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FROM: The Deputy Secretary

July 27, 1995

PROJECT COMPLETION REPORT

MOROCCO

Health Development Project

(Loan 2572-MOR)

Attached is a copy of a memorandum from Mr. Picciotto with its accompanying report entitled "Project Completion Report: Morocco: Health Development Project (Loan 2572-MOR)" dated June 26, 1995 (Report No. 14675) prepared by the Middle East and North Africa Region, with Part II contributed by the Borrower.

Distribution

Executive Directors and Alternates
Office of the President
Senior Management, Bank, IFC and MIGA

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PROJECT COMPLETION REPORT

MOROCCO

HEALTH DEVELOPMENT PROJECT
(LOAN 2572-MOR)

JUNE 26, 1995

Human Resources Division
Country Department I
Middle East and North Africa Regional Office

CURRENCY EQUIVALENTS

At appraisal:

US$1 = Dirham (DH) 9.47
DH1 = US$0.106

1986-1994 Period Average

US$ 1 = DH 8.4
DH 1 = US$ 0.120

FISCAL YEAR OF BORROWER

January 1 - December 31

ABBREVIATIONS AND ACRONYMS

ADB	African Development Bank
FP	Family Planning
IEC	Information, Education and Communication
GDP	Gross Domestic Product
MCH	Maternal and Child Health
MOPH	Ministry of Public Health
PPF	Project Preparation Facility
SIAAP	Service d'Infrastructure des Actions Ambulatoires Provinciales (Division in charge of ambulatory services at provincial level)
UAM	Unité d'Approvisionnement en Médicaments (Drug Supply Unit)

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

June 26, 1995

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: ***Project Completion Report on Morocco Health Development Project (Loan 2572-MOR)***

Attached is the Project Completion Report (PCR) on the Morocco Health Development project (Loan 2572-MOR, approved in FY85) prepared by the Middle East and North Africa Regional Office. Part II was prepared by the Borrower.

The main objective of the project was to accelerate the transition from an urban based and hospital-oriented health system to a more cost-effective system of primary care services emphasizing outreach in rural areas. To achieve this objective the project was to (a) strengthen primary health care delivery, including family planning, in three provinces; (b) strengthen the capacity of the Ministry of Public Health (MOPH) in planning, training, research, evaluation and health service administration; and (c) improve the supply, distribution and control of drugs.

Implementation of primary health care activities in the three pilot provinces was successful as demonstrated by improvements in the accessibility of services and service utilization. Efforts to strengthen the support system were less successful partly because the MOPH was reorganized several times during project implementation. Moreover, the training and health education activities included in the original project design were absorbed into projects financed by other donors and were not evaluated in the PCR. Studies of hospital management and health financing were delayed, but eventually proved useful to the borrower. The drug supply component was a source of considerable discussion throughout project implementation, and resulted in little apparent impact on drug policy.

The outcome of the project is rated as satisfactory. Improvements in the approach to primary health care delivery piloted under the project are being extended to non-project provinces. However, the financial sustainability of the primary health care approach established by the project is uncertain, and is the subject of a continuing dialogue with the borrower. Sustainability is therefore rated as uncertain. Institutional development is rated as modest as systems for assuring local adaptation of service delivery models remain dependent on continued prodding from the central administration rather than on improved organization and better incentives in regional and local administrations.

The PCR provides an adequate account of project implementation. An audit is planned.

Attachment

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PROJECT COMPLETION REPORT

MOROCCO

HEALTH DEVELOPMENT PROJECT
(LOAN 2572-MOR)

Preface

This is the Project Completion Report (PCR) for the Health Project in the Kingdom of Morocco, for which loan 2572-MOR in the amount of US$28.4 million equivalent was approved on June 6, 1985 and made effective on July 29, 1986.

The loan was closed on December 31, 1993 after two extensions from its original closing date of December 31, 1991. Final disbursement took place on April 12, 1994, at which time a balance of US$ 2.6 million was canceled.

The PCR was prepared by Claire Voltaire, MN1HR of the MENA region and reviewed by Roslyn G. Hees, Division Chief, MN1HR, and René Vaurs, Acting Project Adviser, MN1DR.

Preparation of this PCR was begun during the Bank's final completion mission in May 1994. It is based on material in the project file, on the Borrower's financial completion report and on its impact evaluation of the basic health component which was carried out by the three pilot provinces and the Institut National d'Administration Sanitaire. (See Annex).

MOROCCO
HEALTH DEVELOPMENT PROJECT
(LOAN 2572-MOR)

Evaluation Summary

Project Objectives and Description

1. The project aimed at accelerating the shift from an urban-based hospital-oriented health system to a more cost-effective system of primary care emphasizing outreach activities in the rural areas. To that end, the project included four components which aimed at improving: (i) primary care delivery in three pilot provinces by strengthening the infrastructure and equipment as well as the logistics and monitoring of the programs delivery, and the training of medical staff; (ii) the management capacity of the Ministry of Public Health (MOPH) at both central and provincial levels, in terms of planning, training, research and evaluation, and health service administration; (iii) training and IEC programs; and (iv) the supply of basic drugs by establishing a coordinated system for the procurement, storage, formulation, packaging, distribution and control of drugs for the public system.

Summary of Findings

2. The project has mixed results. Two of the four components were completed:

a. The Primary Health Care component was fully implemented in its physical and "software" aspects though a large share of the new facilities only became functional at the very end of the project; to date 29 health facilities out of the 126 (more than 20%) built remain closed due to insufficient staff to man them. In contrast, reorganization of service delivery, planning, supervision and monitoring methods were put in place at the start of the project and are well assimilated by staff in all three provinces. The project has indeed permitted to improve population coverage.

b. It is difficult to measure the extent to which the project has strengthened MOPH management capacity as the ministry underwent several reorganizations during project implementation. While management of civil works certainly improved, procurement, program budgeting and resource allocation remain serious issues for the MOPH. The outcome of the two studies on the financing of the health sector and on hospital management which were carried out is uneven: (i) the health financing study was of good quality and served as a basis to the discussions on health financing reforms which have culminated with the preparation by the Government, with Bank support, of a health insurance reform proposal; (ii) the Hospital Management Study output is more difficult to assess as its diagnostic phase was never followed by the prospective one that was intended to specify and test the options for reform.

c. Training and IEC Component: Only 25% of the funds allocated to this component were disbursed, due to the availability of bilateral funds to finance training activities.

d. Improvement in the supply of basic drugs: This component remains incomplete. Equipment for the drug Unit built under the project has yet to be purchased and, despite some improvements, the Central Pharmacy organization, procedures for the procurement and distribution of drugs remain an issue for the MOPH.

4. Several factors adversely affected project implementation. In particular: (i) the lack of counterpart funds as a result of the economic situation, delays in allocation and release of funds and the weak capacity of MOPH to manage commitments and disbursements; (ii) frequent organizational and staff changes in the MOPH which resulted in a lack of continuity of the dialogue; and (iii) the relative passivity of the Bank contribution in its comments to studies and progress reports and in proposing remedial actions. The main findings of this post-evaluation are the following:

a. The financial sustainability of the system needs to be addressed without delay. The MOPH has already integrated this lesson in its dialogue and indicated its intention to proceed with new investments only when the sustainability of the sector has been addressed i.e, when adequate investment and more importantly recurrent resources can be secured. To that end, the preparation of the proposed FY96 Health Management and Financing Project has been halted. If project does not proceed, the health sector sustainability should be addressed through the FY96 Social Priorities Project.

b. The overall organization of the pharmaceutical sector and the provision of drugs to the public sector need to be reviewed. A thorough review of the pharmaceutical sector and the development of a drugs policy for the public sector should be carried out prior to any further financing of drugs in a project.

c. The policies and project activities cannot be divorced from their implementation structure: The current organization of the MOPH and of the medical provinces is ill-adapted to the objectives pursued by the MOPH and discourage efficiency and accountability. While MOPH is fully aware of this issue and has prepared a new organizational chart more in line with its objectives, it has not yet been implemented. Implementation arrangements for future projects should be an integral part of their design and should take into account the overall organizational structure of the Ministry, or should not proceed without addressing needed changes.

d. The impact of the strategies deployed to deliver basic services (fixed facilities outreach techniques and better organization) should be assessed carefully to facilitate the development of a cost-efficient approach, adaptable to the specificities of each region.

e. The Bank should have a more pro-active attitude in its comments and proposals for remedial actions (ie. restructuring of the project, increasing the supervision of "pilot/demonstrative" aspects of the project). The preparation of new projects should not start before the results of the previous project can be built on, and lessons learned so as to be integrated into the new design.

5. Overall assessment. The project results are partly satisfactory. The improved approach to the delivery of primary health care is being adopted in non-project provinces, although the financial sustainability of the approach remains uncertain and is being examined as part of the Bank's dialogue in the country.

