Report No. 91579-MA

DOCUMENT OF

THE WORLD BANK

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PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$100 MILLION

TO THE

KINGDOM OF MOROCCO

FOR AN

IMPROVING PRIMARY HEALTH IN RURAL AREAS

PROGRAM-FOR-RESULTS

April 3, 2015

CURRENCY EQUIVALENTS

US$1 = 9.6246 Moroccan Dirham (MAD)

(Exchange rate effective as March 4, 2015)

ABBREVIATIONS AND ACRONYMS

AECID	Spanish Cooperation
AFD	*Agence Française de Développement* (French Development Agency)
ANAM	*Agence Nationale de l'Assurance Maladies* (National Health Insurance Agency)
CCM	*Cellule de Coordination des Marchés* (Contract Coordination Cell)
CDC	*Cour des comptes* (Supreme Audit Institution)
CDM	*Commission des Marches* (Procurement Commission)
CHC	Community Health Center
CNCP	*Commission Nationale de la Commande Publique* (National Commission of Public Procurement)
CNOPS	*Caisse Nationale des Organismes de Prévoyance Sociale* (insurance scheme covering civil servants)
CNSS	*Caisse Nationale de Sécurité Sociale (*insurance scheme covering private sector employees)
CPS	Country Partnership Strategy
CSCA	*Centres de santé avec module d'accouchement* (Community Health Center with Delivery Unit)
DELM	*Direction de l'Épidémiologie et de Lutte Contre les Maladies* (Epidemiology and Disease Control Division)
DHSA	*Direction des Hôpitaux et des Soins Ambulatoires* (Hospitals and Ambulatory Care Division)
DIM	*Division de l'Informatique et des Méthodes* (Methods and Informatics
DLI	Disbursement-linked indicators
DP	*Direction de la Population* (Population Division)
DPRF	*Direction de la Planification et des Ressources Financières* (Division of Planning and Financial Resources)
DRH	*Direction des Ressources Humaines* (Human Resources Division)
ESSP	*Etablissement de soins de santé primaires* (primary health care facilities)
ESSA	Environmental and Social Systems Assessment
EU	European Union
FSA	Fiduciary System Assessment
GCCs	General Contract Conditions
GID	*Gestion intégrée de la dépense* (expenditure integrated management)
GOM	Government of Morocco
HMIS	Health Management Information System

HRH	Human resources for health
ICPC	*Instance Centrale de Prévention de la Corruption* (Central Institution for the Prevention of Corruption)
IGF	*Inspection Générale des Finances* (Internal auditor of the Ministry of Finance)
IGM	*Inspection générale ministérielle* (Internal auditor of the Ministry of Health)
IMT	Integrated Mobile Teams
MAGG	Ministry of General Affairs and Governance (*Ministère des Affaires générales et de la gouvernance*)
MCH	maternal child health
MMR	maternal mortality ratio
MNCH	maternal, newborn and child health
MoF	Ministry of Economy and Finance
MoH	Ministry of Health
NCD	Non-communicable disease
OOP	Out-of-pocket
PAP	Program Action Plan
PCIE	*Prise en Charge Intégrée de l'Enfant* (Integrated Child Management Strategy)
PforR	Program for Results
PPD	Public Procurement Decree
RAMED	*Régime d'assistance médicale pour les économiquement démunis* (Health Insurance for Low-income Households)
RMNCH	reproductive, maternal, newborn and child health
SIAAP	*Services d'infrastructures d'actions ambulatoires provinciaux* (provincial out-patient care infrastructure departments)
SMIPF	*Santé Maternelle et Infantile/Planification Familiale* (Maternal and Child Health/ Family Planning)
TGR	*Trésorerie générale du Royaume (*General Treasury of the Kingdom)

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KINGDOM OF MOROCCO

Improving Primary Health in Rural Areas
Program-for-Results

Contents

PAD DATA SHEET

The Kingdom of Morocco

Improving Primary Health in Rural Areas Program for Results

PROGRAM APPRAISAL DOCUMENT

Middle East and North Africa (MENA)
Health, Nutrition & Population Global Practice

Basic Information

Date:	April 3, 2015	Sectors:	Health (100%)
Acting Country Director:	Joelle Bussinger	Themes:	Health system performance (80%) Injuries and non-communicable diseases (20%)
Practice Manager/ Director, HNP GP:	Enis Barış/Olusoji Adeyi		
Program ID:	P148017		
Team Leader:	Nadine Poupart		
Co-Team Leader	Emre Özaltın		

Program Implementation Period:	Start Date:	April 24, 2015	End Date:	June 30, 2019

Expected Financing Effectiveness Date: July 1, 2015

Expected Financing Closing Date: December 31, 2019

Program Financing Data

[X] Loan [ ] Credit	[ ] Grant	[ ] Other

For Loans/Credits/Others (US$M):

Total Program Cost :	US226.2 million equivalent	Total Bank Financing :	US$100 million
Total Cofinancing :		Financing Gap :	

Financing Source	Amount
BORROWER/RECIPIENT	US$15.2 million equivalent
IBRD	US$100 million equivalent
European Union	US$107 million equivalent (Euro 85 Million)
United Nations	US$4 million equivalent
Total	US$226.2 million equivalent

Borrower: Kingdom of Morocco

Responsible Agency: Ministry of Health

Contact:	M. Belghiti Alaoui	Title:	General Secretary
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Expected Disbursements (in USD Million)

Fiscal Year	FY15	FY16	FY17	FY18	FY19				
Annual	0	25	23	25	27				
Cumulative	0	25	48	73	100				

Program Development Objective(s)

The objective of the Program is to expand access to primary healthcare in targeted rural areas in the Program Area.

Compliance

Policy

Does the program depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the program require any waivers of Bank policies applicable to Program-for-Results operations?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the program meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

Overall Risk Rating: Substantial			
Legal Covenants :			
Name	**Recurrent**	**Due Date**	**Frequency**
Schedule 2, Section 1(C)	Yes	4 months after effectiveness	

Description of Covenant

The Borrower shall by no later than 4 months after the Effective Date, establish in form and substance satisfactory to the Bank, and thereafter maintain throughout the Program (i) a steering committee which shall be chaired by the Secretary General of the MoH and include directors of each of the relevant MoH departments, and (ii) a technical committee chaired by the director of DPRF and composed of representatives of each of the relevant MoH departments.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Nadine Poupart	Sr. Economist	TTL	GHNDR
Emre Özaltın	Health Economist	Co-TTL, HMIS	GHNDR
Dominic Haazen	Lead Health Policy Specialist	HMIS	GHNDR
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Khalid El Massnaoui	Sr. Economist	Country Risks	GMFDR
Khadija Faridi	Procurement Specialist	Procurement	GGODR
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Franck Bessette	Sr. Financial management Specialist	Financial Management	GGODR
Laila Moudden	Financial management Analyst	Financial Management	GGODR
Fabian Seiderer	Senior Public Sector Management Specialist	Financial Management	GGODR
Jean-Charles de Daruvar	Sr. Counsel	Country Lawyer	LEGAM
Nathalie Munzberg	Sr. Counsel	Acting Country Lawyer	LEGAM
Aisssatou Diallo	Sr. Finance Officer	Disbursement	CTRL
Loubna Ennadir	Temporary		EXC
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Suiko Yoshijima	Environmental Specialist	Environmental Safeguards	GENDR
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Daniel Dulitzky	Sector Manager	Peer Reviewer	GHNDR
Nedim Jaganjac		Peer Reviewer	GHNDR
Son Nam Nguyen		Peer Reviewer	GHNDR
Moulay Zine-Eddine El-Idrissi		Peer Reviewer	GHNDR
Amy Champion	Operations Analyst	Operations	GPSOS
Mary Lou Bradley	Sr. Operations Officer		GHNDR
Rebecca Lacroix	Jr. Professional Officer	Social safeguards	GSURR

Non Bank Staff

Name	Title	Specialty
Elisabeth Sandor	Consultant	Citizen Engagement
Gilles Dussault	Consultant	Human Resources for Health
Lamyae Hanafi	Consultant	Financial Management
Najat Mjid	Consultant	Social Safeguards
Anouar Khalid	Consultant	Environmental Safeguards
Clara Welteke	Consultant	Economic Analysis
Rima Al-Azar	Consultant	Governance

I. STRATEGIC CONTEXT

A. Country Context

1. **With an average economic growth rate of nearly five percent from 2001-2011, Morocco reduced poverty and boosted shared prosperity.** Extreme poverty has practically been eradicated, dropping from 2 percent to 0.28 percent over the same period.[1] Relative poverty also declined, from 15.3 percent to 6.2 percent, and population vulnerability (those living just above the poverty line) decreased from 22.8 percent to 13.3 percent.[2] Still, nearly 20 percent of the country, or 6.3 million Moroccans, live in poverty or under constant threat of falling back into poverty. Inequality remains an important challenge. Morocco's Gini[3] coefficient of 0.41 reflects stubbornly high levels of inequality. Disparities in poverty rates across regions provide one measure of this inequality: in 2011, the poverty rate in seven of Morocco's 16 regions was higher than the national average, as much as 40 percent higher in three of those regions. Poverty rates are highest in rural areas. Ten percent of Morocco's 13.4 million rural residents lived below the poverty line and accounted for two-thirds of the poor in Morocco in 2011.[4]

2. **The Government's strategic priorities mirror in great part the principles, changes, and actions prescribed by the new Constitution**. This was detailed in the Head of Government's January 2012 speech, which laid out the Government's 2012-2016 program. The Government's program is structured around five mutually-reinforcing pillars: (i) deepening national identity, preserving social cohesion and diversity, and openness; (ii) consolidating the rule of law, strengthening good governance, democratic participation and advancement of regionalization and decentralization, in the context of accountability of the health system and true citizenship; (iii) pursuing strong, competitive, multi-sector, diversified, wealth- and employment-generating, and equitable economic growth; (iv) promoting social programs guaranteeing equitable access to basic services and strengthening solidarity and equal opportunities across citizens, generations, and regions; and (v) consolidation of the country's regional and international credibility and promotion of public services aimed at Moroccans living abroad.[5]

3. **Morocco is experiencing significant political change accompanied by public demand for improved health services.** The new constitution sets the basis for a more open and democratic society. The new constitution also explicitly states that healthcare is a right of the Moroccan people. At the same time, there is demand for improved public services in the health sector. Building on the first ever national consultation on health called *Intidarat*, and with support from King Mohamed VI, Morocco held the second National Conference on Health from July 1-3, 2013[6] to build consensus on the diagnosis of problems in the health sector and set of planned reforms.[7] The conference was anchored by a Royal Letter for action, a 2012-2016 health sector strategy, and a Health Sector White Paper.[8] The consensus recommendations of the conference outline the sectoral reform strategy going forward.

[1] Extreme poverty refers to the population living on less than US$1 PPP/day. The drop is based on the national poverty threshold, corresponding to the equivalent of US$2.15 PPP in 2007.

[2] Alternative poverty measurements confirm this decline. The Alkire-Foster multidimensional poverty rates declined from 28.5 percent in 2004 to 8.9 percent in 2011.

[3] Gini index measures the extent to which the distribution of income or consumption expenditure among individuals or households within an economy deviates from a perfectly equal distribution.

[4] FY14-17 World Bank Group Country Partnership Strategy for the Kingdom of Morocco, The World Bank, 2014 (Report 86518-MA)

[5] Ibidem

[6] The first health conference was held in 1959.

[7] Attendees included line ministries, insurers, medical and nursing associations, private sector, academics, civil society, NGOs, donors, and all other major stakeholders.

[8] *Royaume du Maroc, Ministère de la santé, Livre Blanc : Pour une nouvelle gouvernance du secteur de la santé, Marrakesh, 1-3 juillet 2013*.

B. Sectoral and Institutional Context

4. **Despite recent progress, health indicators remain poor, well behind the levels of comparable countries in the region, and are highly inequitable**. Morocco has made significant progress since the 1990s and especially during the last five years. The maternal mortality ratio has decreased by almost 66 percent in 20 years, from 332 maternal deaths per 100,000 live births in 1992 to 112 deaths per 100,000 live births in 2010. Infant and child mortality levels have been reduced from 84 per 1,000 live births in 1992 to 30 per 1,000 live births in 2011, a reduction of 64 percent. Despite this progress, inequities exist between urban and rural areas, regions, and socio-economic levels. The maternal mortality ratio in rural areas is two times higher than in urban areas (148 versus 73 deaths per 100,000 live births) and child mortality is 40 percent higher in rural areas compared to urban areas. These inequities in health outcomes reflect inequities in access to and in quality of healthcare providers, and inequities in the allocation of resources to public healthcare providers. While the burden of communicable diseases has decreased since 1990, Morocco faces a rise in non-communicable diseases (NCDs) and injuries. In 2011, 18.2 percent of Moroccans suffered from a chronic condition, compared to 13.8 percent in 2004. The prevalence of diabetes among people aged 20 and over is 6.6 percent (or 1.5 million people) and that of hypertension 33.6 percent (or 6 million people).[9]

5. **The organization and delivery of healthcare is fragmented and faces major resource constraints.** There is no continuum of care between ambulatory and hospital care, which complicates effective patient follow-up and generates unnecessary costs. Primary health services suffer from a shortage of inputs, in particular drugs and health personnel. In addition, the system faces a critical shortage of human resources in health (HRH) throughout all categories of health personnel as well as issues of absenteeism, dual practice and inadequate skills. There are regional disparities in the distribution of healthcare personnel and there are also regional imbalances in the distribution of private healthcare providers.[10] Because of a lack of a functioning primary health care, access to essential services are constrained, especially in rural areas as evidenced by the low contact rate (0.4). While the public sector continues to provide the bulk of healthcare services, the private sector is expanding rapidly, with little regulation and data related to its activities. The lack of an integrated, reliable and accessible health information system makes it difficult for the Ministry of Health (MoH) to address these problems and to improve quality and accountability amongst healthcare actors.

6. **Morocco spends less on healthcare compared with countries of similar socio-economic development and out-of-pocket (OOP) expenditures are high**. The main reason for low expenditures and high OOP payments is lower-than-expected public spending as a share of total government expenditures. Though the share of government budget allocated to the health sector has increased by 25 percent since 2007 to reach 3.5 percent in 2013, it remains well below the levels observed in other comparable countries. In collaboration with the MoH, the Ministry of Economy and Finance (MoF) has prepared a Medium-Term Expenditure Framework (MTDF) covering the period 2014-2016, which plans for a 13.6 percent increase in the overall budget allocation to the MoH, compared to 2013.

[9] Diabetes is often associated with Hypertension (65.5% of diabetics are hypertensive).
[10] Approximately 50 percent of all private physicians are located in the Rabat – Casablanca axis, while there are fewer private physicians in the southern provinces (MoH, 2009).

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

7. **The proposed program is in line with the 2014-2017 World Bank Group's Country Partnership Strategy (CPS, report# 86518-MA)**. The 2014-2017 CPS is organized around three strategic results areas: (i) Promoting Competitive and Inclusive Growth; (ii) Building a Green and Resilient Future; and (iii) Strengthening Governance and Institutions for Improved Service Delivery to All Citizens. The proposed Program for Results (PforR) will support the third pillar of the CPS by addressing key issues such as: (i) supporting the reduction of maternal, neonatal, and child mortality in rural areas in nine regions; (ii) supporting the prevention and control of NCDs; (iii) strengthening the mobile health strategy to deliver services to hard-to-reach populations; (iv) contributing to strengthening quality in primary care; and (v) developing an accessible and performing Health Management Information System (HMIS). Because of their sensitivity and recognized importance to Morocco's development, the CPS also proposes to maintain or raise the visibility of three crosscutting themes throughout its program: (i) gender; (ii) youth; and (iii) voice and participation. The Program is aligned with each of these crosscutting themes. The proposed Program's first component will focus on improved primary healthcare for pregnant women, newborns and children under age five in rural areas. Governance within the health sector will be strengthened to improve service delivery of primary healthcare to the targeted beneficiaries, and by giving voice to the citizens through a feedback system. In addition, the Program aims to initiate an incentive system for healthcare providers to improve quality and motivation. The proposed Program will contribute to the World Bank's strategic goals of ending extreme poverty and boosting shared prosperity in a sustainable manner by reducing the gap in access to basic health services between the urban and rural populations. As most of the poor live in rural areas, and most of the regions targeted by the Program have higher poverty rates, the proposed Program will help the poor increase their human capital which will in turn foster their participation in the economy, and increase their productivity and income. The project is also aligned with the MENA Regional Strategy, supporting the pillars on strengthening governance and ensuring social and economic inclusion.

8. **The proposed PforR is also based on the World Bank's 2013-2018 MENA Health Nutrition and Population Strategy (report #81723) which focuses on fairness and accountability as key priority areas for the World Bank's engagement in the region**. The proposed Program would address systematic disparities in health by improving access of the rural population to basic services and by targeting nine regions with low health status indicators. The Governance component will address accountability by making information available at all levels for decision making, improving transparency in the management of human resources, and giving the population both information and voice through mechanisms for feedback, such as Grievance Redress Mechanisms (GRM).

9. **The World Bank engagement in the health sector has revealed the challenges associated with sector reforms.** Expanding health service supply capacity is particularly challenging in rural areas where high degrees of informality and poverty, usually compounded by geographical isolation, determine low levels of demand, making public investments costly and lacking incentives for private provision of services. The last World Bank-financed health project in Morocco was approved in 1998 (Ln. 4424). The project focused on strengthening hospital management and improving health sector financing, but did not address specific health sector reform or systemic issues. Subsequent sector activities and World Bank engagement in other countries have shown that health sector reform relies on the political environment, institutional setup and design and scope of the reforms themselves.[11] These elements were taken into account in designing the proposed Program. The proposed Program will support some new sub-programs (GRM, HRH, HMIS) that imply fundamental and sustained changes which will be challenging in a country like Morocco where the political economy calls for small incremental change over time. Yet the

[11] Harvard University. Health Sector Reform in Africa: Lessons Learned. March 1994.

proposed Program includes a coherent and mutually reinforcing set of activities that have proved to be efficient in other settings.

10. **The PforR is an appropriate instrument to achieve the proposed Program's aim to support a set of improvements in the overall MoH program, rather than a limited number of specific activities**. The results focus of the PforR instrument will incentivize the Government to focus on change management within institutions and to develop capacity needed to achieve desired results rather than concentrating on a limited number of activities. In this context, the PforR will help the Government focus on strengthening the institutional capacity for transparent and efficient health services. Continuous World Bank engagement can have a positive impact on implementation issues and capacity building to ensure that progress is achieved and sustained over a specific period of time. While some programs under the government budget were initially well defined, others were less so. However, the PforR instrument has allowed, during preparation, for the World Bank to help the Government better define programs under key objectives including their strategies, responsible actors, anticipated results, and budgets. The PforR will allow the Government to use country systems subject to the implementation of the actions included in the Program Action Plan (PAP, Annex 8). Also, the PforR instrument being somewhat similar to the European Union (EU) budget support instrument, it allows the two institutions to develop common disbursement-linked indicators (DLIs), as requested by the Ministries of Health and Finance.

II. PROGRAM DESCRIPTION

A. Program Scope

Government program

11. **There are several strategies in place that are driving the reform agenda.** In addition to the 2011 Constitution, which explicitly states that healthcare is a right of the Moroccan people, the following documents are guiding the reforms: (a) the Royal Letter that opened the National Conference on Health (July 2013), which provides a long-term vision, coupled with the proceedings from the conference; (b) the MoH's 2013 health sector White Paper; and (c) the MoH's 2012-2016 Health Sector Strategy.

12. **The following eight priorities of the Government's overall strategy emerge from the various strategic document**s:

A. Strengthening the essential public health functions of the system including: (i) epidemiological surveillance and outbreak alert; (ii) prevention and control of NCDs; (iii) strengthening mother and child health; (iv) health of populations with special needs; and (v) environmental health;
B. Putting health in all policies;
C. Taking action on the determinants of health, including actions carried out at the local level;
D. Promoting universal health coverage to reduce out-of pocket expenditures through: (i) extension and strengthening of the Health Insurance for Low-income Households (*Régime d'assistance médicale pour les économiquement démunis* or RAMED); (ii) development of health coverage for salaried workers; (iii) establishment of a new scheme for independent workers; and (iv) separation of the financing function and the service provision function, including for the RAMED;
E. Improving equitable access to quality health services through: (i) organization and development of emergency healthcare; (ii) extension and improvement of hospital care; (iii) reorganization of the referral system; (iv) development of family health; (v) development of rural health; (vi) technological innovation; and (vii) improved access to and reduced prices of pharmaceuticals;
F. Improving the governance of the system through: (i) strengthening regionalization and development of a local and integrated care network; (ii) development of public-private partnerships;

(iii) strengthening the stewardship function of the MoH (including regulation of the private sector, quality control of public and private providers, treatment protocols, etc.); and (iv) improving accountability mechanisms;

G. Strengthening the HMIS through: (i) computerizing the health information system and opening health information access to a wider audience, including relevant departments in the MoH, other ministries, civil society, and the population; (ii) implementing electronic health records that are appropriately accessible across levels of care and confidential; and (iii) employing new technologies to facilitate information sharing and improved transparence and accountability; and

H. Strengthening human resources for health by: (i) increasing the number of medical and paramedical staff; (ii) reforming medical studies to address personnel shortages and the inadequacy of skills profiles; (iii) understanding the causes of national and international migration; (iv) improving career management and developing non-financial and financial incentives; (v) modernizing HRH management; and (vi) improving on-the-job-training for medical, paramedical and administrative staff.

13. **Under this general strategic framework, the Government has built a program focused on two pillars:** (i) improving health at the primary level; and (ii) improving governance in healthcare. The first pillar includes an "*Action Plan to Reduction of Maternal and Neonatal Mortality, 2012-2016*" complemented by an "*Action Plan to Reduce Maternal, Neonatal and Child Mortality", 2013-2015*"[12] which focuses on nine regions and aims to improve maternal, neonatal and child mortality rates and to provide improved access to health services. The first pillar also covers the implementation of a comprehensive national NCD strategy that focuses on diabetes, hypertension, and feminine cancers. Finally, the Government program's first pillar is supported by a strategy for increasing health coverage in rural areas through mobile units. The second pillar (governance in healthcare) focuses on strengthening the management and distribution of human resources, improving accountability mechanisms, and developing a national, integrated, accessible and sustainable HMIS.

14. **During preparation, the World Bank team supported the MoH to update existing programs and to define new ones as necessary to meet the strategic direction and priorities of the Government.** New programs were defined for HRH and HMIS.

Program Supported by the PforR

15. The Program to be supported by the proposed PforR was defined using three criteria: (i) program duration; (ii) priorities supported; and (iii) geographic area.

16. *Program duration*: The Program will be implemented over four years, from March 2015 to June 2019.

17. *Priorities supported:* The MoH requested support for strengthening primary care in rural areas to address the key problem of disparities in health outcomes. Additionally, the MoH requested that activities covered be cross-cutting and/or multi-sectoral, and/or present technical challenges. Under this framework, priorities were jointly identified by the MoH, the World Bank, and the EU, which is expected to provide parallel financing. The program areas to be covered are regrouped under two components as follows:

1. Expanding equitable access to primary care in rural areas:

[12] *Ministère de la Santé, Plan d'action 2012 – 2016 pour accélérer la réduction de la mortalité maternelle et néonatale - Fin du compte à rebours 2015, septembre 2012; Ministère de la santé, Plan d'accélération de la réduction de la mortalité maternelle, néonatale et infanto-juvénile pour la période 2013-2015, 2013.*

1.1 Reduction of maternal, neonatal, and under five mortality (*government priority A(iii)*);
1.2 Strengthening the detection and management of non-Communicable Diseases (*government priority A(ii)*); and
1.3 Strengthening mobile health coverage (*government priority E(v)*).

2. Improving health system governance at the primary level:
2.1 Defining an incentive system to improve HRH performance (*government priority H(iv)*) based on the current situation analysis;
2.2 Improving accountability (*government priority F(iv)*) through the development of the main annual quality assessment tool (*concours qualité*) and the establishment of a comprehensive GRM; and
2.3 Developing an integrated, computerized and accessible HMIS (*government priority G*).

18. *Geographic areas* (Table 1). The Program to be supported will focus on the nine regions targeted by the Government's program on maternal and child health (Acceleration Plan) for their low health indicators. These regions are: (1) Oriental; (2) Marrakech Tesnift Al Haouz; (3) Tanger Tétouan; (4) Sous Massa Drâa; (5) Ghard Chrarda Beni Hssein; (6) Taza Al Houceima Taounate; (7) Doukala Abda; (8) Tadla Azilal; and (9) Meknès Tafilalet. In these regions, the Program will primarily target rural areas where 83 percent of the total rural population lives.[13] Six of these nine regions show poverty rates above the national average (Table 1).

Table 1. Poverty levels by region, rural areas

Region	**Poverty Rate**
Gharb-Chrarda-Beni Hssen	19.9
Souss-Massa-Daraa	18.6
Doukala-Abda	17.4
Guelmim-Es-smara	17.3
Fès-Boulemane	16.9
Meknes-Tafilalet	16.5
Marrakech-Tensift-Al Haouz	15.8
Oriental	14.7
Taza-Al hoceima-Taounate	12.3
Tanger-Tétouan	12.2
Rabat-Salé-Zemmour-Zaer	11.4
Tadla-Azilal	11.0
Chaouia-Ourdigha	9.5
Laayoune-Boujdour-Sakia El Hamra	7.6
Grand-Casablanca	3.9
Oued Ed-dahab-Lagouira	2.3
National Average	**14,4**

Source: HCP, *Enquête nationale sur les niveaux de vie des ménages 2006/2007*

19. This Program is supported by the proposed PforR and the EU Budget Support Health II Project (through parallel financing) under preparation.

[13] *Ministère de la Santé, La santé en Chiffres, 2012.*

Table 2. Government and PforR Programs, 2015-2018

GOVERNMENT PROGRAM	PforR PROGRAM
1. Expanding equitable access to primary care in rural areas	
1.1 Reduction of maternal, neonatal, and under five mortality	
9 regions Rural and urban Hospital and ESSPs[14]	9 regions Rural ESSPs
1.2 Strengthening the detection and management of NCDs	
National Rural and urban Hospital and ESSPs	9 regions Rural ESSPs
1.3 Strengthening the mobile health coverage strategy	
National (rural)	9 regions (rural)
2. Improving health system governance at the primary level	
2.1 Defining an incentive system to improve HRH performance based on the current situation analysis	
National design National implementation Hospitals, ESSPs	National design
2.2 Improving accountability through: (i) the development of the main quality assessment tool (*concours qualité*)	
National Rural and urban Hospitals, ESSPs	9 regions Rural and urban ESSPs
(ii) the establishment of a comprehensive GRM	
National Rural and urban Hospital and ESSPs	9 regions Rural and urban ESSPs
2.3 Developing an integrated, computerized and accessible HMIS	
Design of national system and implementation in all regions	Design of national system and implementation in one region

Expenditure Framework Analysis

20. **Total expenditure on health, as a percent of GDP, has been steadily increasing** in Morocco, from 5.4 percent in 2008 to 6.4 percent in 2012 and is higher than in Egypt, Algeria and the MENA average. However, Morocco's public expenditure on health is below that of countries of similar socio-economic development. As a consequence, household expenditures are high, representing 62 percent of total health expenditures in 2010.[15] Furthermore, there are substantial potential allocative efficiency gains in how public funds are allocated. Primary care is neglected in favor of spending on tertiary care. This focus on high-end tertiary care over primary and preventive services poses significant risks for the long-term financial sustainability of the sector, particularly as the epidemiological transition takes hold and the system contends with high-cost chronic conditions.

21. **The MoH has proceeded with ambitious reforms to deconcentrate budgetary and managerial autonomy to the regions.** However, most expenditure remains centrally managed and the distribution of the budget remains highly inequitable, both in terms of investments and distribution of health workers, leading to the large disparities in health outcomes observed. Health spending continues to

[14] ESSP: Primary healthcare facility (*Etablissement de soins de santé primaires*).
[15] OOP payments and household contributions to health insurance schemes represent respectively 54 percent and 8 percent of total health expenditure.

disproportionately benefit the richest and inefficiencies in public expenditures are reflected in inequalities in access to care. In Morocco, relative to other countries in the region, disparities between regions, urban and rural areas, and between the rich and the poor are much more pronounced.

22. **In order to improve efficiency of public expenditures on health, the Government has embarked on an ambitious budgeting reform; initiating program based budgeting.**[16] The budget reform aims at strengthening the link between budgeting and strategic priorities and to improve the transparency of budget allocation through the adoption of a programmatic budget structure and budgetary performance objectives and indicators.

23. **Financial sustainability and funding predictability do not pose a specific risk as, overall, budget execution is fairly centralized and the performance of budget execution is fairly satisfactory,** even if end-year budget execution reports are produced with delays (2012 is the last available year). While funding predictability is hampered by the current lack of a credible multi-year budget framework, this is being addressed through the reforms cited. The second National Health Conference of July 2013, which was opened by the letter from His Majesty the King, confirmed that the health sector is a priority.

24. **The budget of the MoH is increasing and there is a 13.6 percent increase planned for the 2014-2016 period over the 2013 budget** (Table 3). The bulk of the budget is spent on salaries which constitute roughly 52 percent of total expenditures. Other expense categories are difficult to discern as there is, as of yet, no programmatic budgeting in Morocco. For example, both "non-personnel" and investments include operational costs, as well as drugs and material purchases under different programs. As such, the World Bank team worked with the relevant MoH departments to budget their existing programs and to design budgets where the programs are new.

Table 3. Ministry of Health Budget and Projected Expenditures 2012-16 (in US$ billion)

Category	2012	2013	Projections		
			2014	2015	2016
Recurrent Expenditure	**1.23**	**1.31**	**1.39**	**1.46**	**1.52**
Personnel	**0.81**	**0.78**	**0.84**	**0.90**	**0.96**
Non-Personnel	**0.42**	**0.48**	**0.49**	**0.50**	**0.50**
RAMED	**-**	**0.04**	**0.06**	**0.06**	**0.06**
Investment	**0.22**	**0.24**	**0.20**	**0.24**	**0.24**
TOTAL	**1.45**	**1.55**	**1.59**	**1.70**	**1.76**

Source: Ministry of Finances, Medium-Term Expenditure Framework 2014-2016, September 2013

25. **The PforR project will cover US$100 million of the Government health program** (Table 4). The Government's existing health program is funded through the annual State budget allocated to the MoH. The proposed PforR operation takes a subset of the Government's health program and supports it

[16] The MoH will join the second wave of ministries for the implementation of the performance informed budgeting reform, which will require them to restructure their budget in a programmatic and multi-annual format and prepare a performance plan (objectives and indicators) for the 2015 budget. The aim is to increase transparency and accountability in the use of public resources while increasing the managerial flexibility and performance orientation along the service delivery chain. The first wave of ministries which undertook this reform includes MoF, MEN (to which the *formation professionnelle* department was just added), Ministry of Agriculture and Marine Fisheries, and the High Commission on Water, Forestry and the fight against Deforestation.

(see Annex 1 for a detailed program description). For MCH and NCDs, the budget outlined comprises activities that pertain to primary care in rural areas, in nine regions. The mobile strategy, human resources and quality assessment budgets have national components for strategy design and budgets for implementation in the nine regions. The HMIS budget covers system design and application in one region.

Table 4. Program Financing
2015-2018 (US$ million)

	Of which**		
Total	**PforR**	**EU***	**UN**
226.2	**100.0**	**107.0**	**4.0**

*1Euro = 1.251USD

** In Morocco donor financing for sector programs/projects do not automatically translate into budget allocation of the same amounts to the relevant sector ministry. These amounts result from annual negotiations between the sector ministry and the MoF during the preparation of the Finance Law.

