digitizing health databases and launching electronic health records, there is a potential risk of privacy breaches that may expose vulnerable groups, primarily women, to different forms of violence. The risk of data breach could also affect different groups and patients and lead to other negative social consequences.

Risks related to language: Low to moderate

13. The topic of languages can be sensitive in Morocco, especially at a time when language dynamics are undergoing significant changes and are at the center of important issues. Morocco has several languages and language variants, giving it the status of a multilingual country. These languages include Moroccan Arabic or Darija, various forms of Amazigh, French, etc.; however, they are not used or recognized by institutions in an equivalent manner.

14. Unlike all previous Moroccan constitutions that recognized only one official language, Arabic, the 2011 constitution is an exception:

> "Arabic remains the official language of the state. The state works to protect and develop the Arabic language and to promote its use. Similarly, Amazigh is an official language of the state, as a common heritage to all Moroccans without exception (excerpt from Article 5)."

15. With plans to launch an integrated information system where all data from public and private health institutions are integrated, as well as efforts to launch electronic medical records at the patient level, language disparities, particularly at the rural level, may disadvantage certain groups and impede their access to basic medical information and services.

Overview Of the Borrower's Environmental and Social Management Systems

Core Principle	**Relevant Policies, Laws, and Regulations**
General principle of social management • Promotion of social sustainability • Avoidance, minimization, or mitigation of risks • Promotion of informed decision-making	**Legal and regulatory framework:** • 2011 Constitution of Morocco • Framework law No 9-21 on Social Protection • Framework law n° 97-13 on the protection and promotion of the rights of disabled people • Framework law n° 103-13 on the fight against all forms of violence against

	women • Labor Code of Morocco • Decree No. 2.11.621 concerning the conditions and organization of public employment competitions • Decree No. 2.05.1367 concerning the performance appraisal of civil servants in public administrations • Decree N° 2.04.403 concerning the conditions of promotion of civil servants in the grade or framework • Law n° 31-13 on the right of access to information • Law n° 09-08 on data protection **Institutional framework:** • National Health Program for the Care of Women and Children Victims of Violence • The National Commission for the Control of Personal Data Protection • The National Committee for Abused Women
General principle of environmental management	**Legal and regulatory framework:** • Law 12-03 on the environmental impact assessment and its related decrees • Law 11-03 relating to the protection and enhancement of the environment • Law 22-07 relating to protected areas • Law 28-00 on the management and disposal of waste, as well as its implementing texts, including the decree on the management of MPWs as well as the decree establishing the list of hazardous waste. • Decree No. 2-04-553 (of Law No. 10-95) relating to spills, flows, discharges, direct or indirect deposits in surface or underground waters • Decree No. 2-05-1533 relating to autonomous sanitation. • Law 65-99 relating to the labor code **Institutional Framework**

	• Sustainable Development Department • Ministry of /health and Social Protection • Ministry of Interior

Assessment Of the Client's Social and Environmental Management Systems
Summary of the Environmental Evaluation

Systems

16. The analysis of the regulatory and institutional frameworks that constitute the national environmental management system has shown their adequacy with the PforR Policy. The gaps identified must be taken into consideration and are linked to i) the integration of the use of ESMPs in the management and environmental monitoring of activities whose risks are moderate and therefore not considered by Law 12-03 on EIAs, and ii) the conduct of public consultations involving stakeholders and parties affected by the Program, and the documented monitoring and evaluation of mitigation measures.

Risks

17. Although the environmental risks of the activities under this Program are characterized as substantial, the Program offers an opportunity both to strengthen the shortcomings mentioned and to improve the system as a whole in a sustainable manner in three areas:

(i) strengthening of the environmental management system;
(ii) implementation of good environmental management practices; and
(iii) monitoring and evaluation of environmental management.

18. To this end, the Program will support specific measures to strengthen the performance of the environmental management system of the various institutions involved in the Program. These measures will be implemented through the implementation of simple environmental diagnosis and monitoring tools; the designation of Environmental Focal Points who will be trained; and capacity building of the actors involved in this Program. All these measures are included in the ESSA and Program Action Plan.

