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Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 15-May-2020 | Report No: PIDA221770

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BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Program Name	Parent Project ID (if any)
Morocco	P173944	Improving Primary Health in Rural Areas and Responding to COVID-19 Pandemic Emergency	P148017
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
MIDDLE EAST AND NORTH AFRICA	21-May-2020	21-May-2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Program-for-Results Financing	MINISTRY OF ECONOMY AND FINANCE (TGR), Ministry of Health, Kingdom of Morocco	Ministry of Health	

Program Development Objective(s)

The objective of the Program is to expand access to primary health care in targeted rural areas and to strengthen detection and case management to respond to the COVID-19 pandemic in the Program Area.

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	184.57
Total Operation Cost	35.00
Total Program Cost	34.91
Other Costs	0.09
Total Financing	35.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	35.00

World Bank Lending	35.00

B. Introduction and Context

Country Context

1. **This proposed additional financing responds to a request for urgent assistance by the Government of Morocco to support the country in managing the health response to the COVID crisis.** The proposed Additional Financing encompasses funds from the Fast Track COVID-19 Facility (FTCF) in the amount of US$35 million and it also proposes to reallocate US$12.98 million of undisbursed funds from the parent PforR. The AF and reallocated funds would support a new emergency COVID-19 response component under the parent PforR to support the government's emergency COVID-19 health sector response plan and would focus primarily on strengthening case detection, surveillance and case management aspects of the response. The proposed AF is part of a larger program of World Bank support for Morocco which also comprises the restructuring to include a health-related catastrophe trigger in an existing Development Policy Financing with Catastrophe Deferred Drawdown Option (disbursed on April 3, 2020, over US$275 million), a new Development Policy Finance for Financial and Digital Inclusion (expected to be presented to the Board in June) in the amount of US$400 million, and portfolio adjustments to support individual sector responses, all of which seek to improve fiscal space and assist Morocco in reducing the health and economic impact of COVID-19.

2. **An outbreak of COVID-19 caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019**, following the diagnosis of the initial cases in Wuhan, Hubei Province, China**.** On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus has rapidly spread across the world. As of May 26, 2020, the outbreak has resulted in over 5.6 million confirmed cases and over 348,000 deaths in 214 countries and territories. Over the coming months, the COVID-19 outbreak has the potential for an increased number of deaths and economic losses in both developed and developing countries. It will also likely have a negative impact on food and nutrition security, particularly for vulnerable populations including children, women, the elderly (particularly those in assisted living facilities), the poor, and prisoners as demonstrated by previous major outbreaks. While proactive containment measures could reduce the loss of life and economic impact of the outbreak, they also have significant negative effects on the economic outlook outside the health sector. Furthermore, with restrictions on movement and closures in place, and as family members fall sick, the burden of care is likely to fall on women. It is therefore critical for the international community to work together to tackle the underlying factors that are enabling the outbreak, support appropriate policy responses, and strengthen prevention and response capacity in developing countries.

3. **Before the outbreak, Morocco had made significant economic and social progress over the past 15 years.** This was due to large public investments, political, institutional and sector reforms, and measures to ensure macroeconomic stability. The sustained economic growth had resulted in declining poverty, improved life expectancy, as well as improved provision and delivery of public health services. Prudent macro-economic management had led to moderate external debt levels, low inflation, a competitive exchange rate and had earned the country an investment grade rating in BBB-.

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Development challenges included significant inequalities, particularly between urban and rural areas, and job creation which fell significantly behind the numbers of young people entering the labor force. High youth unemployment and inactivity resulted.[1] Economic growth, though, was forecasted to rise to 3.6 percent for 2020 before the COVID outbreak started.