26. **The overall programmatic budget is US$226.2 million** (Table 5). The EU project is planned to be negotiated during Q1 of calendar year 2015. While this introduces some uncertainty to the overall budgetary envelope, the risk of the EU withdrawing the proposed financing is negligible. For MCH, the budgeting is based on the Budget of the 2012-16 Acceleration plan (which budgets investments, activities, and salaries), projected out to the lifetime of the PforR, with additionally planned activities, removal of completed activities, and limited to the rural and primary setting.[17] For mobile health, the quality contest, and NCDs, costing is based on historical budgets, similarly projected out to the lifetime of the PforR, limited to the appropriate PforR boundaries and with the cost of salaries estimated and added.[18] For HRH and HMIS, these are new programs that have been costed and budgeted going forward, for the lifetime of the PforR.

Table 5. Program Cost
2015-2018 (US$ million)

Sub-program	Cost
Acceleration plan for reducing maternal and child mortality	67.4
Detection and control of NCDs	90.2
Mobile Strategy	26.9
Human Resources in Health (incentive scheme)	2
Quality Assessment (*concours qualité*)	2.4
HMIS	37.3
Total	**226.2**

Source: World Bank and Ministry of Health, 2014

[17] For activities that pertain to multiple settings (urban and rural and/or primary and secondary/tertiary) estimates as to the share of budget for the rural/primary setting are made according to relevant criteria (e.g. number of health facilities; number of staff; staff salaries; investment budget etc.).
[18] Program budgets, where they exist, do not include salaries. When estimating and budgeting salaries, we assume that the ratio of salary to investment+ recurrent costs is the same within programs/activities as the overall ratio.

B. Program Development Objective

27. The objective of the Program is to expand access to primary healthcare in targeted rural areas in the Program Area.

C. Program Key Results and Disbursement-Linked Indicators

28. The key results for the proposed operation will be:

- Increased use of primary healthcare services in targeted rural areas;
- Improved accountability of the health system vis-à-vis the population in targeted rural areas; and
- Establishment of the HMIS in all public health facilities in one region.

29. Disbursement-linked indicators (DLIs) that have been selected identify key results linked to the Program. Attention has been paid to a number of criteria. First, DLIs are achievable and challenging at the same time, combining ambition and feasibility so that the financial risk attached to each DLI will have the right impact. Second, the DLIs allow for a regular disbursement flow. Third, the DLIs are strongly aligned with government priorities, which should guarantee both synergistic effect and sustainability. Some DLIs may be shared with the planned EU-financed Budget Support Health II Project[19] which is expected to reinforce the GOM incentive to meet their target values. The complete DLI Matrix is provided in Annex 3. There are also seven non-DLI indicators in the Results Framework (Annex 2). A Results Chain, showing the links between sectoral challenges, Program activities, outputs, outcomes, and DLIs is presented in Annex 4.

30. The DLIs for the Program are the following:

- **DLI 1**: Increase in number of pregnant women receiving antenatal care during a visit to a rural ESSP in the Program Area.
- **DLI 2**: Increase in number of deliveries of rural women attended by skilled health personnel in public health facilities in the Program Area.
- **DLI 3**: Increase in number of new visits of children under 5 to a rural ESSP in the Program Area for curative care.
- **DLI 4**: Increase in number of patients with diabetes diagnosed and treated at a rural ESSP in the Program Area.
- **DLI 5**: Increase in number of visits to rural ESSPs in the Program Area
- **DLI 6**: % of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main annual quality assessment (*concours qualité*).
- **DLI 7**: Establishment of the HMIS in one region within the Program Area.

D. Key Capacity Building and Systems Strengthening Activities

31. The preparation and implementation of the Program will benefit from technical assistance activities from various donors and the World Bank. Firstly, the MoH is receiving support to strengthen the primary care level from the French Development Agency (AFD) through the REDRESS-P Project (a

[19] To be confirmed once the EU Project is approved in May 2015.

€35 million loan of which €34 million for budget support and €1 million for technical assistance), accompanied by a technical assistance grant (€0.2 million), to be completed by July 2015. The technical assistance focuses on activities that will contribute indirectly to the achievement of the DLIs by: a) supporting the MoH in drafting a primary health strategy; b) improving the organization of ESSP management; c) developing tools to evaluate ESSP performance; d) introducing family health records, including computerization; d) developing the referral system (for maternal and neonatal health, high blood pressure, diabetes, oncology and mental health); e) strengthening the regrouping of ESSPs into "districts" at the local level; and f) supporting a study to establish an accreditation system for ESSPs with delivery services.

32. Secondly, AECID, the Spanish Cooperation, signed in 2014 a Grant agreement (€0.7m) that complements the AFD support, focusing on: (a) the introduction of a Master degree in family and community health; (b) the definition and implementation of a new ESSP model; and (c) support to ESSP management and regrouping of ESSPs. Thirdly, the EU is defining a technical assistance program that will accompany their project under preparation. This technical assistance may support the development of the National HRH Strategy, directly linked to the indicator on the incentive scheme for HRH. Fourthly, the United Nations (UN) system provides technical assistance on all sub-programs (except the mobile health coverage). In particular, the World Health Organization (WHO) has assisted the MoH in developing sub-program 1.1 (Accelerating the reduction of maternal, neonatal, and under five mortality) which is being implemented with support from UNICEF. The WHO is also helping the MoH to develop an integrated NCD strategy (completed in 2014).

33. Finally, the World Bank has mobilized US$365,000 from the MENA multi-donor trust fund (P148409, TF016295) to begin technical assistance towards implementation of the first phase of the HMIS pillar, which will contribute to achieving DLI 7. The funds will be used to support preparatory design and technical work, capacity building, and consensus-building activities.

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

34. The two most critical stakeholders involved in the proposed Program are the MoH and the MoF. In the context of the proposed Program, the MoH will be responsible for the implementation of the health sector reforms according to priorities and directions defined in the strategic documents. The MoF will provide political and budget support to the MoH in implementing the program. The MoF will also be responsible for disbursing funds linked to the achieved DLIs. The MoH is also responsible for implementing reforms that will achieve the results targeted by the proposed Program. The MoH General Secretariat will oversee Program implementation while the Division of Planning and Financial Resources (DPRF) will act as its secretariat, providing the necessary data, reports, etc., to the World Bank.

35. Additional key institutions that will be involved in project implementation are: (a) the regional directorates; provincial directorates, SIAAPs, and health facilities; (b) health workers unions; (c) the national health insurance agency (*Agence Nationale de l'Assurance Maladie*, ANAM); (d) the insurance schemes covering civil servants (*Caisse Nationale des Organismes de Prévoyance Sociale*, CNOPS) and private sector employees (*Caisse Nationale de Sécurité Sociale*, CNSS); (e) private insurers; and (f) civil society. Representatives of these departments/institutions will be regularly sensitized and consulted on planned reforms and their progress through workshops and retreats.

36. A draft Implementation Manual detailing the roles of these actors is being prepared by MoH, and will be adopted by June 30, 2015, as presented in the Program Action Plan (Annex 8).

B. Results Monitoring and Evaluation

37. The MoH, through DPRF, will be responsible for assembling all the data and documentation necessary for monitoring, verification, and evaluation purposes. The MoH 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 MoF.

38. The World Bank will provide implementation support based on the detailed Implementation Support Plan (Annex 9), whose focus would be on timely implementation of the agreed Program Action Plan (Annex 8), 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 nongovernment counterparts and relevant partners, and visits to Program sites and facilities, as needed. With regard to 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 MoH, retaining the right to make the final decision, for disbursement purposes, on whether the agreed DLIs have been achieved.

C. Disbursement Arrangements and Verification Protocols

39. The total amount of the loan proceeds will be divided among the seven DLIs. These allocations were determined by: (i) the nature of the DLIs (with a stronger weight granted to outcome-centered DLIs); and (ii) the amount of resources needed to meet the targets. The financing amount for each DLI will be further broken down into sub-allocations, corresponding to years and sub-targets. Scalable disbursement will be applied to DLIs 1 to 6.

40. To support faster implementation of activities to achieve DLIs, an Advance of US$25 million equivalent will be disbursed once the proposed Program is declared effective. This Advance would be available throughout the project implementation on a revolving basis. If by the closing date the Advance, or some portion thereof, is still outstanding and a DLI or a combination of DLIs are not met, the Government will need to refund the outstanding balance.

41. 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 *Inspection générale ministérielle (IGM) of the MoH* IGM reports directly to the Health Minister, who ensures its independence vis-à vis MoH services and enables IGM access information and data. In addition, in the context of the ongoing global budgetary reform, IGM is benefitting from training on performance-based budgeting that confirms the institution’s capacity to perform this verification role.

42. The technical audit will be based on a review of the documentation provided centrally by the MoH, including the HMIS data, and on-site verification in a representative sample of areas targeted by the Program where ESSPs, including CSCAs, and hospitals (for DLI 2) will be randomly selected. The technical audit will verify:

- The HMIS system and procedures at ESSP/hospitals, and provincial directorate levels, and their aggregation at the central level (for DLIs 1 to 6);

- The accuracy of the *quantity* of services as reported in the HMIS database (DLIs 1 to 5);
- Proofs of ESSPs participation in training sessions *and* availability of an action plan to improve quality based on the recommendations included in the *Concours Qualité* audit report (DLI6); and
- Relevant documentation regarding progress in the development of the HMIS (DLI7).

43. The verification of the quantities of services for DLIs 1 to 5 would include: (i) Desk review of the completeness of the reporting and the final data (by month) for each of the 9 target regions; (ii) Follow up on any major variations (annual increases or decreases of 10% or more); (iii) On-site review to check submitted reports against registers and other facility-based data for a random sample of facilities from each of the nine target regions; and (iv) Random contact tracing via mobile phone for a sample of patients on registers.

44. In addition to verifying the HMIS data, the technical audit will seek to explain any discrepancy found with the audit data, and make recommendations that will be used to improve the HMIS.

45. A discrepancy of up to five percent between the HMIS data and technical audit data will be accepted. In case of a higher discrepancy, disbursement (which will be scalable for DLIs 1 to 6) will be adjusted, based on the technical audit data. The technical audit will be carried out annually, starting with the 2015 data which will be used as the baseline. In the DLI indicators matrix (Annex 3), the stated baseline figures (at the national level) will be replaced by the actual 2014 figures (for the nine target regions), once available (end 2015), and verified (as soon as possible during Program implementation) and this will be used as the baseline. The DLI amounts per service will be adjusted accordingly using the formula presented in Annex 3.

46. Upon achievement or partial achievement of a DLI, the MoH would provide the World Bank with evidence supported by the relevant documentation. Following the World Bank's review of the complete documentation, including any additional information considered necessary, the World Bank would send an official communication to the Ministries of Health and Finance as to the achievement of the DLI(s) and the level of Program financing proceeds available for disbursement against each particular DLI, including any partial disbursement for the scalable sub-allocation of DLIs 1 to 6.

47. Disbursement requests (Withdrawal Applications) will be submitted to the World Bank by MoF using the World Bank's e-disbursement system and standard disbursement form along with Request for Advance signed by the government's authorized signatory. During the project life, in addition to a disbursement request for the Advance (US$25 million), for DLIs which are not yet achieved, MoF would also be able to submit disbursement requests for DLI(s) that are already achieved for the amounts above the mentioned available Advance. Such disbursement requests can be submitted individually on achievement of a single DLI or grouped together as a set of DLIs are achieved in a given period and submitted as a consolidated disbursement request. A copy of the World Bank's official communications confirming the DLI achievement should be attached to the disbursement requests.

IV. ASSESSMENT SUMMARY

A. Technical

Program's strategic relevance and technical soundness

48. The Program itself is mainstreamed within the overall activities of the MoH, which will facilitate its implementation. By focusing in rural areas, which usually include those in the poorest income

quintiles, the Program will address the dual goals of improved service delivery and poverty reduction. For example, if the 40 percent difference between rural and urban child mortality (cf. para. 4) can be reduced, the impact in terms of increased economic potential could be significant. The focus on rural health is appropriate given the current situation in the country, the potential health and economic benefits, and the availability of specific plans and strategies to address the situation. Moreover, the fact that the Program focuses not just on service delivery but also on the key enabling factors for improving results on the ground--human resources, accountability, and information management--indicates that the program structure has a high probability of improving the overall situation if implemented as designed.

Governance structure and institutional arrangements

49. An adequate governance structure and institutional arrangements are in place to implement the Program. The two most critical stakeholders involved in the proposed Program are the MoH and the MoF. The MoH is responsible for the implementation of the health sector reform according to priorities and directions defined in the strategic documents. The MoF will provide political and budget support to the MoH in implementing the program and receive the transfers linked to the achieved DLIs. The MoH General Secretariat will oversee program implementation while the DPRF will act as its secretariat, providing periodic supervision reports and information to the World Bank.

Expenditure frameworks

50. The components of the Government program are financed by a combination of the Government of Morocco (GOM), World Bank, EU (as parallel financing), and other donor funding (see Table 4 in Section II). The EU budget support project is expected to be Euro 85 million, to which will be added Euro 5 million in complementary aid (technical assistance, audits, etc.). The Government has committed a sufficient budget (once strengthened by PforR, EU and other donor financing) to achieve the Program targets.

Results framework and monitoring and evaluation capacity

51. A set of specific, measurable and relevant indicators was agreed with the GOM to monitor the Program. While the overall M&E system of the MoH needs major improvements in terms of integration, timeliness and accessibility, individual systems at the sub-program level provide reliable and valid data to monitor the indicators, as evaluated by the EU during the implementation of PASS I.

52. DPRF of the MoH is responsible for collecting data for DLIs 1, 2, 3 and 5. Primary healthcare facilities transmit the data monthly and manually to the *service d'infrastructures d'action ambulatoires provincial* (SIAAP) which is responsible for data verification and entry. The vast majority of SIAAPs have a statistician. Others benefit from the support of statisticians in nearby hospitals. The SIAAP then sends the files manually each month to DPRF which verifies and aggregates the data of all provinces of the country. Data is entered into the M&E system for Maternal and Child Health/ Family Planning (SMIPF) that was established with UNDP's support in 2010-2013. Training and staff visits between the central and provincial levels take place on a regular basis to ensure quality control. DPRF, which has four engineers in statistics and five technicians, plans to develop a web-based application that will provide the data centrally in real time. This system will be rolled out at the end of 2014 and should be completed by the end of 2015. In the meantime, and given the manual support and quality control process, data for these four indicators are available in n + 1 for year n. Hence, baseline values for DLIs 1, 2, 3 and 5 are from 2012 as data for 2013 is not yet available.

53. Data for DLI 4 are centralized by DELM which has three in-house statisticians, including one for diabetes, one hypertension and respiratory diseases, and one for mental health, responsible for data aggregation, verification, quality-control and analysis. The provincial delegations receive quarterly reports and conduct data verification and entry. The data for year n is available more rapidly than for the previous set of DLIs, i.e., four months after the end of the calendar year.

54. The *concours qualité* has its own information system managed by the hospitals and ambulatory care Division (DHSA). The current routine system can track DLI 6. At the national level, the Quality Unit of DHSA is staffed by five people, who are supported by DHSA's statisticians and ITs when needed. At the regional and provincial level, the system relies on regional and/or provincial focal points. Each round spans over two calendar years (e.g., the 2014 edition began in September 2014 and is scheduled to be completed in spring 2015). Data from the edition of the year n are available during the year n +1.

55. Information for DLI 7 is text-based and will be collected from the relevant MoH units by DPRF.

Economic rationale

56. The proposed Program components provide a set of activities to improve quality and efficiency in primary care as well as improving management and policy-making capacity at all levels of the system. The rationale for public interventions and the focus on rural primary care are demonstrated by the current inequities in health outcomes between urban and rural areas, which are matched my inequalities in the distribution and availability of health services. The project will address rural health through focus on MCH and NCDs and reaching remote populations with mobile health teams. Project components to improve the quality of public facilities through the quality assessment as well as the scheme to improve health worker productivity through the incentivization scheme are both, by definition, public sector interventions. Finally, the HMIS technical work and system definition are public sector goods, with input from all stakeholders. However, the system itself will be open to development by the private sector.

57. While a quarter of Moroccans do no seek medical care when ill, this proportion increases up to a third in rural areas. In addition, only half of the deliveries are attended by qualified medical staff in rural areas, while in urban areas this proportion is 92 percent. Overall, yearly per capita heath seeking behavior is 0.6 (in public health structures) and only 0.36 in rural areas (compared to the minimum of 1.0 recommended by WHO) and the poorest account for only 18 percent, 13 percent, and 11 percent of dispensary, health center and hospital patients, respectively. While addressing disparities is an issue of social justice, there are considerable economic benefits as well, at both the individual level, through impacting productivity, employment, and out-of-pocket expenditures, and at the population level, through impacts on costs to governments and business. The government Program in the health sector, partially supported by this PforR, is an important component of promoting economic opportunities for sustainable and inclusive growth and ensuring efficient and appropriate provision of basic services to the population and promoting good governance.

58. The World Bank has a long engagement in the health sector, globally and in Morocco in particular. The WB has been supporting the GoM and MoH through technical assistance, including for planning and stakeholder consultations for health sector reform, universal health coverage (UHC) and for HMIS. The Bank can provide the technical and financial support required to achieve key program goals, including dialogue with the MoF to ensure that the program is adequately funded to ensure resources required to achieve targets are available and mobilizing trust fund and other sources for technical assistance in identified target areas.

B. Fiduciary

59. A Fiduciary System Assessment (FSA) of the World Bank-financed program has been conducted at the identification and assessment phases in accordance with the Bank's Operational Policy OP/BP 9.00, in close collaboration with the technical team and through analysis of available documents and reports and working sessions with the main stakeholders. The FSA considered whether the Program 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. The scope of the FSA covered the Program Institutional framework, fiduciary management and procurement capacity and implementation performance, institutions, and systems responsible for anti-corruption aspects within the Program. Findings from the assessment, as well as a review of existing analytical and diagnostic work, conclude that the overall fiduciary and governance framework provides reasonable assurance that the financing processes will be used for the intended purposes to support the implementation of the proposed PforR.

60. Most of the country-level weaknesses identified during the FSA will be addressed under ongoing reforms and new legislation including the Organic Finance Law, the law on access to information and public complaints to be enacted, and the public procurement reform in progress (including the new public procurement decree in effect since January 2014 and the decree that created the new national commission on public procurement). The programmatic and performance informed budgeting foreseen in the Organic Finance Law is currently being tested in the ministry for the 2015 budget. The new public procurement decree introduced an improved complaint handling mechanism and e-procurement procedures. A government-wide complaint handling policy is being finalized and will be applicable across the sector (see Annex 1, Section II, 2.2).

61. The overall fiduciary risk for the health sector PforR is rated "moderate." The main risks and corresponding mitigation measures are specified in the Program Action Plan and Annex 5.

62. Financial controls: the Inspectorate General of Finance (*Inspection Générale des Finances, IGF,* or internal auditor of the MoF) was designed by the Government to conduct external audits for MoH. IGF is not an independent agency but has proven its credibility and has been accepted by the World Bank. The same arrangement will be maintained under the Program. The latest performance audit report of the MoH made relevant recommendations such as, establishing effective functions for management control and internal audit both at the central and regional levels, strengthening human resources and addressing inadequacies of the health information system not allowing support to effectively implement, monitor and evaluate health programs.

63. The Supreme Audit Institution (*Cour des comptes, CDC)* and the Regional Courts of Account are the main institutions in charge of external audit within the Morocco PFM system. The scope of their mission was broadened to include management audit, and to ensure that the control of accounts and management of local governments' statutory financial audits conducted by the CDC are satisfactory with respect to the application of international standards and the scope of their mission. The World Bank will continue its dialogue with the CDC to explore their potential involvement in the external audit of Bank-financed projects and programs.

C. Environmental and Social Effects

64. The Program will not finance any construction work (health care centers, housing for health care personnel, etc.). However, rehabilitation of existing ESSPs and upgrading of their equipment (such as plumbing, painting, electricity) will be supported. The Program will not finance any activity leading to land acquisition, or involuntary settlement, or activities that could have an adverse economic impact on

the population, or that are likely to alter natural habitats significantly or cause substantial changes in biodiversity zones and/or potentially important cultural resources.

65. The Program will mainly finance: the acquisition and/or the renewal of medical and technical equipment of the primary care facilities, the purchase of drugs and pharmaceutical products along with 57 mobile health care units to add to the MoH's fleet in the nine target regions; the acquisition of computer hardware to develop the health management information system and a pilot system in one region; the establishment of standardized care procedures related to mother and child health and non-communicable diseases; the development of health educational tools; and capacity building activities.

Environmental and Social Risks Associated with the Program

66. Main Environmental Risks. Overall, all of the negative impacts likely to be generated by the Program affect a limited area. They are easily controllable and manageable, provided that the mitigation measures set out in the Implementation Manual (being drafted) are applied and carried out during Program implementation. The environmental risks associated with the Program are moderate in scope, reversible and easily controllable, in view of the health objective of the Program, the geographical area affected; the low volumes of medical and pharmaceutical waste produced by ESSPs; the nature of the Program activities mainly focusing on strengthening MoH processes; and the recommended measures to mitigate and monitor impacts, which are familiar, manageable and effective. Yet, the activities planned under the Program will produce more medical and pharmaceutical waste. Without adequate mitigation measures, this waste could have a negative impact on the natural habitat and natural resources in the case of ESSPs located near or in sites of biological or ecological significance or even in nature parks. The increase in the fleet of mobile health care units will lead to increased pollution and volumes of waste oils. Disposal of this waste must comply with national regulations.

67. Main Social Risks. Given the type of activities carried out under the Program, the social impacts are expected to be beneficial: improved access to primary health care; lower maternal and infant mortality and morbidity rates; lower prevalence of complications arising from hypertension and diabetes. No adverse economic impacts on vulnerable populations are expected. Risks of negative social impacts are low. They mainly stem from: a) weaknesses in equitable access to primary healthcare, particularly for the most vulnerable populations; b) inadequate handling and response to complaints or grievances from Program beneficiaries.

Environmental and Social Management Systems

68. Environmental Management System. The environmental assessment and monitoring procedures used by the DELM need to be updated and completed to overcome the shortcomings identified by the environmental assessment and to comply with national regulations relating to medical waste management, liquid waste management and waste oil management (see Program Action Plan in Annex 8). It should be noted that the Ministry of the Environment and the MoH are jointly drafting an order for the implementation of the recommendations under Decree 2-09-139. This Order will be based on the National Plan for Medical and Pharmaceutical Waste Management that is being prepared by the Ministry of Environment, in collaboration with the MoH, and with GiZ's support. The Plan is expected to be completed by May 2015.

69. Social Management System. The social management system (laws, regulations, institutions, etc.) as a whole complies with the requirements of the Bank's Operational Policy OP 9.00, but there are still areas for improvement, such as: systematic inclusion and participation of local populations and grassroots organizations; setting up easily accessible local grievance mechanisms that are adapted to the local

population's educational attainment and available in their own language; strengthening the social management capacities of ESSP personnel.

70. Even though the environmental and social impacts of the activities under the Program are categorized as moderate, the Program is an opportunity to address the shortcomings mentioned above and to strengthen the MoH's overall environmental and social management system. For this purpose, the Program will support specific measures to strengthen the environmental and social system. These measures are set out in the Program Action Plan.

D. Integrated Risk Assessment Summary

Integrated Risk Assessment Summary

Risk	**Rating**
Technical	Substantial
Fiduciary	Moderate
Environmental and Social	Moderate
Disbursement-Linked Indicator	Moderate
Overall Risk	**Substantial**

Risk Rating Explanation

71. Risks and risk management measures are described in Annex 7. The overall risk rating for the Program is **substantial**. The **technical** risk is deemed substantial. The insufficient allocation of budget and human resources in the sector could jeopardize the implementation of the Program activities. The scope of the program will require substantial coordination between the various departments of the MoH but also coordination between the central, regional and local levels. Some sub-programs, especially the HMIS, are technically complex. The overall **fiduciary risk** is moderate given the: (i) lack of an independent procurement appeals system and clear process for handling complaints; (ii) quality and timeliness of annual audited financial statements; (iii) effectiveness of internal audit function and follow-up of audit recommendations; (iv) low capacity of procurement staff in small and remote procuring entities; and (v) need for stronger fiduciary management capacity. The **environmental and social safeguards risk** is rated moderate. The potential negative environmental impacts would affect a limited area. They are easily controllable and manageable, provided that the mitigation measures summarized in this document are applied and carried out during the program implementation phase. Given the type of activities carried out under the Program, the social impacts should be beneficial. The potential negative social impacts are low (e.g. lack of equitable access to primary health care for the most vulnerable populations, complaints or grievances from persons who feel that they have been disadvantaged in terms of access to primary health care) and addressed under the Governance component of the Program. The risks related to the **DLIs** are deemed to be moderate. The DLIs and targets were identified jointly with the MoH and take into account the MoH's experience with the EU's previous budget support operation (PASS I) which included unrealistic or poorly defined targets.

E. Program Action Plan

72. Based on the technical, fiduciary and environmental and social systems assessments (Annexes 5-7), a time-bound PAP (Annex 8) was developed with the Government to address the most critical steps for the Program to achieve its objectives. Government's full commitment to implementing the PAP actions has been confirmed. Compliance to and implementation of the PAP will be systematically monitored by the World Bank during implementation support.

Annex 1: Detailed Program Description

PROGRAM DESCRIPTION

73. There are several strategies in place that are driving the reform agenda. In addition to the 2011 Constitution, which explicitly states that healthcare is a right of the Moroccan people, the following documents are also guiding the reforms: (a) the Royal Letter that opened the National Conference on Health (July 2013), which provides a long-term vision, coupled with the proceedings from the conference; (b) the 2013 health sector White Paper; and (c) the 2012-2016 Health Sector Strategy.

74. The PDO of the proposed PforR is **to expand access to primary healthcare in targeted rural areas in the Program Area**. The operation will contribute to the Government's health sector program by disbursing funds against achievements of the following key results: (i) expanding equitable access to primary care in rural areas; and (ii) improving health system governance at the primary level.

75. To achieve these results, the proposed PforR program will support the following two main components of the Government's program with a focus on primary care in rural areas in target regions (Table 6):

1. Expanding equitable access to primary care in rural areas:
   - 1.1 Reduction of maternal, neonatal, and under five mortality;
   - 1.2 Strengthening the detection and management of non-communicable diseases; and
   - 1.3 Strengthening mobile health coverage.

2. Improving health system governance at the primary level:
   - 2.1 Defining an incentive system to improve HRH performance based on the current situation analysis;
   - 2.2 Improving accountability through the development of the main quality assessment tool (*concours qualité*) and the establishment of a comprehensive GRM;
   - 2.3 Developing an integrated, computerized and accessible HMIS.

Table 6: Government and PforR Programs, 2015-2018

Government PROGRAM	PforR PROGRAM
1. Expanding equitable access to primary care in rural areas	
1.1 Reduction of maternal, neonatal, and under five mortality	
9 regions Rural and urban Hospital and ESSPs	9 regions Rural ESSPs
1.2 Strengthening the detection and management of non-communicable diseases	
National Rural and urban Hospital and ESSPs	9 regions Rural ESSPs
1.3 Strengthening mobile health coverage	
National (rural)	9 regions (rural)
2. Improving health system governance at the primary level	
2.1 Defining an incentive system to improve HRH performance based on the current situation analysis	
National design National implementation Hospitals, ESSPs	National design
2.2 Improving accountability through (i) the development of the main quality assessment tool (*concours qualité*)	
National Rural and urban Hospitals, ESSPs	9 regions Rural and urban ESSPs
(ii) the establishment of a comprehensive GRM	
National Rural and urban Hospital and ESSPs	9 regions Rural and urban ESSPs
2.3 Developing an integrated, computerized and accessible HMIS	
Design of national system	Design of national system and implementation in one region

I. Expanding equitable access to primary care in rural areas

76. Strategic activities under this pillar include: (i) reduction in maternal, neonatal, and under five mortality; (ii) prevention and control of NCDs; and (iii) strengthening the mobile health coverage strategy.

1.1 Reduction of maternal, neonatal, and under five mortality

77. Morocco has already made substantial progress in reducing deaths among mothers and children. The maternal mortality ratio has decreased by almost 66 percent in 20 years, from 332 maternal deaths per 100,000 live births in 1992 to 112 deaths per 100,000 live births in 2010. Infant and child mortality levels have been reduced from 84 per 1,000 live births in 1992 to 30 per 1,000 live births in 2011, a reduction of 64 percent. The *Action Plan to Reduce Maternal and Neonatal Mortality, 2012-2016,* completed by the *Action Plan to Reduce Maternal, Neonatal and Child Mortality, 2013-2015* aim to bring about even greater progress. They set the country on a course to achieve reductions in under-five and maternal mortality of 70 percent and 82 percent, respectively, from the 1990 levels by 2015.

78. Under the Plans, services will be available for free, equipment and infrastructure will be upgraded, health workers will get more training on best practices, communities will be involved as an interface between the population and health services, and accountability mechanisms will be put in place at the regional and local level. Transportation systems will be improved so that pregnant women can travel safely from home to hospital, and those with complications will be able to get caesarean sections.

79. The 2013-2015 Plan targets seven regions for which the following indicators are lower than the national average, according to the 2011 DHS:[20] (i) number of prenatal consultations; (ii) percentage of deliveries attended by skilled health personnel; (iii) child malnutrition rates; and (iv) implementation of the Integrated Child Management strategy (PCIE, *Prise en Charge Intégrée de l'Enfant)* program in ESSPs. Seven out of the 16 regions of the country correspond to these criteria and will be targeted under the Program: Oriental (seven provinces), Marrakesh Tensift Al Haouz (six provinces), Tanger Tetouan (seven provinces), Sous Massa Drâa (nine provinces), Gharb Chrada Beni Hssen (three provinces), Taza-Al Hoceima-Taounate (four provinces), and Doukkala-Abda (four provinces). In addition, the Program will target two other regions, Tadla-Azilal and Meknès-Tafilalet because they include some provinces (Azilal, Khénifra Errachidia and Midelt) which are rural, remote and difficult to access and which deserve particular attention.

80. In these nine regions live eighty three percent of the rural population of Morocco, and sixty-six percent of the total population (representing 21.4 million people).

Table 7. Selected health indicators by region

Region (urban and rural)	% who receive prenatal consultations*	% deliveries attended by skilled personnel*	Prevalence of stunting in children under 5 yrs. of age (2011)**	No. of provinces in each region implementing PCIE*
Sous-Massa-Drâa	63	67	24.4	3
Tanger Tetouan	51.6	67.6	14.1	6
Taza-Al Hoceima-Taounate	61.2	65.9	18.7	3
Oriental	70	69.5	9.0	3
Doukkala-Abda	65.9	89	10.2	0
Gharb Chrada Beni Hssen	79	91	23.2	3
Marrakesh Tensift Al Haouz	75	83	19.6	3
Tadla-Azilal	91	82	11.7	0
Meknès-Tafilalet	90	83	17.8	2
Morocco	**77**	**74**	**14.9**	

* *Action Plan to Reduce Maternal, Neonatal, and Under-five Mortality 2013-2015*
** *Enquête sur la Population et la Santé Familiale, 2011*

81. **The expected results of these interventions include**: (a) an increased percentage of pregnant women receiving antenatal care during a visit to a health provider; (b) a higher percentage of deliveries attended by skilled health personnel in public health facilities, for women living in rural areas; (c) higher numbers of new visits of children under five for curative care to a rural ESSP; and (d) higher numbers of consultations among the rural population to a rural ESSP.

[20] *Ministère de la Santé, Enquête sur la Population et la Santé Familiale*, 2011.

1.2 Strengthening the detection and management of non-communicable diseases

82. The MoH seeks to strengthen the detection and management of NCDs at the primary level, in rural areas.

83. Regarding prevention, the MoH will organize: (i) awareness campaigns targeted to the general population, schools and health professionals in rural areas regarding the dangers of smoking and the benefits of a healthy and balanced diet and physical activity; (ii) local activities on the promotion of healthy lifestyle (within mosques, colleges, schools, ESSPs, mobile teams, local radio broadcasts, souks, etc.); and (iii) training sessions in the field of smoking cessation for health workers.