19. Medical and pharmaceutical wastes (MPWs) management at the ESSP level needs to be improved. Also, this report recommends the development of regional and/or provincial plans for the management of MPWs to ensure the safety of users (health care staff and users) and to comply with current regulations.

20. The management of liquid effluents at the ESSP level must begin with an analysis of the current situation to assess the impact and risks of effluents generated by these structures, mainly in rural areas.

Capacities

21. The analysis of the capacities of the institutions involved in the program has made it possible to highlight an initial (moderately satisfactory) experience through the previous Health Sector Support PforR (P148017). Apart from ANEP (Agence nationale des équipements publics), the entities that will be involved

in the implementation of the Program show shortcomings in terms of (i) identification and evaluation of impacts, (ii) environmental control and monitoring of activities covered or not by the national EIA system, and (iii) organization with the necessary capacities for the implementation of an environmental management system.

22. The evaluation of the action plan of the ESSA of the previous PforR highlighted the significant delay in the designation of E&S focal points at the national and regional levels, which limited the dissemination of the procedures for E&S management as well as carrying out actions relating to a) the development of medical waste management plans, b) the diagnostic study of the waste treatment system, and c) the analysis of the wastewater management systems of the treatment center. For these reasons, the Implementation Completion and Results (ICR) report of the previous Program rated the E&S management as moderately satisfactory. **The main lesson learned** from this Program concerns the designation, from the start, of the focal point at the PMU level and his counterparts at the level of the entities participating in the implementation of the Program. The **second lesson** corresponds to the mission letter of the focal points which must be clear and precise and communicated to the entities which designate the focal points so that their choice is informed and that the persons designated are informed from the start of their mission and their responsibilities. A draft mission letter is proposed in appendix 3, it can be adapted according to the specificities.

23. The MSPS should ensure that E&S focal points are appointed within the GSTs being set up. These focal points must undergo training on the E&S Technical Manual and must be operational to monitor the E&S aspects of their activities.

24. The DEM has developed a first experience in E&S management thanks to a project financed by AFD. The DEM has been designated E&S focal point for this project.

25. The completion of the rehabilitation program involving 395 public PHC has been entrusted to a delegated contracting authority (National Agency for Public Facilities - ANEP).

26. ANEP's sustainable development policy is reflected in the design and implementation of projects. In this context, ANEP has developed Sustainable Development criteria that they use when developing their project, particularly for certain trades such as air conditioning. These criteria are used by engineers at each stage: design, implementation and monitoring.

27. ANEP regional representations have experience with AfDB in the E&S management of public PHC rehabilitation activities.

ESSA Action Plan

28. These findings justify the need to operationalize a training module focused on the development and implementation of an environmental management system that will enable the MHSP and stakeholders to carry out their activities in compliance with national environmental management regulations.

29. This training module for the MHSP E&S focal point and stakeholder focal points should focus on

- Regulatory requirements for environmental management.

- Identification and assessment of environmental impacts.
- Categorization of funded activities according to their potential to generate impacts.
- Identification of good environmental practices and impact mitigation measures.
- Tools for monitoring and reporting on the implementation of mitigation measures, including any incidents/accidents that occurred during the implementation of program activities.

30. The staff who will receive this training should act as environmental focal points within their structure because they will be equipped and trained to perform the tasks listed in the mission statement for this position (ensure, in close collaboration with all stakeholders coordination and monitoring of the implementation of actions to strengthen environmental management systems; collection and centralization of all information related to environmental risks and their mitigation measures; monitoring and evaluation of the implementation of mitigation measures and integration of data into the information (system and reporting). The training module could be adapted to be provided to all Program stakeholders (including deconcentrated entities). Training modules and training plan will be developed by MHSP.

31. The risk analysis identified which of the activities in this Program should be screened for environmental impacts prior to their selection (rehabilitation of public PHC facilities). Screening tools and a simplified ESMP model are proposed in the annex.

32. The implementation and monitoring of mitigation measures during the construction and operation phase of these activities will be carried out by the ANEP Environmental focal point, in coordination with the MHSP Environmental focal point.