4. **Morocco is entering a deep recession due to the outbreak, with both fiscal and external deficits widening rapidly.** Potential tightening of credit conditions, weaker growth, and the diversion of expenditures to fight the outbreak are likely to cut into government revenues and its ability to invest to meet infrastructure, education, health and gender goals. This is driven by a drop in the production of goods and services, a reduction in exports, disruption of global value chains, as well as a decline in tourism due to travel restrictions and border lockdowns. Morocco's economy has plunged into a deep recession, exerting a negative effect on GDP: according to the International Monetary Fund, the 2020 projected real GDP growth is expected to be -3.7 percent (annual percentage change)[2]. The growth contraction is primarily due to the impact of the COVID-19 pandemic on non-agricultural growth (-4.2 percent in 2020). The crisis will also adversely affect the fiscal deficit and in turn central government debt as tax revenues, customs duties and grants decline, and as the authorities ramp up spending on healthcare and social safety nets. The fiscal deficit is projected to rise to 7.5 percent of GDP in 2020 (compared to a projected 3.7 percent pre-COVID-19 pandemic) and consequently, the central government debt will grow to 76 percent of GDP in 2020 compared with 65.7 percent in 2019. The current account deficit is expected to widen significantly in 2020 from 4.1 percent of GDP in 2019 to 8.4 percent in 2020.

5. **Morocco is confronting the COVID-19 pandemic and has already taken significant steps to contain the outbreak within the country.** As of May 26, 2020, the outbreak has resulted in 7,556 confirmed cases, including 202 deaths.[3] Over 4,800 cases have recovered. Most reported cases are in the urban regions of Casablanca-Settat (31 percent), Marrakech-Safi (18 percent), Tangier-Tetouan-Al Houcima (14 percent), and Fes-Meknes (14 percent), with continued growth in confirmed cases across the country, demonstrating the need for a national response. As of March 18, 2020, the government has taken stringent measures to contain the virus. International flights have been cancelled and maritime and land borders have been closed. Gatherings of over 50 people are banned, and public venues, schools, mosques and non-essential businesses are closed. A state of emergency was declared on March 20, 2020 until May 24, 2020 and a 12-hour daily curfew is imposed, extended until June 11, 2020. The government has also created an inter-ministerial COVID-19 commission composed of representatives from the Ministry of Health (MoH), the Royal Gendarmerie, the Ministry of Interior and other key stakeholders. Furthermore, Morocco has set up a special COVID-19 Pandemic Fund with an estimated financing amount of approximately US$3 billion to deal with the emergency. The Fund is intended to stimulate the national economy, especially sectors that are heavily impacted by the crisis, lessen social stresses related to COVID-19 and cover health sector response.

6. **Morocco has been augmenting its level of preparedness and response to prevent the potential for greater loss of life.** To finance the immediate health sector response, the government has

[1] Chauffour, J-P et al. 2018. *Kingdom of Morocco. Governing Towards Efficiency, Equity, Education, and Endurance. A Systematic Country Diagnostic.* World Bank Group. Available publicly for download at http://documents.worldbank.org/curated/en/375771529960237724/Morocco-Systematic-Country-Diagnostic

[2] https://www.imf.org/en/Countries/MAR#ataglance

[3] http://www.covidmaroc.ma/pages/Accueil.aspx

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committed and transferred a total of US$195 million from the COVID-19 Fund to the MoH budget. The committed resources contribute to finance the government's preparedness plan which was developed in collaboration with WHO, including drugs, equipment and medical supplies. On April 1, 2020, the MoH announced the acquisition of 100,000 tests, and COVID-19 testing capacity has been reinforced in 13 public and private laboratories. The government has also invested in the production of masks and hydroalcoholic solutions and regulated their prices. Standard operating procedures and protocols for quarantine, isolation, case management, and infection prevention and control (IPC) have been developed. In terms of actual isolation/quarantine and case management, several military facilities (including temporary hospitals - *Hôpitaux de campagne*) have been mobilized at the regional level, while 46 public hospitals were strengthened to handle and treat coronavirus patients. For COVID-19 cases, the government has been scaling up hospital beds and intensive care units (ICU) capacity, bringing the total capacity of ICU beds to 1,640 and the total number of hospital beds to over 20,000.[4] Private clinics will be called upon if the number of cases cannot be accommodated in public facilities. 138 ambulances were dedicated to COVID-19 response, and efforts are ongoing to reinforce health workers capacity. Three hotline numbers were put in place and Information, Education and Communication materials and messages have been developed. A fully electronic health information system has been put in place which will regularly be updated with laboratory testing results, enabling real-time epidemiologic reporting and informing evidence-based decision-making.