84. With regards to screening, the MoH will: (i) equip each health center and mobile team with screening equipment (electronic sphygmomanometers, wall sphygmomanometers, glucometers, test strips, gynecological tables, kits for cervical cancer screening); (ii) training of health staff at the ESSP level on screening techniques and the people who should be targeted by screening; and (iii) conduct screening activities, including for diabetes, hypertension and breast cancer among the target populations.

85. Finally, the MoH will: (i) disseminate standards of care to all ESSPs and mobile teams; (ii) train professionals on standards of care; (iii) provide health facilities with basic essential drugs; (iv) establish a therapeutic education program on diabetes; and (v) establish the chain of specialized care.

86. **The expected results of these interventions include:** (a) improved knowledge of healthy lifestyles, the dangers of smoking, and the need for regular screening regarding NCDs, both by the general population and by health workers; and (b) increased numbers of diabetic and hypertensive patients screened and being treated for their conditions according to acceptable standards of care.

1.3 Strengthening mobile health coverage

87. The use of mobile health services to ensure access to essential health interventions in rural areas that are either remote or difficult to access has been an important government initiative since 2010. The mission of the mobile team is to: (a) provide essential high quality healthcare services close to rural populations and in remote locations where access to health facilities is difficult; (b) contribute to improving the performance of national health programs; and, (c) ensure regular access to services to meet the needs and expectations of the target population.

88. The criteria for coverage by a mobile team include populations living more than 6km from a health facility, or communities located within 6km if the geography is difficult or there are specific epidemiological issues in that location. The package of activities provided by the mobile team should be diversified and integrated, combining curative services, preventive and health promotion activities. The package is expected to take into consideration the epidemiological profile of the target populations and meet the needs and expectations of these populations, while responding to the objectives of national health programs.

89. The main services offered by mobile teams include: (a) curative services (medical examination, diagnosis, treatment, and referral; monitoring of chronic patients (diabetes, heart disease, hypertension) nursing; emergency medical care; (b) family planning; (c) monitoring of pregnancy and childbirth, including prenatal consultation, postnatal consultation, and vaccination of women of childbearing age against tetanus; (d) protection of child health, including systematic reviews of healthy children; vaccination; administration of vitamins A and D; weight monitoring and treatment of malnutrition; screening and treatment of diarrheal diseases and acute respiratory infections; (e) health promotion in

schools; (f) epidemiological surveillance and environmental health; (g) chronic disease surveillance, including screening of non-communicable diseases (e.g., diabetes, hypertension) and screening for breast and cervical cancer; and, (h) health promotion activities: Information, Education and Communication (IEC) with the selection of topics based on local health priorities. The services provided must take into account the local epidemiology and the team must organize to meet all needs and expectations of the target population.

90. The mobile team should be composed of a general practitioner; a nurse, preferably a nurse trained in maternal and child health and family planning; an environmental health technician; and a driver. Team members with other profiles may be added according to need. It is preferable that the team members are from the area being served so that the teams have knowledge of the population being served and prevalent health problems. Health professionals involved in mobile teams should be trained on the management of the mobile team and master the standards and procedures for programming and implementation. The frequency of mobile team visits should take into account the epidemiological profile at the local level; the geographic accessibility of the location; and the number of vehicles mobilized. There must be at least one visit per quarter to monitor health programs, but this rate is increased by the availability of human and other resources, as well as the epidemiological context.

91. While there has been some success to date, improving the quality and scope of services of mobile teams, and their coverage, is needed. In 2014, 369 mobile teams were operating at the national level, a number that remains insufficient to cover the targeted population estimated at 4.5 million rural inhabitants. The Program will support: (i) the purchase and equipment and medical supplies of 57 mobile units to be attached to ESSPs of the 9 target regions; (ii) strengthening of the technical platform of existing mobile units; and (iii) capacity building for health care providers in the management of mobile medical units.

92. **The expected results of these interventions include:** (a) a higher proportion of the rural and remote population covered by mobile teams; (b) an increased number of pregnant women receiving antenatal care during a visit by the mobile team; (c) higher numbers of new visits of children under 5 for curative care to mobile teams; and, (d) higher numbers of consultations by mobile teams among the rural population.

II. Improving health system governance at the primary level

2.1 Defining an incentive system to improve HRH performance once the current situation is assessed

93. To improve the performance of medical and paramedical staff, the MoH would like to develop an incentive mechanism that improves productivity and the quality of services. The Program will support a diagnostic study and the design of the mechanism, including: measurable program objectives, performance criteria for the allocation of subsidies to the various categories of staff in the different health facilities.

94. **The expected results of these interventions include:** an incentive mechanism to improve HRH performance is designed and endorsed by all stakeholders, including professional associations, MoF and Ministry of Civil Service and Public Management Modernization.

2.2 Improving accountability at the primary health care level through the development of the annual quality assessment tool (c*oncours qualité*) and the establishment of a comprehensive GRM

95. The main quality assessment tool in the health sector (*concours qualité*) consists of an annual competition between health facilities to achieve the highest quality of health service provided. The process entails a self-assessment, in which staff at participating health facilities complete standardized questionnaires that measure a range of quality indicators (user satisfaction, care accessibility and availability, rationalized use of resources, security and responsiveness, leadership, community participation, and institutional functionality), as well as an audit by peers. In return for enrolling in *concours qualité* and highlighting their strengths and weaknesses, employees have greater access to supplemental training programs and centers may become eligible to receive new equipment or even to receive funds for renovation. So far, the facilities that have been participating in *concours qualité* mainly belong to the hospital level and/or urban areas. In 2013, 86 urban hospitals and 173 urban health centers participated in *concours qualité* versus 82 rural health centers, participation rates being 61 percent, 22 percent and 4 percent, respectively

96. The World Bank PforR Program will support the MoH's program to expand participation in *concours qualité* at the primary healthcare level in the nine targeted regions, including in rural areas. The Program covers annual reviews of the quality assessment tool (based on the feedback provided by the peers responsible for the audits and the personnel of the health centers that were audited during the previous round); training, including for the personnel of all the centers that are enrolled; self-assessments; audits (including a new module about implementation of previous recommendations); and publications and dissemination events for an increased number of primary healthcare facilities, in particular rural ones (see Table 8 below). The Program covers both rural and urban areas as both urban and rural health centers will jointly benefit from most of the aforementioned activities.

Table 8. Participation rates in *concours qualité*

	2013-14 (baseline)	2014-15	2015-16	2016-17	2017-18
Participation rate of CSCAs	14%	20%	25%	40%	60%
Number of participating CSCAs	55	80	99	160	240
Participation rate of primary health care centers	9%	12%	14%	20%	27%
Number of participating primary health care centers	255	330	399	560	740

97. **The expected results of these interventions include**: (a) better awareness about quality among the personnel of primary healthcare facilities; and (b) an increased number of initiatives to improve the quality of services.

98. This accountability component also includes the establishment of a comprehensive GRM. For now, the Ministry of Health has several mechanisms to collect grievances: (i) a newly established Division within the *Inspection générale* staffed by four professionals; (ii) a hotline (*Cellule d'écoute*) which is directly attached to the Secretary General's office that is currently staffed by four telephone operators who have received training on how to respond to phone calls and register the complaints received on Excel sheets but do not have procedures on how to analyze and respond to the complaints; (iii) at the decentralized level, there are multiple informal channels of complaints (e.g., directly at the facilities or to regional officials from the MoH and other departments, including the Ministry of Interior). The MoH will develop an effective GRM easily accessible to women, poor and marginalized communities, including through the revival of the national hotline. To do so, the MoH plans to: (i) clarify the institutional structure, roles and responsibilities in order to streamline the GRM; (ii) develop a preliminary Implementation Manual to guide the process of addressing grievances, including through a technical workshop with key MoH staff and other department staff at the central level as well regional staff and facility staff; (iii) pilot the new GRM for one year; (iv) review the Implementation Manual and

(v) roll out the GRM. These measures will take into account the national policy (inter-ministerial decree) for complaints handling and will include procurement and fiduciary complaints handling systems.

99. **The expected results of these interventions include**: (a) a better understanding of the patient and population's needs, (b) a better awareness about the patient and population's satisfaction with service delivery and (c) an improved answerability to the complainants.

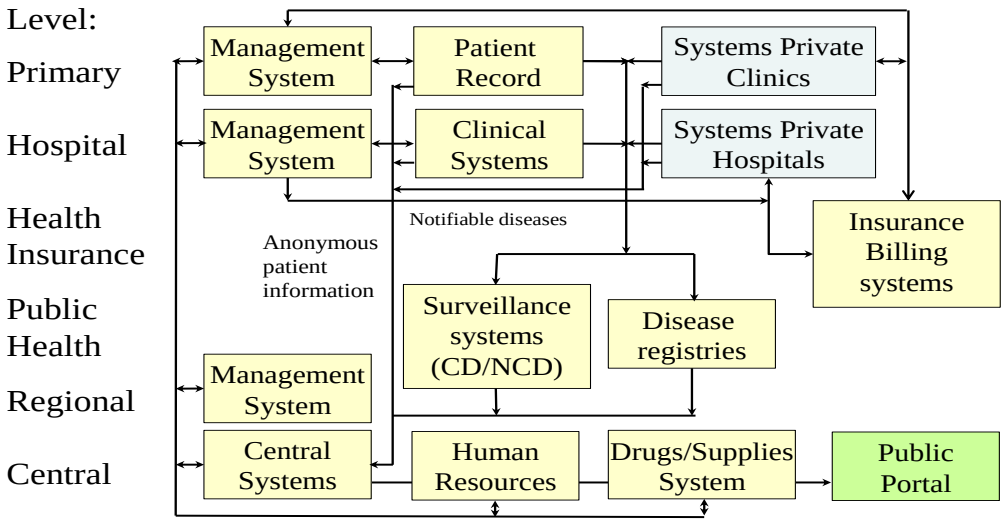
2.3 Developing an integrated, computerized, and accessible HMIS

100. The Government program aims to develop an integrated health information system that supports both improved service delivery and improved management of the system that will progressively replace the existing system. This system is envisaged to be operational nationally in 2025. The World Bank PforR Program will support the implementation of the Government's HMIS Strategy over four years (2015-2018). Overall, the Program covers laying the strategic, legal, institutional, governance and structural groundwork for putting in place a national, integrated and computerized HMIS, including its implementation in one region (Meknes-Tafilalet).

101. The groundwork entails setting up provincial (six) and regional (one) system and integrating them into the central system. Specifically, the Program will support: (a) foundational and analytical work (*urbanisation*) which includes an analysis of the existing HMIS (what it currently covers and its status), formulation of the data dictionary and coding standards, formulation of the data model which includes data flows and types of data across the health system, and the formulation of national charts of accounts and statistics; (b) updating the HMIS Master Plan to take account of the findings of step (a); (c) the development of integrated computerized systems in one region, including modules for surveillance, referral and counter-referral, facility management (finance, billing, materials management, etc.), clinical management and patient flow, and patient management (patient electronic records); (d) the development of central support structures and functions (e.g., data warehouse, decision support, etc.); and (e) the establishment of an adequate and instant access to information by all stakeholders, including various branches of the MoH, other government departments, civil society and the public, including the use of new technologies to facilitate the sharing of information and improve transparency and accountability. The overall architecture of the proposed HMIS is shown in Figure 1.[21]

[21] The exact target architecture will be defined during the process of 'urbanization.'

Figure 1. Proposed Target HMIS Architecture



102. **The expected results of these interventions include**: (a) technical work carried out and HMIS Master Plan updated; (b) data center is operational; (c) regulatory and governance structures are defined and related laws passed; and (d) HMIS is functional in one region, with the ability to link to the national system.

IMPLEMENTATION ARRANGEMENTS

103. The two most critical stakeholders involved in the proposed Program are the MoH and the MoF. The MoH is responsible for the implementation of the health sector reform according to priorities and directions defined in the strategic documents. The MoF will provide political and budget support to the MoH in implementing the program and receive the transfers linked to the achieved DLIs. The MoH General Secretariat will oversee program implementation while the DPRF will act as its secretariat, providing periodic supervision reports and information to the World Bank.

104. Within the MoH, the following departments will be involved at the central level. Under Component 1, *Direction de la Population* (DP) is responsible for the implementation of the MCH plan and the mobile team plan, jointly with the DHSA. DELM will be responsible for the implementation of the NCD sub-program. Under Component 2, the DRH will be responsible for preparing the HRH incentive mechanism jointly with DPRF. The introduction of any financial incentives will require approval of the MoF and the Ministry of Civil Service and Public Management Modernization (*Ministère de la fonction publique et de la modernization de l'administration*), as well as professional associations. DHSA will also be responsible for the development of quality assessments at the primary health care facility level, in particular its Quality Service (*Cellule qualité*), which is responsible for the organization of *concours qualité* every year. *Secrétariat général* will be responsible for the establishment of a comprehensive GRM. Two MoH departments are principally involved in project implementation under the HMIS component: the DPRF and the DIM. The DPRF will be leading the overall strategy and coordination with key stakeholders whereas the DIM will lead the technical components, program design and implementation. Two committees have been formed to oversee the Program: (1) a steering committee, chaired by the Secretary General, and composed of the directors of each of the MoH departments; and (2) a technical committee, chaired by the director of DPRF, and composed of representatives of each of the concerned MoH departments.

105. The program will also involve the services at the local levels. This includes the regional[22] and provincial directorates; provincial out-patient care infrastructure departments (provincial out-patient care infrastructure departments, *services d'infrastructures d'actions ambulatoires provinciaux*, SIAAP) in charge of coordinating health activities at the provincial level, and health facilities.

106. Additional key institutions that will be involved in project implementation are: (a) health workers unions; (b) ANAM, which regulates insurance schemes; (c) the insurance schemes covering civil servants (CNOPS) and private sector employees (CNSS); (d) private insurers; and (e) civil society. Representatives of these departments/institutions will eventually be added to the steering committee, and will be regularly sensitized and consulted on planned reforms and their progress through workshops and retreats.

[22] The 16 regional directorates in the country are responsible for the implementation of the national health policy at the regional level. Their tasks include: (i) public health protection and health surveillance; (ii) strategic planning; (iii) financing and financial management; (iv) human resource management; (iv) control and coordination of the actions of healthcare facilities; (v) ensuring the availability, quality and accessibility of medicines and non-drug pharmaceuticals (Source : *Arrêté de la ministre de la santé n° 1363-11 du 16 mai 2011 relatif aux attributions et à l'organisation des services déconcentrés du ministère de la santé*).

Annex 2: Results Framework Matrix

*The baseline values for DLIs 1 to 6 are estimates; they are national figures and will be updated once the figures for the 9 target regions have been issued by the HMIS, due before the first disbursement.

Program Development Objective: to expand access to primary healthcare in targeted rural areas in the Program Area.

PDO Level Results Indicators	Core	DLI	Unit of Measure	Baseline	Target Values				Frequency	Data Source/Methodology	Responsibility for data collection
					2015	2016	2017	2018			
PDO Indicator 1: Increase in number of pregnant women receiving antenatal care during a visit to a rural ESSP in the Program Area	☐	■	%	206,000 (2014 estimate)	0.97	2.18	3.88	5.83	Yearly	Routinely collected	DPRF
PDO Indicator 2: Increase in number of deliveries of rural women attended by skilled health personnel in public health facilities in the Program Area	☐	■	%	234,000 (2014 estimate)	1.71	3.42	5.13	7.26	Yearly	Routinely collected	DPRF
PDO Indicator 3: Increase in number of new visits of children under 5 to a rural ESSP in the Program Area for curative care	☐	■	%	1,345,000 (2014 estimate)	1.50	2.50	3.50	5.00	Yearly	Routinely collected	DPRF
PDO Indicator 4: Increase in number of patients with diabetes diagnosed and treated at a rural ESSP in the Program Area	☐	■	%	205,300 (2014 estimate)	4.09	8.62	13.10	17.63	Yearly	Routinely collected	DELM
Intermediate Results Pillar 1: Expanding equitable access to primary care in rural areas											
Increase in number of visits to rural ESSPs in the Program Area	☐	■	%	4,900,000 (2014 estimate)	1.30	2.30	3.30	4.30	Yearly starting in 2016	Routinely collected	DHSA
Number of patients with hypertension diagnosed and treated in rural ESSPs	☐	☐	Number	180,000 (2013)	273,000	277,000	280,000	287,000	Yearly	Routinely collected	DELM

Intermediate Results Pillar 2: Improving health system governance at the primary level											
% of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main annual quality assessment (concours qualité)	☐	■	%	20% (2014)	30%	40%	50%	60%	Yearly	Routinely collected	DHSA
Establishment of a comprehensive GRM	☐	☐	Text	No	Diagnosis, strategy and draft GRM Implementation Manual completed.	Pilot GRM launched	Pilot GRM evaluated Implementation Manual reviewed	Roll out of the comprehensive GRM	Yearly	World Bank Supervision	SG
Definition of an HR incentive mechanism in rural ESSPs	☐	☐	Text	No	Diagnostic study completed.	Implementation mechanism defined, including target indicators, performance criteria, and beneficiaries. Legal documents drafted	N.A.	N.A.	First two years.	World Bank Supervision	DRH and DPRF
Establishment of the HMIS in one region within the Program Area	☐	■	Text	No	Urbanization process, data dictionary and Data Model complete	HMIS Masterplan updated and validated	Data Center is operational; regional and provincial reporting systems (in one region) are functional	Legal documents drafted, HMIS operational in >80% of facilities in one region	Yearly	World Bank Supervision	DPRF / DIM
Key Fiduciary Performance Indicators											
Percentage of regions that have established an internal audit unit	☐	☐	%	0	50%	75%	85%	100%	Yearly	Annual reports, annual audit reports	IGF, IGM, Internal audits departments
Percentage of regional and provincial staff that have been trained on procurement and financial management. (at least two days)	☐	☐	%	0	50%	75%	85%	100%	Yearly	Annual reports, annual audit reports	IGF, IGM, Internal audits departments
Percentage of	☐	☐	%	0	50%	75%	85%	100%	Yearly	Annual reports,	IGF, IGM,

provinces in the Program area which have put in place an action plan to address IGF audit recommendations										annual audit reports	Internal audits departments
Percentage of IGF main audit recommendations that are part of the action plan and that are effectively implemented.	☐	☐	%	0	50%	75%	85%	100%	Yearly	Annual reports, annual audit reports	IGF, IGM, Internal audits departments

Annex 3: Disbursement Linked Indicators, Disbursement Arrangements and Verification Protocols

Disbursement-Linked Indicator Matrix

*The baseline values for DLIs 1 to 6 are estimates; they are national figures and will be updated once the figures for the 9 target regions have been issued by the HMIS, due before the first disbursement.

	Total Financing Allocated to DLI	***As % of Total Financing Amount***	***DLI Baseline***	***Indicative timeline for DLI achievement***			
				2015	***2016***	***2017***	***2018***
DLI 1: Increase in number of pregnant women receiving antenatal care during a visit to a rural ESSP in the Program Area			206,000 (2014 estimate)	0.97%	2.18%	3.88%	5.83%
Allocated amount:	**US$14 m**	**14%**		**2,329,331**	**2,905,660**	**4,082,333**	**4,682,676**
DLI 2: Increase in number of deliveries of rural women attended by skilled health personnel in public health facilities in the Program Area			234,000 (2014 estimate)	1.71%	3.42%	5.13%	7.26%
Allocated amount:	**US$14 m**	**14%**		**3,297,521**	**3,297,521**	**3,297,521**	**4,107,437**
DLI 3: Increase in number of new visits of children under 5 to a rural ESSP in the Program Area for curative care			1,345,000 (2014 estimate)	1.50%	2.50%	3.50%	5.00%
Allocated amount:	**US$10 m**	**10%**		**3,000,000**	**2,000,000**	**2,000,000**	**3,000,000**
DLI 4: Increase in number of patients with diabetes diagnosed and treated at a rural ESSP in the Program Area			205,300 (2014 estimate)	4.09%	8.62%	13.10%	17.63%
Allocated amount:	**US$20 m**	**20%**		**4,639,818**	**5,138,968**	**5,082,246**	**5,138,968**
DLI 5: Increase in number of visits to rural ESSPs in the Program Area			4,900,000 (2014 estimate)	1.30%	2.30%	3.30%	4.30%
Allocated amount:	**US$10 m**	**10%**		**3,023,257**	**2,325,581**	**2,325,581**	**2,325,581**

DLI 6: % of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main annual quality assessment (concours qualité)			20 % (2014)	30%	40%	50%	60%
Allocated amount:	**US$8 m**	**8%**		**2,000,000**	**2,000,000**	**2,000,000**	**2,000,000**
DLI 7 : Establishment of the HMIS in one region within the Program Area			No	'Urbanization' process, data dictionary and Data Model complete	HMIS Masterplan updated and validated	Data Center is operational; regional and provincial reporting systems (in one region) are functional	Legal documents drafted, HMIS operational in >80% of facilities in one region
Allocated amount:	**US$24 m**	**24%**		**5,000,000**	**5,000,000**	**7,000,000**	**6,750,000**
Front-End Fee:							**250,000**
Total Financing Allocated:	**US$100 m**	100%		**23,289,927**	**22,667,730**	**25,787,681**	**28,254,662**

DLI Verification Protocol Table

#	*DLI*	*Definition/ Description of achievement*	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLI and data/result verification*		
				Data source/agency	*Verification Entity*	*Procedure*
1	Increase in number of pregnant women receiving antenatal care during a visit to a rural ESSP in the Program Area	Number of women receiving antenatal care (new cases) during a visit to a rural ESSP/baseline	Yes	Routine administrative data. Existing Information System of SMIPF (*Santé Maternelle et Infantile/Planification Familiale*)/DPRF	*IGM*	An annual technical audit will be carried out by the *Inspection générale ministérielle (IGM) of the MoH*. The technical audit will be based on a review the documentation available centrally and on-site verification in a representative sample of areas targeted by the Program. The verification of the quantities of services for DLIs 1 to 5 would include: (i) Desk review of the completeness of the reporting and the final data (by month) for each of the 9 target regions; (ii) Follow up on any major variations (annual increases or decreases of 10% or more); (iii) On-site review to check submitted reports against registers and other facility-based data for a random sample of facilities from each of the nine target regions; and (iv) Random contact tracing via mobile phone for a sample of patients on registers. A discrepancy of up to 5% between the HMIS data and technical audit data will be accepted. In case of a higher discrepancy, disbursement (which will be scalable for DLIs 1 to 6) will be adjusted, based on the technical audit data. The technical audit will be carried out annually, starting with the 2015 data which will be used as the baseline.
2	Increase in number of deliveries of rural women attended by skilled health personnel in public health facilities in the Program Area	Number of deliveries attended by skilled health personal in public health facilities for women living in rural areas/baseline	Yes	Routine administrative data. Existing Information System of SMIPF/DPRF	*IGM*	
3	Increase in number of new visits of children under 5 to a rural ESSP in the Program Area for curative care	Number of new visits of children under 5 for curative care to a rural ESSP/baseline	Yes	Routine administrative data. Existing Information System of SMIPF /DPRF	*IGM*	
4	Increase in number of patients with diabetes diagnosed and treated at a rural ESSP in the Program Area	Number of patients with diabetes diagnosed and treated in rural ESSPs/baseline	Yes	Routine administrative data. DELM	*IGM*	
5	Increase in number of visits to rural ESSPs in the Program Area	Number of medical consultations (new cases) in rural public ESSPs/baseline	Yes	Routine administrative data. Existing Information System of SMIPF) /DPRF	*IGM*	
6	% of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main annual quality assessment (concours	Numerator: number of rural CSCAs that participated in *concours qualité* Denominator: number of CSCAs	Yes	DHSA (Quality Service)	*IGM*	

	qualité)					
7	Establishment of the HMIS in one region within the Program Area		No	DPRF / DIM	*IGM*	

Bank Disbursement Table

#	DLI	Bank financing allocated to the DLI (US$M)	Of which Financing available for		Deadline for DLI Achievement[1]	Minimum DLI value to be achieved to trigger disbursements of Bank Financing [2]	Maximum DLI value(s) expected to be achieved for Bank disbursements purposes [3]	Determination of Financing Amount to be disbursed against achieved and verified DLI value(s) [4]
			Prior results	Advance				
1	Increase in number of pregnant women receiving antenatal care during a visit to a rural ESSP in the Program Area	**14**	**0**		**Dec-18**	0.97%	5.83%	If the Bank finds that one of Result Related to Disbursements Linked Indicators (DLI) was partially achieved, provided that at least the reference value of said DLI has been exceeded, the Bank may authorize the withdrawal of a portion of the amount of loan assigned to said DLI, according to the following formula: *Loan amount allocated to the DLR* divided by the *number of percentage points by which the DLR exceeds the Baseline Value* multiplied by the *number of percentage points by which the actual result achieved exceeds the Baseline Value*. If the Bank finds that one of the DLI was not reached on the date on which it was to be, or if a DLI has been exceeded, the Bank may: (a) authorize the withdrawal of amounts calculated using the above formula to the maximum amount allocated to the DLI; (b) reallocate all or part of the amounts allocated
2	Increase in number of deliveries of rural women attended by skilled health personnel in public health facilities in the Program Area	**14**	**0**		**Dec-18**	1.71%	7.26%	
3	Increase in number of new visits of children under 5 to a rural ESSP in the Program Area for curative care	**10**	**0**		**Dec-18**	1.50%	5.00%	

4	Increase in number of patients with diabetes diagnosed and treated at a rural ESSP in the Program Area	**20**	**0**		**Dec-18**	4.09%	17.63%	to the Loan said DLR to any other DLR (s) within the amount allocated to the DLR; and / or (c) cancel all or part of the amounts of the Loan then allocated to said DLI.
5	Increase in number of visits to rural ESSPs in the Program Area	**10**	**0**		**Dec-18**	1.30%	4.30%	
6	% of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main annual quality assessment (concours qualité)	**8**	**0**		**Dec-18**	30%	60%	
7	Establishment of the HMIS in one region within the Program Area	**23.750**	**0**		**Dec-18**	'Urbanization' process, data dictionary and Data Model complete.	Legal documents drafted, HMIS operational in more than 80% of facilities in one region	**n/a**
	Front-end Fee	**0.250**						
	TOTAL	**100**	**0**	**25**				

Methodology to Determine Target Values

107. The following process was used to determine the 2014 baseline estimates and target values for DLIs 1, 2, 3 and 5: In consultation with the MoH, it was agreed to use historical data from 2007 through 2012 to provide trend information for informing the setting of the targets. This information was extracted from the existing Ministry publication "*Santé en Chiffres.*" It was also agreed that the official data for expected births in 2010 and 2011 were not reliable, so these data were adjusted by interpolating between 2009 and 2012. For each indicator a trend line was plotted based on the historical data. Due to the already (relatively) high level of pre-natal consultations and facility-based deliveries, it was agreed that a logarithmic regression would be used for DLIs 1 and 2. For under-5 consultations (DLI3) and contact rate in rural ESSPs (DLI5), a logarithmic regression was also used (for DLI5 we used data from 2005-2013). A relative stagnation is expected as the efforts of the MoH to increase the contact rate in rural areas faces insufficient human resources. In addition, socio-economic and cultural constraints are tied to the lack of increased demand by the rural population. These regressions were used to project the expected growth and coverage and/or services in the absence of the project. It was agreed that the DLI would be restricted to the 9 target regions. Therefore, all baselines and targets are adjusted to correspond to the appropriate population for the 9 regions. The target values are presented as the percent increase in the baseline values to take into account that the baseline values are national and will change once the baseline values for the nine targeted regions are determined.

108. Following a discussion with the Ministry, the following targets were agreed:

(a) For pre-natal consultations (DLI 1) it was agreed that for 2015 the target would be the trend line value plus 1.8 percentage points; for 2016, the trend line plus 2.2 percentage points; for 2017, the trend line plus 3.0 percentage points; and for 2018, the trend line plus 4.2 percentage points. These targets would result in 24,778 more cases of pre-natal care over the life of the project, compared to the "no project" scenario. For the purposes of DLI administration, these percentages were converted to actual numbers of services.

(b) For facility-based deliveries (DLI 2), the target for 2015 is the trend line plus 2.4 percentage points; for 2016, the trend line plus 2.7 percentage points; for 2017, the trend line plus 3.1 percentage points; and for 2018, the trend line plus 4.1 percentage points. These targets translate into 20,983 facility-based deliveries, compared to the "no project" scenario.

(c) For under-5 consultations (DLI 3), the 2015 target would be the trend line value plus 8,000 services; for 2016, the trend line plus 11,000 services; for 2017, the trend line plus 16,000 services; and for 2018, the trend line plus 28,000 services.

(d) For the number of diabetics diagnosed and treated (DLI4), the 2015 target was the value of the trend line. An addition to the trend value was not used as for other DLIs because the diagnosis and treatment of diabetics is directly related to the government strategy and plan and they have budgeted to reach these numbers for the target years 2015-2018.

(e) For contact rate in rural ESSPs (DLI5), an approach similar to (a) was used, since the indicator was expressed as the average number of services per capita. For 2015 the target would be the trend line value plus 0.01 services per capita; for 2016, the trend line plus 0.005 services per capita; for 2017, the trend line plus 0.015 services per capita; and for 2018, the trend line plus 0.02 services per capita. For the purposes of DLI administration, the contact rates were converted to actual numbers of services.

109. For DLI 6, the World Bank team and MoH counterparts, including DHSA, designed and costed a roll-out plan for *Concours qualité* along with a timeline and targets.

110. For DLI 7, the World Bank team and MoH counterparts, including the DIM and DPRF, designed and costed an HMIS strategy along with a time-line and targets. The urbanisation process which will generate the information and technical outputs necessary to design the HMIS Masterplan is expected to take one year. The writing of the Masterplan, the consultations among all stakeholders, consensus building and validation is expected to take another year. The third year, the project expects that the information backbone of the system will be in place. In the final year, the HMIS is expected to be operational in one area, as a proof-of-concept and pilot which will inform the subsequent rollout and scale-up.

Annex 4: Technical Assessment (Full Text)

A. Description and Assessment of Program Strategic Relevance and Technical Soundness

a. Strategic Relevance

111. **Morocco is experiencing significant political change and increased demand for improved public health services.** The new constitution sets the basis for a more open and democratic society. The new constitution also explicitly states that healthcare is a right of the Moroccan people. At the same time, there is demand for improved public services in the health sector. Building on the first ever national consultation on health called *Intidarat*, and with support from King Mohamed VI, Morocco held the second National Conference on Health from July 1-3, 2013[23] to build consensus on the diagnosis of problems in the health sector and set of planned reforms.[24] The conference was anchored by a Royal Letter for action, a 2012-2016 health sector strategy, and a Health Sector White Paper.[25]

112. The Royal Letter released during the second National Conference on Health states that "*access to healthcare services (…) is crucially important for a dignified life and for the achievement of comprehensive, sustainable human development*" and recognizes that the "*constraints…are mainly due to the limited resources available on one hand and the ever-growing, yet legitimate expectations of the citizens.*" Given its current macroeconomic constraints and a long-standing under-investment in the health sector, the country is primarily focusing on increasing the performance of the health system through the identification and implementation of key reforms that will help remove bottlenecks and address priority issues. These reforms will support the needed transformation of the health system and its adaptation to the ongoing political, demographic and epidemiological changes and could overtime help make the case for increased budget in the health sector. The need to respond to the demand for improved access to, and quality of, healthcare services (including through the emblematic pro-poor non-contributory health coverage scheme called RAMED) places the questions of equity and accountability at the center of the reforms. The country is expecting the donor community to support the planned or ongoing reforms within a short- to medium- term period and to help demonstrate, through the monitoring of specific results indicators, that Morocco is putting in place a more patient-centered, equitable and accountable health system.