PROJECT COMPLETION REPORT
MOROCCO
HEALTH DEVELOPMENT PROJECT (LOAN 2572-MOR)

PART I. PROJECT REVIEW FROM BANK'S PERSPECTIVE

BACKGROUND

1. In the late 1970s, Morocco faced major economic and financial difficulties. While the population was increasing rapidly, GDP growth slowed down, fiscal and external imbalances reached peak levels, in particular after the 1979 drought and unemployment increased, varying between 22 to 30 percent. In 1980, with Bank and IMF support, the Government adopted an ambitious plan for recovery aimed at liberalizing the economy and redressing fiscal imbalances. The prospect of a period of financial constraints resulting from these reforms induced the Government to examine the possible impact of dwindling average family income and food availability on the population health status. At the time, Maternal and Child Health (MCH), Family Planning (FP) and nutrition programs reached less than one-third of the target population, transportation costs for outreach activities were soaring and budgetary allocations for drugs were grossly insufficient. The MOPH endeavored to review its strategy, placing emphasis on the expansion of primary health to the entire population. Such strategic thinking was integrated in the 1981-85 National Economic Plan.

2. The Government's medium- and long-term objectives for the population, health and nutrition sectors, which project objectives derived from, included:

a. in *population*, to control demographic growth so as to limit size to 30 million or less by 2000 by stepping up population activities and raising contraceptive prevalence;

b. in *health and nutrition*, to minimize the impact of the economic crisis on the health of the population, to improve MOPH's management and hospital performance, and identify cost-effective alternatives to the current health and nutrition programs. Because of its heavy dependance on external funds, the Government's long-term objectives were to secure an adequate financing scheme for health care activities and eliminate pockets of malnutrition by raising domestic food production.

PROJECT OBJECTIVES AND DESCRIPTION

3. The project objectives, as defined in the Staff Appraisal Report, were to assist the Ministry of Public Health (MOPH) in strengthening and accelerating its on-going shift from an urban-based hospital-oriented health system to a more cost-effective system of primary care emphasizing outreach activities in the rural areas.

4. The project consisted of four components which aimed at:

a. *strengthening primary health care* in three provinces as a means to test a new delivery scheme before its implementation countrywide. Special attention was given to six core programs: immunization, FP, MCH, nutrition, front-line curative care and basic sanitation. The organization of the system was conceived to deliver these programs through polyvalent purpose staff, according to several types of strategies adapted to local conditions (terrain, population density..) by using a different mix of types of facilities, outreach techniques and staff. To achieve this objective, the following activities were to be implemented: upgrading and expanding the physical infrastructure; providing equipment; training of health staff; improving logistics and monitoring implementation to allow continuous adjustments. To that end, the project financed construction and rehabilitation of buildings, equipment, drugs, per-diems and vehicles;

b. *strengthening the management capacity of MOPH* at central and provincial levels. The objectives were to improve capacities in terms of health sector planning, staff training, research and evaluation, and public health service administration, as a necessary condition for a large scale extension of the health care delivery experience to the rest of the country. Specifically, this component was to: (i) strengthen the planning capacity of the MOPH Infrastructure and Planning Department, in which the Project Unit was based; (ii) improve MOPH administration in particular in the areas of program budgeting and resource allocation, procurement and bidding procedures, civil works and maintenance, and management of personnel; and (iii) support the implementation of a health services monitoring and evaluation system and the realization of two studies on the financing of the health sector and hospital management. To that end, the project financed technical assistance and expert services, training and equipment;

c. *strengthening training and IEC programs*; specifically this component was to: (i) strengthen the capacity to train paramedical personnel by completing the pedagogic equipment of a college of public health which had been financed under the Bank Third Education Project; and (ii) increase the capacity of the MOPH Health Education unit to produce IEC materials by providing audio-visual, printing and graphic equipment as well as technical assistance and fellowships for the production and dissemination of IEC materials; and

d. *improving the supply of basic drugs* by (i) improving procedures and establishing a coordinated system for the procurement, storage, formulation[1], packaging, distribution and control of drugs for the public health system; and

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1/ Formulation is the final stage of drug production, from intermediate ingredients to final or finished form. It consists of simple mechanical operations such as mixing, solving or dispersing and fragmentation into dosage forms.

(ii) redefining the respective roles of the Pharmacie Centrale, the National Drug Control Laboratory and the Drug Supply Unit (UAM) to be created under the project. Disbursements on this component were conditioned upon the creation of the structure in charge of managing this unit. To this end, the project was to finance the construction of storage, packing and shipment space, a packaging unit and a small formulation laboratory as well as the related equipment, training and technical assistance.

5. Clarity of Objectives. Overall, the project objectives were well defined and were an integral part of the Government objectives which were also supported by other donors and international organizations involved in Morocco (UNICEF, USAID, WHO). They were consistent with the Bank assistance strategy in the social sectors which included improving basic social services in rural areas and encouraging a shift from capital and foreign exchange intensive hospitals to expanding basic health services.

6. The degree of Government commitment to the project varied between components:

a. The extensive preparation work carried out by the MOPH over the period 1979-1984 for the Primary Health component with the support of a project preparation facility (PPF), ensured a good understanding of the concepts and a strong ownership especially at provincial levels;

b. The second component -- Management -- responded to the perceived needs of the MOPH and was meant to support its on-going structural reorganization. With regards to the studies, addressing sector financing and hospital management issues was rightly perceived by the Borrower as a means to develop a sustainable system in the medium and long term.

c. The third component --Training and IEC-- aimed at completing activities started in the Third Education Project (Loan 1220T-MOR), and as such its objectives were not reassessed and its implementation not expected to be problematic.

d. While the objectives of the last component -- the improvement of the supply of basic drugs - were shared by all involved, the means to achieve them seem to have been ambiguous from the on-set of the project. There has been no doubt that the creation of the drug unit and the reorganization of the drug supply system were fully justified from a public health perspective. However, the scope of this component and the private pharmaceutical sector seem to have evolved early in the project, increasing doubts as the economic viablility of the approach adopted.

PROJECT DESIGN

7. This first Bank project in the health sector in Morocco initially included two components: basic health services and management capacity. Its design aimed mainly at creating a replicable model of basic health care while at the same time, strengthening the MOPH management capacity. It was also aimed at building a knowledge base, in particular in the areas of sector financing and hospital management which would have helped increase sector sustainability and would have permitted to build on initial achievements. The IEC and drugs supply components were added at a later stage of preparation, and their integration in the main concept of the project was not as strong.

8. The design of the project aimed successfully at improving the technical aspects of basic health care delivery, as well as the management of programs. The health planning activity which took place was a bottom-up effort in which each provincial unit defined its problems, goals, management modes and monitoring tools. However, the functional links between this unit (Service d'infrastructure des actions ambulatoires provinciales, SIAAP) in charge of ambulatory care and inter alia of the six core programs supported by the project, the medical province and the different departments at the central level were not redefined to ensure the coherence of the project with the overall organizational structure of the system . This may be explained by the fact that the MOPH was, at the time of appraisal, under-going a structural reorganization to eliminate the existing dichotomy between the administrative and technical functions. As a result the provinces had to concentrate their efforts in implementing as best as they could, directives from the central level, sometimes to the detriment of the more pro-active approach promoted by the project, in which they defined their objectives and strategies according to local priorities.

9. In the early 1990s, the MOPH underwent another reorganization which increased the number of departments at central level and provided them with increased autonomy. The provinces found themselves faced with an even greater number of interlocutors. Basic core programs were rightly being delivered by the same multi-purpose medical staff, and their supervision, monitoring and evaluation done by the same persons at provincial level. Nevertheless, at central level, program guidelines, training, monitoring and financing remained vertical, creating some overlaps and/or conflicting messages which made integration and coordination at the provincial level more difficult and cumbersome. The transfer of the Project Unit from the Direction des Affaires Techniques (Division de la Planification), to the Direction de la Prévention et de l'Encadrement Sanitaire created an additional discrepancy between functions and structure.

10. Finally, with regard to the drug supply component, the project design foresaw the need for a close collaboration with the pharmaceutical private sector. However, it failed to set in place the mechanisms which would have ensured its collaboration.

PROJECT IMPLEMENTATION

11. All project components were completed with the exception of the Drug Supply Unit and of the Training and IEC component which were executed only partially. Several factors influenced project implementation, causing significant delays:

a. *Lack of counterpart funds*: Insufficient budgetary allocations as a result of the economic situation, delays in allocation and release of funds, political resistance to favor these provinces over others, and weak capacity of MOPH to manage commitments and disbursements, resulted in important delays from the project inception. In particular, the initial lag between Board presentation (June 1985), loan effectiveness (July 1986) and the first disbursements (March 1987), which was due to the lack of budgetary allocation, was never caught up. As a result, the loan closing date had to be extended twice (from December 31, 1991 to December 31, 1993).

b. *Frequent changes in the MOPH and in the Bank*: Both institutions encountered several structural reorganizations and changes in individual responsibility. This resulted in additional delays as new mechanisms had to be designed and new managers had to become familiar with the project before taking action. This loss of momentum affected the levels of funds allocated to the project, as "lobbying" for the project was weaker. The transfer of responsibility for civil works from the MOPH to the Ministry of Public Works also caused delays in the construction of facilities.

c. *Relative passivity in the Bank's contribution*: The frequent changes in task management described above and the conflicting priorities due to the simultaneous preparation and implementation of the Health Sector Investment Project (Loan 3171) led to a relative passivity of the Bank. It was slow or even silent in commenting on the two studies (Health Financing and Hospital Management) carried out by the Borrower, or on the project mid-term review prepared by the MOPH. The persistent misunderstanding in the realization of the last component -- improvement of the supply of drugs, which remains incomplete is another example, as explained in paragraph 19.