33. The environmental focal point at MHSP will ensure the implementation of the Action Plan for this ESSA and ensure that the environmental management system in place is functional and effective.

34. In conclusion, the environmental management system applicable to the Program is generally in line with the PforR Policy. The environmental risks are characterized as "low to moderate" and are considered acceptable. To mitigate these risks, the Program will strengthen environmental capacities at the Program level through adequate organization, continuous training, the establishment of mechanisms and tools (trained focal point, screening and monitoring sheets, land management procedure, ESMP) and environmental management performance indicators and regular monitoring and evaluation.

35. To this end, the ESSA action plan, which will be an integral part of the Program's action plan, provides for specific measures to strengthen the quality and performance of the MHSP environmental management system.

Summary of the Social Evaluation

Bank Policy for PforRs: Social management procedures and processes are designed to (a) promote social sustainability in program design; (b) avoid, minimize, or mitigate adverse impacts; and (c) promote informed decision-making regarding program financing.

Program procedures should:

- Operate within an adequate legal and regulatory framework to guide program-level environmental and social impact assessments.
- Incorporate recognized elements of good environmental and social assessment practice, including:
- Ensure early identification of potential impacts.
- Ensure consideration of policy, technical, and site alternatives (including the "no action" alternative).
- Ensure explicit assessment of potential induced, cumulative and transboundary impacts
- Ensure identification of mitigation measures for adverse environmental or social impacts that cannot otherwise be avoided or minimized.
- Have clear articulation of institutional responsibilities and resources to support plan implementation; and
- Ensure responsiveness and accountability through stakeholder consultation, timely dissemination of program information, and appropriate grievance redress.

APPLICABLE

Core Principle 1 is considered in terms of environmental and social management for the health sector during the implementation of the program, as a key instrument to establish and strengthen existing environmental and social management systems under the Ministry of Health and Social Protection and other implementing agencies.

Applicable DLIs	**Systems' evaluation**	**Gaps**
DLI 1: Implementation of the new deconcentrated governance system, DLI 3: Improved content, quality, accessibility and use of health data DLI 5: Special status for health workers established to improve the quality of health service delivery DLI 6: Improved training capacity for priority cadres in ISPITS DLI 8: Quality of care at hospitals and public PHC evaluated and improved	**National policies and regulations:** The Moroccan government has a solid legal and policy framework to protect, conserve, and mitigate negative social impacts. The above-mentioned laws, decrees, programs, and commissions aim to ensure social justice in health facilities for both staff and patients. **Grief Redress Mechanism** The purpose of the Chikaya National Complaints Portal is to receive complaints and grievances from citizens and ensure their processing and follow-up; answer their	-Program-related social risk provisions are fragmented in different legislations. This can be explained by the fact that social risk management concerns multiple themes such as education, labor management, social protection/development, among others. It is therefore necessary to develop a policy that consolidates all relevant regulations to ensure that social inclusion, human rights and labor rights are respected. - The program itself does not provide clear mechanisms to ensure adequate controls on social impacts and approaches to mitigate potential risks. -The relevant institutions and agencies of the program lack sufficient resources to monitor and enforce social risk management and regulation. The

	questions; present solutions to citizens' problems as well as receive their observations, proposals and remarks. **Environmental and Social Awareness** There are many active civil society actors in the health sector who are making significant contributions to raising awareness of environmental, social, and behavioral changes.	availability of adequate staff and financial resources, the administrative and political will of enforcement agencies, and the level of awareness of social and environmental laws are essential conditions for effective enforcement of environmental and social legislation. -The program does not have specific staff to conduct environmental and social analyses.