113. The proposed Program addresses the following key issues which are at the center of the inequitable access to health care in Morocco.

114. **Access to primary healthcare is inequitable and of low quality**. There are important disparities in terms of access to primary healthcare. The MoH runs 2,689 primary health facilities ((ESSPs), of which 72 percent are located in rural areas. However, only 34 percent and 43 percent of primary care physicians and paramedical staff, respectively, work in rural ESSPs. The productivity of each ESSP is highly variable with, for example, the number of consultations per facility varying substantially between regions.[26] Quality of services is deemed low as evidenced by the 2010 Health Users' Survey: 59 percent of patients in rural ESSPs complained about the cost of prescription drugs (51 percent in urban ESSPs),

[23] The first being held in 1959.
[24] Attendees included line ministries, insurers, medical and nursing associations, private sector, academics, civil society, NGOs, donors, and all other major stakeholders.
[25] *Royaume du Maroc, Ministère de la santé, Livre Blanc : Pour une nouvelle gouvernance du secteur de la santé, Marrakesh, 1-3 juillet 2013*.
[26] The number of consultations per facility varies from 5,075 in the Guelmim-Es-Semara region to 22,588 in the Grand Casablanca region.

58 percent of the waiting time (45 percent in urban ESSPs), 62 percent of the quality of infrastructure (55 percent in urban ESSPs), 29 percent of the facility hygiene (45 percent in urban areas) and 21 percent of the integrity of health staff (25 percent in urban areas). The Public Expenditure Tracking Survey shows that patient dissatisfaction was associated with objective characteristics of ESSPs: staff absenteeism, limited training, and lack of infrastructure maintenance.[27] Finally, 60-75 percent of patients do not receive the basic care that would be necessary for the prevention and early management of NCDs (blood pressure, weighing, physical examination, and interview on medical history).

115. **Health human resources are scarce, inequitably distributed, and poorly trained**. While there is recognition that the health system in Morocco faces a shortage in HRH, there is also a consensus that the management of existing health personnel is not satisfactory: the distribution of HRH is inequitable across the country and does not reflect population needs, particularly in rural areas. Medical and para-medical training does not match population needs and access to in-service training is insufficient and its impact not evaluated. MoH capacity to design and implement active retention and career management policies has been relatively poor. Incentives for health teamwork, including medical and non-medical personnel, are limited. In the absence of a health information system, planning and management of needs and employment are not sufficient.

116. **The health sector is suffering from governance challenges undermining accountability vis-à-vis the population and equal access to quality health care services, which is now a constitutional right (art 157)**. The Royal Letter that opened the National Conference in July 2013, the sectoral White Paper, the 2012-2016 Health Sector Strategy, and the Conference proceedings recognize that the health system governance needs to be improved to achieve more accountability and equity. Two weaknesses were jointly identified by the MoH, the World Bank, and the EU as key governance issues that should be addressed by this joint program. First, there is a lack of regulation and control of health care providers, including certification systems and settlement regulation mechanisms for private providers. This results in important inequities in terms of distribution of health services. Second, there is an urgent need to increase the legitimacy of the current health care facilities, making it more accountable to the population and curtailing corruption.

117. **Morocco lacks an integrated, computerized, and accessible HMIS**. Effective and efficient operation of a modern health system will require developing an integrated, computerized, and accessible HMIS. Data collection in specific areas (for example, for pharmacovigilance and for specific vertical programs such as maternal-child health) and a master plan for the development of a HMIS have been achieved in recent years. However, the master plan was not implemented and the HMIS remains largely paper-based, fragmented and compartmentalized, with each unit collecting its own data, often redundantly, creating a significant reporting burden at the level of service delivery, with little integration of data centrally, and little useful data for facility level clinical and administrative decision-making. National statistics are published with a two-year delay and valid, reliable, and complete data are not available to policy makers in a timely fashion. The information systems for health human resources and medications are not functioning. There is no interoperability between the information systems of the main insurers, or for data collected for the medical assistance scheme for the economically disadvantaged (RAMED). The private sector is not part of the information system, and there is no integration across these various systems. The lack of data contributes to the lack of transparency and accountability in the sector, with little recourse for citizens to address issues of access, quality and health system responsiveness and makes it difficult for the government to assess the success of current and planned reforms addressing inequalities and quality of services in the health sector. The establishment of a computerized HMIS system is a top priority for the MoH (as well as a key component of the sectoral White Paper, the consensus recommendations of the Second National Conference on Health, and the

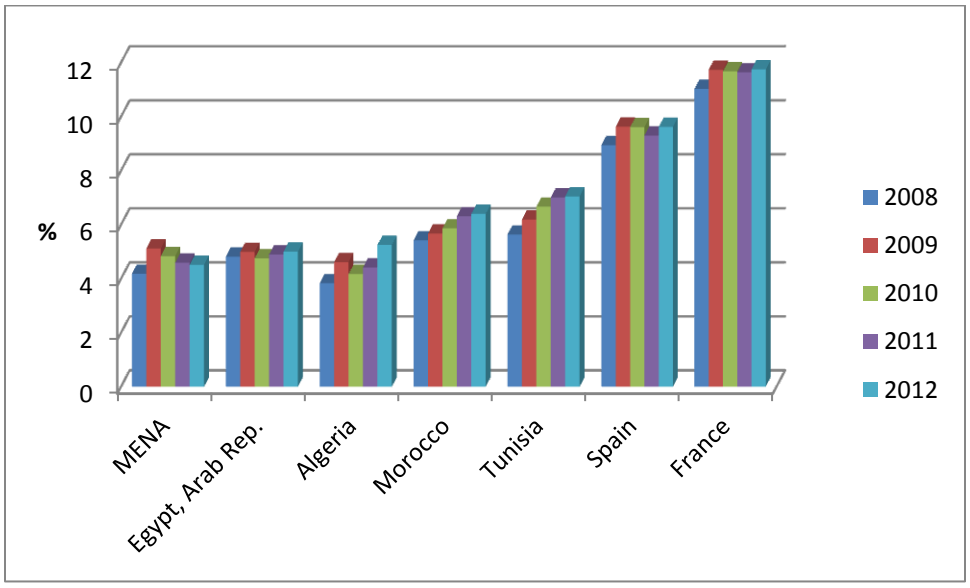
[27] World Bank, Forthcoming.

2012-16 Health Sector Strategy) and an integral component necessary for the success of planned reforms in the health sector.

118. T**he MoH is very focused on these issues, with various departments being involved in developing the overall government program**. The program itself is mainstreamed within the overall activities of the MoH, which should facilitate its implementation. By focusing on those in rural areas, who are also usually those in the poorest income quintiles, the program should address the dual goals of improved services delivery and poverty reduction. For example, if the 40 percent difference between the rural child mortality ratio and the urban one can be reduced, the impact in terms of increased economic potential could be significant. The team therefore feels that the focus on rural health is quite appropriate given the current situation in the country, the potential health and economic benefits, and the availability of specific plans and strategies to address the situation. Moreover, the fact that the program focuses not just on service delivery but also on the key enabling factors for improving results on the ground–human resources, governance and accountability, and information management–indicates that the program structure has a high probability of improving the overall situation if implemented as designed.

119. **Total expenditure on health, as a percent of GDP, has been steadily increasing** in Morocco, from 5.4 percent in 2008 to 6.4 percent in 2012 and is higher than in Egypt, Algeria and the MENA average, but below expenditures on health in Tunisia, France and Spain (Figure 2).

Figure 2. Total Health Expenditure as a percent of GDP
2008-2012

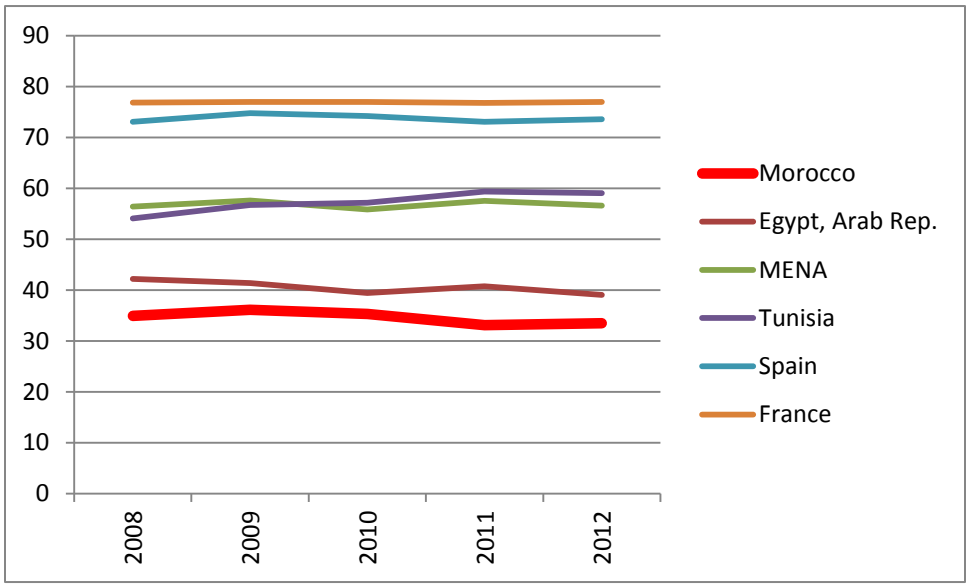


Source: Authors Calculations, World Bank Databank WDI Database, accessed June 2014

120. **However, Morocco's public expenditure on health is below that of countries of similar socio-economic development.** Public expenditure on health as a percent of total government expenditure is at the same level it was in 2008 (6 percent) and indeed has recently decreased after a brief rise in 2009 and 2010. Furthermore, as a percent of total health spending, Morocco's public health spending share at around 33 percent is well below regional averages and comparator countries (Figure 3). As a

consequence, household expenditures are high, representing 62 percent of total health expenditures in 2010.[28]

Figure 3. Public Health Expenditure as a percent of Total Health Expenditure 2008-2012

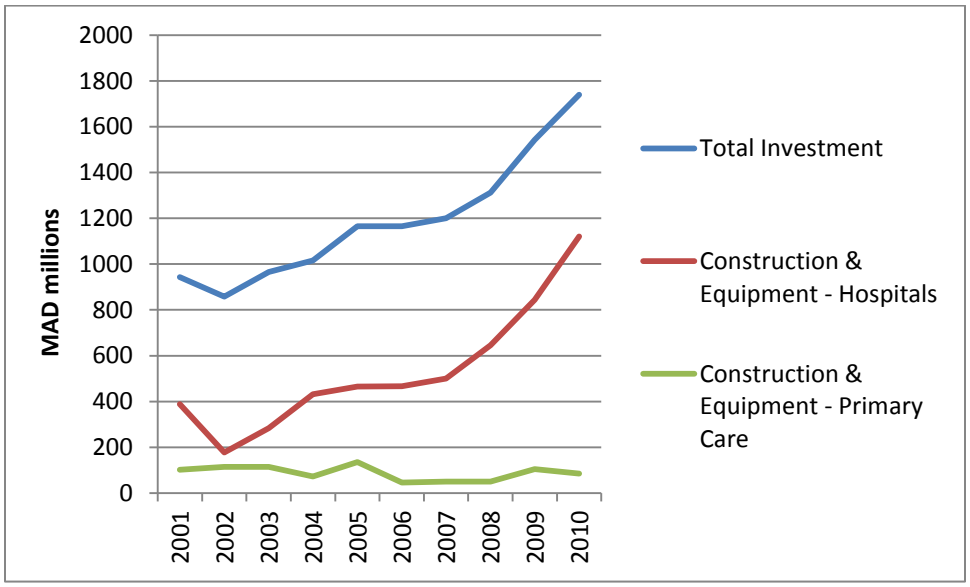


Source: World Bank Databank World Development Indicators Database, accessed June 2014

121. **Furthermore, there are substantial potential allocative efficiency gains in how public funds are allocated.** Primary care is neglected in favor of spending on tertiary care. The hospital share of the investment budget is large and growing while the share of primary care is small and declining. In 2010, 60 percent of investments were allocated to hospitals while only 5 percent were allocated to primary care (Figure 4). The five university teaching hospitals (CHUs) in particular represented 19 percent of the total MoH budget and, from 2005 to 2010, saw a 2.5 fold increase in their budgets while the overall budget of MoH increased only 1.7 fold. This focus on high-end tertiary care over primary and preventive services poses significant risks for the long-term financial sustainability of the sector, particularly as the epidemiological transition takes hold and the system contends with high-cost chronic conditions.

[28] OOP payments and household contributions to health insurance schemes represent respectively 54 percent and 8 percent of total health expenditure.

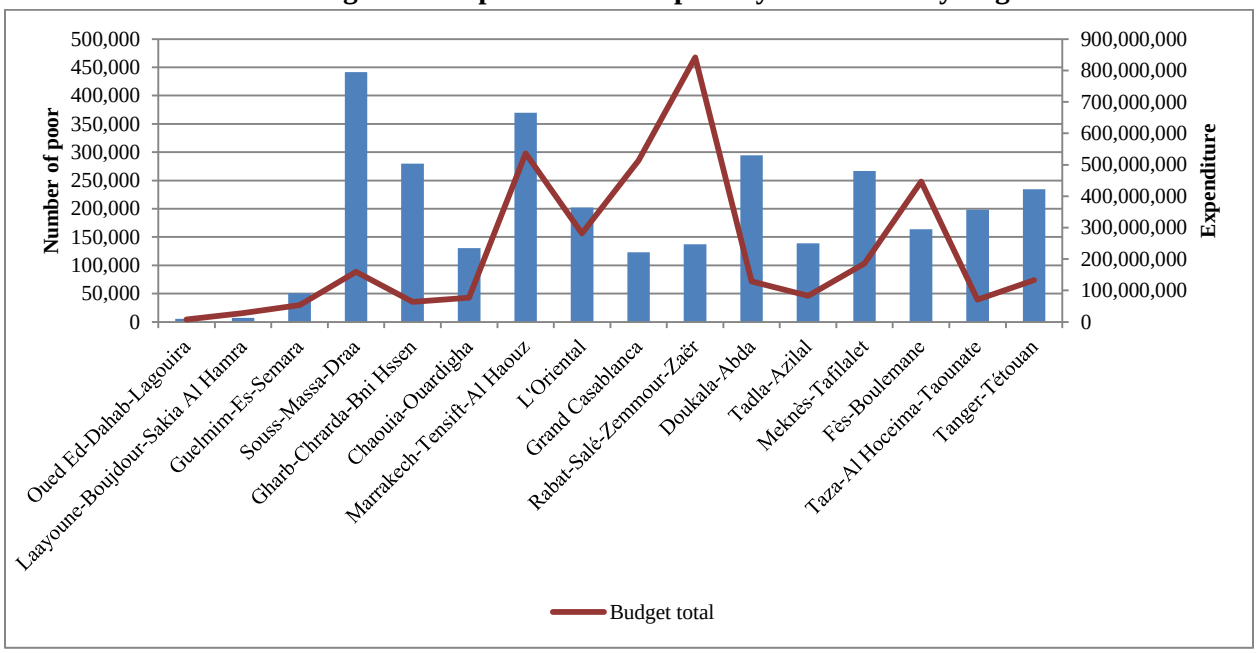
Figure 4. Investment: Total and for Hospital & ESSB construction and equipment 2005-2010



Source: Authors Calculations, data from Morocco PER, World Bank 2012

122. **The MoH has proceeded with ambitious reforms to deconcentrate budgetary and managerial autonomy to the regions.** However, most expenditure remains centrally managed and the distribution of the budget remains highly inequitable, both in terms of investments (Figure 4) and distribution of health workers, leading to the large disparities in health outcomes observed. Health spending continues to disproportionately benefit the richest and inefficiencies in public expenditures are reflected in inequalities in access to care. In Morocco, relative to other countries in the region, disparities between, regions, urban and rural areas, and between the rich and the poor are much more pronounced (Figures 5 and 6).

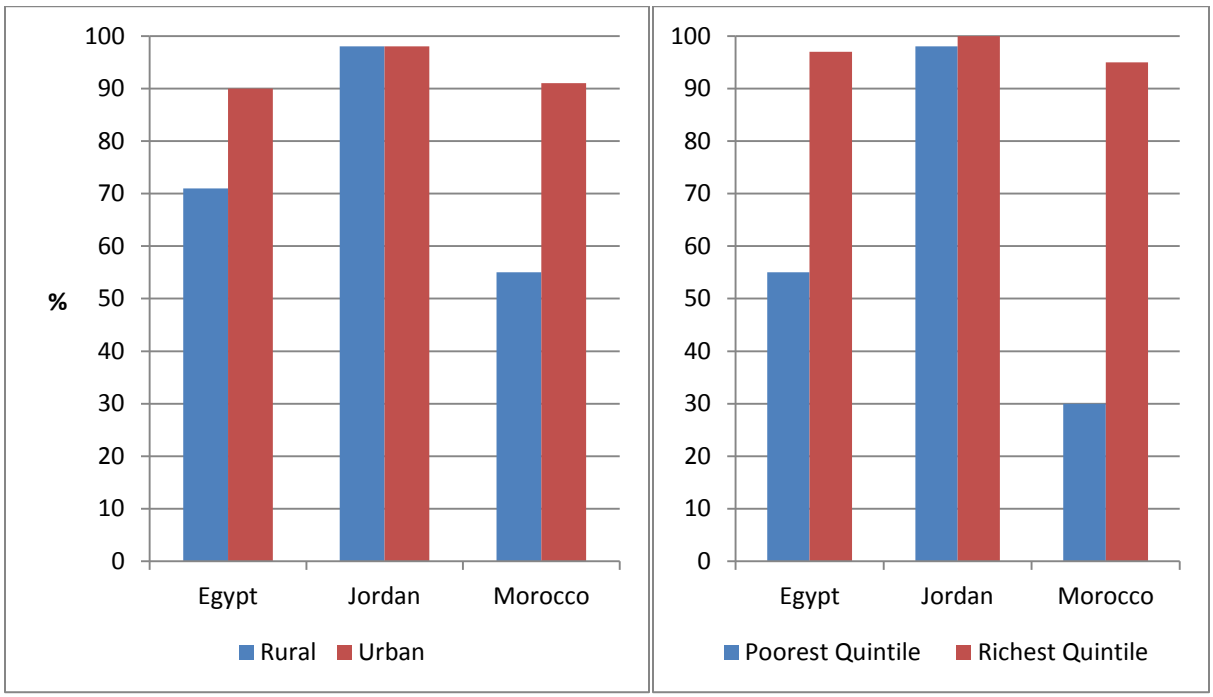
Figure 5. Expenditures and poverty head count by Region



Source: Morocco PER, World Bank 2012

Figure 6. Assisted Delivery by Setting and Income

Source: Morocco PER, World Bank 2012



123. **The budget formulation process, structure and classification are as follows**: the current Government program covers the period 2012-2016. It outlines the main policy priorities and objectives including in terms of macro-economic policy and public finances, such as bringing down the budget deficit to three percent GDP by 2016 (compared to 7.4% in 2012). This overall program is complemented by sector specific strategies covering different time horizons and budget resources. While these policy priorities and strategies inform the budget preparation, there is no formal or systematic link. The proposed Program will be included in the annual budget of the Government of Morocco under the existing budget lines grouped under the MoH budget.

124. **Budget documentation (*morasse budgétaire*) allows for adequate presentation of the Program's proceeds.** Budget classification for the MoH is centered on a regional classification[29] and budget proposal is supported by a detailed financial programming that is available at the budget submission stage. The adaptation of the budget process to the new organic law will be taken into account in a "Budget discipline circular" in preparation that will cancel and replace existing regulation and will consolidate good practices already in use. These planned reforms will allow for even further improvements in tracking of public expenditures and expenditures related to the PforR project components.

125. **In order to improve efficiency of public expenditures on health, the Government has embarked on an ambitious budgeting reform; initiating program based budgeting.**[30] The budget reform aims at strengthening the link between budgeting and strategic priorities and to improve the transparency of budget allocation through the adoption of a programmatic budget structure and budgetary performance objectives and indicators. The Supreme Audit institution (*Cour des comptes*) regularly includes in its work program evaluation of Health programs which involves at the same time regularity audits and performance audits.[31] The reform envisages that observations from the *Cour* will be acted upon according to a firmly established and implemented action plan. The draft organic law introducing these changes has been prepared and is still pending adoption by parliament. The swift implementation of this reform will increase the consistency between the budget and the government's priorities. For the 2014 budget, four ministries tested this new budget structure and presented to parliament a programmatic budget and performance objectives, with the support from the World Bank. The government program includes a fiscal target (a deficit of three percent GDP by 2016). However, Morocco does not yet publish a multiannual budget framework. Multiannual budget programming is foreseen in the draft organic finance law. Morocco reports (to the IMF) and publishes its fiscal data on a regular basis. The budget classification uses a combination of an administrative and economic classification, with a special code for the regions. The budget is also presented with a functional classification aligned with COFOG. The budget is comprehensive, covering the General Budget of the State (BGE), the supplementary budgets (BA), the special treasury accounts (CST) as well as the autonomously managed government services (SEGMA). Transfers to agencies and local governments are recorded, not their own revenues in the absence of consolidated accounts. The current roll out of the

[29] Going forward, the regional classification will be detailed in five programs which have now defined (under the *loi de finances* 2015).

[30] The MoH will join the second wave of ministries for the implementation of the performance informed budgeting reform, which will require them to restructure their budget in a programmatic and multi-annual format and prepare a performance plan (objectives and indicators) for the 2015 budget. The aim is to increase transparency and accountability in the use of public resources while increasing the managerial flexibility and performance orientation along the service delivery chain. The first wave of ministries which undertook this reform includes MoF, MEN (to which the *formation professionnelle* department was just added), Ministry of Agriculture and Marine Fisheries, and the High Commission on Water, Forestry and the fight against Deforestation.

[31] The *Cour* published in 2013 a report on pharmaceutical management by the MoH.

same financial management information system (GID) to local governments should facilitate such consolidation in the near future.

126. **Financial sustainability and funding predictability do not pose a specific risk as, overall, budget execution is fairly centralized and the performance of budget execution is fairly satisfactory,** even if end-year budget execution reports are produced with delays (2012 is the last available year). While funding predictability is hampered by the current lack of a credible multi-year budget framework, this is being addressed through the reforms cited and, furthermore, the health sector has gained national prominence and priority on the national agenda with the recent National Health Conference which was opened by the letter from the king. Furthermore, monthly budget execution reports are published with less than three months delays on the TGR's website and the report dated December 2013 shows a commitment of 86 percent of budgeted expenditures. No end-year report is yet available for 2013.[32] The latest end-year budget execution report for Health (2012) shows a high execution rate for current expenditures (100.95 percent) but a low execution for investment expenditures (42 percent).

127. **The budget of the MoH is increasing and there is a 13.6 percent increase planned for the 2014-2016 period over the 2013 budget** (Table 9).

Table 9. Ministry of Health Budget and Projected Expenditures

2012-16 (in US$ billion)

Category	2012	2013	Projections		
			2014	2015	2016
Recurrent Expenditure	**1.23**	**1.31**	**1.39**	**1.46**	**1.52**
Personnel	**0.81**	**0.78**	**0.84**	**0.90**	**0.96**
Non-Personnel	**0.42**	**0.48**	**0.49**	**0.50**	**0.50**
RAMED	**-**	**0.04**	**0.06**	**0.06**	**0.06**
Investment	**0.22**	**0.24**	**0.20**	**0.24**	**0.24**
TOTAL	**1.45**	**1.55**	**1.59**	**1.70**	**1.76**

Source: Ministry of Finances, Medium-Term Expenditure Framework 2014-2016, September 2013

128. **The PforR project will cover US$100 million of the Government program** (Table 10). The Government's existing program is funded through the annual budget of the State under the MoH budget. The proposed PforR operation takes a subset of the Government's program and supports it, the details of which are provided in the detailed Program description section of this document. For MCH and NCDs, the budget outlined comprises activities that pertain to primary care in rural areas, in nine regions for MCH and NCDs budgets. The mobile strategy, human resources and quality assessment budgets have national components for strategy design and budgets for implementation in the nine regions. The HMIS budget covers system design and application in one region.

[32] https://www.tgr.gov.ma/wps/wcm/connect/88fafd8042afaa46800fcb4ee5b22fb0/BSFP+DECEMBRE+2013.pdf?MOD=AJPERES&CACHEID=88fafd8042afaa46800fcb4ee5b22fb0

Table 10: Program Financing
2015-2018 (US$ million)

	Of which**		
Total	**PforR**	**EU***	**UN**
226.2	**100.0**	**107.0**	**4.0**

*1Euro = 1.251USD

** In Morocco donor financing for sector programs/projects do not automatically translate into budget allocation of the same amounts to the relevant sector ministry. These amounts result from annual negotiations between the sector ministry and the MoF during the preparation of the Finance Law.

129. **The overall programmatic budget is US$226.2 million** (Table 11). The EU project is planned to be negotiated in May 2015. While this introduces some uncertainty to the overall budgetary envelope, the risk of the EU withdrawing the proposed financing is negligible. For MCH, the budgeting is based on the Budget of the 2012-16 Acceleration plan (which budgets investments, activities, and salaries), projected out to the lifetime of the PforR, with additionally planned activities, removal of completed activities, and limited to the rural and primary setting.[33] For mobile health, the quality contest, and NCDs, costing is based on historical budgets, similarly projected out to the lifetime of the PforR, limited to the appropriate PforR boundaries and with the cost of salaries estimated and added.[34] For HRH and HMIS, these are new programs that have been costed and budgeted going forward, for the lifetime of the PforR.

Table 11: Program Cost
2015-2018 (US$ million)

Sub-program	Cost
Reducing maternal and child mortality	67.4
Detection and control of NCDs	90.2
Mobile Strategy	26.9
Human Resources in Health (incentive scheme)	2
Quality Assessment (*concours qualité*)	2.4
HMIS	37.3
Total	**226.2**

[33] For activities that pertain to multiple settings (urban and rural and/or primary and secondary/tertiary) estimates as to the share of budget for the rural/primary setting are made according to relevant criteria (e.g. number of health facilities; number of staff; staff salaries; investment budget etc.).
[34] Program budgets, where they exist, do not include salaries. When estimating and budgeting salaries, we assume that the ratio of salary to investment+ recurrent costs is the same within programs/activities as the overall ratio.

b. Technical Soundness

130. The Results Chain in Table 12 links the sectoral challenges to the Program activities, outputs, outcomes, and related DLIs for each pillar.

Table 12: Results Chain

Sectoral Challenges	Activities	Outputs	Outcomes	Related DLI
Pillar 1: Expanding equitable access to primary health care in rural areas				
Limited access to MCH care in rural areas	ESSPs upgrading; Improvement of technical and biomedical equipment of ESSPs, strengthening the technical platform of existing ESSPs; Purchase of essential drugs and vaccine for MCH; Upgrade existing ESSPs facilities; Improvement of transportation systems for pregnant women presenting complications home to hospital. Establishment of standardized care procedures related to MCH; Development of health educational tools. Organization of training sessions on best practices for ESSPs health workers. Conducting awareness raising and health education to promote breastfeeding, prevent nutritional deficiencies and strengthen child immunization	Rural ESSPs of target regions are upgraded when necessary, and their health staff has the necessary equipment, drugs and tools to provide quality services.	(a) an increased use of antenatal care during pregnancy; (b) increased skilled birth attendance; (c) improved access and use of primary health care in rural areas by children under 5; and (d) improved access and use of primary health care in rural areas by rural populations.	**DLI 1**: Increase in the number of pregnant women receiving antenatal care during a visit to a rural ESSP in the Program Area. **DLI 2**: Increase in the number of deliveries of rural women attended by skilled health personnel in the Program Area. **DLI 3**: Increase in the number of new visits of children under 5 for curative care to a rural ESSP in the Program Area. **DLI 5**: Increase in the number of visits in rural ESSPs in the Program Area.
Limited access to prevention and control of NCDs in rural areas.	Distribution to ESSP (health centers and mobile units) of screening equipment; training ESSP staff on screening techniques; conducting screening activities for diabetes, hypertension and breast cancer on target population. Dissemination of standards of care to ESSPs (health centers and mobile units); training of professionals on standards of care; provision of ESSPs with basic essential drugs for hypertension and diabetes; establishment of a therapeutic education program on diabetes; and establishment of the chain of specialized care.	Rural ESSPs of target regions have received the equipment, training, drugs, and tools for prevention and control of NCD diabetes, hypertension, and breast cancer.	(a) improved knowledge of healthy lifestyles, the dangers of smoking, and the need for regular screening regarding NCDs, both by the general population and by health workers; and (b) increased numbers of diabetic and hypertensive patients screened and being treated for their conditions according to acceptable standards of care.	**DLI 4**: Increase in the number of patients with diabetes diagnosed and treated in the Program Area.

Sectoral Challenges	Activities	Outputs	Outcomes	Related DLI
For a large portion of the rural population, physical access to ESSPs is difficult due to distance and geography.	Purchase of equipment and medical supplies for mobile units of the 9 target regions; Strengthening of the technical platform of existing mobile units; Capacity building for health care providers in the management of mobile medical units.	Mobile units visit remote areas regularly (at least four times per year) and provide the ESSP package of services to the population.	(a) an increased use of antenatal care; (b) improved access and use of primary health care in rural areas by children under 5; and (c) improved access and use of primary health care in rural areas by rural populations.	**DLI 1**: Increase in the number of pregnant women receiving antenatal care during a visit to a rural primary healthcare facility in the Program Area. **DLI 3:** Increase in the number of new visits of children under 5 for curative care to a rural ESSP in the Program Area. **DLI 5**: Increase in the number of visits in rural ESSPs in the Program Area.
2. Improving health system governance at the primary level				
Productivity of medical and paramedical staff is insufficient, and there is staff absenteeism.	Analysis of existing incentive schemes; Design of a new mechanism to improve HRH performance.	An incentive mechanism to improve HRH performance is designed and ready for implementation.	The MoH is ready to implement a mechanism that allows improving performance of staff in target rural ESSPs (as measured by agreed criteria of assiduity, productivity, and quality of services)	None. Results indicator only.
Low accountability in rural ESSPs	Expanding participation in *concours qualité* at the primary healthcare level, including in rural areas Annual Review of the quality assessment tool Training sessions for the personnel of all the centers that are enrolled; Publications and dissemination events for an increased number of primary healthcare facilities, in particular rural ones	All CSCAs that participate in *Concours qualité* have participated in training sessions All CSCAs that participate in *Concours qualité* have prepared an action plan to improve quality based on the recommendations included in the audit report	Better awareness about quality among the personnel of primary healthcare facilities; and An increased number of initiatives to improve the quality of service delivery.	**DLI 6**: Percentage of rural CSCAs in the Program Area that participate in the main annual quality assessment (*concours qualité*)
Effective and efficient operation of a modern health system will require developing an integrated, computerized, and accessible HMIS.	Design of national system Implementation in one region	Technical work carried out and HMIS Master Plan updated; Data center is operational; ; and HMIS is functional in one region, with the ability to link to the national system.	Establishment of the HMIS is all public facilities in one region	**DLI 7**: Establishment of an HMIS in one region within the Program Area

Pillar I: Expanding equitable access to primary care in rural areas:

1.1 Reduction of maternal, neonatal, and under five mortality

131. The interventions related to maternal and child health have been used in a variety of countries around the world with great success. In fact, the global investment framework for women's and children's health[35] estimates that investments in reproductive, maternal, newborn and child health (RMNCH) in lower-middle income countries such as Morocco, could yield up to 11.3 times their value in economic and social benefits. This framework analysis includes many of the interventions contained in the government program with respect to accelerating the reduction of maternal, neonatal, and under-five mortality and supported through this sub-component, such as improving ante-natal care, facility-based delivery, and emergency transportation for pregnant women.