PROJECT RESULTS AND OUTCOME

12. Primary Health Care. This component was fully implemented in its physical as well as its "software" aspects though a large share of the new facilities only became functional at the very end of the project; to date 29 health facilities out of the 126 (more than 20%) built, remain closed due to insufficient staff to man them. In contrast, reorganization of service delivery, planning, supervision and monitoring methods, were put in place at the start of the project and are well assimilated by staff in all three provinces. As illustrated by the MOPH

mid-term review and final evaluation of the component, progress has also been achieved by the provinces in evaluation of outputs and outcomes.

13. The global management and planning methods put in place during the project have enabled the efficient deployment of staff which in turn permitted an improved population coverage in the three provinces. The Health service monitoring system put in place as part of the project has facilitated the decision process and provided a number of monitoring and impact indicators. However, as illustrated by the MOPH evaluation report (see examples in Table 4 in Annex to this PCR) the selection of these indicators does not always permit to link coverage and impact.

14. As shown in the table below, access to a health facility has been greatly improved. The ratio of population to health facility has evolved greatly during the project period from one basic center for 75,000 in 1985 to one for 44,000. While the number of general practitioners allocated to the project area doubled during the 1985-92 period (from 33 to 61), the number of para-medical staff only progressed for the same period from 717 to 841.

Percentage of Population with access to
a health facility in the project area

	1985	1988	1990	1992
< 3 Km	28	31	33	38
3 to 6 Km	14	15	17	14
6 to 10 Km	22	23	22	23
> 10 Km	36	31	28	25

15. Before being fully assessed, the deployment strategies for basic health care delivery developed in the project were generalized to all provinces, with external support from: (i) the Bank through the Health Sector Investment Project (Loan 3171-MOR), though with an evolution of the six core programs supported and, (ii) since 1992, the African Development Bank (ADB) in ten provinces. Considering the importance of the investments realized, in particular with regards to the construction of new centers, the achievements of the project have to be assessed in the context of their cost efficiency. This analysis should:
(i) distinguish the earlier phase of the project during which improvements in service coverage were registered, though the new centers had not yet been constructed, suggesting that the reorganization of the provinces alone contributed to a large extent to the results obtained; and
(ii) the cost-efficiency of the centers constructed cannot be assessed over the period of the project alone.

16. Strengthening of MOPH Management Capacity. The MOPH underwent several reorganizations during project implementation which did not always seem to be technically motivated. The project design did not take into account the then upcoming reorganization. Under these conditions, it is difficult to measure the extent to which the project improved central management as it was intended (see para. 4.b). While management of civil works certainly improved, procurement, program budgeting and resource allocation remain serious issues for the MOPH. This is compounded by the "balkanisation" of the MOPH Departments characterized by overlapping and scattered responsibilities which prevent measuring output and efficiency, and promoting accountability.

17. The health service monitoring system was put in place in the provinces, as described in para 13 above. The outcome of the two studies on the financing of the health sector and on hospital management which were carried out, is uneven:

a. The health financing study was of good quality, considering the lack of information available at the time. It resulted in a thorough data collection and analysis. The study served as a basis to the discussions on health financing reforms which have culminated with the preparation by the Government, with Bank support, of a health insurance reform proposal. This study has however not yet translated into concrete results in the financing of the system. An indirect benefit of the study was a transfer of know-how between the foreign firm and the teams of local consultants, jointly in charge of its realization. This fruitful association led to the emergence of a group of young Moroccan experts who has since then contributed significantly to the debate on health issues. This study also led to the creation, within MOPH, of a Health Economics Unit.

b. The Hospital Management Study output is more difficult to assess. The diagnostic phase to which each hospital included in the study actively participated, was never followed by the prospective one that was intended to specify and test the options for reform. Also, due to a lack of counterpart capacity or a shift in MOPH priorities, the results of the initial phase were insufficiently discussed.

18. The results of the Training and IEC component are less clear. Only 25 percent of the funds initially allocated were actually disbursed. Half of this amount financed the equipment of the College of Public Health and the balance financed the production and dissemination of IEC materials. The lack of disbursements on this component is due to the availability of bilateral funds to finance the training activities. Though no formal amendment to the loan agreement was made, this component seems to have been dropped and was therefore not supervised.

19. There is a discrepancy between the initial design of the last component - Improvement of the drug supply - described in paragraph 4.d, and its actual implementation, which remains unexplained by existing documentation and is probably at the origin of the misunderstanding between Bank and the MOPH. This was compounded by the fact that, until recently, the Bank's position with regard to drug sector policy was unclear. The UAM was built, though with three years delay, and with a design which does not correspond to its initial more modest concept. However the equipment remains to be purchased and, more importantly, the legal structure of UAM and the terms of its relationship with the private pharmaceuticals sector are still undefined. Despite some improvements, the Central Pharmacy organization, procedures for the procurement, distribution and control of drugs still need to be improved.

PROJECT SUSTAINABILITY AND FUTURE OPERATION

20. Technical Sustainability. The global management methods and deployment strategies developed in the project to deliver the six core health programs have become an integral part of planning practice and are unlikely to disappear. However, some of the key features of this strategy, such as the travelling nurse who greatly contributed to the increase in population coverage, are being put in question as this category of staff who is more likely to accept this function has been eliminated in favor of more qualified nurses. It may therefore prove more difficult, especially in the mountainous provinces with dispersed population, to attract new candidates. Signs of low morale are already evident in this category of staff, whose working conditions have deteriorated (lack of maintenance of motorcycles, delays in payment of per diem,..). Similarly, unless drugs and contraceptives, and means of transportation for the mobile teams remain regularly available, it is unlikely that the provinces will be able to maintain their coverage level. This situation is the more problematic that the population expectations have risen with the educational level and the previous availability of services.

21. Financial Sustainability. The operating budgets of the provinces had a line item specific to the project. However, no provision has been made to ensure an appropriate level of operating budget after project closing to continue financing the drugs, per diems, and other consumable items necessary to ensure the functioning of the programs. It is therefore expected that the project investments will not be preserved and that the achievements realized in terms of population coverage will not be sustained, unless a sufficient allocation for recurrent costs is maintained.

22. Both the Bank's on-going Health Sector Investment Project and the ADB recent Basic Health Project which finance operating costs, have equally failed to integrate mechanisms to ensure the progressive sustainability of the health system which would reflect the priority given to basic health services by the Government. On the contrary, the inclusion in the Health Sector investment Project (Loan 3171-MOR) of a significant component for the provision of drugs was an implicit acceptance that the financing of these operating costs would continue to depend on external financing.

23. The low level of national resources available in the public health sector and the related heavy reliance on external funds to finance not only investments but, increasingly, operating expenditures, considerably limit the MOPH capacity to articulate its operational priorities and control allocation of resources. All resources are already pre-allocated and pre-spent and the margin of maneuver is limited.

BANK PERFORMANCE

24. During the 15-year period between project identification and loan closing, the Bank performance can be characterized by its irregularity, in terms of (i) the frequency of its missions and exchanges with the Borrower, and (ii) the quality and emphasis of its contribution and of the high turnover of its project managers, compounded by its organizational changes. Two phases can be distinguished:

a. The first phase (preparation - early implementation) from 1979 to 1987, during which the project was handled by a specialized non-regional PHN Department. Field visits and correspondence, although infrequent, were very focussed and led to a systematic and thorough review of each of the project components, a broad discussion of all issues and agreement on the remedial actions and next steps.

b. The post-Bank's reorganization phase, which scattered available health specialist resources. During this period, and even more after the start of the Health Sector Development Project (Loan 3171-MOR) which overshadowed the first project, supervision became less systematic, of shorter duration, concentrating on a limited number of themes -- mainly disbursement procedures and budgetary allocations -- which were rightly perceived as obstacles to timely implementation. As a result, difficulties in the realization of some of the components remained unseen or unaddressed for a long time. Bank documentation reflects this situation and progress and difficulties on some of the components remained unreported. Overall, Bank's attitude during the supervision period was rather passive and resulted in a number of missed opportunities to deepen the dialogue with the Borrower as illustrated by the following examples:

- The Borrower's mid-term review report of the project was received but not commented on. Similarly, it is only after the strong insistence of the MOPH that the Bank commented on the study of health financing and there is no record on any written comment made to the MOPH on the hospital management study.