7. **Morocco needs to mobilize additional resources in the short term to combat COVID-19.** As noted earlier, the government announced a COVID-19 Fund of US$3 billion to respond to immediate needs in the health sector and provide an economic stimulus. While significant funding has been sourced domestically, raising additional funds quickly remains critical to expanding fiscal space and ensuring sustained support to respond to the pandemic. Therefore, Morocco has been mobilizing support from various partners for that purpose, including: (i) in-kind donations from China and Center for Disease Control - Africa; (ii) US$650,000 (6.6 million Moroccan Dirham - MAD) from the United States Agency for International Aid (USAID) to strengthen laboratory capacity; (iii) US$3.4 million through a United Nations COVID-19 support plan which includes US$2.4 million from WHO and US$662,000 from the United Nations Children's Fund (UNICEF); and (iv) the potential reallocation of planned support in the amount of 300 million Euros from the European Union (EU) towards budget support to combat the pandemic. Similar support has been proposed by the French Development Agency, United Nations Population Fund, European Investment Bank, Islamic Development Bank and African Development Bank, focusing primarily on budget support and medium-term assistance. Discussions are in progress with the government with regards to finalizing the extent of additional donor support.

Sectoral and Institutional Context

8. **Morocco has recorded significant improvements in its health outcomes over the past few decades.** Maternal mortality ratio has decreased by almost 68 percent in 25 years (1992-2018)[5] and under-five mortality level has been reduced by 64 percent during the same period. However, when compared with regional peers with similar socio-economic levels, Morocco's indicators appear to be lagging.[6] Furthermore, Morocco faces significant inequalities between rural and urban areas in terms of

[4] https://atlasinfo.fr/coronavirus-le-maroc-dispose-de-1-640-lits-de-reanimation.html
[5] Source: Demographic and Health Survey (enquête nationale de la population et de la sante de famille - ENPSF) 2018
[6] In 2018, Maternal Mortality Rate in Morocco stood at 72.6 per 100,000 livebirths, compared with 44.3 in Tunisia and 15 in Lebanon. Under five mortality rate was 22.16 per 1,000 livebirths compared with 14 in Tunisia or 8 in Lebanon.

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health outcomes and particularly in relation to maternal and child mortality indicators, as well as stunting.[7] Morocco has also been undergoing an epidemiological transition, with over 75 percent of the mortality being attributable to non-communicable diseases (NCDs) mainly due to an increasing burden of hypertension and diabetes for both sexes.[8] According to the 2017-2018 STEPwise Approach to NCD Risk Factor Surveillance survey, women have a higher prevalence of hypertension, diabetes, cholesterol and obesity. The epidemiological transition has been coupled with a demographic transition where average life expectancy is 76 years, 12 percent of the population is aged over 60 years, and the total fertility rate is 2.4 births per woman. The combination of an aging population and increasing NCD prevalence puts Moroccans at elevated severity and mortality risk associated with COVID-19. Additionally, disrupted services due to attention on COVID-19 combined with movement restrictions and concerns surrounding access to care during an infectious outbreak could result in fewer women receiving antenatal care particularly in some rural areas where resources are more constrained and distances to health care facilities are far.[9]