1.2 Strengthening the detection and management of non-communicable diseases

132. With regard to the proposed NCD interventions, there is also ample evidence that these activities are technically sound. The WHO/World Economic Forum report entitled "From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries"[36] includes cervical cancer screening, as well as screening and appropriate drug therapy for cardiovascular disease and diabetes as "best buys." The report suggests that the cost of implementing these interventions in lower-middle income countries would be roughly US$1.50 per capita annually, and that the return on this investment over time would be about 3:1. In human terms, the report estimates that "…at least 10-15 percent of premature deaths could be successfully averted through the scaled-up implementation of a core intervention package."[37]

133. International experience also suggests that the focus on service provision should be accompanied by concomitant attention to health system strengthening needs, including human resources management, governance and accountability and timely and accurate information to monitor performance and support both the clinical practice and the overall management of the system. The Global Investment Framework[38] "emphasizes the broader links to, and need for, health systems strengthening," and the analysis specifically included the additional investment needs for training and supervising health workers, improving health information systems, and allocating resources to support good governance through informed and transparent decision. The government program has similarly taken these lessons into account.

134. Overall, therefore, from a technical point of view, the government program focuses on the key issues and includes the necessary health system strengthening activities that will support the achievement of the development objectives.

1.3 Strengthening mobile health coverage

135. In the context of Morocco, characterized by difficult access to health services and given the scattered nature of rural residence, mobile approaches are considered essential to strengthen health coverage in rural areas. Such approaches have shown that they are able to meet the care needs for these

[35] Stenberg, K. et al, "*Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework,*" The Lancet, 2014; 383: 1333–54.
[36] *From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries*, WHO and WEF, 2011.
[37] Ibid, p. 9.
[38] Op Cit., p. 1334.

populations by providing an extension of the health center that can reach people who find it difficult to otherwise access health services. Important success factors for this approach are the degree to which mobile team visits are planned in concert with all stakeholders, and the fact that the service package takes into account the achievement of priority health goals as well as the specific local epidemiology. Another important success factor is the degree to which mobile teams are closely integrated into the overall health care delivery system. This includes: (i) the involvement of all levels, central, regional, provincial and local, in management activities related to the mobile team; (ii) the degree of planning and the clear definition of objectives that is done before the deployment of the mobile team; (iii) the focus on the expectations and needs of the target population with respect to curative care, including the provision of essential drugs, preventive care and information needs for promoting their own health; (iv) promoting the continuum of care by ensuring the care and monitoring of patients who need to be referred to other levels of care such as hospitals or specialized mobile medical units; and, (v) the focus on the systematic evaluation of activities taking into account the dimensions of effectiveness, efficiency and quality of services. The MoH evaluation of mobile services has suggested the need to expand the scope of the program and the range of services that these mobile units can provide. The Government program takes these recommendations into account both by expanding the number of units and the services that they will provide.

136. A number of other countries have also successfully developed mobile health teams as a way to get health services to rural and remote areas. For example, Integrated Mobile Teams (IMT) have been established in Burundi,[39] originally to support family planning and sexual and gender based violence services for populations in transition, but subsequently expanded to ante-natal care, prevention and treatment of malaria, nutrition, safe water, immunizations, and sanitation services. Preliminary observations suggest that IMTs are reaching an important number of male clients—a segment of the population difficult for static facilities to reach—with a variety of services, including family planning. The approach shows strong potential for long-term sustainability, as IMT activities are now integrated into participating health districts' workplans, and are slated to take place monthly in each district. Data currently available suggest this is an effective and much needed means of reaching the country's sizeable and disproportionately underserved populations in transition. Similarly, a mobile health team approach called "MAILAFIYA" in the federal capital region of Nigeria successfully provides primary health care services to rural and remote areas. The program won the 2013 UN Public Service Award for Excellence in Service Delivery, with the following citation:

> *The World Health Organization (WHO) estimated that in FCT, adequately serving the population would require 434 Primary Health Centers (PHCs). Only 179 existed, many of which were operating at sub-optimal levels. Rural populations had to travel long distances to reach these centres. The project sought to address these through integrating data banks into a central database and improving health care services using mobile teams to reach remote areas with extremely difficult terrain. The program generates real time data from the field. This resulted in the reduction of the cost of providing healthcare delivery of services and enhanced planning and evaluation of the health system. A preliminary survey report revealed that, there has been an increase in access to health care from 17% to 71% in all the communities of the Federal Capital Territory. The program has created a dependable database for improved management of health care.*[40]

[39] Introducing Integrated Mobile Teams to Burundi: Technical Update, Pathfinder International, 2012.
[40] 2013 United Nations Public Service Awards Winners Fact Sheet, p. 6.

Pillar II: Improving health system governance at the primary level

2.1 Defining an incentive system to improve HRH performance based on the current situation analysis

137. There is evidence that financial incentives can have positive effects on staff performance in terms of productivity and dimensions of quality of services such as respect of professional norms and satisfaction of users; incentives can also lead to lower rates of absenteeism. However, it is established that their effects on motivation will only be short-term if not combined with non-financial incentives such as access to continuing professional development and career opportunities, good quality supervision, and competent management. It is also recognized that motivation alone does not guarantee improvements in performance. Factors like improved infrastructures and access to equipment, medicines and modern communication technologies, and organizational structures and modalities that promote efficiency, like decentralization of decision-making and teamwork are just as important.

138. The success of financial incentives requires that a number of conditions are met: a clear definition of the objectives pursued; design of the mechanism which includes explicit, measurable and transparent criteria of allocation of benefits to the eligible organizations and of distribution among the different categories of workers; involvement of stakeholders in the design phase to ensure their endorsement; good planning of implementation and availability of needed technical capacity; and monitoring of results and adjustment as needed.

139. An evaluation of experience of introducing performance-based financing and remuneration in the Democratic Republic of Congo, supported by the Bank shows that it had positive effects on health workers' behaviors but had not led to increased demand for services.[41] This suggests that it is of prime importance that the populations served by ESSPs must also be informed of the existence and of the functioning of the mechanism.

2.2 Improving accountability mechanism through the development of the main annual quality assessment (*concours qualité*) and the establishment of a comprehensive GRM

140. A spate of research in health policy and management suggests that governance arrangements at multiple levels have an important effect on the quality of health care, including accountability mechanisms at the facility itself. In 2007, the MoH launched the first round of its main quality assessment tool (*concours qualité*) to improve the quality of care of public hospitals and primary care facilities. *Concours qualité* consists of competitions between health facilities to achieve the highest level of quality of care. Based on the logic that competition and recognition of good work motivate people to seek improvement, the *concours qualité* is designed to promote the upgrading of care among participating facilities. The process entails a self-assessment, in which staff at participating health centers fill out standardized questionnaires that measure a range of quality indicators, as well as an audit by peers. The heads of provincial delegations currently select centers which participate, based on the motivation of the team, their openness to change and willingness to adopt new procedures, and their prospects for winning. In return for enrolling in *concours qualité* and highlighting their strengths and weaknesses in a transparent manner, employees have greater access to supplemental training programs and health centers may become eligible to receive new equipment or even to receive funds for renovation.

[41] Huillery E., Seban J., Pay-for-Performance, Motivation and Final Output in the Health Sector: Experimental Evidence from the Democratic Republic of Congo (http://www.bsg.ox.ac.uk/sites/blavatnik/files/documents/paper_DRC_April2014.pdf).

141. A qualitative study was recently conducted by the World Bank to explore the linkages between governance arrangements at multiple levels and the quality of healthcare. About half of the selected facilities had participated in *concours qualité* at least once. The study revealed substantial variation in the quality of care. A consistent array of factors were observed at facilities that performed well, including larger patient loads, reasonable wait times despite high demand, good management and availability of stocks, consumables, and equipment, and detailed and regular maintenance of patient medical records, among other factors. In particular, the vaccines and other medications are stored properly and carefully, the pharmacy is well managed and stocked, and all personnel follow the proper protocols for disposing of medical waste; medical staff keeps consistent medical records, abide by clear procedures for storing and restocking medications and consumables, and keep careful records related to the upkeep, repair, and replacement of equipment; clever ways to ensure that patients form lines when waiting for services to avoid crowding.[42] Staff members claim that the adoption of these procedures led to reduced wait times and improved monitoring of patient health status.

142. The study suggests five factors that are associated with improvements in the quality of healthcare at Moroccan primary health care centers, including participation in *concours qualité*.[43] The comparison of facilities that had and had not previously competed in the national *concours qualité* demonstrated that the program has a clear, positive effect on the management and administration of participating health centers. The mere act of enrolling in the program generates transfer of knowledge and procedures to the managers of health centers. The head doctors and nurses of all participating health centers unanimously attested that the adoption of systematic procedures for maintaining medical records, monitoring stocks of medications, consumables and equipment, and tracking vaccinations and other health campaigns in the community were developed in preparation for the competition and maintained thereafter. As a result, participating centers maintained better systems of record keeping, managing stocks and equipment, and disposing of medical waste. Staff members also attested that these changes resulted in better tracking of patient health status and reduced wait times. Senior staff members of facilities participating in the program now subscribe to a set of management principles based on teamwork, openness to innovation, and continuous quality improvement, and are more open to pursuing partnership to improve access to medical care in their communities (see Box 1 for specific testimonies).

[42] For example, at a center in a small provincial town, the management devised a small window near the exit of the facility dispenses medications prescribed to patients. To access the window, patients must pass through a corridor created by a half-wall which was designed to accommodate one wheelchair and no more than one person at a time. The center is in the process of constructing a similar structure so that patients line up single file outside the facility while waiting to enter during the morning rush. At a center in another provincial city, a nurse stationed at the entrance greets patients and issues them colored tickets that correspond with color-coded signs indicating the different departments in the facility. The system ensures that illiterate patients know where to go even if they cannot read the signs posted in the center.

[43] The four other factors are as follows: (i) strong leadership, i.e. dynamic, energetic and visionary head doctors; (ii) team spirit, i.e. a sense of a shared mission and collaborative ethic and regular meetings such as staff meetings and training workshops for all the staff; (iii) effective coordination with local and regional services from the MoH that helps ensuring that stock-outs of medications and equipment do not occur, that facilities receive needed resources when available, and that local innovations are developed for local problems; (iv) partnerships and community relations that encourage openness in the community to health promoting practices which might otherwise be viewed as violations of culturally conservative norms.

Box 1. Testimonies about the positive impact of participation of primary healthcare facilities in *concours qualité*

When asked what changed in her health center after participation in *concours qualité*, the head doctor of a center in a semi-urban area claimed that wait times plunged, regular staff meetings were institutionalized, more management and administrative protocols were introduced, posters informing patients of the center's policies and providing information on the importance of good health were displayed around the facility, and sanitary procedures were greatly enhanced, potentially reducing infection rates. The head doctor at another semi-urban center noted that participation in *concours qualité* greatly improved relations among staff members, who now share a team spirit. The competition inherent in the *concours qualité* process also encouraged her staff members to adopt and adhere to many administrative changes. In particular, she noted that the stocking and storing procedures for medications have improved substantially after participating in *concours qualité*. At another health center in a provincial town, the head doctor emphasized that everything is far more structured and organized at her center after it enrolled in *concours qualité* while the staff members feel more valued. She noted that dynamism and will already existed among staff members but they subsequently learned about specific procedures and systems to improve the operation of the center. "We wanted to work but didn't know how," said the head doctor.

These observations from centers that participated in the *concours qualité* contrast sharply from those provided by staff at facilities that did not enroll in the program. For example, in a semi-rural facility, basic sanitary practices were deficient and the examination rooms did not have separate medical waste containers. At another non-participating facility in a small provincial town, the medical staff could not report on the system for managing drug stocks and were bewildered when asked to report on the management procedures used in the facility.

143. The clear positive impact of *concours qualité* is testament to the value of the program. However, the program currently confronts a sustainability issue on the one hand and the limited participation at the primary healthcare level. Participating in *concours qualité* requires committing the time to prepare for the competition while meeting the needs of a heavy patient load. Also, participating centers attract more and more patients, even from beyond their catchment areas, as news of their improved quality of care travels. As a result, high performing centers may face heavier strains on their material and human capital than other health centers or than they experienced prior to enrollment in the program. As a consequence, there is a high annual turnover of primary health care centers. In addition, the number of primary healthcare centers that participate in *concours qualité* is limited, particularly in rural areas. In 2013, nine percent of primary healthcare centers participated in *concours qualité*, and 4 percent of rural centers, compared to 22 percent of urban centers.

144. As a consequence, the MoH is aiming at gradually universalizing participation in *concours qualité* of primary health care centers, in particular in rural areas. As the tools (standardized questionnaires and audits) are adapted to the biggest facilities instead of the smallest ones (dispensaries, health centers without delivery services), the rollout of the program will mainly focus on rural CSCAs during the 2015-2018 (see Table 13 below).

Table 13. Participation rates in concours qualité

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Participation rate of CSCAs	14%	20%	25%	40%	60%	85%
Number of participating CSCAs	55	80	99	160	240	337
Participation rate of primary health care centers	9%	12%	14%	20%	27%	34%
Number of participating primary health care centers	255	330	399	560	740	937

145. The Government's program to improve accountability in the health sector also includes the establishment of a comprehensive GRM. For now, the Ministry of Health has several mechanisms to collect grievances: (i) a newly established Division within the *Inspection générale* staffed by four professionals; (ii) a hotline (*Cellule d'écoute*) which is directly attached to the Secretary-General's office which is currently staffed by four telephone operators who have received training on how to respond to phone calls and register the complaints received on Excel sheets but do not have procedures on how to analyze and respond to the complaints; (iii) at the decentralized level, there are multiple informal channels of complaints (e.g., directly at the facilities or to regional officials from the MoH and other departments, including the Ministry of Interior). The MoH will develop an effective GRM easily accessible to women, poor and marginalized communities, including through the revival of the national hotline. To do so, the MoH plans to: (i) clarify the institutional structure, roles and responsibilities in order to streamline the GRM; (ii) develop a preliminary Implementation Manual to guide the process of addressing grievances, including through a technical workshop with key MoH staff and other departments' staff at the central level, as well regional staff and facility staff; (iii) pilot the new GRM for one year; (iv) review the Implementation Manual; and (v) roll out the GRM. These measures will take into account the national policy (inter-ministerial decree) for handling complaints and will include procurement and fiduciary complaints handling systems.

2.3 Developing an integrated, computerized and accessible HMIS

146. The Morocco 10-year HMIS flexible strategy and budget were developed with the support of the World Bank team. They include on the technological solution side, the following modules: reporting; facility management; patient management (patient electronic records); referral; quality assessment; and provincial/regional/central data analysis and reporting systems, as well as the central data warehouse. However, HMIS reform is one of governance and a technological solution alone is often unsuccessful if it does not address the underlying political economy and behavioral factors: those influencing the successful introduction of a health management system include objectives, planning and strategy, stakeholders roles and responsibilities, social and cultural aspects, technology, human capacity development, participation and awareness and financial aspects and sustainability.[44,45]

147. The Government program addresses these factors. A year of preliminary work will be done to map the current and target HMIS architecture, including the governance structure under planned reforms. Another year will further be taken to complete a data model, data dictionary and coding standards.

[44] Chetley, A. (2006), Improving health, connecting people: the role of ICT in the health sectors of developing countries a framework paper. *InfoDev*, 31 May 2006.

[45] Kyu Kim, K, Michelman, E., (1990). An Examination of Factors for the Strategic Use of Information Systems in the Healthcare Industry. *MIS Quarterly*, Vol. 14, No. 2. (June 1990), pp. 201-215.

148. Overall, the focus is on: (a) putting in place a flexible infrastructure responsive to technological changes and reforms of the future; (b) interoperability of systems; (c) defining the national information management strategy and measurement and evaluation system, building consensus (with all stakeholders, and specifically with health workers) around strategies and reforms, and building the system to respond to those needs; and (d) focusing on the use of HMIS to increase transparency, make data available across the system including to the population, create mechanisms to engender voice and population feedback, decrease inequities, and improve the quality of services delivered.

c. Institutional Arrangements and Capacity

149. The two most critical stakeholders involved in the proposed Program are the MoH and the MoF. In the context of the proposed Program, the MoH is responsible for the implementation of the health sector reform according to priorities and directions defined in the strategic documents. The MoF will provide political and budget support to the MoH in implementing the program and receive the transfers linked to the achieved DLIs. The MoH is also responsible for implementing reforms that will achieve the results targeted by the proposed Program.

150. The Ministry of General Affairs and Governance (MAGG) will ensure coordination between the MoH and other departments, including the Ministry of Finance, a role that MAGG has been playing satisfactorily for other World Bank operations.

151. Within the MoH, Program implementation will be coordinated by DPRF under the supervision of the General Secretary who has been closely involved in the preparation phase. The following Directions (departments) will be involved at the central level. Under component 1, DP is responsible for the implementation of the MCH plan and the mobile team plan, together with the DHSA. The DELM will be responsible for the implementation of the NCD sub-program. Under component 2, the DRH will be responsible for preparing incentive measures for the HRH. The introduction of any financial incentives would require the approval of the MoF and the Ministry of Civil Service and Public Management Modernization, as well as the Government General Secretariat for any associated legal revisions. DHSA will be responsible for the development of quality assessments at the primary health care facility level, in particular through its Quality Service (*Cellule qualité*), which is responsible for the organization of *concours qualité* every year. *Secrétariat général* will be responsible for the establishment of a comprehensive GRM. Two MoH departments are principally involved in project implementation under the HMIS component: DPRF and the DIM. The DPRF will be leading the overall strategy and coordination with key stakeholders whereas the DIM will lead the technical components, program design and implementation. Two committees have been formed to oversee the implementation of the Program: (1) a steering committee, chaired by the Secretary General, and composed of the directors of each of the MoH departments; and (2) a technical committee, chaired by the director of DPRF, and composed of representatives of each of the relevant MoH departments.

152. The program will also involve the services at the local levels. This includes the regional[46] and provincial directorates; provincial out-patient care infrastructure departments (provincial out-patient care infrastructure departments*, services d'infrastructures d'actions ambulatoires provinciaux*, SIAAP) in charge of coordinating health activities at the provincial level, and health facilities.

[46] The 16 regional directorates in the country are responsible for the implementation of the national health policy at the regional level. Their tasks include: (i) public health protection and health surveillance; (ii) strategic planning; (iii) financing and financial management; (iv) human resource management; (iv) control and coordination of the actions of healthcare facilities; (v) ensuring the availability, quality and accessibility of medicines and non-drug pharmaceuticals (Source : *Arrêté de la ministre de la santé n° 1363-11 du 16 mai 2011 relatif aux attributions et à l'organisation des services déconcentrés du ministère de la santé*)

153. Additional key institutions that will be involved in project implementation are: (a) health workers unions; (b) ANAM, which regulates insurance schemes; (c) the insurance schemes covering civil servants (CNOPS) and private sector employees (CNSS); (d) private insurers; and (e) civil society. Representatives of these departments/institutions will eventually be added to the HMIS steering committee, and will be regularly sensitized and consulted on planned reforms and their progress through workshops and retreats.

154. The MoH is highly committed to implementing this program (including the PAP) and appears to have the capacity to do so, given appropriate support in terms of financing and coordination.

155. In terms of fraud and corruption risks, the specific measures in the PAP should ensure that these issues are addressed during the implementation of the Program. Beyond this, the specific activities in the program related to governance and accountability, as well as the proposed "public portal" in the HMIS component, should help to improve transparency and reduce the opportunities for fraud and corruption.

B. Economic Analysis

Introduction

156. The economic analysis of the PforR project focuses on three key areas: (i) justification for public sector provision; (ii) the project's development impact; and (iii) the World Bank's comparative advantage and value added.

157. The proposed project has two components: (a) supporting primary care in rural areas; and (b) strengthening governance. The second component is also principally focused on primary health. This focus is strongly aligned with the World Bank Group's strategic goals of ending poverty and boosting shared prosperity in a sustainable manner and furthermore aligned with the HNP Global Practice's orientation towards Universal Health Coverage – to ensure that all Moroccans obtain the health services they need without suffering financial hardship when paying for them.

158. Aggregate health indicators mask important inequalities in Morocco, particularly between rural and urban areas. These inequalities mirror, and are intrinsically linked to, inequalities in economic development. For example, while the maternal mortality ratio (MMR) has declined from 332 to 112 deaths per 100,000 live births between 1997 and 2010, the rural MMR (148 deaths per 100,000 live births) remains double that in urban areas (73 deaths per 100,000 live births). Similarly, while the infant mortality rate declined from 82.4 to 28.8 deaths per 1,000 live births from 1992 to 2011, it remained at 35 in rural areas compared to 25.4 in urban. The observations mirror economic development: while the proportion of the population in absolute poverty[47] dropped from 15.3 percent to 9 percent between 2001 and 2007, about 8 million people (a quarter of the population) continue to face either absolute or near poverty and the absolute poverty rate in urban areas was 4.8 percent, compared to 14.5 percent in rural areas.[48]

159. The proposed Program components provide a set of activities to improve quality and efficiency in primary care as well as improving management and policy-making capacity at all levels of the system. The rationale for public intervention and the focus on rural primary care is demonstrated by the current inequities in health outcomes between urban and rural areas, which are matched my inequalities in the

[47] Measured by poverty headcount ratio at national poverty line (% of population).
[48] World Bank, 2012. Country Partnership Strategy Progress Report. World Bank, Washington, DC.

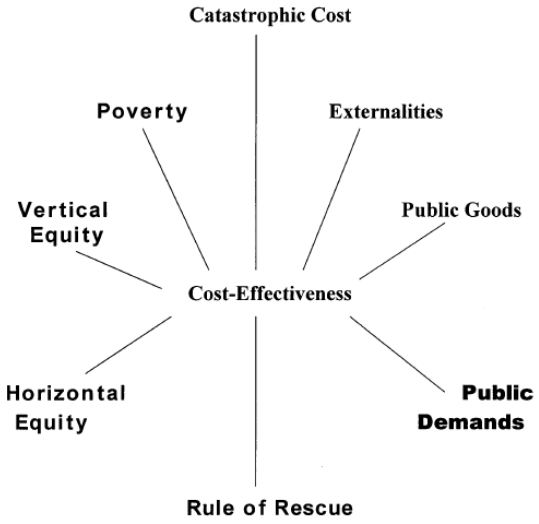
distribution and availability of health services. While a quarter of Moroccans do not seek medical care when ill, this proportion increases up to a third in rural areas; in rural areas, only half of the deliveries were attended by qualified medical staff, while in urban areas this proportion was 92 percent. Overall, yearly per capita heath seeking is 0.6 nationally and only 0.36 in rural areas (compared to the minimum of 1.0 as recommended by WHO) and the poorest account for only 18 percent, 13 percent, and 11 percent of dispensary, health center and hospital patients, respectively.[49] While addressing disparities is an issue of social justice, there are considerable economic benefits as well, at both the individual level, through impacting productivity, employment, and OOP expenditures and at the population level, through impacts on costs to governments and business.

160. The new Constitution in Morocco adopts an institutional model based on the principles of the separation, balance, and complementarity of powers, and provides a framework for good governance and the protection of human rights. The government Program in the health sector, partially supported by this *PforR* is an important component of promoting opportunities for sustainable and inclusive growth through efficient and appropriate provision of basic services to the population and promotion of good governance.[50]

Public Sector Justification

161. Market failures in the health sector and the case for public intervention and financing have been well established starting as far back as 1965 with Kalarman's[51] analysis. There are at least nine criteria related to public intervention in the health sector[52]: economic efficiency criteria (public goods, externalities, catastrophic cost, and cost-effectiveness), ethical reasons (poverty, horizontal and vertical equity, and the rule of rescue), and political considerations (especially demands by the populace) (Figure 7).

Figure 7: Nine criteria for public intervention in the health sector



[49] World Bank, 2013. Public Expenditure Review: Morocco. World Bank, Rabat.
[50] World Bank, 2013. CPS proposed framework. http://www.worldbank.org/content/dam/Worldbank/document/MNA/CPS_proposed_framework_EN.pdf
[51] 1. Klarman HA. (1965). The case for public intervention in financing health and medical services. Med Care.;3:59–62.
[52] Philip Musgrove (1999). Public spending on health care: how are different criteria related? Health Policy 47 207–223

Source: Musgrove Health Policy 47 (1999) 207–223

162. In the case of Morocco and project components, all criteria apply. Equity is perhaps the most important consideration with high urban-rural differences in key health outcomes. Related is the issue of poverty. The market is not able to deal with these issues effectively, and price mechanisms to address access and coverage of the rural poor or to impact important preventive measures related to NCDs are not realistic; public intervention is needed to deal with large variable costs related to differences in concentration of health providers across Morocco. Catastrophic cost is additionally important with over 50% of health care costs in Morocco financed out-of-pocket. There are important externalities of improving health and reducing disparities in health, for example economic impacts discussed below which are not considered in the market price of health provision. Finally, the issue of public demand is important, with high expectations created among the population following inclusion of the right to health in the constitution and expansion of the RAMED regime.

163. The project will address rural health through focus on MCH and NCDs and reaching remote populations with mobile health teams. Project components to improve the quality of public facilities through the quality assessment as well as the scheme to improve health worker productivity through the incentivization scheme are both, by definition, public sector interventions. Finally, the HMIS technical work and system definition are public sector goods, with input from all stakeholders. However, the system itself will be open to development by the private sector.

Health and Economic Development

164. Improving equitable access to primary health in rural areas, through the three subcomponents– the maternal, newborn and child health (MNCH) acceleration plan; mobile health; and non-communicable diseases – impacts directly on health status and health spending through mechanisms described below. Governance, through the three sub-components – accountability; human resources; and HMIS – impacts health and health spending indirectly as well as potentially improving economic outcomes through increased government efficiency.

165. Improved health directly impacts income at national or household levels through the costs associated with detecting and treating illnesses as well as mitigating negative impacts on workforce and decreasing productivity. Changing health status and demographics may have other behavioral effects such as changing the incentives to innovate or to use current innovations if the value of labor is changing due to these factors. While estimates of the size of the positive effect of health on economic development range from almost none[53] to over 90 percent,[54] a reasonable estimate, based on the sum of the literature, is that health accounts for 20-30 percent of the variation in income across countries. Three principal mechanisms account for this variation: human capital effects, through both productivity and education; demographic effects; and savings and investment effects.

Human Capital Effects

166. *Direct effect of health on income through productivity.* Human capital is the set of knowledge and skills acquired throughout life that are used to produce goods, services and ideas, both inside and outside the labor market. Better health contributes to human capital and increases productivity directly by reducing incapacity, debility, and number of days lost to sick leave, and indirectly through its effect on education and cognitive development; healthy people are able to work harder, have more energy, are

[53] Acemoglu D., Johnson S., Robinson J. 2002. Disease and Development in Historical Perspective. Journal of the European Economic Association Papers and Proceedings, v.1, 397-405
[54] Lorentzen P., McMillan J., Wacziarg R. 2005. Death and Development. NBER Working Paper Series. Working Paper 11620.

more physically robust and earn a higher return in the labor market. Declining health, especially in the older ages may induce early retirement and skilled, experienced workers leaving the labor force. This effect may be conceptualized by including health into the Mincer wage equation and estimating the system as a three equation model. Equation 1 shows that health is a function of health and other inputs and exogenous factors. Equation 2 shows that health inputs are a function of income, availability of health inputs. Equation 3 shows that income is a function of health education and other factors. In this model the coefficient on health is the productivity of health, not the rate of return to health. We note that the health inputs (l) are endogenous.

$$H = h(l, g, e1) \quad \textbf{(1)}$$

$$l = d(X, W, g, e2) \quad \textbf{(2)}$$

$$W = w(H, E, Z, e3) \quad \textbf{(3)}$$

Where H = health; l = health inputs; g = exogenous health factors; W = wage (income); X = availability of inputs; Z = covariates on income; E = education; e = error

167. *Indirect effect of health on income through education.* A longer life-span means a longer horizon over which to recuperate investments in education. Lower mortality implies a higher rate of return to education, increasing incentives to invest in education of each child. Decreases in child mortality are associated with decreased fertility which may be mediated through a quality-quantity tradeoff, whereby families have fewer children and invest more in each. The net present value of earning is given in equation 4. Absent from the model is that students who are healthier may have a higher quality of schooling due to improved cognitive uptake, do better in school, and have higher rates of attendance.

$$V(s) = w_S \int_s^n e^{-rt} dt = w_S \frac{e^{-rs} - e^{-rn}}{r} \quad \textbf{(4)}$$

Where s = length of schooling; n =retirement age; Ws =wages; r = discount rate

Age-structure effects

168. Changing health and mortality can indirectly affect income through changing the age structure of a population. Declines in mortality spurs the demographic transition, where declining mortality followed by subsequent declining fertility creates a population "bulge" which then moves across the age groups creating the "demographic dividend" which is a period of time where the dependency ratio (ratio of dependents to working age population) is very low. This influx of working-age people into the population may be a boon for a country's economy and lead to an increase in income. The effect of the age-structure on income may work through both pure accounting and behavioral effects. Accounting and behavioral effects as related to savings are discussed in detail below. Improved health should reduce both the dependency ratio by reducing mortality among economically active and premature retirement resulting from illness. The effect of age structure on income is shown in equation 5 where income per capita is a function of the traditional measure of output per worker, participation rate effects and the age structure effect. It is important to note that demographic effects do not happen automatically but appear to be dependent on the policy, education, and the institutional environment in which they take place.

$$\frac{Y}{N} = \frac{Y}{L}\frac{L}{WA}\frac{WA}{N} \quad \textbf{(5)}$$

Where Y = Income; N = Population Size; L = Workers; WA = Working age population

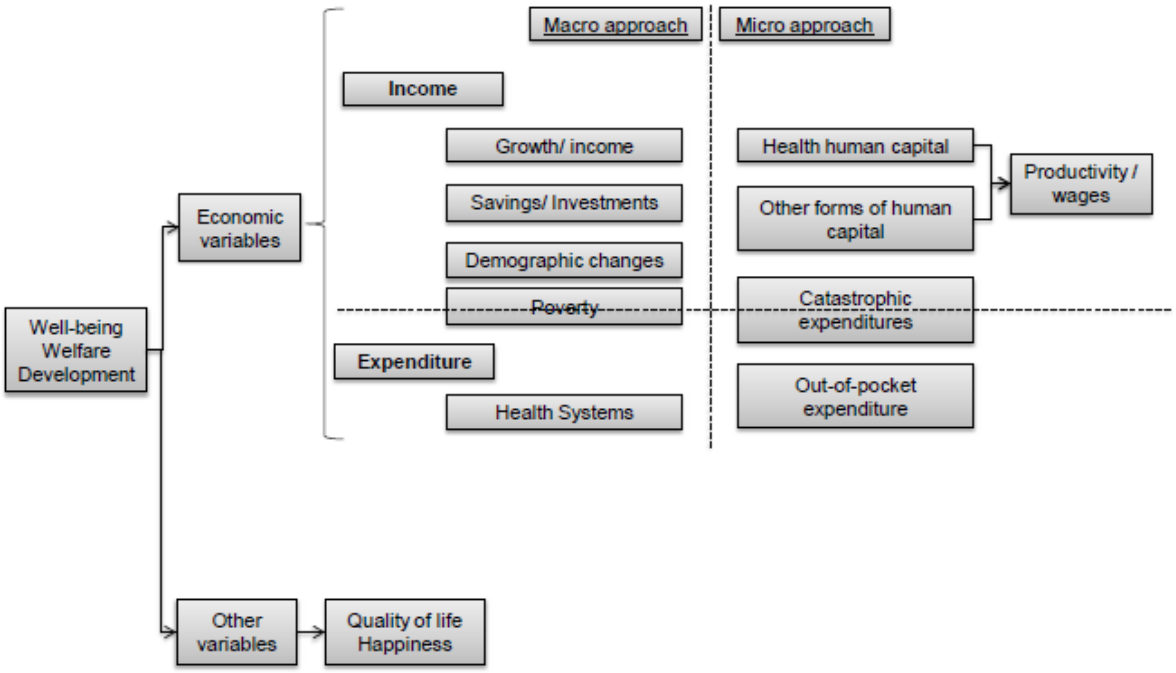
Savings (Investment) Effects

169. Standard econometric theory holds that individuals will borrow at younger ages, save through the middle ages and spend these savings after retirement. A longer life-span, given a fixed retirement rate and ignoring bequests, means a longer horizon over which to recoup investments and savings and should increase saving behavior. The effect of increasing life expectancy is to create a temporary savings boom where, due to the resulting capital stock accumulation, the county settles at a new, higher equilibrium. Savings differ at different ages, peaking between 40 and 60. Demographic effects can temporarily increase the number of people in the prime saving years in a population. How health changes with increased life expectancy is very important for this model. Compression or expansion of morbidity may affect retirement decisions and impact savings rates. This raises questions of participation versus savings; staying in the work force longer reduces incentives to save. Furthermore, increased income should reduce the marginal utility of consumption and favor an increase in leisure thus reducing productivity. At the macro level, the presence of institutions, pensions, social security, health insurance are very important mediators of savings behavior and how it is affected by changes in life expectancy and health status.