Program Action Plan and Recommendations

Action	Description	Respon-sibility	Timing	Completion Measurement
Appointment of Social, and environmental (including gender) focal points at the MHSP	Social inclusion, environment, and gender focal points should be assigned at key central levels, and should be trained to undertake the identification, planning, implementation and E&S monitoring of the program	MSPS	No later than four months after the Effective Date and no later than the start of new Program activities.	Designation letters of focal points within MHSP
Appointment of Social, and environmental (including gender) focal points at regions/GST	Social inclusion, environment, and gender focal points should be assigned at key regional levels, and should be trained to undertake the identification, planning,	GST	No later than one year after the Effective date	Designation of focal points within regions/GST

	implementation and E&S monitoring of the program			
Preparation and implementation of an E&S Technical Manual (as part of the POM) which will provide details on the actions and follow-up to be carried out by the focal points.	- Site monitoring tools (E&S monitoring sheets, anomaly sheets, accident/incident communication procedure and establishment of status reports and associated action plans) -Site monitoring responsibilities -Management of grievances -An elaboration of sexual exploitation/abuse and harassment prevention and response plan for the program, including the designation of gender-based violence prevention specialists, an accountability and response framework, a confidential grievance management mechanism, SEA/SH prohibitions for each project actor, in the form of behavioral standards with explicit SEA/SH prohibitions or codes of conduct, awareness raising and training, and the identification of one or more service providers accessible to complainants in the project area - Reporting methods and frequency -Implementation of the E&S technical manual	MSPS	No later than four months from the Effective Date Incidents/accidents must be reported to the WB no later than 48 hours after they occur	The environmental and social technical manual, including good E&S practices, validated by the World Bank.

Development of a Communication Plan and Engagement with Stakeholders	Development of a plan to identify the key stakeholders involved to strengthen and sustain their engagement throughout the implementation of the program	MSPS	No later than 6 months from the Effective date	Strengthening the Ministry's existing mechanisms for engaging with civil society.
Capacity building in E&S management for all program focal points and stakeholders	Development and implementation of the training plan based on the E&S Technical Manual	MSPS	No later than 6 months from the Effective date	- Training module developed - Training plan developed - Reports on the training carried out
Development of new GRM for PHC rehabilitation work and strengthening of GRM for staff	Development of a protocol to filter grievances from the Chikaya portal related to PforR-funded activities, including rehabilitation works and strengthening the human resources grievance mechanism for staff	MSPS	No later than 4 months from the Effective Date	GRM involving IT and communication managers
Participation in the Bank-financed Technical assistance for the “National Program for the Care of Women and Children victims of violence”	Assistance will be provided based on the Ministry's evaluations of the program and international best practices.	MSPS	18-Mar-2024	Finalization of inputs for the evaluation of the program and definition of policy inputs to strengthen mechanisms
Preparation of regional medical and pharmaceutical waste management plans	(i) Identify the pool of DMPs generated by the ESSPs, (ii) characterize the shortcomings of the current DMPs management system at the ESSP level, (iii) propose measures to	MSPS	No later than 2 years from the Effective Date	Medical and pharmaceutical waste management plans covering the regions targeted by the Program

	develop capacity, comply with current DMP management regulations, and reduce the health risks to health care personnel, visitors, and the general population			
Evaluation of the management of liquid effluents of ESSPs	Diagnosis of the liquid effluent management system in the ESSPs to identify the ESSPs that require improvement of their liquid sanitation system	MSPS	No later than 1 year from the Effective Date	Evaluation of the management of liquid effluents from healthcare centers

ANNEX 6. PROGRAM ACTION PLAN

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement
Finalization of Program Operations Manual (POM) including: administrative and M&E procedures; E&S management, complaints and GRM; PAP; results and verification protocol; reports templates, fraud and corruption reporting; Program area details.	Technical		MHSP	Other	No later than 4 months from the Effective Date	POM finalized and receives no-objection by the World Bank
The Steering committee (SC) annually and the Technical committe (TC) have been constituted and met to monitor Program implementation progress, and each meeting has been instituted by a report which includes the activities for the following year.	Technical		MHSP	Other	No later than 4 months after the Effective Date	The SC, composed of key MHSP and other stakeholders and the TC, composed of the technical directorates and other parties have met no later than 4 months after the effective date. The SC meets regularly on annual basis and the TC meets semesterly.
Capacity building in E&S management for all program focal points and stakeholders.	Environmental and Social Systems		MHSP	Other	No later than 6 months from the Effective date	Development and implementation of the training plan based on the E&S Technical Manual
Preparation and implementation of an E&S Technical Manual (as part of the POM) which will provide details on the actions and	Environmental and Social Systems		MHSP	Other	No later than 4 months from the Effective Date	The environmental and social technical manual, including good E&S practices, validated by the World Bank.