9. **Morocco has been engaged in a process to establish universal health coverage since 2002.** Health financing reform was launched in 2002 with the aim of establishing universal health coverage through: (i) subsidized social health insurance (*Régime d'Assistance Médicale*-RAMED) for the poor and vulnerable groups; and (ii) non-subsidized mandatory health insurance schemes for salaried workers (*Assurance Maladie Obligatoire*). Despite these efforts, only 68.8 percent of the population was covered in 2019, with those in rural areas having significantly lower coverage than those in urban areas. In addition, Morocco has one of the lowest per capita health spending in the Middle East and North Africa region at US$161 per capita, of which only US$69 is financed by the government. Due to low public spending on health at 8 percent[10] of the national budget, health spending predominantly comes from out of pocket payments by households. This situation is likely to be further aggravated with the COVID-19 pandemic, posing additional financial burden on households when seeking needed care and potentially reducing care-seeking behavior.

10. **Morocco has put great efforts to strengthen access to primary health care both in rural and urban areas over the past decade.** Along with the roll out of RAMED, the government has engaged in several actions to increase equitable access to primary care and improve the service delivery in health care facilities in both urban and rural areas, as well as rolling out specific plans to reduce maternal mortality and improve coverage for NCD interventions. The government is also implementing an ambitious reform program, *Plan Santé 2025*, aimed at improving access to health services particularly through strengthening primary health systems in rural areas, strengthening disease control programs and improving governance and resource allocation.

[7] For example, while the under-five mortality rate declined from 47 to 22.16 deaths per 1,000 live births from 2003 to 2018, it remained at 25.99 in rural areas compared with 18.81 in urban areas. Significant inequalities were also reported in terms of stunting: the 2018 stunting rate in rural areas (20.5% in 2018) is twice the rate in urban areas (20.5 percent in rural versus 10.4 percent in urban areas).

[8] *Enquête nationale sur les facteurs de risque communs des maladies non transmissibles* - STEPWISE (2017-2018) - According to the 2018 STEPS survey, 29% of the population suffers from hypertension, 11% from diabetes, and an additional 10% are pre-diabetic. https://www.who.int/ncds/surveillance/steps/STEPS-REPORT-2017-2018-Morocco-final.pdf & IHME Global Burden of Disease data, http://ghdx.healthdata.org/gbd-results-tool

[9] https://www.weforum.org/agenda/2020/04/covid-19-coronavirus-pandemic-hit-women-harder-than-men/

[10] Source WHO, 2017 data

11. **While the government has been improving its capacity to respond to the COVID-19 pandemic, gaps remain in terms of health system and surveillance capacity.** According to the latest Global Health Security (GHS) index, Morocco ranks 68th out of 195 countries, and performs less in some key areas, such as real time surveillance and reporting capacity, epidemiology workforce, health capacity in clinics and hospitals, healthcare access as well as public health and surveillance capacity and financing.[11] According to WHO, Morocco has an International Health Regulations core capacities average score of 75 percent, with its coordination and health service provision having the lowest scores.[12] Currently, testing capacity remains low, with Morocco ranking 105th out of 148 countries in terms of tests done. As of May 19, 2020, Morocco has conducted 100,367 tests, translating into 3 tests per 1,000 population, which is significantly below the 30 tests per 1,000 population threshold recommended for reopening.

Additional financing request

12. **In order to be able to respond quickly and fight the impacts of COVID-19, Morocco has requested urgent assistance from the World Bank to immediately support the health response and economic stimulus.** As a result, the Bank: (i) agreed to the Ministry of Economy, Finance and Administrative Reform's (MEFAR) March 16, 2020 request to restructure the Development Policy Financing with Catastrophe Deferred Drawdown Option (CAT DDO) and include a health-related catastrophe trigger, which led to the disbursement of US$275 million; and (ii) in response to the MEFAR's request of March 26, 2020, initiated the preparation of **a proposed additional financing (AF) with funds from the Fast Track COVID-19 Facility (FTCF) in the amount of US$35 million and with US$12.98 million coming from a reallocation of undisbursed funds from the parent PforR**. The AF and reallocated funds will support a new emergency COVID-19 response component under the parent PforR. These financing sources will support the government's emergency COVID-19 health sector response plan and will focus primarily on strengthening case detection, surveillance and case management aspects of the response.