Analytic Framework

170. The impact of health on economic outcomes can be measured through the impact on income or expenditure and at both the micro and macro levels (Figure 8).

Figure 8: Analytic framework to assess the economic impact of health



Source: Health Effects of Econ Develop: Evidence from developing countries. World Bank 2014

Component-Specific Impacts

1.1 Reduction of maternal, neonatal, and child mortality

171. RMNCH is fundamental to development, which is reflected in Millennium Development Goals 4 (reducing child mortality) and 5 (improving maternal health and achieving universal access to reproductive health). The Government Acceleration plan has 20 sub-components, including those related to facility deliveries and skilled birth attendance; antenatal care; post-natal care; vaccinations; family planning; nutrition; and MNCH service delivery. The project component covers nine regions, which comprise 1,858 health centers, out of which 1,482 are rural and 374 have birthing centers; a population of 18.9 million people, out of which 10.4 live in rural areas; and 395,000 expected births out of which 242,000 will be to rural women (Table 14).

Table 14. Nine Target Regions - MNCH Acceleration Plan

Region	Urban				Rural				
	CSUA	CSU	Pop. ('000)	Births	CSCA	CSC	DR	Pop. ('000)	Births
Meknes-Tafilalet	13	55	1,333	22,398	41	63	90	905	21,320
Tadla-Azilal	5	18	572	10,912	29	42	74	919	20,835
Taza-Al Hoceima-Taounate	9	19	464	8,068	44	74	80	1,386	29,866
Souss-Massa-Darâa Agadir-Ida Outanane	19	37	1,504	26,830	66	144	135	1,872	45,425
Marrakech-Tensift-El Haouz	13	56	1,395	24,428	52	143	96	1,877	45,794
Doukkala-Abda	5	29	776	15,077	20	57	15	1,278	27,447
El Gharb-Chrarda-Bni Hssen	5	29	880	15,793	15	35	29	1,087	24,236
Tanger-Tetouan	4	60	1,629	29,665	34	63	41	1,071	27,209
Total	**73**	**303**	**8,553**	**153,171**	**301**	**621**	**560**	**10,395**	**242,132**

Source: MoH, Santé en Chiffres 2010

172. Over 90 percent of maternal deaths in Morocco are preventable: over one third of all maternal deaths occurred either at home or during delayed transfer to the hospital. Emergency obstetric and neonatal care was provided only in less than 30 percent of the deliveries, while about 86 percent of the audited maternal deaths were post-partum.[55] Similarly, pneumonia, diarrhea, and malaria, accounted for 43 percent and malnutrition contributes to one-third of the under-five deaths. A third of stillborn deaths in developing countries occur during birth, mainly due to maternal conditions such as hypertension and obstructed labor but also partly reflecting poor quality of care and management.[56] Neonatal mortality is increasingly concerning: the proportion of under-5 deaths occurring during the neonatal period is increasing even as under-five mortality declines.[57]

[55] MoH, 2012a. *Etat de santé de la population Marocaine*.
[56] Partnership for Maternal, Newborn and Child Health. 2010. "Knowledge Summary: Prioritize Proven Interventions." http://portal.pmnch.org/downloads/high/Knowledge_for_Action_KS4_highres.pdf.
[57] UN Inter-agency Group for Child Mortality Estimation. 2011. "Levels & Trends in Child Mortality." Report 2011. New York: UNICEF.

173. A recent review of 170 countries found a bi-directional relationship between maternal mortality and economic growth in 68 (40 percent) of countries, including Morocco, and a one-way relationships from maternal mortality to GDP in 50 countries (29 percent).[58] The Project's focus on facility deliveries and skilled birth attendance, as well as antenatal care, has the potential to impact maternal mortality.[59] Reducing the rural-urban MMR gap by a modest 10 percent to urban would save the lives of 70 mothers per year, highly cost effective given that the entire investment budget of the MCH program for 2015 is projected to be US$12.2 million.[60] One study found that the most effective strategy to reduce maternal mortality was increasing coverage of family planning, assuring access to safe abortion for all women desiring elective termination of pregnancy and enhanced access to comprehensive emergency obstetric care for women requiring referral. Mortality was reduced by 75 percent and the strategy had an incremental cost-effectiveness ratio of US$300 per DALY relative to the next best strategy. [61] Another study in India similarly found that increasing family planning was the most effective individual intervention to reduce pregnancy-related mortality and that if in a 5-year period, the unmet need for spacing and limiting births was met, more than 150,000 maternal deaths would be prevented; more than US$1 billion saved; and at least one of every two abortion-related deaths averted.[62]

174. A recent review of 180 [63] countries found a bi-directional relationship between under-five mortality and economic growth in 105 (58 percent) countries, including Morocco, and a one-way relationship in 49 countries (27 percent). Morocco was among countries with the "exceptionally high efficiency" in data envelopment analysis, indicating the larger effect a reduction in mortality will have on GDP. Vaccinations in the first two years of life are linked to later physical and cognitive development (measured by verbal reasoning, math, and language tests) in children; full childhood vaccination for measles, polio, tuberculosis, and diphtheria/pertussis/tetanus significantly increased cognitive test scores relative to children who were not vaccinated (better test scores, on average, by about half a standard deviation).[64] Increasing vaccination rates in rural areas are all highly cost effective. For example, the cost per DALY averted with the traditional "Expanded Program on Immunization" vaccines ranges from US$7 to US$438 and the cost per death averted ranges from US$205 in South Asia and sub-Saharan Africa to US$3,540 in Europe and Central Asia.[65] Furthermore, childhood health has a quantitatively large effect on family income, household wealth, individual earnings and labor supply during adulthood and these estimated effects are larger when unobserved family effects are controlled for.[66]

175. Indices of maternal and child malnutrition (maternal height, birth weight, intrauterine growth restriction, and weight) were related to adult outcomes (height, schooling, income or assets, offspring birth weight, body-mass index, glucose concentrations, blood pressure).[67] Undernutrition is strongly

[58] Amiri & Gerdtham. Impact of Maternal and Child Health on Economic Growth: New Evidence Based Granger Causality and DEA Analysis. March 2013.

[59] Moyer CA et al. Facility-based delivery and maternal and early neonatal mortality in sub-Saharan Africa: a regional review of the literature. Afr J Reprod Health. 2013 Sep;17(3):30-43.

[60] Viscusi, Kip; Joseph E. Aldy (2003). "The Value of a Statistical Life: A Critical Review of Market Estimates throughout the World". Journal of risk and uncertainty 27 (1): 5–76.

[61] Hu et al (2007) - The Costs, Benefits, and Cost-Effectiveness of Interventions to Reduce Maternal Morbidity and Mortality in Mexico.

[62] Goldie et. al (2010) – Alternative Strategies to reduce Maternal Mortality in India: A Cost-Effectiveness Analysis.

[63] Amiri & Gerdtham. Impact of Maternal and Child Health on Economic Growth: New Evidence Based Granger Causality and DEA Analysis. March 2013.

[64] Bloom, D. E., Canning, D., & Shenoy, E. S. (2012). The effect of vaccination on children's physical and cognitive development in the Philippines. Applied Economics, 44(21).

[65] Brenzel L, et al. Vaccine-Preventable Disease. In: Jamison DT, Breman JG et al, editors. Disease Control Priorities in Developing Countries. 2nd edition. New York: Oxford University Press; 2006. P. 389-412.

[66] Smith (2009) – The impact of childhood health on adult labor market outcomes.

[67] Victora et al (2008) – Maternal and child undernutrition: consequences for adult health and human capital.

associated, with shorter adult height, less schooling, reduced economic productivity[68] and better nutrition has been found to increase average wages by 46 percent. Substantial improvement in adult human capital and economic productivity resulting from improved nutrition provides a powerful argument for supporting the government program to improve nutrition in pregnant women and young children.

176. Over four years, it is projected that the project will result in 24,778 additional antenatal care visits and 20,983 additional facility deliveries over what would have been expected based on continuation of current trends (Table 15).

Table 15: Projected impact of PforR on antenatal care and facility deliveries in rural areas

	DLI1- ANC			DLI2- Deliveries		
Year	Base	Projet	Difference	Base	Projet	Difference
2014	206,000	206,000	0	234,000	234,000	0
2015	205,216	208,000	2,784	235,436	238,000	2,564
2016	206,191	210,500	4,309	238,112	242,000	3,888
2017	206,907	214,000	7,093	240,323	246,000	5,677
2018	207,408	218,000	10,592	242,146	251,000	8,854
			24,778			20,983

1.2 Strengthening the Detection and Management of Non-Communicable Diseases

177. The Government program focuses on prevention, detection and treatment of diabetes, hypertension, CVD, and breast and uterine cancers. Morocco is in the midst of a demographic and epidemiological transition with a rapid transition from communicable to chronic conditions, with important cost implications for the health sector. NCDs are the leading cause of death, accounting for 75 percent of all deaths in Morocco, and diabetes is the leading cause of morbidity (followed by preterm birth complications and ischemic heart disease). In 2010, the global cost of CVD is estimated at US$863 billion (an average per capita cost of US$ 125), and it is estimated to rise to US$1,044 billion in 2030 – an increase of 22 percent. Overall, the cost for CVD could be as high as US$20 trillion over the 20-year period (an average per capita cost of nearly US$3,000). Currently about US$474 billion (55 percent) is due to direct healthcare costs and the remaining 45 percent to productivity loss from disability or premature death, or time loss from work because of illness or the need to seek care. The number of new cancer cases in 2009 was 12.9 million, and the 13.3 million new cases of cancer in 2010 were estimated to cost US$290 billion. Medical costs accounted for the greatest share at US$154 billion (53 percent of the total), while non-medical costs and income losses accounted for US$67 billion, and US$69 billion, respectively. The total costs were expected to rise to US$458 billion in the year 2030. People with diabetes lose eight percent of potential work time in low- and middle-income countries and diabetes cost the global economy nearly US$500 billion in 2010, a figure that is projected to rise to at least US$745 billion in 2030, with developing countries increasingly taking on a much greater share of the outlays.[69]

[68] Hoddinott et al (2008) – Effect of a nutrition intervention during early childhood on economic productivity in Guatemalan adults.

[69] Bloom et al. The global economic burden of non-communicable diseases. World Economic Forum 2011.

178. Appropriately shifting care from hospitals to lower cost settings through strengthening primary care, the primary prevention of NCDs, and strengthening the referral system, will be of paramount importance to the sustainability of financing in the health sector in the medium and long term in Morocco. NCDS are projected to cost four percent of GDP in lower and middle income countries and in lower middle income countries, the cumulative loss to diabetes, cardiovascular disease and respiratory infection alone is estimated to be US$1.6 trillion between 2015 and 2025; in Morocco topping US$50 per person per year.[70] Overall, chronic illnesses reduce wages of workers, and limit productivity, with a higher impact on workers with lower incomes.[71] A recent World Bank study indicated that more than half of all patients (54 percent) that received care in Moroccan hospitals directly used these services without a prior referral.[72] Given that CHUs alone are 19 percent of the total health budget, engendering use of primary care and the gatekeeping functions of primary care physicians has potential for considerable economic impact.

1.3 Strengthening the Mobile Health Strategy

179. A key component of reducing inequalities and improving health of rural populations in Morocco is access to health services for remote populations. The outreach strategy supports mobile teams from primary health centers that target these populations. In terms of economic impact, the effect is as described above for RMNCH and NCDs since the task of the mobile teams is to provide vaccinations, refer at-risk pregnancies, encourage facility deliveries, provide nutrition counselling, and treat sick children. Research shows that increasing coverage through outreach is an important component of improving health and that effectiveness of activities is dependent on other governance factor including regular supportive supervision and monitoring and availability of external financial and technical support.[73]

[70] From Burden to Best Buys: Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries. World Economic Forum 2011.
[71] Rivera & Currais, 2005.
[72] World Bank, 2013b World Bank, 2013b. Public Expenditure Review: Morocco. World Bank, Rabat.
[73] Jacobs et al (2012) – Building on community outreach for childhood vaccination to deliver maternal and child health services in Laos: a feasibility assessment.

Figure 9. Impact of meeting DLI targets – reduction in urban: rural ratio in rural contact rate

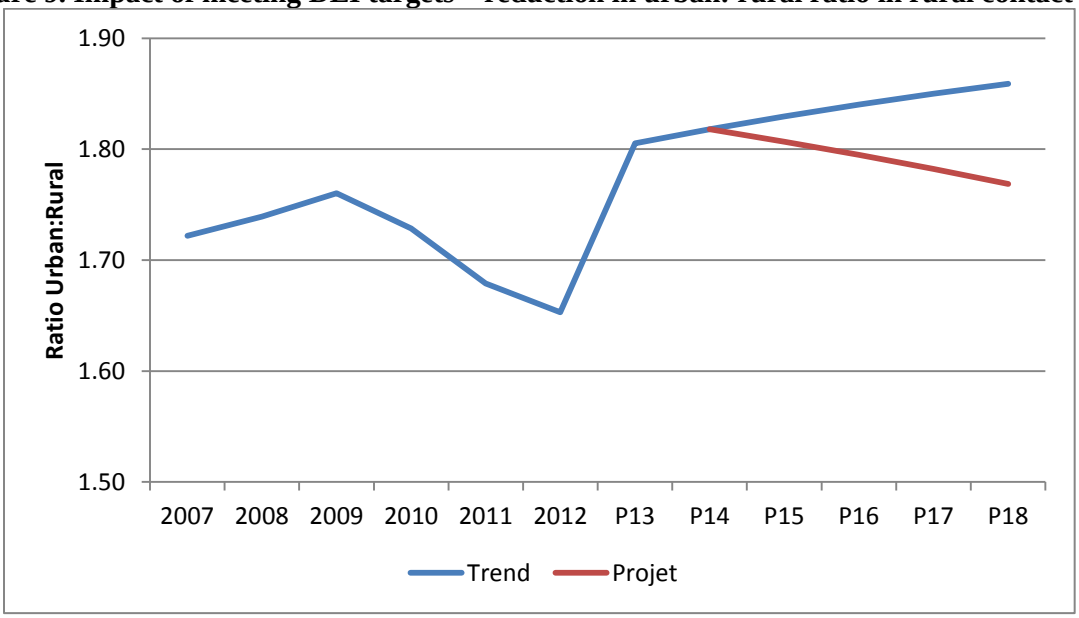
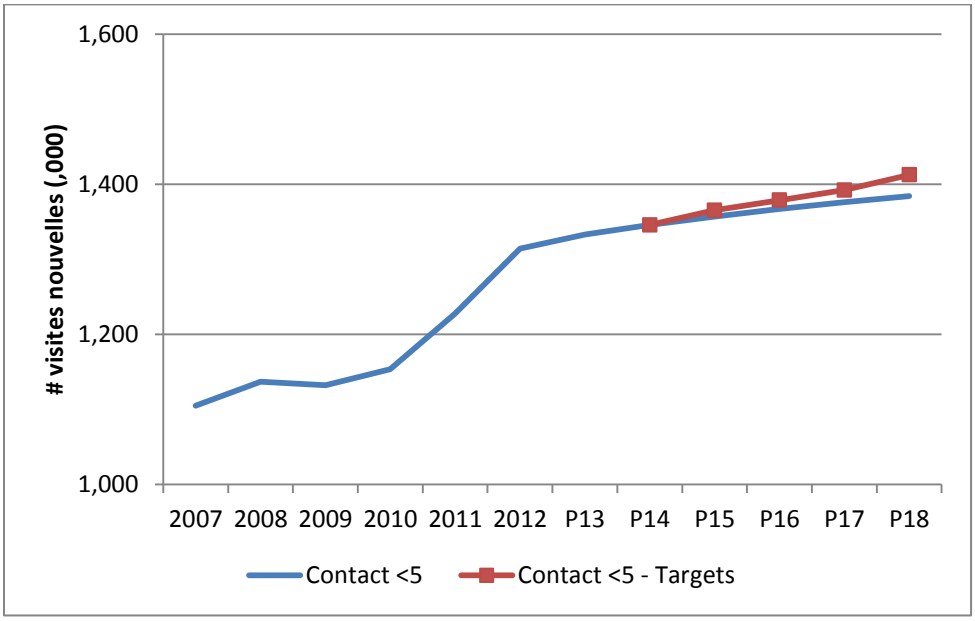


Figure 10. Impact of meeting DLI targets – new primary care visits for children <5



2.1 Preparing an incentive system to improve health worker performance

180. The principal issue of inequality in health outcomes, particularly between urban and rural areas, is linked in part to availability and quality of services. The average ratio of inhabitants per physician in Morocco is 2,107; this ratio is double in Taza al Hoceima Tounate region (4,201), while it is half in the Grand Casablanca area. Moreover, the ratio of inhabitants per nurse also varies greatly across regions,

from 2,147 in Greater Casablanca to 571 in Laâyoune-Boujdour-Sakia El Hamra.[74] Supporting the Government's decentralization program and strategy, for both getting and keeping health personnel in rural areas and for improving their performance through an incentivization system has the ultimate aim of addressing these inequalities.

181. The PforR will support the formulation of an incentive strategy for health personnel. Assessing the economic impact of this limited intervention is difficult. Nonetheless, one review of 48 studies[75] found that the following components (likely to be part of the devised strategy) had positive impacts linked to economic outcomes: (1) continuing education can improve knowledge, skills and performance of certain skills in the short term; (2) supervision improves drug stock management protocols and standard treatment guidelines; (3) payment of incentives can improve performance of a facility and can increase job satisfaction, staff motivation or patient satisfaction. For example, in Cambodia, payment of staff accompanied by other interventions, such as organizational changes, increased the average number of deliveries significantly from 319 to 585 per month and the average bed occupancy rate from 51 to 70 percent. Interventions on the effectiveness of inspection visits, selective punishments and the provision of regulatory documents on the practice of private pharmacies in Laos showed improved practices, such as an increase of 34 percent in the availability of essential dispensing material and of 19 percent in order in the pharmacy. In another review of 83 studies[76] training interventions decreased maternal mortality; HRH policies increased consultation rates and usage of different primary care treatments, also patient satisfaction rates increased, as well as bed occupancy and the number of outpatients. Overall some studies found partial or positive effects of incentives at individual physicians while incentives directed at provider groups reported partial or positive effects on quality measures, but most of the effect sizes were small and financial incentives at the payment system level had mixed results; a negative effect was adverse selection of patients when performance was paid.[77]

182. While the proposed intervention can improve health workers' performance in the pilot region, it is important to note that involvement of local authorities, communities and management; adaptation to the local situation; and active involvement of local staff to identify and implement solutions to problems are key components of effective interventions. Successful interventions are those that increase staff knowledge and skills and motivation. Mechanisms to contribute to motivation are health workers' awareness of local problems and staff empowerment, gaining acceptance of new information and creating a sense of belonging and respect in addition to improvements in quality of care and salary supplements.

2.2 Improving accountability through the development of the main annual quality assessment (concours qualité) and the establishment of a comprehensive GRM

183. The Government program envisages scaling up the *concours qualité* with additional incentivization for ESSPs for implementing the recommendations of the quality evaluation. There are a many studies that look at the impact of quality improvement, often for specific sets of conditions or through various mechanisms. Summary of the evidence from systematic reviews (812 Randomized

[74] Ministère de la Santé (MoH), 2009. National Health Accounts (NHA). MoH, Rabat.
[75] Dieleman et al (2009) – Human resource management interventions to improve health workers' performance in low and middle income countries: A realist view.
[76] Bhutta et al (2010) – Systematic Review on Human Resources for Health (HRH) Interventions to improve Maternal Health Outcomes.
[77] Lewin et al. (2008) – Supporting the delivery of cost-effective interventions in primary health-care systems in low-income and middle income countries: an overview of systematic reviews.

Controlled Trials, interrupted time-series studies controlled before-and-after assessments)[78] on the effects of governance, financial and delivery arrangements found that: (a) regulation can improve the quality of pharmacy services; (b) accreditation of pharmacy outlets can have no strong but some positive effect on the use of unregistered drugs, compared with non-accredited facilities; (c) the effects of franchising interventions on the quality of care, health care behaviors and client satisfaction are unclear and mixed; and (d) that the majority of the interventions are possibly more effective in poorer communities. Reviews on governance arrangements for primary health care, including decentralization of decision making, the regulation of training, or the control of corruption have not shown clear impact.

2.3 Developing an Integrated, Computerized and Accessible HMIS

184. The pricing of information and the usage of information technology infrastructure are challenging: information constitutes a factor of production which is difficult to isolate in the production function and/or measure in use. Many benefits of HMIS, particularly the long term benefits to population health are difficult, if not impossible, to quantify and to assign causally. Benefits include reduced administrative burden; increased efficiency gains from improved base information available to all stakeholders for planning, delivery, and financing; operational efficiency increases from increased speed and efficiency of a less paper-dependent systems; increased quality through reduction of errors and integrated patient management across facilities and the sector; and benefits of the availability of increasingly reliable population statistics. Other potential benefits such as the traceability of medications, reduced error rates, unnecessary treatment, use of information, facilitating reform towards more advanced provider payment systems to name a few are difficult to quantify. These measurement and methodological problems means that quantitative cost-benefit and cost-effectiveness analysis, which requires specifying alternative approaches to achieving comparable results, are usually not practical instruments for economic analysis of information systems projects in the health sector. Once the Government HMIS program has been costed, we propose a more modest calculation of the lifecycle costs and payback periods for technology and associated administrative costs calculated through return-on-investment calculations.

C. The World Bank's Added Value

185. The World Bank has a long engagement in the health sector, globally and in Morocco in particular. The WB has been supporting the GoM and MoH through technical assistance, including for planning and stakeholder consultations for health sector reform, universal health coverage (UHC) and for HMIS. Overall, in health, the World Bank's comparative advantage is in systems building and strengthening. The Bank's health sector strategy is focused on supporting countries to create health systems that deliver results for the poor and that are sustainable.[79] This includes leading in multisectoral action in health and functions related to financing, management, pharmaceuticals, human resources, and insurance in national health systems.

186. The Bank has important expertise in coordinating the complex set of interventions that comprise the Government's rural health plan. Overall, the PforR program will aim to strengthen existing Government systems and programs. The Bank has long been involved in MCH, with over 400 projects

[78] Lewin et al. (2008) – Supporting the delivery of cost-effective interventions in primary health-care systems in low-income and middle income countries: an overview of systematic review.

[79] President Jim Yong Kim (2012) Opening Plenary of the International AIDS Conference 2012, Washington, DC, United States.

completed in over 100 countries. The Bank also has been a leader in the area of NCDs, contributing to the knowledge in the field and engaging in many projects related to the economics, prevention and treatment of NCDs in countries at different stages of the epidemiological transition. In both fields, the World Bank provides strong technical expertise and project design and management. Improving the health workforce in developing countries is an important pillar of the World Bank's health systems strengthening agenda; the Bank assists countries in implementing evidence-based human resources for health strategies in selected thematic areas (labor market, fiscal and costing analysis, pre-service training costing, as well as political economy of human resources for health reform) and is a global leader in performance based financing and designing incentivization systems to improve quality and retention of health workers. HMIS reform involves many actors and systems across the health sector and, as such, is strongly aligned with the Bank's comparative advantage in systems strengthening. HMIS reform touches on health financing, patient management, surveillance, pharmaceuticals and health human resources among others and also requires stakeholder coordination and consensus building across a large number of departments, ministries, and organization, all areas where the World Bank can potentially add value.

187. Furthermore the program action plan includes key system strengthening activities, which the Bank has experience carrying out across countries and projects. The social and environmental safeguards, particularly those aspects aimed at strengthening the Government's systems dealing with medical waste, are fields where the Bank brings experience and expertise.

188. Finally, the World Bank can provide the technical and financial support required to achieve key program goals. This includes dialogue with the MoF to ensure that the program is adequately funded. It also includes mobilizing trust fund and other sources for technical assistance in identified target areas. For example, the Bank has mobilized important resources to support the government to begin the initial technical work required for the HMIS sub-program.

Annex 5: Fiduciary Systems Assessment (Full Text)

A. Executive Summary

189. A Fiduciary System Assessment (FSA) of the Bank-financed Program has been conducted at the identification and appraisal phases in accordance with OP/BP 9.00, in close collaboration with the technical team and through analysis of available documents and reports and working sessions with the main stakeholders. The objective of the assessment was to consider whether Program 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. The Program procurement systems were assessed as to the degree to which the planning, bidding, evaluation, contract award, and contract administration arrangements and practices provide reasonable assurance that the Program will achieve intended results through its procurement processes and procedures. The financial management systems were assessed as to the degree to which the relevant planning, budgeting, accounting, internal controls, flow of funds, financial reporting, and auditing arrangements provide reasonable assurance on the appropriate use of Program funds and safeguarding of its assets. The fiduciary assessment also considered how Program systems handle the risks of fraud and corruption, including by providing Grievance Redress Mechanisms, and how such risks are managed and/or mitigated.

190. The Program's financial management and procurement systems and institutions provide reasonable assurance that the financing under the Program is used for intended purposes, with due regard to the principles of economy, efficiency, effectiveness, transparency and accountability. Specifically, the MoH financial management systems for the Program (planning, budgeting, accounting, internal controls, funds flow, financial reporting, and auditing arrangements) provide a reasonable assurance on the appropriate use of Program funds and safeguarding of its assets because they are based on a solid central government PFM and procurement framework and a reasonable financial management and procurement system at the MoH level.

191. The scope of the FSA covered the Program Institutional framework, fiduciary management capacity and implementation performance, and institutions and systems responsible for anti-corruption aspects within the Program. The FSA, with the context of reviewing the performance of institutions responsible for implementing and management program expenditures, is based on a sample of a regional delegation in Gharb-Chrarda to review their fiduciary management capacity.

192. Most of the country-level weaknesses identified during the FSA will be addressed under ongoing reforms and new legislation including the organic finance law, the law on access to information and public complaints to be enacted in addition to the public procurement reform underway. The programmatic and performance informed budgeting foreseen in the organic finance law is currently tested in the ministry for the preparation of 2015 budget. The new public procurement decree introduced an improved complaint handling mechanism and e-procurement procedures. A government wide complaint handling mechanism is being finalized and is expected to be implemented across the health sector. Specific measures to implement the new requirements are going to be built into the Program as agreed with the GoM.

B. Background and institutional arrangements

193. The FSA covers: (i) the MoH institutional framework, and (ii) the fiduciary management capacity and implementation performances. The findings outlined in this report are based on the results of the site visits, including site visits to central and local executing agencies and procuring entities, and the current knowledge of Moroccan Public Procurement and Financial Management systems (as documented in the 2010 Use of Country System Piloting Program report, evaluation of systems, processes and financial management institutions in Morocco (PEFA, 2009) and the Country Financial Accountability Assessments (CFAA, 2007) in Morocco. .

97. This report begins with a presentation of the institutional arrangements under the program, followed by the performance of the Program's fiduciary setup according to different themes. Based on those findings, a section on fiduciary risks presents the overall and specific risks, and although the entire report touches upon the areas of governance, anti-corruption and social accountability throughout, a special section is dedicated to these issues. The final sections cover the inputs to the implementation support plan and the supporting annexes.

B.1 LEGAL, REGULATORY AND INSTITUTIONAL FRAMEWORK AT COUNTRY LEVEL

194. **A new organic finance law is currently being adopted by parliament.** It aims to strengthen and modernize public financial management. It introduces key measures aimed to better control the wage bill and to limit "carry forwards" as well as programmatic performance informed budgeting. The latter aims to strengthen transparency and accountability in the management of public resources, by requiring ministries to: (i) restructure their budget in programs in line with their strategy and core functions; (ii) publish and commit to corresponding performance objectives and indicators; and (iii) establish a robust performance dialogue and monitoring and evaluation system. The Head of Government has instructed, in his circular dated June 12, 2014, nine ministries, including the MoH, to implement this performance informed budgeting reform for the 2015 budget. This reform will also require the revision of the MoH's information system to ensure a regular monitoring of its performance indicators. This structural reform represents an opportunity to strengthen managerial responsibility and accountability along the service delivery chain but requires strong leadership and adequate human and financial resources.

195. The Government has made important progress in terms of fiscal transparency as evidenced by the increase of the open budget index from 28/100 in 2010 to 38/100 in 2012. The detailed budget is publicly available on the Ministry of Economy and Finance (MoF) website. The above-mentioned performance budgeting reform will further increase transparency of budget's allocation and their use.

196. **A new public procurement decree (PPD) was adopted in December 2012 and came into** effect **on January 1, 2014**. This decree replaces the decree of 2007 and seeks to address some of the main weaknesses and gaps that have continued to characterize Morocco's procurement system, in particular in terms of transparency, accountability, efficiency, risks of corruption, and mechanisms of complaint and redress.[80] Key features of the new decree include the unification of the regulatory framework for procurement to include the entire public sector (applying to local governments as well as

[80] Including the OECD/DAC Methodology for Assessing Procurement Systems assessment of the Use of Country System pilot program in 2010-2011.

all administrative enterprises). It also brings the selection and award methods for architect contracts in line with the principles of competition and equal treatment of bidders.

197. **In addition, the new PPD reinforces the legal basis for e-procurement in Morocco.** Morocco's public procurement portal has been operational since October 2007, with responsibility for its development and management vested in the General Treasury of the Kingdom (TGR). The e-portal has increased the availability of information, especially in terms of making calls for proposals widely available, making contract-related documentation available to all potential bidders, disclosing an estimated cost for the goods or projects to be procured, and publishing the results of tendering contests. The portal is now able to publish bids and calls for tender, and it also features database that tracks information about procurement procedures (including multimedia guides) and contract amounts per year. Additional features for the next phase are currently in development, with the application texts about to be published. These include electronic submission of bids, a suppliers' database, electronic reverse auctions, and grouped purchases. The full use of the system has been available since January 1, 2015.

198. **There are plans in Morocco to considerably empower the existing national procurement regulatory body "Procurement Commission" and extend its resources and authority.** A draft decree to establish a National Commission of Public Procurement (*Commission Nationale de la Commande Publique,* CNCP) to replace the Procurement Commission (*Commission des Marchés,* CDM) is currently being validated by the General Secretariat of the Government (SGG), in collaboration with MoF. The Commission will remain under the purview of the SGG. Reforms are intended to strengthen the CNCP's powers and responsibilities, and the Commission will become a permanent, more representative, and professional body. The reforms will also dramatically increase the Commission's autonomy and independence, providing it with its own budget, offices, and more, professionally qualified staff.

199. In addition, the PPD also makes provisions for a more effective **complaint management system/ appeals mechanism**. A law for arbitration and mediation procedures was introduced as part of the 2007 reforms, but many of its provisions have remained unsatisfactory. As per the 2007 decree, the procurement (non- judicial) complaint treatment is part of the responsibilities of the CDM.