- The implementation of the component aiming at improving the supply of drugs is another case in point. While the appraisal documentation clearly defines the drug Supply unit as a "procurement, packaging, distribution and limited formulation unit, with a close collaboration

with the private sector", this unit seems to have evolved -- at least in its building design --into a full production unit. This evolution which is not documented in the files, has resulted in a misunderstanding between the MOPH and the Bank. Despite its skepticism that a public production unit was economically justified considering the rapid evolution of the Moroccan private pharmaceutical industry, the Bank failed to clearly state its position or to provide the necessary support to: (i) undertake a full assessment of the economic feasibility of this unit; and (ii) develop a coherent drug policy. At the same time, the Bank sent opposite signals that the component could proceed by giving non-objection to the procurement documents for the construction and equipment of the UAM, and providing informal advice on its status.

BORROWER PERFORMANCE

25. Overall, Borrower's performance was excellent with regards to analyzing issues and conceptualizing strategies. However, the project suffered from difficulties in operationalizing the policies defined and the implementation capacity of the MOPH remains weak as a result of its structural organization. During the second half of implementation, the project seems to have been put on "automatic pilot" and activities were being carried out -- though at a slow pace-- without a thorough review of their impact. This is the more surprising that this pilot experience was meant to lay the ground work for broader reforms countrywide, and that the technical aspects of service delivery were indeed generalized.

26. With regards to the realization of the health financing study, the Borrower's performance was commendable. The report was produced, discussed extensively within the health sector (through workshops, seminars...) and more generally in the Government. The MOPH was very successful in mobilizing external support (USAID, WHO..) on the topic, and translating the study's recommendations and implications into operational activities, such as the health insurance proposal.

27. Although difficult to assess in the absence of records, the Borrower's performance on the Hospital Management Study was not as good. Counterparts do not seem to have reviewed the study's findings with the consulting firm and very few discussions of the report took place. It is only with the preparation of the Hospital Management Project that the dialogue with the Bank on that subject was renewed.

KEY LESSONS LEARNED

28. Both the Bank and the MOPH should make more systematic use of the findings of this project to build on their future operations. Though a good opportunity was missed with the on-going Health Sector Investment Project (Loan 3171-MOR), since it started before the lessons of the previous one could be fully drawn, its implementation has permitted a better understanding of the issues which should be addressed. The areas of focus of future operations should be:

a. The financial sustainability of the health system needs to be addressed without delay. The MOPH has already integrated this lesson in its dialogue and has indicated its intention to proceed with new investments only when the sustainability of the sector as a whole has been addressed ie. when adequate investment and more importantly recurrent resources (staff salaries, drugs...) can be secured. To that end, the preparation of the proposed FY96 Health Management and Financing Project has been halted although it attempted to support health financing and hospital management reforms identified through the two studies supported by the project. If the Health Management project does not proceed, the health sector sustainability should be addressed through the FY96 Social Priorities Project.

b. The overall organization of the pharmaceutical sector and the provision of drugs to the public sector need to be reviewed. The continued financing of drugs through external funds has been a disincentive to exploring more cost-effective alternatives and to rationalizing the procurement of drugs. This has been ultimately detrimental to the development of a fair and transparent competition within the private sector and very costly for the Government, as the prices of drugs produced in Morocco are high and foreign exchange is mobilized to finance what should be local costs. A thorough review of the pharmaceutical sector and the development of a drugs policy for the public sector should be carried out prior to any further financing of drugs in a project.

c. The policies and project activities cannot be divorced from their implementation structure: The current organization of the MOPH and of the medical provinces is ill-adapted to the objectives pursued by the MOPH and discourage efficiency and accountability. While MOPH is fully aware of this issue and has prepared a new organizational chart more in line with its objectives, it has not yet been implemented. Implementation arrangements for future projects should be an integral part of their design and should take into account the overall organizational structure of the Ministry, or should not proceed without addressing needed changes.

d. The relative impact of the strategies deployed to deliver basic services (fixed facilities, outreach techniques and better organization) should be assessed carefully to facilitate the development of a cost-efficient approach, adaptable to the specifications of each region.

e. The Bank should ensure that appropriate mechanisms are included in the project design or, whenever possible, implemented prior to effectiveness to meet intended objectives. While the project design clearly stated that UAM should collaborate with the private sector, this failed to happen. The Bank should also have a more pro-active attitude in its comments and proposals for remedial actions (ie. restructuring of the project, increasing the supervision of "pilot/demonstrative" aspects of the project). The preparation of new projects should not start before the results of the previous project can be built on, and lessons learned so as to be integrated to the new design.

PROJECT COMPLETION REPORT
MOROCCO
HEALTH DEVELOPMENT PROJECT (LOAN 2572-MOR)

PART II. PROJECT REVIEW FROM BORROWER'S PERSPECTIVE

EXECUTIVE SUMMARY

INAS' mandate is to evaluate the Health Development Project in three provinces: Agadir, Taroudant and Settat. This project was implemented in these provinces in 1986 and comprises 4 main components:

1. Development of health services at the provincial level;

2. Management, research and evaluation at the level of the Ministry of Public Health;

3. Health training/education at the national level; and

4. Basic drug supply at the national level.

The project covers 2 million inhabitants and includes all levels of the system. Our evaluation mainly concerns the first component of the project: **The development of basic health services.**

This evaluation was carried out by INAS, UGP and teams from the three provinces. There has been no foreign technical assistance. Funds were allotted for the purpose of this evaluation from INAS' general budget and was about DH 50,000. This amount financed three three-day workshops in Rabat for a dozen participants. The evaluation was delayed from original schedule for logistical and human reasons (change of directors and staff responsible for health services in the provinces, weak research capacity of provinces).

An implementation progress report was attached to this evaluation to inform managers at central level on the dysfunctions identified during this crucial phase of the project, and in particular the status of implementation of the infrastructure and equipment components and, the ending of the project budgetary allocation. The proposed corrective measures are forwarded to all central managers.

The principal limitation of this evaluation is the time frame 1985-1992. In 1992, the newly built infrastructure was not quite functional. We therefore expect an under-estimated view of the level of health coverage in terms of access, availability and use.

To validate this evaluation, it is recommended to update this data through a second evaluation in 1996.

The main point of this evaluation is that local teams have been trained and involved in all stages, specific training on research methodology was taught to some participants.

The province presently has a detailed data base by sector and district which will serve for the planning of health services and the management of programs at the local level.

Evaluation of the Resources put in place.

- **Infrastructure**:

  Infrastructure in the project area increased from 137 to 192 basic health services facilities. Architecture is satisfactory and well received by staff and population.

. Facilities are large, but nurses quarters are found small.

. Completion time of a random sample of 51 health facilities shows that 50% were built with within one year (3 months in Settat and 4 years in Taroudant).

- **Equipment**:

. All facilities are sufficiently equipped and equipment remains in stock in provincial storage pending the opening of the recently completed facilities.

. In Settat, there is equipment in stock for peripheral laboratories that should be redeployed for the national level.

. The quality of equipment is adequate and appreciated by professionals. The Radiology units suffer serious problems with the relationship user-supplier (breakdown, absence of corrective maintenance and installation problems).

- **Budget**:

. Public works and equipment used 60% of the budget allotted to the project. In 1992, the project represented between 81% and 18% of the operating budget depending on line items. This budget covered transportation expenses, office supplies, hygienic products, gas, drugs. The portion allotted to rural areas is important for all provinces.

. The project management unit produced a financial evaluation report on the project.

- **Human resources**:

In the three provinces, a total of 134 nurses were assigned between 1985-1992. The ratio nurses/health services facilities (all categories) reached 4.44% in 1992 compared to 5.25% in 1985.

Staff assignments do not correspond in parallel to the needs of the 50 new completed facilities which started operations in 1992. The situation will be worse if the other completed facilities are open (another twenty centers).

Process Evaluation:

Project Implementation mechanisms represented an experiment for the Ministry of Public Health. Management structures were implemented and terms of reference were identified and set at all levels (central and provincial). However, the following problems were identified: lack of coordination, lack of synchronization central/peripheral, set up of the various project components and mobility of operational and supervisory staff.

All project components under consideration were set up according to a plan which differs from one province to the other (see documents from provinces).

Due to project size and requirements, the management component has become a priority over research.

The study of this process is a lesson for everyone planning a similar project. This study on the process is documented in each province's specific report.

Impact Evaluation :

There has been a marked improvement of all priority health programs. In 1992, the immunization completion rate was 82%. The rate of recruitment of women in obstetrics reached 38%. Childbirth in supervised environments reached 35% (of which 45% in ambulatory environment). There is improvement in tuberculosis screening and a decrease of the 5 target diseases in the 3 provinces.

Indicators in these provinces are slightly above national averages.

According to the Ministry of Health's Office of Information and Statistics, infant mortality has significantly decreased between 1985 and 1992 for the 3 overall provinces. This decrease is similar to that of the national level.