PforR Program Scope

13. **The original Program "Improving Primary Health in Rural Areas Program-for-Results" scope was composed as follows:** It included seven Disbursement-linked Indicators (DLIs) focusing on improvements in antenatal care visits, skilled deliveries, number of sick child visits, diabetes diagnosis and treatment, overall visits to rural primary health centers, participation of health facilities in quality competitions, and establishment of health management information system (HMIS). The Program was meant to address Morocco's low public health financing, lack of financial risk protection and significant inequality between urban and rural areas in terms of access to health services. In addition, it meant to address poor maternal and child health outcomes in rural areas associated with low utilization of health services and a lack of an integrated focus on primary care. In addition, the Moroccan health system was also struggling to respond to a dual burden of disease emerging from a significant increase in the burden of NCDs with limited coverage for the diagnosis and treatment of hypertension. Through the preparation of the operation, the World Bank engaged with the government to define the two results areas to strengthen the health system with a focus on benefiting the rural population, by expanding the

[11] https://www.ghsindex.org/wp-content/uploads/2019/08/Morocco.pdf
[12] https://extranet.who.int/e-spar

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coverage of maternal and child health services and primary level services addressing NCDs and improving quality assurance and information systems. The process of defining these results areas was an entry point into a sector with limited ongoing policy dialogue, as well as an opportunity to address the constraints related to the building blocks of the health system.

14. **Under the AF, the scope of the parent PforR would be expanded to include a new results area on the emergency COVID-19 response and support** to strengthen prevention, detection, surveillance and case management. As mentioned above, Morocco has already commenced a program of response with the MEFRA allocating additional resources to the MoH for the COVID-19 response. The PforR will therefore be optimal as an accountability and prioritization tool, replenishing some of these much-needed resources to the MEFRA for other critical aspects of their emergency response. It will also provide significant support to the MoH to: (i) help ensure that the resources are planned and implemented effectively in responding to the COVID-19 crisis; quickly and effectively improve detection and surveillance; and (ii) strengthen the health system and hospital readiness for this emergency. In addition, the AF builds on the already strengthened primary health system supported under the parent PforR such as improvements in access to primary care especially for non-communicable diseases and for those in remote areas through mobile medical units. This will further mitigate the comorbidity threat posed by COVID-19, given its more significant adverse impact on those with unmanaged NCDs. Similarly, it will ensure the continuation of essential services, as well as continued investments in human capital.

15. **The financing of the proposed new program area will rely on two sources:**

(a) **Undisbursed funds under the parent PforR with two disbursement-linked indicators (DLIs) expected to be partially achieved.** Specifically, the DLI related to the deliveries attended by skilled health personnel in rural public health facilities (DLI2) has not fully achieved its yearly targets and recent calculations show that, as a result, an approximate US$12.23 million will not be disbursed by December 31, 2020. In addition, the DLI for quality assessment (DLI 6), for which results were only partially achieved in 2015, will not fully disburse at the end of the Program, leaving US$0.75 million undisbursed. Hence, a total of US$12.98 million would be reallocated to support the new COVID-19 program area.

(b) **A funding envelope of US$35 million** is available for Morocco under the FTCF.

16. Channeling this AF within the parent PforR will enable rapid response in the short term. The proposed additional financing represents an expansion of the scope of the parent Program and it uses the same implementation arrangements and infrastructure to facilitate the rapid scale-up of financing. Furthermore, additional financing will allow the government to continue monitoring the original results framework and documenting progress towards achievement of the original Program objectives, which remain relevant. As such, the combination of additional financing and reallocation of funds towards the emergency COVID-19 response will support an effective and rapid response to the pandemic.