follow-up to be carried out by the focal points.						
Development of new GRM for ESSP rehabilitation works, including grievances from personnel and contractors	Environmental and Social Systems		MHSP	Other	No later than 4 months from the Effective Date	GRM developed and available for personnel and contractors
Appointment of environmental and social (including gender) focal points at regions at MSPS	Environmental and Social Systems		MSPS/GST	Other	No later than four months year after the Effective date	Designation letters of focal points within MSPS
Evaluation of the management of liquid effluents of ESSP: Diagnosis of the liquid effluent management system at ESSP in order to identify ESSP that require an improvement of their liquid sanitation system.	Environmental and Social Systems		MHSP	Other	No later than 1 year from the Effective Date	Evaluation of the management of liquid effluents from healthcare centers
Preparation of regional medical and pharmaceutical waste management plans	Environmental and Social Systems		MHSP/GST	Other	No later than 2 years from the Effective Date	Medical and pharmaceutical waste management plans covering the regions targeted by the Program
Development and implementation of the training plan on the Environmental and Social Good Practice Guide	Environmental and Social Systems		MHSP	Other	No later than 6 months from the Effective Date	- Training module developed - Training plan developped - Reports on the training carried out
Development of a Communication Plan and Engagement with Stakeholders	Environmental and Social Systems		MHSP	Other	No later than 6 months from the Effective date	Development of a plan to identify the key stakeholders involved to strengthen and sustain their engagement throughout the implementation of the program
Appointment of environmental and social (including gender) focal points at regions at	Environmental and Social Systems		MSPS	Other	No later than one year after the Effective	Designation letters of focal points within GST/regions

GST					date	
Ensure that procurement plans are prepared and implemented in accordance with the existing regulations	Fiduciary Systems		DPRF/DEM/DAMPS/GST	Recurrent	Continuous	Annual Procurement plans are published no later than the end of Q1 of the fiscal year and are implemented in accordance with the existing regulations .
Set up the internal audit unit in accordance with the regulations in force (new decree)	Fiduciary Systems		MEF/DPRF	Other	Date of publication of the decree	Application of the decree and operationalization of the internal audit unit within the ministry (internal audit unit with its staff; management tools of the function put in place; number of internal audit mission reports; allocated budget etc.)
Develop and implement a program to enhance capacity-building on the new procurement decree.	Fiduciary Systems		TGR	Due Date	01-Jan-2024	A capacity strengthening program on the new procurement decree is prepared and implemented by TGR
Include in the bidding documents an eligibility check clause	Fiduciary Systems		MSPS/GST	Other	Continious	An eligibility check clause included in the bidding documents and implementing agencies are required to ensure that any person or entity debarred or suspended by the Bank is not awarded a contract under the Program
Follow up on audits recommendations of the Porgram	Fiduciary Systems		DPRF and IGM	Recurrent	Continuous	Number of audit recommendations implemented and timely reported in the Program activity reports
Strengthen coordination between implementing entities and develop tools for collecting budget execution and accounting data at the level of each implementing entity and capacity building actions	Fiduciary Systems		DPRF	Other	Six months following the Effective Date	Financial and budgetary information is included in the half-yearly activity report and is considered to be acceptable and audited financial statements prepared and submitted on time
Implement a semi-	Fiduciary		DEM/DPRF/DAMPS/GS	Recurrent	Semi-	A reporting is done through the

annual reporting mechanism including (i)Public Procurement: Tenders and procurement-related complaints; and (ii) Financial Management	Systems		T		Annually	minutes of technical committees, on a semi-annual basis
Develop in the program operations manual (POM), the tools and procedures for collection, consolidation, reporting, on fraud and corruption and identify the responsible entity.	Fiduciary Systems		DPRF/IGM	Recurrent	Semi-Annually	Number of cases of fraud and corruption systematically reported in Program activity reports