RESULTS

Service Delivery:

- Access:

The 1992 situation showed that, on average, every citizen, may find a clinic within 14 km. This distance varies depending on the province.

Population located farther than 10 km from a clinic dropped from 40 to 28% (extremes vary between 23 and 37%).

40% of inhabitants have access to a basic health center (35% minimum, 48% maximum).

- Availability:

Basic health services (CPN, immunizations, PF, corrective, etc.) are available in most of the basic health services facilities.

Delivery Strategy:

60% of population was covered by the urban and rural fixed site (1992):
12% by outreach teams.
19% by outreach personnel by contact point.
5% by house visits.
It is expected that the fixed site strategy will predominate over other delivery after the opening of about 20 centers.

The outreach strategy is hampered by difficulties at : viability, logistics, management and efficiency.

Integration:

In all newly completed health facilities, a model of integration of health services has been developed, particularly for the SMI/PF/Childbirth. The same polyvalent staff ensures the care of beneficiaries in its entirety in the same space and for different needs. This experiment has every chances of being successful. It will be interesting to study it after a while.

Efficiency:

In the fixed strategy, the improvement of diagnostic tools, technology, allocation of essential drugs were accompanied by an improvement of care.

Use of health services:

All health facilities are under-utilized. In some centers, it is way beneath all acceptable norms despite availability of required resources. The rate average occupation rate of certain childbirth units varies between 22% in Settat and 42% in Agadir. This is quite low.

OTHER ISSUES:

1. Traditional midwives: The experience is positive and replicable. Its limits reside in the difficulty of maintaining motivation and ensuring continuity of supervision by the health team.

2. In-service training: The in-service training program is presently solid at the level of these provinces. Skills and attitudes are improved for overall personnel, particularly technical personnel of SIAAP. The decentralization of the training process started at the level of these provinces to extend to the national level. The managers of these provinces designed the training modules on the management process and participated in the revision of health programs structures at the national level.

3. Peripheral laboratories: There is a wide gap (as to performance and output) among laboratories. The problem of these laboratories is supervision and management of these units. Staff and population are satisfied with this technology.

4. Community participation: The population, through local authorities and groups, has been informed and solicited to participate in the design phase of the project. The actual role of the population could not be assessed in this study. It remains that its contribution is punctual and consists of mainly the allocation of required resources (land, fuel, etc.) and not the decision-making process. The project did not identify one preferable approach on which professionals could build on.

5. Competence of management personnel

There is improvement in the managerial and programming capacity of all higher level staff of SIAAP and health districts. This situation may deteriorate if it does not resist the changes in the local political and administrative environment (partitioning, change of responsibilities, mobility of staff, lack of motivation).

RECOMMENDATIONS

1. A second evaluation covering 1993 and 1994 is required to confirm the trend observed.

2. The achievements of the project must be sustained by local authorities.

3. The dysfunctions observed and reported to the central authorities will need to be considered for this and future projects.

4. The after-project financing needs must be assessed so that inadequate budget be provided in order to prevent the rapid degradation of the project's assets.

5. Any project must be preceded by a strategic evaluation. Decisions should remain subject to modifications during the life of the project and design should not be considered as immutable.

6. It is important to ensure the stability of key-personnel of the project at least until the end of the implementation phase.

7. The Health Development Project was a good vehicle for increased exchanges of views, communications, challenges between and with the local and central team. It spread the philosophy of basic health services which all teams adhered to and defended. What are the alternatives to create today in its place? Provincial teams are already discussing the "funeral of the project".

PROJECT COMPLETION REPORT
MOROCCO
HEALTH DEVELOPMENT PROJECT (LOAN 2572-MOR)

PART III. STATISTICAL INFORMATION

TABLE 1: RELATED BANK LOANS

Loan Title	Purpose	Year of Approval	Status
Preceding Operations			
This loan was the first Bank loan in the sector in Morocco. Prior to this loan, Bank involvement in the health sector was limited to a schistosomiasis component in the agriculture development Doukkala I Project (Loan 1201-MOR) and to a health manpower training component in the Third Education Project (Loan 1220T-MOR) which consisted in the construction, furnishing and equipping of a college of Public Health in Rabat, a school of medical technicians in Casablanca and three nursing schools in Oujda, Fes and Agadir.			
Following Operations			
Health Sector Investment Project (Ln 3171-MOR)	To support the Government strategy to reinforce (a) basic health; (b) referral, emergency and diagnostic services provided at regional and provincial hospitals, and building and biomedical equipment maintenance capabilities; (c) administration and management of services provided by the MOPH in order to increase efficiency, and facilitate the implementation of administrative reforms designed to decentralize the management of health services; and (d) sector and policy reforms which address longer term issues related to the evolution and structure of the public and private sector health services delivery systems, financing mechanisms, and the mobilization of resources in support of the sector.	FY90	Under supervision. 21% disbursed. Closing date: December 31, 1996 (likely to be posponed).
Social Priorities Project	The proposed project would assist the Government in the implementation of its social strategy to help the least advantaged groups of Moroccan society play a full role in the country's economy, thus contributing both to increased productivity and enhanced equity. The basic health and nutrition component of this project would support the implementation of the medium-term action plan aiming at improving access of the target rural population to a package of essential services. To that end it would implement a number of intertwined actions: (a) rehabilitating/expanding the health infrastructure, while providing the necessary material, drugs (including contraceptives) and equipment; (b) promoting outreach and demand promotion strategies for the delivery of essential clinical and preventive services in remote areas; (c) strengthening and expanding FP services, and stimulating further demand for FP services (e.g. IEC programs); (d) improving the nutritional status of high risk groups and implementing programs to reduce the prevalence of micronutrient deficiencies; and (e) supporting actions aimed at redeploying and retraining the medical and paramedical personnel, in particular in the area of supervision and monitoring at the provincial level.	Planned FY96	Under Preparation
Health Management Project	The project would support Government efforts to (i) address major hospital internal efficiency issues to contain costs while improving quality of services; and (ii) introduce new health financing reforms, able to increase the level of resources available and promote equity. The proposed project would include the following components: (a) development of hospital management capacities; (b) improvement of service quality; and (c) development and implementation of new financing mechanisms and institutional development.	Planned Fy 96	Under preparation Borrower asked to delay project preparation until sector financing issues have been addressed at the Governmental level.

TABLE 2: PROJECT TIMETABLE

Steps in Project Cycle	Date Planned*	Date Actual
Identification	n/a	September 1979
Project Preparation Facility (PPF)	June 83	
Preparation	n/a	April 1980, June 1981
Appraisal	n/a	October 1984
Negotiations	n/a	April 1985
Board Presentation	n/a	June 6, 1985
Signing	Before October 1985	January 17, 1986
Effectiveness	October 1985	July 27, 1986
Midterm review carried out by the Borrower	December 1987	November 89
Project completion	June 30, 1990	**
Loan closing	December 31, 1991	December 31, 1993

*As provided in Project Brief for processing steps up to Board Presentation, and in the Staff Appraisal Report (SAR) for steps occurring after Board Presentation.

**All components were completed by June 1993 with the exception of the Drugs supply unit which remains incomplete to date. (see para. 19) and the IEC component which was dropped.

TABLE 3: LOAN DISBURSEMENTS: CUMULATIVE ESTIMATED AND ACTUAL (US$ million)

	FY86	FY87	FY88	FY89	FY90	FY91	FY92	FY93	FY94
Appraisal Estimate	1.3	5.0	10.4	16.4	22.4	26.9	28.4	-	
Actual	0	0.13	1.13	3.54	7.93	13.98	19.33	23.52	25.84
Actual as % of estimate	0	0.02	0.1	0.21	0.35	0.52	0.68	0.82	0.90
Date of final disbursement	April 1994								

TABLE 4: SELECTED MONITORING AND IMPACT INDICATOR IN THE PROJECT AREA

	1985	1988	1990	1992
IMMUNIZATION				
- Vaccinal Coverage (BCG) (Recruitement rate of children less than one year old)	66%	83%	84%	92%
- Incidence of declared cases				
* Whooping-cough	393	11	10	14
* Measles	149	120	46	537
* Polio	4	0	0	0
FAMILY PLANNING				
* Rate of new acceptors (pills)	7%	9%	14%	13%
* Rate of new acceptors (IUD)	0.25%	0.56%	0.65%	1.7%
* Contraceptive prevalence rate*	NA	NA	NA	NA
BASIC HEALTH SERVICES				
* Drop-out rate for tubercolosis treament	26%	16%	7%	4%
MCH				
* % of assisted deliveries	21%	24%	28%	35%
* % of assisted deliveries occurring in BHC	22%	26%	32%	45%
* Infant Mortality**	NA	57‰	52‰	48‰
* Number of neonatal tetanus cases	23	15	2	0
SANITATION				
* % Water points treated	75%	71%	81%	87%
* Incidence of Typhoid	37	15	12	9

Source: MOPH Project Evaluation Report (August 1994).