Proposed changes

17. The proposed changes to the parent PforR include: (i) reformulating the PDO; (ii) revising the results framework, namely, (a) reducing the scope of two DLRs whose achievement is rendered even more difficult by the COVID-19 crisis and (b) introducing two new DLIs and an intermediate results

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indicator for improving testing capacities and case management for COVID-19; (iii) reallocating undisbursed funds under the two DLIs (US$12.98[13] million) to support the COVID-19 response; (iv) extending the parent PforR closing date from December 31, 2020 to June 30, 2021; and (v) adding a new results area focusing on emergency COVID-19 response. While the parent PforR focuses on rural areas of seven regions, the added results area would support both rural and urban areas of nine regions, including the already supported seven regions, given the generalized nature of the COVID-19 pandemic. These changes are further detailed in the following sections.

C. Program Development Objective(s)

Program Development Objective(s)

18. **The new PDO would be "to expand access to primary health care in targeted rural areas and to strengthen detection and case management to respond to the COVID-19 pandemic, in the Program Area."[14]** The expanded PDO would ensure that the PforR can help respond to the threat posed by the COVID-19 pandemic while continuing to strengthen the health system and enabling responsiveness to this emergency by supporting the government's pandemic preparedness plan. Achievement towards the revised PDO and expanded objective will be measured through a revised results framework to include four new indicators:

(a) **PDO level indicators:**
- **PDO indicator 5** (new DLI 8): "Number of Polymerase Chain Reaction (PCR) tests conducted to diagnose COVID-19"; and
- **PDO indicator 6** (new DLI 9): "Number of health care facilities designated COVID-19 facilities and equipped as per MoH guidelines".[15]

(b) **Intermediate results indicator:**
- "Number of designated laboratories with COVID-19 diagnostic capacities established per MoH guidelines".

19. **The parent PforR indicators remain valid and relevant, and the original objective is largely achievable.** It was agreed that the government would continue tracking progress related to the original indicators as part of the MoH's routine monitoring exercise with no additional disbursement to be made beyond original time period of the parent PforR (2015-2018) for the original results areas regardless of additional progress being made beyond this period.

[13] Exact undisbursed amount under parent PforR is US$ 12,981,261.4

[14] Program Area under the parent program refers to DLIs 1 to 7 implemented in rural areas for seven targeted areas, namely "*regions of Béni Mellal-Khénifra, Drâa-Tafilalet, Fès-Meknès, Marrakech-Safi, Oriental, Souss-Massa and Tanger-Tétouan-Al Hoceïma*". The expanded Program Area for DLI 8 and 9 includes urban and rural areas of nine regions, three provinces and one municipality in the south, namely *" (a) regions de Béni Mellal-Khénifra, Casablanca-Settat, Drâa-Tafilalet, Fès-Meknès, Marrakech-Safi, Oriental, Rabat-Salé-Kénitra, Souss-Massa and Tanger-Tétouan-Al Hoceïma; (b) provinces of Guelmim, Tan-Tan and Sidi Ifni; and (c) municipality of Assa."*

[15] MoH guidelines are being updated, and equipment lists for ICU units and treatment centers have already been developed. ICU unit equipment includes resuscitation ventilators, oxygen supplies and defibrillators, beds and trolleys. Similar equipment lists have been defined for isolation rooms. Criteria for designation includes geographic location as well as facility capacity..