200. Likewise, the new constitution introduced citizen's right to access information (art. 27), to be consulted (art. 13) and to complaints (art. 15) in order to strengthen the governance of public services and to strengthen public participation. These core governance reforms apply to the health sector as of 2015 and are considered key levers to improve the transparency and accountability across the sector and mitigate the shortcomings highlighted in many reports (Supreme Audit Institution, SAI, economic and social council, the Central Institution for the Prevention of Corruption (ICPC), etc.).

201. **Program Financing and Expenditure Framework**. The proposed PforR Program involves an outlay of $100 million as World Bank financing and which is part of the overall government program of improving access to primary healthcare in rural areas. The government's existing program is funded through the annual budget of the State under the MoH budget. The development objective of the proposed Program is to i) expand equitable access to primary care in rural areas; ii) improving health system governance at the primary level; The proposed PforR operation takes a subset of the Government's program and supports it, the details of which are provided in the detailed Program description section of this document. The proposed Program will be included in the annual budget of the Government of Morocco under the existing budget lines grouped under the MoH budget.

202. **The budget formulation process, structure and classification is the following**: The current Government program covers the period 2012-2016. It outlines the main policy priorities and objectives including in terms of macro-economic policy and public finances, such as bringing down the budget

deficit to 3% GDP by 2016 (compared to 7.4 % in 2012). This overall program is complemented by sector specific strategies covering different time horizons and budget resources. While these policy priorities and strategies inform the budget preparation, there is no formal or systematic link. The current budget reform aims at strengthening this link and the transparency of budget allocation through the adoption of a programmatic budget structure and performance objectives and indicators. The draft organic law introducing these changes has been prepared and is still pending adoption by parliament. The swift implementation of this reform would increase the consistency as well as the transparency of the multiyear budget. For the 2014 budget, four ministries will test this new budget structure and present to Parliament a multiyear budget and preparation of performance objectives, with the support from the Bank. The government program includes a fiscal target (a deficit of 3% GDP by 2016) and the PLL agreed with the IMF includes fiscal forecast. However, Morocco does not yet publish a multiannual budget framework. Multiannual budget programming is foreseen in the draft organic finance law. The budget classification is consistent with GFS 2001 and the government subscribed to the IMF's SDDS on the norms and codes for fiscal information. Morocco reports (to the IMF) and publishes its fiscal data on a regular basis. The budget classification uses a combination of an administrative and economic classification, with a special code for the regions. The budget is also presented with a functional classification aligned with COFOG.

203. The budget is comprehensive; covering the General Budget of the State (BGE), the annexed budgets (BA), the special treasury accounts (CST) as well as the autonomously managed government services (SEGMA). Transfers to agencies and local governments are recorded, not their own revenues in the absence of consolidated accounts. The recent roll out of the financial management information system (GID) to local governments should facilitate such consolidation in the near future.

204. **Program's financial sustainability and funding predictability do not pose a specific risk.** Funding predictability is hampered by the lack of a multi-year budget framework. Nevertheless, overall, budget execution is fairly centralized and the performance is fairly satisfactory, even if end-year budget execution reports are produced with delays (2012 is the last available year). Monthly budget execution reports are published with less than 3 months delay on the TGR's website and the report dated December 2013 shows a commitment of 86% of budgeted expenditures. No end-year report is yet available for 2013[1]. The latest end-year budget execution report for health (2012) shows a high execution rate for current expenditures (100.95%) but a low execution for investment expenditures (42%).

205. **There are little elements to measure the efficiency of program expenditures.** Generally, **there** is a lack of evaluation of public expenditure efficiency in Morocco, which led to an ambitious budget reform leading to program based budgeting with a performance approach, and annual evaluation of performance and the use of performance indicators. The MoH is actively working on this reform, described in more details supra. The Supreme Audit institution (*Cour des comptes*) regularly includes in its work program evaluation of health programs which involves at the same time regularity audits and performance audits. The Cour published in 2013 a report on pharmaceutical management by the MoH. There is little evidence that observations from the Cour are acted upon according to a firmly established and implemented action plan.

B2. PROGRAM ACTIVITIES

[1] Ref. https://www.tgr.gov.ma/wps/wcm/connect/88fafd8042afaa46800fcb4ee5b22fb0/BSFP+DECEMBRE+2013.pdf?MOD=AJPERES&CACHEID=88fafd8042afaa46800fcb4ee5b22fb0

206. The program will be implemented at central and decentralized levels, involving several national and regional directorates of the MoH, in the targeted areas. Within the areas of intervention, the program will finance various services, equipment, goods and works for the implementation of its activities as defined in Program description (see above) and in the Results Chain (see Annex 4). More specifically, the Program will finance: (i) the acquisition of medical and technical equipment for primary care facilities; (ii) works for upgrading of primary health care facilities (iii) the purchase of drugs and pharmaceutical products; (iv) the acquisition of 57 mobile health care units for the nine target regions; (v) the acquisition of computer hardware for development of the national health management information system and a pilot system in one region; (vi) the acquisition of screening equipment (electronic sphygmomanometers, wall sphygmomanometers, glucometers, test strips, gynecological tables, kits for cervical cancer screening,…) for each health center and mobile team (vii) the services for establishment of standardized care procedures related to mother and child health and non-communicable diseases; (viii) the services for development of health educational tools; (ix) the services for development of an appropriate grievance mechanisms easily accessible to local populations in one pilot region, to be replicated in the other targeted regions; (x) the services for the promotion of healthy lifestyle (within mosques, colleges, schools, ESSPs, mobile teams, local radio broadcasts, souks, etc.); (xi) the services for awareness campaigns targeted to the general population, schools and health professionals in rural areas on thematic such as the dangers of smoking and the benefits of a healthy and balanced diet and physical activity; (xii) various capacity building activities at central and decentralized levels targeting mainly health workers; etc.

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B3. SUMMARY OF FIDUCIARY RISKS AND MITIGATION ACTIONS

207. The overall fiduciary risk for the health sector PforR is rated "**Moderate.**"

208. 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, then those related to the implementing agencies (*Directions centrales et regionales du MoH*) with regard to their capacity and the way they are organized to implement the Program and carry out fiduciary function. The main risks and proposed mitigating measures are specified in the summary table below:

Table 16: Fiduciary issues specific to the Program

Topic	Risks	Mitigation or Resolution
Planning and budgeting	The Delegations' budget delay in some regions hinders procurement and project's implementation	Transferring credits to *sous-ordonnateurs at the beginning of the fiscal year*
Bidding and contracting	Risks are related to: (i) quality of technical specifications and terms of reference; (ii) quality of bidding documents; (iii) Rigor of bid evaluation; and (iv) quality of works, goods, or services delivered. The procedures and control framework are adequate, but the risks persist because of the large number of contracts with low capacity, dispersed at the regional level	(i) The preparation of a fiduciary section within the PIM; (ii) expanded audit review; (iii) fiduciary training program; (iv) establishment of Fiduciary Coordination Committee;(v) Strengthened grievance redresses procedures; and (vi) more effective procurement reporting in the HMIS with key fiduciary performance indicators.
Program reporting	Current HMIS does not provide adequate standard procurement reporting.	Establishment of the HMIS in one region *(DLI # 7)*

Procurement oversight, and internal control and audit	*Procurement oversight* is carried out by the MoF. The *Cellule de Coordination des Marchés* (CCM, Contract Coordination Cell) at the MoH ensures prior control of all documents at the central level. A similar prior control is needed at the regional level as well. *Internal audits:* there is a room for improvement but the situation has evolved favorably recently. The MoH is part of the process of rationalization of ex-ante financial controls at the commitment phase that has been supported by the Governance DPL series. This cross-governmental process is promoting a risk-based approach (contrôle modulé) to financial controls instead of a systematic approach. MoH has been placed in category one (low risk) and therefore applies the alleviated control framework (*contrôle allégé*).	(i) Establishing effective functions for management control (*contrôle de gestion*) and internal audit both at the central and regional level; (ii) harmonizing the organizational chart and operational guidelines of the 16 regional directorates; (iii) developing the expenditure analysis function of the DPRF; (iv) capacity building of authorizing officers and their fiduciary teams; and (v) internal audit entities to be created at the regional level.
Program Audit	Program audit is carried out by IGF. In addition, the DPRF has taken the initiative to commission to KMPG an audit of all budget managers (*sous-ordonnateurs)* for fiscal years 2011-2012 and covering a wider scope including compliance and performance. Audit reports provide reasonable assurance of the use of funds by executing agencies. However, follow-up of audit recommendations need to be improved.	A Fiduciary Coordination Team will develop guidance and standard on Program Financial Statements Audit, Technical audit, and measures to include coverage of Procurement activities with sufficient details. The implementation of audit recommendations will be prioritized.
Institutionalizing grievance and appeal system	There is no formal grievance redress mechanism (GRM) in place yet. A Government wide policy/decree is currently being finalized and will need to be implemented in the health sector. The Government is developing an access to information law which is in the process of being enacted.	(i) formalizing and mainstreaming a GRM across the sector, including procurement-related complaints, in line with the national policies and reforms; (ii) more proactive disclosure of information and the implementation of the government's access to information policy; (iii) publishing asset declarations of high officials and managers
Planning and managing Human Resources	Strengthen fiduciary management capacity and human resources,	(i) increasing the share of human resources and training budget devoted to fiduciary management; (ii) institutionalizing a fiduciary training program (initial and on job) for authorizing officers and their fiduciary staff.

C. MoH and Program Fiduciary Arrangements and Performance

C.1 PROGRAM PLANNING AND BUDGETING

209. The MoH's budget is prepared in an orderly manner, and budget documentation (*morasse budgétaire*) allows for adequate presentation of program's proceeds. Budget classification for the MoH is centered on a regional classification which is then detailed in five programs covering all operations. The budget proposal is supported by a detailed financial programming that is available at the budget submission stage. The adaptation of the budget process to the new organic law will be taken into account in the implementing decree and in the "Budget discipline circular" in preparation that will replace existing regulation and will consolidate good practices already in use.

210. The Delegations' budget is prepared annually in October for the next year. At the same time, a projection is prepared also for the subsequent two years. These projections are approved by the Regional director and then the DPRF. The MoF board approves the budget by the end of the budget preparation year. During the year, the budget may be revised a few times if necessary.

211. As stated in the MoH *Arrête* of Procurement Arrangements (1363-11, pages 56-58), the framework of the MoH is organized through centralized procurement involving one division and two procurement units under the General Secretary's supervision:

- The Population Division procures vaccines through UNICEF to ensure quality, cost and on time delivery.

- The Supply Unit (*Division de l'approvisionnement*) ensures: the implementation of common expenditure in different departments and the procurement, storage and distribution of pharmaceuticals and medicinal products. This division includes the supply, contracts, and inventory management services.

- The Cars and General Affairs Unit is responsible for cars management and maintenance and means of mobility department. This division includes: Transportation means management, cars maintenance and General affairs services.

212. The PPD lays out various methods for the control and oversight of evaluation committees, as they are involved in one of the most critical aspects in the procurement process. The first control is outlined in Article 34 of PPD and provides for an ex-ante review by a Moroccan controller (*Controleur des Engagements*) who represents the MoF/TGR and is responsible to check compliance with the provisions of the PPD, especially in terms of bid opening. After the evaluation is completed (in which the controller is not involved), the report and the draft contract are submitted for the controller's review and approval/formal clearance (*Visa préalable*) which is required before a contract can be signed. The PPD includes other provisions to mitigate risk in such contracts. Besides, the CCM located in Rabat is an entity in charge of the procurement pre and post-revues including contracts study, monitoring, advisory and audit.

213. A second control is an annual audit that was established for all activities performed by the MoH. This audit covers a review of procurement procedures and contract management and is conducted jointly by the IGF under the MoF and the MoH General Inspectorate.

214. Finally, all entities implementing Program activities are also subject to review on regularity, economy, and efficiency by the Supreme Audit Institution (*Cour des Comptes*) at the central level and the regional courts (*cours régionales*) at the local level.

215. **Record Keeping and Document Management Systems.** In general, procurement documentation is kept in all the related procuring entities facilities. At the provincial level, procurement documents are managed by three different units: (i) the contracting unit (*Service Contrats*) and (ii) the accounting unit under "*Division du Budget et du Matériel*," and (iii) the accounting unit under the "*Division de l'Equipement.*"

216. Since data entry and report generation processes are very aggregated[81] and not integrated, it is highly recommended to review and improve the fiduciary reporting.

C2. PROCUREMENT PLANNING

217. Funds for public procurement contracts are secured from the state budget. An annual procurement plan is prepared on the basis of the annual budget of MoH. The MoH issues a Decision with which the annual procurement plan is approved. In preparing the procurement plan, the MoH collects information with regard to the needs of the various departments within the MoH and also from the various health institutions (state and county hospitals, primary health care departments, etc.). It contains information in line with the requirements of PPD, i.e., including the subject matter of procurement and its reference number, estimated value, type of public procurement procedure, including the procedure for awarding of a public service contract, as relevant, information if the public procurement procedure would result in a public procurement contract or a framework agreement, planned commencement of the procedure and the planned duration of the public procurement contract or the framework agreement.

C3. PROGRAM PROCUREMENT

218. Procurement Management of the Program is proposed to be carried out using Morocco's existing systems and processes for Public Procurement Management. The Program will be located within the country's budgetary framework and will rely on existing institutional systems for implementation.

219. The procurement assessment included questions on: (i) Cost effectiveness: Bidders' qualifications, bids evaluation, and contract award; (ii) Competitiveness and compliance in Procurement process; (iii) Compliance: Procurement review and oversight; (iv) Staffing,(v) contractors debarment and (vi) contract of management.

220. **Cost effectiveness: Bidders' qualifications, bids evaluation, and contract award.** In terms of economy, the Population Division orders vaccines through the UNICEF. The MoH follows the PPD dispositions in terms of procurement for medicines, equipment and vaccines. But, the PPD requires estimates publishing which makes it difficult for the procuring entities to negotiate and get better deals in terms of costs. Beyond procurement, there is room for improvement in logistics and distribution as ESSPs are experiencing many shortages and late deliveries, especially for medicines, due to the absence of a tracking and reporting system.

221. **Competitiveness and compliance in the Procurement process**. The PPD states that bidding documents (DAO) must state the qualification criteria of bidders (*eligibilité*) and bid evaluation criteria (*classement des offres*). However, it is not explicitly stated that the bid evaluation criteria, other than price, must be expressed in monetary terms. Such practices can decrease the level of transparency in procurement processes as they allow the potential for procurement processes to unjustifiably favor a specific candidate and therefore affect negatively thoroughness of bid evaluation.

222. The potential negative impact on the Program of these practices is limited given the standardization of bidding documents, although in some cases the rating/scoring system will be also used for qualification. To further mitigate this risk, the GoM has prepared guides to explain the preparation of bidding documents, and made them available in the public procurement portal. However, inexperienced staff may need more details than is provided in the guides. For example, and according to the CCM

[81] See IGF-IGM report of 2008.

frequent and recurrent observations, standard bidding documents are used in a very mechanical manner due to lack of fiduciary skills or training (implementation strictly following ”word for word” the Standard Forms).

223. In the Program, this risk will be mitigated in part by increasing the knowledge of responsible stakeholders through a large capacity building initiative including: (i) dissemination of simplified and updated manuals for procurement; (ii) availability of other documentation tools (electronic web based etc.); and (iii) implementation of provincial fiduciary capacity building plans. The CCM can be used as a fiduciary training platform as the CCM responsible is already providing trainings at the regional levels.

224. **Compliance: Procurement review and oversight.** Public contracts executed at the regional level are subject to systematic ex-ante control by the regional services of the TGR.

225. The last findings of the Inspection bodies (IGF and the MoH General Inspection, IGM) ex-post reviews are related to 2007 and 2009 exercises and there is an independent auditor report undergoing. The main findings were in general caused by weakness of staff capacities in small or remote procuring entities as evidenced by (i) unclear or imprecise technical specifications and ToRs, (ii) poor quality of bid evaluation reports due to poor quality of bidding documents; (iii) non-compliance with contract terms, (iv) additional work not formalized contractually; (v) short-lists including unqualified bidders.

226. **Complaints Handling Mechanism**. The other main issue identified in the Bank’s diagnostics that could affect the Program is the lack of an independent procurement appeal system and a clear process for handling complaints. The GOM is taking action on this weakness in the ongoing public procurement reform process through new laws or decrees currently under preparation as well as through a government complaint handling policy/decree being finalized and to be implemented across the health sector.

227. **Staffing**. Most fiduciary staff is hired from the medical human resources pool. Although this brings in technical knowledge while dealing with ESSPs and hospital management, the fiduciary capacity of the staff needs to be strengthened. A thorough (initial, continuous and on-the-job) training program for fiduciary management needs to be developed.

228. **Debarment of Contractors.** In accordance with the World Bank’s Anti-Corruption Guidelines for PforR operations, the Program will take steps to ensure that “any person or entity debarred or suspended by the World Bank is not awarded a contract under or otherwise allowed to participate in the Program during the period of such debarment or suspension.” At the conclusion of the procurement process for each contract and prior to the award of the contract, the MoH will publish the details of the contract award in the national public procurement portal. MoH will verify the names of the contractor against the World Bank’s database (www.worldbank.org/debarr) of debarred or suspended contractors to ensure that no such contractor is awarded any contract under the Program.

229. **Contract management.** There is no formal data with regard to contracts administration. For facilitating the contract administration and its monitoring, it is recommended that an adequate contract administration and monitoring system is defined, including defining the process and capacity needed, the evidence of contract performance with regard to time, quality and cost, inspection of quality of the goods and services delivered, timeliness of payment and effective contractual dispute resolution, as applicable, and enforcement of contractual remedies. The focus would be to ensure the continuous and sustainable development of the capacity of staff in procurement and contract management, both at the central and regional levels.

C4. PROGRAM FINANCIAL MANAGEMENT FRAMEWORK

230. Financial Management of the Program is proposed to be carried out using Morocco's existing systems and processes for Public Financial Management. The Program will be located within the country's budgetary framework and will rely on existing institutional systems for implementation. The three entities that will be involved in the financial management and oversight for the Program are:

- *The Ministry of Health*: The MoH is managed through framework where 90 percent of the ministry's voted credits are transferred to 99 secondary credit managers (*délégation de crédits aux sous ordonnateurs)*. Only nine of these secondary credit managers are central directors. All others are regional directors (there are 16 health regional directorates), heads of delegations (each region is composed of several delegation) and managers of autonomous entities. Various autonomous government agencies (*établissements publics),* hospitals or agencies are under the legal supervision of either the center of the regional level. The MoH is very advanced in the regionalization process that is ongoing and is part of the upcoming organic finance law. Most of the Program funds will therefore be managed at the regional/*délégation* level. Primary health care units (ESSPs) do not manage credits and are managed for finance and procurement at the *délégation* level.

- *DPRF:* The DPRF is composed of three units: (i) a budget unit in charge of financial programming, budget discussions with MEF, resource allocation as well as budget execution; (ii) an accounting unit in charge of managing credit transfers to *sous-ordonnateurs* and prepare budget execution reports that are reconciled with data from the Budget unit and from the cross-governmental GID (*gestion intégrée de la dépense*) system managed by the TGR of the MoF; and (iii) a monitoring and evaluation unit which plays a traditional role of compiling dashboards and reports that is now a feature of the GID system. The unit is trying to evolve towards an expenditure analysis function at the project level including analysis of physical outputs (*observatoire des ressources).*

- *The General Treasury of the Kingdom (TGR):* The TGR, part of the MoF, plays an essential role in the monitoring of budget execution, as directed by Art. 124 of the General Accounting Regulation (Order No. 330-66 of April 21, 1967), which stipulates that TGR must "send a monthly report to the Finance Ministry presenting a statement of budget transactions, special account transactions, and cash flow transactions for the month," accompanied by statements for previous periods. TGR summarizes this data in its "Monthly Statistical Bulletin for Public Finance," published on its website. Through TGR's data sheets, the central offices of the technical ministries have access to detailed data on the execution of their budgets; the main ministries use this information to prepare a quarterly update of budget execution. The MoF Budget Division prepares a budget execution report for each ministry at the end of the year, and the main ministries' own financial staff prepares the administrative accounts (*compte administratif*) by budget chapter, article, paragraph and line. These documents are sent to the Court of Accounts for their report on the budget review act. Besides, the TGR is also in charge since 2006 of commitment controls. A series of rationalization reforms have provided line ministries with more autonomy in managing their budgets (partial fungibility) and have implemented a system of ex ante financial controls more risk-based, less systematic and focused on high-value/high-risk operations. It has still to be seen whether this protracted reform agenda has had sustainable behavioral impact.

231. ***Program Financial Management Risk Assessment.*** The Financial Management arrangements of the program will be the responsibility of the DPRF of the MoH. The assessment of these financial management (FM) arrangements is satisfactory because they are based on a solid central government PFM framework and a reasonable financial management system at the MoH level. The main FM risk is linked to change management and the capacity of the DPRF to implement the new organic law in terms of performance-based budgeting, multi-year perspective for financial programming and regionalization. The PAP would have to support this change management with adequate fiduciary measures and adequate measurement in the results framework. Though the discussion has to stay open at this stage, it is not anticipated that an FM-related DLI would be necessary or useful.

232. The PFM systems in the country are generally considered good by international standards as it is reflected in the 2009 Morocco Public Expenditure and Financial Accountability assessment. Morocco has since then continued the reform efforts in PFM, in particular through strengthening of performance-based budgeting as well as transparency and access to information and a rationalization of controls of public expenditures. These are elements of the dialogue with the Development Partners that are reflected in the results framework of the Hakama DPL. These evolutions will be generalized and fully implemented when the new organic finance law is voted (it has been sent to Parliament).

233. Nevertheless, some of the weaknesses noted in 2009 still remain. The delays in producing central government annual financial statements are still important and they are currently available only for the fiscal year 2010. There is still insufficient information on assets and liabilities, though an ambitious accounting reform plan has been designed (*reforme comptable de l'Etat*) with a modernized chart of accounts and new accounting norms, but is still not implemented. The multi-year perspective for allocation of budget resources is still largely virtual and the Medium-Term Expenditure Framework is still not used as a budgeting tool. Besides, performance-based budgeting is still largely at an experimental and notional phase.

C5. INTERNAL CONTROLS AND INTERNAL AUDIT

234. In terms of internal controls, there is room for improvement but the situation has evolved favorably recently. First, the MoH is part of the process of rationalization of ex ante financial controls at the commitment phase that has been supported by the Governance DPL series. This cross-governmental process is promoting a risk-based approach (*contrôle modulé*) to financial controls instead of a systematic approach. Each ministry and agency are evaluated by the IGF in terms of internal control system and placed in a specific category. This audit is performed by the TGR at the sous-ordonnateur level. MoH has been placed in category one (low risk) and therefore applies the alleviated control framework (*contrôle allégé*). Second, the DPRF has taken the initiative to commission to KPMG an audit of all *sous-ordonnateurs* for FY 2011-2012 and covering a wide scope including compliance and performance. Provisional audit reports were received in October 2013 and *sous-ordonnateurs* comments were included. The MoH is expecting to receive the definitive version of these audit reports shortly.

235. The MoH is subject to various layers of internal audit interventions. The first layer is the audit of sous-*ordonnateurs* commissioned by DPRF with the intention to make it a permanent feature of the internal control framework. Then the Ministerial Inspectorate of the MoH (*Inspection Générale*) which reports directly to the Minister is implementing an annual program of controls and audits. Finally, IGF, with a cross-ministerial mandate, is also regularly conducting audits in the health sector, with the TGR complementing this work at the sous-ordonnateur level. This internal audit process is quite complete but with a potential weakness in terms of coordination. It is also quite difficult for the TGR to implement their vast program of audit of sous-ordonnateurs across government given the limited capacity assigned to this mission. Besides, evidence of systematic follow-up of audit findings is lacking. There is a potential for improving complementarity and impact of those audits.

C6. PROGRAM AUDIT

236. The external auditor of public funds managed by the MoH is the *Cour des comptes* (Moroccan Supreme Audit Institution, CDC). The *Cour* has a systematic jurisdictional mandate over the annual accounts (*comptes de gestion*) produced by the government accountants (from the TGR) assigned to the MoH at central and deconcentrated levels. They also perform routinely performance audits (covering evaluation of results, inspection of physical assets, assessment of internal controls, etc.). The *Cour* has

started recently to conduct thematic audit in the health sector (one or two per year). The themes recently covered hospital infrastructures, primary health care, or in 2012 pharmaceuticals management (published in the 2013 report). The findings of these investigations are part of the *Cour's* annual report, published in Arabic and French on the *Cour's* website.

C7. PROGRAM ACCOUNTING AND FINANCIAL REPORTING

237. All payments of the Program will be made through the centralized Treasury system of the TGR. Program funds will be entirely reflected in the budget of the State. No primary health facility or autonomous government agencies will receive and manage funds through the Program.

238. All payments and accounting of expenditures are conducted within the network of TGR accountants who use the various cross-governmental Integrated Financial Management Information systems like GID for expenditures and *Gestion intégrée des ressources* for tax collection. There is one ministerial treasurer per ministry who is the TGR accountant for all credits managed at the central level. Credits managed at the regional and delegation levels are paid and accounted for by the Regional Treasurer-Payer who is responsible for all *sous-ordonnateurs* in the region (for the MoH or other ministries) and is the head of a network of *Trésoriers préfectoraux*. Some expenses are committed at the regional level but paid at the center level if they are above a specific threshold. Treasurers-Payers produce an annual account sent to the *Cour des comptes*. Recently, because the MoH has been evaluated as a low risk entity by the IGF, a number of financial controls at the commitment and at the payment stages are in the process of being partly and progressively "internalized" within the MoH.

239. The MoH will be the Program Manager for the PforR Program. The MoF will be responsible for the management of these funds. MoH, and in particular DPRF, will also be responsible for preparing the Program Financial Statements compiling them from financial reports produced by *sous-ordonnateurs*. The protocols for the receipt and compilation of annual Program financial statements will be discussed and agreed with counterparts by appraisal. The annual audit of the Program financial statements will be carried out by the IGF. The terms of reference for the audit will be discussed and agreed with the IGF.

C8. FUNDS FLOW ARRANGEMENTS

240. The program will use the funds flow arrangements used for the execution of the Budget of the State. The funds of the World Bank will be transferred to the Treasury current account at the Bank Al-Maghrib (Central Bank) managed by the TGR in an account to be created for this Program at the Bank Al-Maghrib.

D. Anti-Corruption and Accountability

241. The PPD became effective on January 1, 2014. It emphasizes the modernization of public procurement with further use of electronic tools (reverse auction) and among the ultimate objectives the reduction of potential for corruption and fraudulent practices. The modernization efforts of public procurement were supported by the World Bank through Institutional Development Fund (IDF) grants (2005 and 2009). The World Bank is also currently supporting the Moroccan Government through an IDF grant (US$400,000) aiming at providing capacity building and institutional development support to assist in strengthening the CDM hosted by the SGG to successfully perform its nation-wide mandate which includes among others the handling and management of complaints.

242. Morocco's electronic public procurement portal managed by TGR has increased widely the availability of information related to public procurement (calls for proposals, the contract-related

documentation for all potential bidders, etc.). It allows greater disclosure of estimated cost for the goods or projects to be procured, dissemination of and publishing the results of tendering contests. Supported by the new PPD, which reinforces the legal basis for e-procurement, additional features have been in place since January 1, 2015: electronic submission of bids, suppliers' database, electronic reverse auctions and grouped purchases. .

243. Inadequate human and financial resources allocated to the CDM prevented it from fulfilling the complete set of responsibilities entrusted to it, which contributed to a lack of efficient regulatory and coordination mechanisms. Its role in handling complaints was minimized by a lack of binding decision power, and the inability for complainants to directly address complaints to the CDM. To address these deficiencies, the Moroccan Government launched an ambitious reform to considerably extend the institutional structure resources, and authority of the existing CDM. A draft decree to establish a CNCP to replace the CDM is currently being adopted by the SGG in collaboration with other stakeholders including the MoF. The reforms will also dramatically increase the Commission's autonomy and independence, providing it with its own budget, offices, and more, professionally qualified staff.

244. Furthermore, the Procurement unit of the MENA Region launched a study in Morocco (and another country in the region) aiming at supporting the governments in developing an efficient and effective public procurement reform implementation strategy that is customized to the specific conditions of the country. This would be achieved through a better understanding of the environment and the factors affecting the implementation of procurement reform.

245. **Arbitration and measures to fight Fraud and Corruption.** The arbitration system is required by law but has not been reflected in the existing General Contract Conditions (GCCs). GCCs for Goods, which are the ones missing, will be prepared and disseminated under the IDF grant supporting the capacity building and institutional development of the CDM. The PPD also makes provisions for a more effective complaint management system/ appeals mechanism. A law for arbitration and mediation procedures was introduced as part of the 2007 reforms, but many of its provisions have remained unsatisfactory. As per the 2007 decree, the procurement (non- judicial) complaint treatment is part of the responsibilities of the CDM. However, as noted above, up until now the CDM has lacked fundamental means and resources to play and enforce its role effectively. A variety of factors limiting the effectiveness of the complaints system have been identified, including undefined complaint handling procedures (i.e., timeframes for decisions to be reached), the non-binding nature of decisions, the lack of representation of bidders.

246. In addition, the country has taken a number of measures to promote ethics and fight against fraud and corruption including the creation of the ICPC and an agency to fight money laundering. The ICPC has established an electronic system enabling citizens to anonymously report corruption and fraud, although no mechanism of investigation or sanction, other than judicial, is in place. In the spirit of the new constitutional reform, the ICPC should see an evolution of its independence and be in charge of new missions to enhance the fight against these scourges (investigations, sanctions, etc.) with new powers which will be enforceable once the set of corresponding law/decrees is enacted.

247. The existing PPD provides that any entity engaged in fraud may be excluded from award of contracts with a given department or from all public contracts procured by the State by decision of the concerned minister in the first case and of the Head of Government in the second case. In both cases the decision must be submitted to the opinion of the national Central Procurement Tender Board.

248. **Improvement of program systems to fight fraud and corruption.** Morocco's new constitution, enacted on 1 July 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 new Constitution sets the ground for more transparency and 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.

249. The Program mainstreams a range of measures at fiduciary and technical design level to mitigate fraud and corruption risks. Among the key measures: a) the strengthening of the control framework through the systematic action plan at central and regional levels for implementation of audit recommendations made by IGF, Court of Account and external auditors; b) the establishment of internal audit units at regional levels to help ensure compliance with fiduciary requirement; c) the set-up of a formal Grievance Redress Mechanism and the introduction of a central database accessible at regional level, for monitoring the submission and treatment of grievances and facilitating reporting; and d) the development of dedicated fiduciary modules in the new HMIS of the ministry in order to produce relevant and representative procurement related information enabling to assess performance (see KFPIs). The government's program will benefit from EU financial support in the way of parallel financing. Thus, in addition to the internal control framework, the Program is subject to external audits appointed by the EU.

250. The Government will use its own systems to take all appropriate measures to prevent fraud and corruption in connection with the Program. Also, it has to use the PforR Anti-Corruption Guidelines, including giving the World Bank the right to access information in a non-intrusive way. The World Bank debarment list, which is easily accessible, will be checked by all procuring entities before awarding contracts. This is not expected to pose significant problems. The Government has developed experience on this with the EU Anti-Fraud Office. Reporting to the Bank on allegations occurring under the Program and their handling will be carried out by the DPRF through the annual reports on Program implementation. The Government will collaborate with the World Bank on the investigations of allegations which the World Bank intends to pursue. Program participants (including executing entities, suppliers, contractors and subcontractors) will be notified of the potential to be subjected by an investigation of their books and accounts through a standard clause inserted in the bidding documents and contracts.