* The 1992 DHS estimates the national prevalence rate at 41.5%. Only new acceptors and recruitment rates were monitored at province level

** Estimates, for two of the 3 provinces.

TABLE 5: STUDIES INCLUDED IN PROJECT

Study	Purpose	Status	Impact of Study
1. Health Service Monitoring	MOPH was to implement a comprehensive monitoring and evaluation system for the present project, including family planning programs as a first step toward monitoring the progress of the Health Development Plan as a whole. Data collected by health facilities was to be processed and complemented by operational or evaluative research.	A service monitoring system was put in place in the provinces which has facilitated the decision process and permitted the mid-term review and post-evaluation of this project.	Data collection remains oriented towards services provided by the centers and is not often related to the total population. It is unclear whether these statistics, which represent a heavy administrative burden for the staff are fully utilized in decision making.
2. Study on the Financing of the Health Sector	Its purpose was to analyze the availability and allocation of funds, and the efficiency and equity of the present and alternative financing schemes.	Study completed in October 90. Was followed by several seminars and workshops to mobilize external support and led to the creation of a Health Economics Unit within MOPH.	The study's recommendations are being implemented, and have resulted in particular in the development of a health insurance scheme.
3. Study on Hospital Management	Since hospitals absorb 72% of MOPH's operating budget, the study focused on hospital performance, cost containment and possible methods of cost recovery, in accordance with the alternatives of the study on financing.	Diagnostic completed in June 89. The assessment focussed on 5 areas: Structural and physical characteristics of the hospital sector within MOPH, human resources, financial resources and organizational structure.	While the diagnostic phase was carried out and provided insight on hospital management the prospective phase intended to specify and test options for reform was not carried out. This phase is however expected to be developed as part of the Health Management project preparation.

TABLE 6A: PROJECT COSTS

Item	Appraisal Estimate (US$M)			Actual/latest estimate (US$M) 1/		
	Local costs	Foreign costs	Total	Local costs 2/	Foreign costs 2/	Total
Development of basic health services	12.5	10.7	23.2	20.7	17.6	38.3 3/
Strengthening of MOPH Management	0.8	0.9	1.7	0.7	0.9	1.6
Strengthening of training and EIC Capacity	0.5	1.1	1.6	0.1	0.3	0.4
Improvement of drug supply system	2.4	4.4	6.8	4.7	8.2	12.94/
Total Baseline Costs	16.2	17.1	33.3	26.2	27.0	53.2
Contingencies	7.1	7.2	14.3			
PPF						0.06
Total Project Costs	23.3	24.3	47.6	26.2	27.0	53.3 5/

1/ Exchange rate used corresponds to 1986 - 1993 average (US$ 1 = DH 8.4)
2/ Share of foreign costs in total calculated on the basis of appraisal estimates.
3/ Increase in cost of this component is due to the cumulative effects of:
(i) an increase in the number of centers built;
(ii) delays in implementation; and
(iii) increase in the square footage of the center following the adoption of modular plan.
4/ Estimated cost of completing component. Expended to date : US$ 4.8M.
5/ Estimated cost of completing the project. Expended to date: US$ 41.9M.

TABLE 6B: PROJECT FINANCING 1/

Source	Appraisal Estimate (US$M)			Actual/latest estimate (US$M)		
	Local costs	Foreign costs	Total	Local costs	Foreign costs	Total
IBRD	4.1	24.3	28.4	1.5	24.0	25.5
Government	19.2	-	19.2	16.4	-	16.4
Total	23.3	24.3	47.6	17.9	24.0	41.9

1/ This table reflects the financing arrangements for expenses already occurred. Financing source to complete the project (US$ 11.4M) has not yet been determined.

TABLE 7: STATUS OF LEGAL COVENANTS

Agree./Sect.	Coven. Type	Present Status	Original Fulfill. date	Revised fulfill. date	Description of covenant	Comments
3.02 (a)	7	CP			Establish & maintain a drug supply unit to undertake responsibility for the carrying out of the drug supply program included in Part D of project.	Only construction was completed. The legal status of the unit remains to be defined and equipment to be ordered.
3.02 (b)	4	CP	Each FY	-	Each fiscal year DSU is provided, through separate annual budgetary allocations, with funds sufficient to enable it to meet the estimated expenditures required for the carrying out of such a program.	Counterparts funds were insufficient for timely implementation.
Sc. 5.1a	5	C	-	-	Maintain & continue to operate PIU.	
Sc. 5.1a	5	C	-	-	DIPC continues to carry its operations with assistance of qualified staff in adequate numbers.	
Sc. 5.1a	5	CP	-		DSU is vested with responsibility for drug supply operation.	
Sc. 5.2a	5	C	12/31/86		Furnish to Bank proposed action plans for strengthening MOPH management.	
Sc. 5.2b	7	C			Thereafter carry out such plans.	Implemented 1990.
Sc. 5.3a	8	C	12/31/85		Establish & maintain thereafter an interministerial committee to coordinate study on health sector financing (part B.3b) & review results of the study.	
Sc. 5.3b	7	C	12/31/86		Furnish to Bank detailed report on progress in carrying out study.	Report completed October 1990.
Sc. 5.4a	5	C	12/31/87		Furnish to Bank detailed report on progress in carrying out study on hospital management (part B.3b)	Delayed by delay in project effectiveness. Report received 6/30/89.
Sc. 5.5a	7	C	12/31/87		Furnish to Bank detailed report on progress implementation of project, including findings and recommendations of health program study (part B.3b).	
Sc. 5.6a	7	NC	by 12/31 of each year	dropped	Furnish to Bank detailed program of production and dissemination of IEC material during the year following calendar year of health education materials (part C.2).	This project component has been dropped because of the availability of concessional funding for health education programs.
Sc. 5.6b	7	NC			Thereafter carry out such a program.	See above.
Sc. 5.7a	7	NC			Furnish to Bank for approval proposed programs of fellowship training (parts B, C, D) and lists of proposed candidates for training.	See above.
Sc. 5.7b	7	NC			Thereafter carry out such programs.	See above.

Status

1. Account/audit
2. Financial Performance/generate revenue from beneficiaries
3. Flow and utilization of Projects funds
4. Counterpart funding
5. Management aspects of the Project or of its executing agency
6. Monitoring review and reporting
7. Implementation
8. Sectoral or cross-sectoral budgetary or other resource allocation
9. Sectoral or cross-sectoral budgetary/institutional action
10. Other

C - Complied with
NC - Not complied with
CP - Complied with Partially

TABLE 8: BANK RESOURCES: STAFF INPUTS

Stage of project cycle	Planned		Actual	
	Weeks	US$	Weeks	US$
Through appraisal	n/a		85.6	
Appraisal - Board	n/a		79.6	
Board - Effectiveness	n/a		n/a[1/]	
Supervision	n/a[3/]		110.8	
Completion	n/a		7[2/]	
TOTAL			283	

1/ Period Board & effectiveness cumulated with supervision.
2/ Estimate
3/ Data on planned staffweeks only exist for the period 89-94 and correspond to 85.5 sw (or average of 14.2 per year) which compare to an actual time of 76.2 sw for that period (or 12.7 average per year).

TABLE 9: BANK RESOURCES: MISSIONS
A. PREPARATION

M/Y	No. persons	Days in Field	Skills	Comments
- March 1979 (Identification)	5	11 11 11 11 11	PH Specialist Loan Officer Education Specialist PH Specialist PH Specialist UNFDA	
- September 79 Preparation	4	10 10 10 10	RH Specialist Education Sp. Loan Officer PH Specialist	
- April 80 Preparation	4	11 11 11 11	PH Specialist Economist Loan Officer PH Sp. Consultant	
- June 81 Preparation		5	Economist	
- June 83	5	5 10 5 5 5	Economist 1w Architect 2w PH Specialist 1w PH Specialist 1w Imp. Specialist 1w	
- October 24 - Nov. 5, 83	2	12 8	PH. Specialist PH. Specialist	
March 84	1	20	PH. Specialist	
July 84 (Pre.appraisal)	1	3	PH. Specialist	
Sept. 84 Appraisal	9	20 20 20 20 20 20 20 ? ?	PH. Specialist Health Economist Economist Architect PF. Consultant Pharmac. Syst. Consultant Research Assistant Division Chief Loan Officer	
March 85	1	7	PH. Specialist	Review of project timetable and its budgetary implications

TABLE 9 CONTINUED
B. SUPERVISION

M/Y	No. persons	Days in Field	Skills	Project Rating		Problems
				Overall rating	Dev. rating	
- June 86 (29 to 9)	3	12 12 15	PH. Specialist PH. Specialist Economist			
April 87	3	12 12 12	PH. Specialist Operations Assistant Health Economist			Reviewed new organizational Structure of MOP & IEC component slow to start
- February 88	1	? 1/	Disbursement Officer			Discussions on opening of Special Account
- August 88 2/	3	8 8 8	Health Specialist PH. Physician Architect	2	1	- Lack of operating resources - Restructuration of tuberculosis program
- January 89	4	8 8 8 8	PH. Specialist PH. Physician Pop. Specialist Hospital Ad. Sp.	2	1	
- October 89 2/	4	5 5 5 5	Health Specialist PH. Physician Architect Education/Training Sp.	2	1	- Mid-term review carried out by MOPH
- June 90 2/	3	5 5 5	Health Specialist Financial Analyst Architect	2	1	- Delays in payments to contractors; funds to be delegated to provinces - Bids for UAM to high
- November 90 2/	2	9 9	Health Specialist Financial Analyst	2	1	- Slow implementation - Projects costs to be updated
- February 91 2/	1	9	Financial Analyst			-Health Financing report received - New bid document for UAM reviewed
- May 91 2/	3	9 9 9	Health Specialist Financial Analyst Architect	2	1	-Discussion on feasibility of UAM

1/ Multi purpose missions. Share of time allocated to project not available.