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D. Environmental and Social Effects

20. **The expanded scope of the AF introduces new environmental or social risks.** The Environmental and Social (E&S) systems ratings were moderately satisfactory over most of the parent Program implementation period, mostly due to the delayed hiring of E&S focal points in the MoH and the regions. The designation of such E&S specialists will be necessary to manage the increased scope of the Program. The expansion of testing and the increased demand on medical personnel will require the E&S systems to include: (i) management of data and data privacy regarding testing results and confidentiality of patients' data; (ii) the safety of medical personnel dealing with COVID-19 patients and, ultimately, other infectious diseases; and (iii) solid waste management including health care facility infectious waste. Volumes of such waste will increase because of higher generation of PPEs such as gloves, face and nose masks, waterproof protective gowns, rubber boots, rubber aprons, paper tissues and other contaminated materials. The protection of medical personnel is supported through the acquisition of PPE and improved hygiene in hospitals, which is covered by an indicator of the additional financing. Morocco's law No 09-08, dated February 18, 2009 relating to protection of individuals regarding the processing of personal data and its implementation Decree n° 2-09-165 of May 21, 2009 (together with the Data Protection Law), with the Data Protection National Commission (*Commission Nationale de Protection des Données Personnelles*) as authority, are the framework governing data protection and privacy.[16] Data protection requirements are intended to be aligned with EU requirements. Personal data is defined as any information regardless of their nature and format, relating to an identified or identifiable person, including genetic data, and does thus cover patients and other data created in the hospitals and laboratories.

21. **Improvements of the E&S systems:** Further improvements will be needed in the field of solid waste management in hospitals and field hospitals, including collection, storage, transport, treatment and disposal. The management of wastewater and grey water will need to be strengthened and improved, mainly at the level of field hospitals. Acquisition of private land should not be necessary for the AF as for the parent Program, and activities requiring such acquisition will be excluded from the Program. Applicable protocols and guidelines of MoH will contain mechanisms to ensure the inclusion of vulnerable populations (elderly people, youth, female-headed households/widows, orphans, the homeless, etc.), including regarding communication and access for all. Protocols will have to ensure infected persons, women and men, in remote areas will have equal access to the Program benefits, and that guidelines are followed during the pandemic such as WHO guidance on risk communication and community engagement.[17] The Grievance Redress Mechanism (GRM) of the Program has been fully rolled out and integrated with a national system (Chikaya.ma) as well as rolled out regionally. It is receiving and resolving several thousand complaints per year. The Program will be further strengthened centrally and regionally to be able to manage the enlarged regional scope and new tasks under the AF, including grievances that will arise during the COVID-19 crisis.

[16] https://www.cndp.ma/images/lois/Loi-09-08-Fr.pdf, https://www.cndp.ma/images/lois/Decret-2-09-165-Fr.pdf, https://www.cndp.ma/fr/

[17] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/risk-communication-and-community-engagement. Community messaging will also take into account different gender-based differences in hygiene and sanitation practices, as well as the different role women and men play at home and in society. https://www.who.int/docs/default-source/coronaviruse/covid-19-sprp-unct-guidelines.pdf

22. **An Environmental and Social Systems Assessment (ESSA) addendum is being finalized to assess the program's E&S systems ability to handle the AF.** The ESSA addendum assesses the existing health waste management protocols of MoH, protocols of laboratories and data controllers regarding data confidentiality, and existing protocols regarding the protection of medical personnel, in settings such as ICU and quarantine units. The ESSA of the parent Program was consulted with representatives of civil society on February 4, 2015. Stakeholders that have not yet been included in consultations may be laboratories and other data controllers regarding the treatment of testing data. Additional consultations are being conducted prior to the completion of the additional financing appraisal through non-contact methodologies as appropriate. Comments of such public consultations will be included in the final ESSA addendum and action plan. In addition, consultations will be undertaken during the program implementation to ensure communication with stakeholders and beneficiaries, following established WHO and MoH protocols. To the extent possible, data collection and monitoring will be done in a sex and age disaggregated manner to contribute to a better understanding of the demographic profile of the affected population.

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E. Financing

23. **Expenditure framework analysis.** Under the parent PforR, the total budget of the government program for 2015-2018 was US$246 million and the parent PforR contributed US$100 million. The expenditure program defined under the parent program will remain the same under the scope of the new Program, and it will be documented accordingly. The new total government program is therefore US430.57 million and the PforR will contribute US$ 135 million.