Transparency Accountability

251. ***Transparency and information disclosure.*** The MoH and all health facilities will be subject to the new law on access to information. This law requires public bodies to disclose proactively, including on line, key information about its services, organization, finances and programs. The MoH will also be required to appoint an information officer and to set up a system whereby citizens can request information and complain in case their request hasn't been fulfilled. The ministry will thus need to review its internal organization, procedures and information management system to comply with the law. Bidding documents are free of charge and they can be downloaded from the procurement portal. The bids opening sessions are public, but the opening of technical and financial envelopes is not simultaneous. However, in most cases, these openings are held on the same day (same meeting) because of the simplicity of related operations. Under this Program, both the MoH website as well as the national procurement portal maintained by the TGR should be used for publishing of advertisements and awards disclosure. As outlined earlier, procurement plans when available and bidding opportunities are well advertised. The list of attendees during bid-opening is not systematically established ("because it is not required by the decree" according to interviewees), however publishing the results of the award is made by posting and sending letters to all candidates. They often are invited at the same time to come to

withdraw their bid securities. Among the improvements of HMIS under the Program, the number of participants in each bidding process will be measured within the KFPIs.

252. ***Accountability.*** Program execution is based on administrative and existing provincial structures that will be involved. Responsibilities within the administrative structures are clearly defined.

253. The involvement of each administrative office and each project in the program is defined by circulars. The Program Implementation Manual will provide the definition of the roles and responsibilities. Program implementation is delegated to decentralized services of the state whenever sufficient management capacity is available. But the level of capacity required is not defined anywhere and no evaluation mechanism is established. In the Program, systematic assessment of fiduciary capacity will be undertaken to trigger specific training and mentoring programs/actions as well as provincial service support.

254. ***FM risk management measures.*** Public procurement decree provides the list of evaluation committee's permanent members: three Representatives of the project owner, one representative of TGR and one representative from MoF if the amount of contract is above MAD 30 million. The committee should invite a representative of Ministry of Commerce if the contract amount is above MAD 1 million.

255. The World Bank's right to investigate issues of fraud and corruption has been discussed with the government.

E. Inputs To Implementation Support Plan

256. In providing Implementation Support, the World Bank governance team will monitor overall performance (improvement) of financial management and procurement systems. Specifically the team will: (i) check progress of the governance and fiduciary reforms at country level; (ii) assess the efficiency of fiduciary oversight system; (iii) support design, implementation and evaluation of governance and fiduciary capacity building plan; (iv) check implementation of the Program grievance redress mechanism and of the complaints policy; and (v) monitor achievement of key fiduciary indicators. The measures are detailed in Annex 9.

257. **Key Performance Indicators (KPIs) mentioned in Annex 2 will be used to monitor fiduciary performance**. KPIs will be checked and analyzed by the World Bank twice a year during implementation support missions and appropriate follow-up will be undertaken when red flags arise from analysis of these indicators.

258. **Key Procurement Performance Indicators.** Key procurement indicators related to various stages of the procurement process have been selected to monitor program performance in this area. These indicators, which range from preparation stage to execution, are all selected from the public procurement database managed by the TGR (Table 17).

Table 17. Key Procurement Performance Indicators

Procurement Stage	Corresponding indicators in public procurement database of TGR	Indicators	Definitions

Preparation	IC14	Number of bidders having submitted an offer	Number of bidders that submitted their bids (average= Number of bidders that submitted their bids/ Number of invitations to bid or calls for proposals or requests for bids or quotations, with bids opened and contracts awarded)
	IC18	Time period for award of contract following an invitation to bid/ a call for proposals/ a request for quotations	Time period for award of contract following an invitation to bid or a call for proposals or a request for quotations ([Sum of (award date- bid opening date)] / Number of invitations to bid or calls for proposals or requests for quotations, with bids or proposals or quotations opened and contracts awarded)
Payment	IC58	Time period for payment of invoice	Time period for payment of invoice

Annex 6: Summary of the Environmental and Social Systems Assessment

Context and Objectives

259. An Environmental and Social Systems Assessment (ESSA) has been prepared for the proposed PforR. The ESSA examines environmental and social management systems that are applicable to the program in order to assess their compliance with the Bank's Operational Policy OP/BP 9.00 that applies to PforR financing. It aims to ensure that the Program's environmental and social risks will be managed adequately and that it complies with the basic principles of sustainable development.

260. The ESSA examines the compliance of the Program systems with the requirements of OP 9.00, regarding the following points: (i) the laws, regulations, procedures, etc. (the "system as defined"); and (ii) the capacity of the Program institutions to implement the systems effectively (the "system as it is applied in practice"). It identifies and analyzes the differences between the national systems and the core principles that apply to the Program and recommends actions to improve the compliance of environmental and social management systems with OP 9.00 requirements.

ESSA Approach

261. The preparation of the ESSA and the development of measures to strengthen the environmental and social management system have benefited from various inputs, information and an extensive consultation process, including:

1. ***Interviews and field visits:*** The review was based on:
    a. Interviews with technical staff in the relevant institutions in the government and visits to a representative sample of ESSPs, including ten rural community health centers and community health centers with delivery units to assess the status of environmental and social safeguard systems at the health center level.
    b. Visits to community structures and programs established by local government and civil society organizations in partnership with the MoH, such as the Dar al Oumouma (Maternity House), and health education actions.
    c. Meetings with technical and financial partners working in the healthcare field in Morocco.
    d. Interviews with representatives of civil society and private sector organizations.

2. ***Desk review:*** the review covered environmental and social legislation and regulations that apply to the Program, the relevant documents, and reports on previous and current projects in the health sector supported by the World Bank or other partners.

3. ***Initial consultation meetings:*** meetings were held with technical staff in the MoH and the Ministry of Energy, Mines, Water and the Environment, development partners working in the healthcare field in Morocco, and representatives of the private sector and civil society to develop a better understanding of procedures, standards and approaches.

4. ***Validation workshop:*** An initial internal consultation workshop took place during the appraisal mission in October 2014. A larger consultation workshop was held on February 4, 2015 with development partners, and civil society and private sector organizations. The draft

ESSA report will be disseminated before the workshop. The feedback from the workshop will be incorporated in the ESSA and a full list of the participants and a summary of their feedback will be appended to the ESSA report.

5. ***Document dissemination:*** The ESSA report will be publicly disclosed through the World Bank Infoshop and the MoH website.

Main Program Components and Activities

262. The purpose of the Program is to increase access of rural populations to quality primary healthcare services. The rural areas targeted are in nine priority regions[82] identified by the Ministry of Health as having health indicators that are lower than the national averages. The Program will run for four years, from April 2015 to June 2019, and cover the areas and sub-programs described in Section II and activities described in Annex 1.

263. The Program will not finance any construction work (healthcare centers, housing for healthcare personnel, etc.). However, rehabilitation of existing ESSPs and upgrading of their equipment (such as plumbing, painting, electricity) will be supported. The Program will not finance any activity leading to land acquisition, or involuntary settlement, or activities that could have adverse economic impact on the population.

264. Procurement under the Program will be limited to: (a) the acquisition and/or the renewal of medical and technical equipment of the primary care facilities; (b) the purchase of drugs and pharmaceutical products; (c) 57 mobile health care units to be added to the MoH's fleet in the nine target regions; (d) the acquisition of computer hardware to develop the health management information system and a pilot system in one region; (e) the establishment of standardized care procedures related to mother and child health and non-communicable diseases; (f) the development of health educational tools; (g) the development of an appropriate grievance mechanisms easily accessible to local populations in one pilot region, to be replicated in the other targeted regions; and (h) capacity building activities.

265. The Program will not finance activities entailing irreversible, critical and large-scale environmental and social impacts. No Category A type of activities (such as: (i) activities that are likely to alter natural habitats significantly or cause substantial changes in biodiversity zones and/or potentially important cultural resources; or (ii) activities that require displacement of residents or businesses and/or the expropriation of large tracts of land) will be financed under the project.

Institutions, Roles, Responsibilities and Coordination

266. The key players involved in implementing the proposed program are the MoH and the MoF. The MoH is the main beneficiary and will be responsible for implementing the reform of the health sector in accordance with the priorities and guidelines defined in the strategy documents. The MoF will be the recipient of the transfers related to the DLIs. The MoH is also responsible for implementing the reforms that will make it possible to achieve the results set out in the Program Action Plan.

267. The following MoH divisions will be involved at the central level:

[82] The Program will target rural municipalities in nine regions that are isolated and/or have low rates of antenatal examinations, skilled birth attendance, high rates of child malnutrition and an absence or low level of pediatric integrated care: (a) Oriental; (b) Marrakech Tensift Al Haouz; (c) Tanger Tétouan; (d) Sous Massa Drâa; (e) Gharb Chrarda Beni Hssein; (f) Taza Al Houceima Taounate; (g) Doukkala Abda; (h) Tadla Azilal; and (i) Meknès Tafilalet.

- The DP will be responsible for implementing the Maternal and Infant Health Action Plan and the Action Plan for developing mobile health care teams. The same Division will also be in charge of developing the health management information system and the pilot system in one region of Morocco.
- The DELM will be responsible for implementation of activities related to prevention and treatment of NCDs in ESSPs community health centers.
- The DRH will be responsible for drafting the human resources strategy and overseeing decentralization measures and incentives. However, the introduction of financial incentives will require the approval of the MoF.
- The DHSA will be in charge of encouraging more CSCAs to participate in quality competitions and monitoring the rates of implementation of quality audit recommendations.
- The DPRF will be in charge of developing the HMIS and piloting it in one region.

268. The program will also involve decentralized health sector staff:

- In the regional health directorates located in regional capitals, who are in charge of oversight and coordination of health care institutions' activities, human resources management, fiscal and financial management, and program assessments.
- The prefecture and provincial staff, who are in charge of running, supervising and coordinating preventative and curative health care in their areas; the staff of provincial out-patient care infrastructure departments (SIAAP), who are in charge of coordinating the prefectures' and provinces' health activities relating to prevention, epidemiology, environmental health and out-patient care.
- The medical directors and head nurses of the health centers concerned, who are in charge of administrative management and organizing and delivering care in the health centers.

269. In addition, the National Health Insurance Agency will be mobilized for the HMIS.

270. The MoH's General Secretariat will supervise program implementation with the DPRF acting as the secretariat and providing the Bank with the necessary data, reports, etc.

Environmental and Social Risks Associated with the Program

Main Environmental Risks

271. Overall, all of the negative impacts likely to be generated by the Program affect a limited area. They are easily controllable and manageable, provided that the mitigation measures summarized in the ESSA document and to be set out in detail in the Implementation Manual are applied and carried out during the Program implementation phase. The environmental risks associated with the Program are generally low to moderate in scope, reversible and easily controllable, in view of:

i) The health objective of the Program (improving equitable access to basic care and lowering maternal and infant mortality rates);
ii) The geographical area affected, which is limited to nine target regions;
iii) the low volumes of medical and pharmaceutical waste produced by the CHCs and the CSCAs;
iv) The nature of the Program activities, which are mainly focused on strengthening processes at the MoH and should not create any significant pollution or environmental damage; and

v) The recommended measures to mitigate and monitor impacts, which are familiar, manageable and effective.

272. Public information and participation are guaranteed under the Constitution.[83] However, the system as applied does not include specific mechanisms for public information or consultations, or for managing potential conflicts and thus ensuring that impacts are mitigated to acceptable levels.

273. The activities planned under the Program will produce more medical and pharmaceutical waste due to the increase in access to primary healthcare. Without adequate mitigation measures, this waste could have a negative impact on the natural habitat and natural resources in the case of CHCs and CSCAs located near or in sites of biological or ecological significance or even in nature parks.

274. Most of the planned activities should not raise particular risks in terms of workers safety as the Program is not financing construction work. However, public safety could be affected by the current medical waste disposal practices and also workers involved in the collection, transportation and treatment of medical waste. Public and worker safety protection measures against these potential risks will comply with the relevant national and international regulations.

275. The increase in the fleet of mobile healthcare units will lead to increased pollution and volumes of waste oils. Disposal of this waste must comply with national regulations.

Main Social Risks

276. Given the type of activities carried out under the Program in the 9 target regions (which are aimed at improving rural populations' access to primary maternal and infant health care and screening and treatment of non-communicable diseases (diabetes and hypertension), that are equitable and high quality) the social impacts are expected to be beneficial: improved access to primary health care; lower maternal and infant mortality and morbidity rates; lower prevalence of complications arising from hypertension and diabetes.

277. Furthermore, the Program does not call for any construction work. There will be therefore no acquisition of land or physical resettlement under the program. The activities supported under the Program mainly involve strengthening and improving the quality of care provided by existing community health centers (CHCs and CSCAs) and by mobile teams. In addition to improving the health centers with better and more functional equipment, the Program will improve the working conditions for health care personnel. No adverse economic impacts on vulnerable populations are expected.

278. Risks of negative social impacts are low. They mainly stem from:

a) The weaknesses in equitable access to primary health care, particularly for the most vulnerable populations; and

b) The inadequate handling and response to complaints or grievances from Program beneficiaries.

279. The Program aims precisely at improving equity and inclusion in primary health care in the most disadvantaged rural areas. It introduces measures to manage these risks through its governance

[83] Article 27: Citizens shall have the right to access information held by the public administration, elected institutions and public service bodies.

component, particularly by establishing local mechanisms for accountability and management of complaints.

Environmental and Social Management Systems

Environmental Management System

280. The environmental assessment and monitoring procedures used by DELM need to be updated and completed to overcome the shortcomings identified by the environmental assessment and to comply with national regulations relating to 1) medical waste management, 2) liquid waste management and 3) waste oil management. The main areas for improvement to be included in the Program Implementation Manual that will be provided to SIAAPs and the CHCs and CSCAs are summarized below:

- Packaging and storage procedure for sharp medical waste;
- Packaging and storage procedure for organic medical waste;
- Disposal procedure for sharp medical waste;
- Procedure for on-site disposal of organic medical waste;
- Septic tanks and dry well maintenance procedure;
- Storage and disposal procedure for waste oil; and
- Contents of monitoring reports.

281. It should be noted that the MoH and the Ministry of the Environment are jointly drafting an Order for the implementation of the recommendations under Decree 2-09-139. This Order will be based on the National Plan for Medical and Pharmaceutical Waste Management that is being prepared by the Ministry of Environment in collaboration with the MoH, and with GiZ's support. The Plan is expected to be completed by April 2015.

Social Management System

282. The 2011 Constitution enshrines the right to health[84], equity and non-discrimination[85], participatory governance and social accountability[86] and the recognition of Tamazight as an official language.[87]

283. The MoH conducted extensive public consultations, known as "*Intidarat Assiha*" in 2012 and 2013 in order to identify public and professional expectations and frustrations with regard to the health system. The findings of the consultation gave rise to a White Paper on "New Health Sector Governance," which was presented at the Second National Conference on Health in July 2013.

284. The 2012-2016 health strategy focuses on equitable access to health care (particularly in rural areas) and health sector governance.

[84] The right to life [Article 20], including the fight against preventable mortality; the right to healthcare, the right to health security and medical coverage and to a healthy environment, [Article 31]; the right to health for "citizens and groups with special needs" [Article 34]; the right to " equitable coverage and continuity of treatment" [Article 154

[85] Gender equality (Article 19), and inclusion of persons with special needs (Article 34).

[86] Public consultation and participation in developing and monitoring programs (Article 136, Article 139); petitions (Article 15); access to information (Article 27); management of grievances (Article 156).

[87] Article 5.

285. The community health program was strengthened to improve community involvement and participation. Measures included developing a community participation guide, setting up community health focal points in four regions targeted by the Program (Oriental, Tanger-Tétouan, Taza-Al Hoceima-Taounate, Sous Massa Draa) and inclusion of a community health module in the health training institutes' curriculum.

286. Partnerships were forged with local governments and civil society organizations, particularly for actions concerning maternal and infant health (Dar al Oumouma, health education and promotion activities, medical transport, drug stocks and medical equipment), screening and treatment of non-communicable diseases, and medical caravans. However, these actions do not cover all primary health care institutions, especially in rural areas. Collaborative structures and mechanisms for dialogue, consultation and decision-making have not been officially established. There has been little development of public-private partnerships in rural areas, largely because of the lack of grassroots organizations and the lack of support for such organizations.

287. Under the grievance management arrangements, people who feel disadvantaged by lack of access to care/drugs or corruption may contact Head Nurses, the Medical Directors of Primary Health Care Institutions, the Provincial Delegates or the Regional Managers. Letterboxes have been installed in ESSPs. Complaints are recorded in logbooks. The public can also use mechanisms that are not specific to the health sector, such as rural municipal governments, local governments, independent constitutional appeal bodies (local offices of the National Human Rights Council, the Mediator and the Agency for Preventing and Fighting Corruption). However, most of the complaints are made orally at the local level and are not recorded. The local arrangements for hearing and dealing with complaints are informal and unsuited for rural residents, who are mainly illiterate. This makes it impossible to ensure rigorous monitoring of the types of grievances and the steps taken to address them.

288. As part of quality control, a self-assessment system and a quality competition for ESSPs have been introduced to assess such factors as (i) user satisfaction; (ii) care accessibility and availability; (iii) community participation; and (iv) institutional functionality. This quality control system aims to strengthen the performance of the institutions and promote certification and accreditation.

289. The social management system (laws, regulations, institutions, etc.) as a whole complies with the requirements of OP 9.00, but there are still areas for improvement, such as:

- Systematic inclusion and participation of local populations and grassroots organizations;
- Setting up easily accessible local grievance mechanisms that are adapted to the local population's educational attainment and available in their own language; and
- The social management capacities of Primary Health Care Institution personnel.

Contents of the Program Action Plan

290. Even though the environmental and social impacts of the activities under the Program are categorized as low to moderate, the Program is an opportunity to address the shortcomings mentioned above and to strengthen the MoH's overall environmental and social management system. For this purpose, the Program will support specific measures that are presented in the Program Action Plan and their implementation will be checked during supervision missions.

291. These actions fall into three areas: i) actions to strengthen the environmental and social management system; ii) actions to strengthen implementation and monitoring; and iii) actions to strengthen management capacities.

Strengthening of the Environmental and Social Management System

292. The relevant recommended actions can be summed up as follows:

- Preparation of a Program Implementation Manual (PIM) that includes (i) environmental and social management procedures and tools, (ii) implementation, monitoring, and reporting procedures. The PIM must be simple, easy to use and accessible to all personnel. The final version will be available in French, Arabic and Tamazight. The PIM will: (i) enable the rural primary health care (at SIAAP and ESSP levels) to identify environmental and social impacts and the appropriate mitigation measures; and (ii) provide players with practical tools for assessing and monitoring impacts, and implementing mitigation measures;
- Monitoring and evaluation personnel of SIAAPs will be in charge of monitoring environmental impacts, mitigation measure, and reporting;
- The MoH prepares a diagnostic study of the liquid waste system in rural ESSPs;
- Strengthening of the grievance redress mechanism system (through the accountability and *concours qualite* sub-components); and
- Integration of social and environmental data (collected using the forms appended to the PIM) into the HMIS.

Strengthening Implementation and Monitoring of the Environmental and Social Management System

293. The relevant recommended actions can be summed up as follows:

- Preparation by the nine target regions of regional plans for medical and pharmaceutical waste management, based on the National Plan; their production of annual progress reports on the implementation of the regional plans; and
- Environmental and social reporting: monitoring forms in the PIM will be filled up by the managers of the ESSPs, consolidated at the provincial level and entered into the HMIS. Implementation monitoring reports of the technical portion of the PIM will include monitoring of environmental and social mitigation measures.

Strengthening Environmental and Social Management Capacities

294. The relevant recommended actions can be summed up as follows:

- Training of SIAPPS and ESSP staff in rural areas targeted by the Program on the relevant aspects of the PIM related to social and environmental safeguards; and
- Review of the self-assessment guides by the Quality Unit of DHSA, including monitoring of environmental and social mitigation measures, and full participation in the quality competition for ESSPs.

Annex 7: Integrated Risk Assessment

MOROCCO : Program-for-Results PROGRAM FOR IMPROVING PRIMARY HEALTH IN RURAL AREAS

<table>
<tr><td colspan="5">PROGRAM RISKS</td></tr>
<tr><td>1 Technical Risk</td><td colspan="4">Rating: Substantial</td></tr>
<tr><td rowspan="2">Description: MoH Low Capacity
Overall capacity of the MoH at the central, regional and local levels is relatively limited. The pace of sector reforms has traditionally been slow, due to the lack of skilled human resources and the lack of effective coordination between the different departments of the MoH, and between the central and local levels, despite government’s commitment.</td><td colspan="4">Risk Management: The proposed program is expected to be supported in parallel by the European Union which would provide a Euro 2 Million grant for technical assistance. Some sub-programs are also supported by the UN system (e.g. MCH,). In addition, an MDTF has been mobilized to support the HMIS pillar. Additional TA should be mobilized for GRM, HRH, the verification protocol, and the diagnostic study of the liquid waste system in rural ESSPs.</td></tr>
<tr><td>Resp: World Bank</td><td>Stage: Implementation</td><td>Due Date: recurrent</td><td>Status: In progress</td></tr>
<tr><td rowspan="2">Description: Human Resources for Health

The incentive mechanism that will be defined and prepared may be implemented with difficulties.</td><td colspan="4">Risk Management: Technical assistance is planned to support the design of the scheme. The incentive mechanism will reflect international best practices and its design will involve key stakeholders (the MoF, Ministry of Civil Service, unions, etc.), which should facilitate the Government’s decision to implement it.</td></tr>
<tr><td>Resp: MoH and World Bank</td><td>Stage: Implementation</td><td>Due Date: Recurrent</td><td>Status: Not yet due</td></tr>
<tr><td rowspan="2">Description: HMIS

A. The HMIS system requires an initial design of a set of technical documents and the implementation of a set of technical actions; B. Implementation of the setup of the hardware, software, and data entry, management and dissemination protocols will be challenging; C. There may be competition for control of management of data within the MoH and potential resistance to solutions proposed; D. Sustainability of the sub-program will be at risk if health workers do not buy in to the concept.</td><td colspan="4">Risk Management : Technical assistance towards capacity building and integrated support towards defining strategies and writing of technical documents is planned –MDTF funds towards this task have been mobilized and are proceeding in parallel; B. Technical assistance towards capacity building and support toward setting up hardware and software is planned; C. A technical committee and a steering committee (chaired by the Secretary General) have been created to drive the process and manage internal divisions. A capacity building workshop and a 1-day retreat for the committees was completed in September – MDTF funds towards this task have been mobilized and are proceeding in parallel; D. Two consultative and consensus building workshops are planned for the national M&E and HMIS master plan strategies and will include all key stakeholders. MDTF funds towards this task have been mobilized and are proceeding in parallel.</td></tr>
<tr><td>Resp: World Bank and MoH</td><td>Stage: Implementation</td><td>Due Date: Recurrent</td><td>Status: Ongoing</td></tr>
</table>

<table>
<tr><td>2 Fiduciary Risk</td><td colspan="4">Rating: Moderate</td></tr>
<tr><td rowspan="2">Description: Taking into account the new organic finance law, the MoH needs to put in place an integrated Information system combining financial, budget and performance data.</td><td colspan="4">Risk Management: The HMIS component should take this need into account, making sure that procurement FM and performance data are channeled to the MoH efficiently.</td></tr>
<tr><td>Resp: MoH</td><td>Stage: Implementation (Advanced procurement)</td><td>Due Date: December 2015</td><td>Status: Not yet due</td></tr>
<tr><td rowspan="2">Description:

Delays in submitting the audit report</td><td colspan="4">Risk Management: Auditors need to start their mission in a timely manner and DPRF needs to have all the financial statements ready on time after year close.</td></tr>
<tr><td>Resp: MoH</td><td>Stage: Implementation</td><td>Due Date: December 2015</td><td>Status: Not yet due</td></tr>
<tr><td rowspan="2">Description:

Insufficient knowledge of the new procurement decree effective January 1st, 2014</td><td colspan="4">Risk Management: Capacity building in procurement carried out according to a well elaborated plan from effectiveness throughout implementation start mitigating the low capacity of the MoH staff.</td></tr>
<tr><td>Resp: World Bank</td><td>Stage: Preparation and first semester of implementation</td><td>Due Date: Recurrent</td><td>Status: Ongoing</td></tr>
<tr><td rowspan="2">Description:

Anti-corruption/ debarment and investigation audit measures might not be in place.</td><td colspan="4">Risk Management: The World Bank team to make sure that the relevant provisions are implemented. The MoH to implement the ICPC recommendations.</td></tr>
<tr><td>Resp: MoH and World Bank</td><td>Stage: Preparation and Implementation</td><td>Due Date: Recurrent</td><td>Status: Not yet due</td></tr>
<tr><td rowspan="2">Description:

Lack of fiduciary performance management system</td><td colspan="4">Risk Management: Follow-up of selected and relevant fiduciary performance indicators throughout the program duration</td></tr>
<tr><td>Resp: World Bank</td><td>Stage: Implementation</td><td>Due Date: Recurrent</td><td>Status: Not yet due</td></tr>
<tr><td rowspan="2">Description:

The new GRM system foreseen offers an opportunity to institutionalize the current MoH complaints system.</td><td colspan="4">Risk Management: The GRM system needs to take into account fiduciary related complaints.</td></tr>
<tr><td>Resp: MoH</td><td>Stage: Preparation</td><td>Due Date: December</td><td>Status: Not yet</td></tr>
</table>

			and implementation	2015	due
3 Environmental and Social Risk	**Rating:**	**Moderate**			
Description : The environmental risks associated with the Program are moderate. Yet, the activities planned will produce more medical and pharmaceutical waste. Without adequate mitigation measures, this waste could have a negative impact on the natural habitat and natural resources. The increase in the fleet of mobile health care units will lead to increased pollution and volumes of waste oils. Disposal of this waste must comply with national regulations. The social impacts of the Program are positive, particularly for poor and vulnerable populations in rural areas. The risk for negative social impacts is low. The main risk revolves around the failure to achieve Program objectives themselves, for instance through lack of equity in access to primary health care and failure to properly account for complaints or grievances from beneficiaries.	**Risk Management**: The Program will not finance any activity leading to land acquisition, or involuntary settlement, nor activities that could have adverse economic impact on the population. To manage social and environmental risks, the Program will support specific measures to strengthen: i) the environmental and social management system; ii) system implementation and monitoring; and iii) environmental and social management capacities. These measures are presented in the PAP.				
	Resp: MoH		**Stage:** Preparation and implementation	**Due Date:** Cf. PAP in Annex 8	**Status:** ongoing
4 Disbursement linked indicator risks	**Rating:**	**Moderate**			
Description : Poorly defined DLIs may lead to problems with their reporting and data inaccuracy. Too ambitious targets may lead to failure in reaching them.	**Risk Management**: DLIs and targets were identified jointly with the MoH to ensure they are well defined and achievable. In particular, the proposed DLIs and target values under Pillar I take into account the MoH's experience with the EU's previous budget support operation (PASS I) which included unrealistic or poorly defined targets.				
	Resp: MoH and World Bank		**Stage:** Preparation	**Due Date:** March 10 2015	**Status:** Completed
OVERALL RISK RATING					
Overall, the risk rating for the proposed operation is substantial mainly due the technical difficulties associated with the introduction of new sub-					

programs, the limited implementation capacity, and the resource constraints environment under which the MoH has traditionally operated.

Annex 8: Program Action Plan

Action Description	DLI	Covenant	Due Date	Responsible Party	Completion Measurement
Project Implementation Manual (PIM)					
Finalize the PIM by incorporating the new procedures of the National Plan for Medical and Pharmaceutical Waste Management.	All	No	June 30, 2015	MoH	Revised Manual submitted to the World Bank and judged acceptable by the Bank.
Dissemination and training on social and environmental aspects of the PIM for personnel in the nine targeted regions.	All	No	2016	MoH	Dissemination plan, training plan,
Environmental and social management system (ESMS)					
The responsible persons in the nine targeted regions will ensure follow-up of environmental aspects according to indicators given by the MoH	All	No	April 2016	MoH	Monitoring indicators agreed upon
The nine target regions prepare regional plans for medical and pharmaceutical waste management, based on the National Plan The nine target regions produce annual progress reports on the implementation of the regional plans.	All	No	December 31, 2016 2017- 2018	MoH	9 regional plans 9 annual progress reports
Diagnostic study of the liquid waste system in rural ESSPs	All		December 2015	MoH	Study
The diagnosis of the current GRMs, the strategy and the draft GRM implementation manual are completed The pilot GRM is launched The pilot GRM is evaluated and the implementation manual is reviewed The reviewed comprehensive GRM is rolled out	All	No	December 2015 December 2016 December 2017 December 2018	MoH	Grievance management procedures MIS Reports
Fiduciary System					
Audit 1) Setting up of internal audit and management control functions at the central and regional levels of the MoH. At the regional levels, these functions will be located within the Regional directorate of Health.	All	No	2015-2016	MoH	WB Supervision

2) Agree on improved terms of reference for audit, including procurement and governance				IGF	
Support to the implementation of the new PFM framework and organic finance law. This involves support in the preparation of a multiyear budget and a draft performance plan, contracting and monitoring and evaluation system	All	No	2015-2016	MoH	WB Supervision

Annex 9: Implementation Support Plan

Main focus of Implementation Support

Time	*Focus*	*Skills Needed*	*Resource Estimate*	*Partner Role*
First 24 months	HRH. Support to preparation of implementation of pay-for-performance mechanism: Conception of mechanism, implementation strategy, training of MoH staff, preparation of evaluation plan	Knowledge of pay-for-performance experiences, experience in HRH management	20K	
	GRM. Support to preparation of diagnosis and draft manual of procedures	Operational experience in establishing GRMs	5K	
	Support to the diagnostic study of the liquid waste system in rural ESSPs undertaken	Environmental safeguard specialist	8K	
	Support to the PIM finalization and dissemination plan	Expreiene in Operations Manual	5K	
12-48 months	HRH. Support to implementation, evaluation	Experience in evaluation	20K	
	GRM. Support to implementation and evaluation	Operational experience in establishing GRMs	10K	
Program duration	Monitor overall financial management and procurement systems at country and program levels, including KPIs, (during each supervision mission).	Governance Global Practice team : financial management, procurement, Public Financial Management, Governance	20K	

First twelve months	Advice on the implementation of the petition and access to information policy in the health sector, including anti-corruption and grievance redress initiatives required for the program, (during program supervision missions).	Governance Global Practice team : financial management, procurement, governance	N/A	Implement the petition decree and access to information law
12-48 months	Support to the implementation of the new PFM framework and organic finance law. This involves support in the preparation of a programmatic budget, including a Medium Term Expenditure Framework (MTEF), a performance plan, contracting and M&E system, in the context of the "new Governance framework implementation support project" (P143979).	Budget and performance management expertise	MoH + MoF resources+ with support from the "new Governance framework implementation support project" (P143979)	Implement the new OBL
12-48 months	Capacity building on public procurement	Procurement, contracting and training expertise	MoH	Organize and implement training program Transfer of knowledge
12-48 months	Support to the fiduciary teams working at the *sous-ordonnateur* level in terms of financial programming, financial reporting, budget execution, procurement.	Financial management and governance expertise	MoH	Disseminate at the central and local levels

Task Team Skills Mix Requirements for Implementation Support (per year)

Skills Needed	*Number of Staff Weeks*	*Number of Trips*	*Comments*
TTL	***15***	*2*	*DC based*
Public health Specialist	***7***	*2*	*DC based*
M&E Consultant	***4***	*2*	*Internationally recruited*
GRM establishment and evaluation	***4***		*DC based*
HMIS	***4***	*2*	*DC Based*
Human resources management, capacity building, evaluation	***4***	*2*	*Internationally recruited*
Financial management	***3***	*0*	*Based in Country Office*
Procurement	***3***	*0*	*Based in Country Office*
Environment	***4***	*2*	*DC Based*

Role of Partners in Program implementation

Name	*Institution/Country*	*Role*
EU		*Coordinate with GoM on verification of data for common DLIs* *Joint supervision missions*