2/ Starting August 1988, all missions covered both the Health Development Project and the Health Sector Investment Project. Mission time has been apportioned equally to each project which is likely to overestimate time actually spent on the first project.

TABLE 9 CONTINUED

B. SUPERVISION (LTD)

M/Y	No. persons	Days in Field	Skills	Project Rating		Problems
				Overall rating	Dev. rating	
October 91	4	8 8 8 8	Sr. PHN Specialist PH. MD Hospital Administ. Sp. Architect	2	1	- Disbursement Issues - lack of counterpart funds - Request for postponement of closing date
- May 92	2	5 5	Financial Analyst Implementation Specialist	2	1	- Limited budget allocations
- November 92	3	9 9 9	Financial Analyst Implementation Specialist Health Specialist	2	1	- Some centers ready but not staffed - Status of UAM to be defined - MOPH Negotiating with the Pharmaceutical private sector
- April 93	2	3 3	Project Officer PH Specialist	2	1	UAM equipment and status
- May 94 (PCR)	1	6	Project Officer	-	-	----------

Document de
La Banque Mondiale

A N'UTILISER QU'A DES FINS OFFICIELLES

Rapport No. 14675

RAPPORT D'ACHEVEMENT DU PROJET

ROYAUME DU MAROC

PROJET DE DEVELOPPEMENT DE LA SANTE
(PRET 2572-MOR)

26 juin 1995

Division de la Population et Ressources Humaines
Département I
Région du Moyen Orient et Afrique du Nord

TRADUCTION NON-OFFICIELLE A TITRE D'INFORMATION

DEVISES EQUIVALENTES

A l'évaluation:

1$EU = 9.47 DH (Dirham)
1DH - 0.106 $EU

Moyenne sur la période 1986-1994:

1$EU =
1DH =

EXERCICE DE L'EMPRUNTEUR

1er janvier - 31 décembre

ABREVIATIONS ET ACRONYMES

BAD	Banque Africaine de Développement
IEC	Information, Education et Communication
MSP	Ministère de la Santé Publique
PF	Planification Familiale
PIB	Produit Domestique Brut
PPF	Mécanisme de Financement de la Préparation des Projets
SMI	Santé Maternelle et Infantile
SIAPP	Service d'Infrastructure des Actions Ambulatoires Provinciales
UAM	Unité d'Approvisionnement en Médicaments

TABLE DES MATIERES

RAPPORT D'ACHEVEMENT DU PROJET

ROYAUME DU MAROC

PROJET DE DEVELOPPEMENT DE LA SANTE (Prêt No. 2572-MOR)

Préface

Ce document constitue le Rapport d'Achèvement du Projet (RAP) de Développement de la Santé au Royaume du Maroc, pour lequel le Prêt 2572-MOR, d'un montant de 28,4 millions de $EU équivalents, a été approuvé le 6 juin 1985 et mis en vigueur le 29 juillet 1986.

Le Prêt a été clôturé le 31 décembre 1993 après deux extensions de sa date de clôture originale du 31 décembre 1991. Le dernier déboursement a eu lieu le 12 avril 1994, date à laquelle le solde de 2,6 millions de $EU a été annulé.

Le RAP a été préparé par Claire Voltaire, MN1PH de la Région du Moyen Orient et d'Afrique du Nord, et inclut les commentaires des personnels de la Banque ayant été impliqués dans le projet et dans le dialogue sur le secteur santé. Il a été révisé par Roslyn G. Hees, Chef de Division, MN1PH, et René Vaurs, Chargé du programme pour le Maroc, (MN1CO).

La préparation de ce rapport a commencé durant la dernière mission de la Banque relative à ce projet, en mai 1994. Ses conclusions sont basées sur les informations contenues dans les archives du projet. L'Emprunteur a contribué à sa préparation en soumettant un rapport d'Achèvement financier complet, et en réalisant une évaluation de l'impact de la composante de santé de base du projet, dont le résumé est joint en annexe à ce rapport.

RAPPORT D'ACHEVEMENT DU PROJET

ROYAUME DU MAROC

PROJET DE DEVELOPPEMENT DE LA SANTE (Prêt No. 2572-MOR)

Résumé synthétique de l'évaluation

Résultats du Projet

Les résultats du projet sont mitigés. Deux des quatres composantes ont été complétés.

1. Services de Santé Primaire. Cette composante a été exécutée dans sa totalité, tant sur le plan physique que technique bien qu'une grande partie des locaux ne soit devenue fonctionnelle qu'à la fin du projet; à ce jour, 29 des 126 formations sanitaires médicales (plus de 20%) construites restent fermées faute de personnel. Par contre, la réorganisation des modes de prestations de services, les méthodes de planification et de supervision, ont été mises en place dès le début du projet et sont bien assimilées par le personnel des trois provinces. Si les accomplissements de cette composante sont indéniables, il n'en demeure pas moins que les investissements réalisés sont importants et nécessitent une évaluation complète de leur rentabilité.

2. Renforcement de la capacité de gestion. Il est difficile de mesurer dans quelle mesure le projet a renforcé la capacité de gestion du MSP, celui-ci ayant subi plusieurs réorganisations durant l'exécution du projet. Bien que le suivi des travaux ait certainement été amélioré, la passation de marchés, l'allocation des ressources et la programmation budgétaire des programmes demeurent des problèmes importants pour le MSP.

3. Recherche et Evaluation. Le résultat des deux études entreprises sur le financement du secteur de la santé et sur la gestion hospitalière est inégal : (i) l'étude sur le financement de la santé était de bonne qualité et a servi de base aux discussions sur les réformes de financement de la santé qui ont culminé avec la préparation, par le Gouvernement, avec le soutien de la Banque, d'une proposition de réforme de l'assurance maladie; (ii) le résultat de l'étude sur la gestion hospitalière est plus difficile à évaluer. La phase diagnostic n'a jamais été suivie d'une phase devant spécifier et tester les options de réforme.

Quels enseignements tirer de l'expérience ?

4. Les résultats et l'expérience de ce projet devraient être utilisés plus systématiquement dans la préparation de nouvelles opérations. Notamment, il devrait être tenu compte des éléments suivants :

a) La question de la pérennité financière du système doit être abordée très rapidement. Le MSP a indiqué son intention de ne procéder avec de nouveaux projets financés par la Banque que lorsque la pérennité du secteur sera assurée à savoir, lorsqu'un niveau adéquat d'investissement, et de manière plus importante encore, de ressources récurrentes (salaires, médicaments, etc.) peut être assuré. A cette fin, la préparation du Projet proposé de Financement et de Gestion de la Santé prévue pour l'exercice 1996 a été interrompue. Si ce projet ne se matérialise pas la question de la pérennité du secteur de la santé devrait être abordée dans le cadre du projet proposé de Priorités Sociales (exercice 1996).

b) L'organisation globale du secteur pharmaceutique et l'approvisionnement en médicaments du secteur public doivent être examinés de manière approfondie. Une revue détaillée du secteur pharmaceutique et le développement d'une politique du médicament pour le secteur public devraient être entrepris avant tout futur financement de médicaments dans un projet.

c) Les mesures et activités mises en oeuvre dans le cadre d'un projet et la structure organisationnelle adoptée pour leur exécution doivent être en harmonie. L'organisation actuelle du MSP et des provinces médicales est mal adaptée aux objectifs poursuivis par le MSP et décourage l'efficacité et la responsabilisation. Bien que le MSP soit conscient de ce problème et ait préparé un nouvel organigramme mieux adapté à ses objectifs, cette organisation n'a toujours pas été mise en place. Les mécanismes d'exécution des projets devraient être etablis dès la conception du projet et tenir compte de la structure organisationnelle d'ensemble du Ministère, ou ces projets ne devraient pas être entrepris sans adresser les changements nécessaires.

d) L'impact relatif des stratégies mises en place pour assurer les services de santé de base (centres fixes, itinérance et meilleure organisation) devrait être évalué en détail pour faciliter le développement d'une approche rentable, adaptable aux spécificités de chaque région.

e) La Banque devrait avoir une attitude plus proactive dans ses commentaires et propositions palliatives (restructuration du projet, accroissement de la supervision des aspects "pilotes/démonstratifs" du projet).