24. As afore-mentioned, Morocco's public spending on health remains very low compared with regional peers and health spending as percentage of national budget has been stagnant around 7% between 2010 and 2017. The government has been increasing its budget slightly in 2019 and 2020 to cover the new *plan santé* 2025 related activities. However, the COVID-19 pandemic has posed stringent constraints on the MoH budget, and since the declaration of state of emergency, the government has allocated an additional budget of US$195.3 million to the MoH. The allocated amount is to support activities related to COVID-19 emergency response, including detection, surveillance and case management. The allocated budget finances the procurement of drugs, equipment and medical supplies, which not only includes fund transfers to the trust account of the central pharmacy, but also the purchase of technical equipment, hygiene and disinfection products, and other medical equipment for laboratories and hospitals. Table 1 below summarizes the government budget to respond to the emergency COVID-19 component and the corresponding AF government program which is US184.57. The proposed Program will cover US$47.98 million of the government COVID-19 emergency response budget (table 2). The Program expenditure constitutes only 26 percent of the government program and will mainly focus on the immediate response through provision of equipment and supplies needed for detection, surveillance and case management.

Table 1: Ministry of Health Budget Composition for COVID-19 Emergency Response

Category of expenditures	Government COVID Financing (US$)		Government program scope (US$) for AF
Maintenance allowance	US$	976,563	0
Drugs, equipment and medical supplies	US$	184,570,313	184,570,313
Other operating costs	US$	5,859,375	0
Human resources (allowances)	US$	3,906,250	0
Total	US$	195,312,500	184,570,313

Table 2: Additional program financing by source of financing

Source	Amount (USD$, million)	%
Total operation financing	184.57	100
Counterpart financing	136.59	74
PforR IBRD financing	12.98	7
COVID-19 Facility	35	18.9

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New results area proposed under the AF

25. **In line with the government priorities, one results area would be added to the Program to focus on the emergency COVID-19 response**. This results area would be to provide immediate support to respond to the COVID-19 pandemic. In particular, it would support enhancement of disease detection capacities through provision of technical expertise, laboratory equipment and systems to ensure prompt case finding and contact tracing consistent with WHO guidelines in the Strategic Response Plan. It would also enable Morocco to mobilize surge response capacity through trained and well-equipped frontline health workers. Supported activities which will be supported and monitored during the Program lifetime would include:

- **Case Detection, Case Confirmation, Contact Tracing, Case Recording and Case Reporting.** This would help: (i) strengthen disease surveillance systems, public health laboratories, and epidemiological capacity for early detection and confirmation of cases; (ii) combine detection of new cases with active contact tracing; (iii) support epidemiological investigation; (iv) strengthen risk assessment, and (v) provide on-time data and information for guiding decision-making and response and mitigation activities. Additional support would be provided to strengthen health management information systems to facilitate recording and on-time virtual sharing of information.

- **Health System Strengthening.** The Program would support the health care system for preparedness planning to provide optimal medical care, maintain essential community services and minimize risks for patients and health personnel, including training health facilities staff and front-line workers on risk mitigation measures and providing them with the appropriate personal protective equipment (PPE) and hygiene materials. Strengthened clinical care capacity could be achieved through financing plans for establishing specialized units in selected hospitals, treatment guidelines, clinical training of health workers and hospital infection control guidelines. This would include support for intensive care facilities within hospitals with medical equipment and training of health teams.

26. **Two DLIs will incentivize this results area** as follows: (i) DLI 8 "Number of Polymerase Chain Reaction (PCR) tests conducted to diagnose COVID-19" (US$21 million); and (ii) DLI 9 "Number of functional health care facilities designated COVID-19 facilities and equipped as per MoH guidelines" (US$26.98[18] million).

27. Finally, and in line with the current implementation circumstances, the Program monitoring and reporting will be on annual basis to cover the end of each calendar year.

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[18] The exact amount is 27,981261.4

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