5. Evaluation globale: Les résultats du projet sont modérémment satisfaisant. L'approche améliorée utilisée pour assurer les services de santé de base a été adoptée dans d'autres provinces. Cependant, la pérénnité financière du projet et plus largement du système reste une question préoccupante, qui fait partie intégrante du dialogue entre l'Emprunteur et la Banque.

RAPPORT D'ACHEVEMENT DU PROJET

ROYAUME DU MAROC

PROJET DE DEVELOPPEMENT DE LA SANTE (Prêt No. 2572-MOR)

HISTORIQUE

1. A la fin des années 70, le Maroc s'est trouvé confronté à des difficultés économiques et financières majeures. En même temps qu'un accroissement rapide de la population, le PIB a diminué, les déséquilibres fiscaux et externes ont atteint des niveaux élevés, en particulier après la sécheresse de 1979, et le taux de chômage a augmenté, fluctuant entre 22 et 33%. En 1980, avec l'appui de la Banque et du FMI, le Gouvernement a adopté un plan de redressement ambitieux visant à libéraliser l'économie et redresser les déséquilibres fiscaux. La perspective d'une période de contraintes financières résultant de ces réformes a conduit le Gouvernement à examiner l'impact éventuel d'un effritement des revenus des ménages et de la pénurie des denrées alimentaires sur la santé de la population. Les programmes de nutrition, de Santé Maternelle et Infantile (SMI) et de Planification Familiale (PF) ne bénéficiant qu'à un tiers de la population ciblée, les frais de transport pour les activités d'atteinte des populations isolées explosant et les allocations budgétaires pour les médicaments étant très insuffisantes, le Ministère de la Santé Publique (MSP) s'est mobilisé pour revoir sa stratégie. Une telle réflexion stratégique fut intégrée dans le Plan Economique National de 1981-1985.

2. Les objectifs à moyen et long-terme du Gouvernement pour les secteurs de population, Santé et nutrition, dont découlent les objectifs du projet, étaient les suivants:

a) En matière de Population : Contrôler l'accroissement démographique pour en limiter la population à 30 millions ou moins en l'an 2000 en augmentant les activités et la prévalence contraceptive.

b) En matière de Santé et Nutrition : Minimiser l'impact de la crise économique sur la santé de la population, en améliorant la gestion du MSP et la performance des hôpitaux, et en identifiant des programmes de nutrition et de Santé efficace en terme de coûts. Les objectifs à long-terme du Gouvernement étaient également de développer un schéma de financement adéquat pour les soins de santé et d'éliminer les poches de malnutrition en augmentant la production locale de denrées alimentaires.

OBJECTIFS ET DESCRIPTION DU PROJET

3. Les objectifs du projet, tels que définis dans le Rapport d'Evaluation du Projet, étaient de permettre au MSP de renforcer et d'accélérer sa transition d'un système de Santé essentiellement urbain, et axé sur les soins hospitaliers vers un système de soins de santé primaire moins couteux tirant partie d'une approche itinérante dans les zones rurales.

4. Le projet comprenait quatre composantes visant à:

a) *Renforcer les soins de santé primaire dans trois provinces en testant un nouveau système avant de l'appliquer à l'ensemble du pays.* Une attention particulière fut donnée à six programmes de base: immunisations, PF, SMI, nutrition, soins curatifs primaires et assainissement de base. L'organisation du système fut conçue pour offrir ces programmes par l'intermédiaire de personnel polyvalent, et selon plusieurs types de stratégies adaptées aux conditions locales (terrain, densité de population, etc.) en utilisant différentes combinaisons de ressources (locaux, techniques et personnel). Pour atteindre cet objectif, les activités suivantes ont dû être exécutées: l'extension et la rénovation de l'infrastructure physique, un apport en équipement, et la formation du personnel médical; l'amélioration de l'organisation des services et du suivi de l'exécution pour permettre des ajustements constants. A cette fin, le projet a financé la construction et la réhabilitation de centres, des équipements, médicaments, indemnités journalières et véhicules.

b) *Renforcer la capacité de gestion du MSP aux niveaux provincial et central.* Les objectifs étaient d'améliorer les capacités de planification du secteur de la santé, de formation du personnel, de recherche et évaluation, et d'administration de services publics de santé. Plus particulièrement, cette composante consistait à (i) renforcer la capacité de planification du Département d'Infrastructure et de Planification du MSP, où l'Unité du Projet était située; (ii) améliorer l'administration du MSP, particulièrement en matière d'allocation des ressources de budgétisation des programmes, de passation des marchés et appels d'offres, de suivi des travaux de génie civil, de maintenance et de gestion du personnel; et (iii) introduire un système d'évaluation et de contrôle des services de santé et réaliser deux études sur le financement du secteur santé et sur la gestion hospitalière. A cette fin, le projet a financé l'assistance technique et les services d'experts, la formation et de l'équipement.

c) *Renforcer les programmes d'IEC et de formation.* Plus précisément, cette composante devait (i) renforcer la capacité de formation du personnel paramédical en complétant l'équipement pédagogique d'un collège de santé publique qui avait été l'objet du Troisième Projet d'Education financé par la Banque; et (ii)

augmenter la capacité du Service d'Education pour la Santé du MSP de produire des matériaux IEC en fournissant des matériels audiovisuels, des équipements d'impression et graphique de même que de l'assistance technique et des bourses d'études sur la production et dissémination des matériaux IEC; et

d) *Améliorer la disponibilité des médicaments en* (i) améliorant les procédures et établissant un système coordonné de passation de marchés, d'entreposage, de formulation[1], de conditionnement, de distribution et de contrôle des médicaments pour le système de santé publique; et (ii) redéfinissant les rôles respectifs de la Pharmacie Centrale, du Laboratoire National de Contrôle des Médicaments et de l'Unité d'Approvisionnement en Médicaments qui devait être créée dans le cadre du Projet. La création de la structure responsable de la gestion de cette dernière unité était une condition de décaissement de cette composante. Afin de réaliser cette composante, le projet devait financer la construction de locaux d'entreposage, de conditionnement et d'expédition, une unité d'emballage, et un petit laboratoire de formulation ainsi que l'équipement, la formation et l'assistance technique.

5. Clarté des Objectifs. Dans l'ensemble, les objectifs du projet étaient bien définis et faisaient partie intégrante des objectifs du Gouvernement qui étaient également soutenus par d'autres donateurs et organisations internationales actives au Maroc (UNICEF, USAID, OMS, etc.). Ils étaient cohérents avec la stratégie d'assistance de la Banque dans les secteurs sociaux qui encourage l'amélioration des services sociaux de base dans les zones rurales, et l'évolution d'un système orienté vers des soins hospitaliers coûteux en capital et devises vers une expansion des services de santé de base.

6. Le niveau d'engagement du Gouvernement vis-à-vis du projet a varié selon les composantes :

a) le travail exhaustif de préparation accompli par le MSP sur la période 1979-1984 pour la première composante du projet (Santé Primaire), avec le soutien d'un Fonds de Préparation des Projets (PPF), a assuré une bonne compréhension des concepts et un engagement total tant au niveau provincial que central;

b) la deuxième composante --- Gestion -- répondait aux besoins identifiés par MSP et devait soutenir sa réorganisation structurelle en cours. La réalisation des études qui abordaient les problèmes de financement du secteur et de gestion hospitalière,

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[1] La formulation est la phase finale de la production de médicaments, d'ingrédients intermédiaires à la forme finie ou finale. Elle consiste de simples opérations mécaniques telles que le mélange, la dilution ou dispersion et fragmentation sous forme de dosages.

était, à juste titre, perçue par l'emprunteur comme moyen de développement d'un système solide à moyen et long-terme.

c) La troisième composante -- Formation et IEC -- visait à compléter les activités entamées dans le cadre du Troisième Projet d'Education (Prêt No. 1220T-MOR), et de ce fait, ses objectifs n'ont pas été réévalués et aucune difficulté n'a été anticipée dans son exécution.

d) Bien que les objectifs de la dernière composante -- l'amélioration de l'approvisionnement en médicaments -- aient été partagés par toutes les parties, les moyens de les atteindre paraissent avoir été ambigus dès la mise en oeuvre du projet. La création de l'unité de médicaments et la réorganisation du système d'approvisionnement en médicaments n'ont posé aucun doute quant à leur justification d'un point de vue de santé publique. Cependant l'évolution de cette composante et du secteur pharmaceutique privé semblent avoir, dès le début du projet, augmenté les doutes quant à la viabilité économique de l'approche.

CONCEPTION DU PROJET

7. Ce premier projet de la Banque dans le secteur de la santé au Maroc avait au début de la préparation du projet deux composantes: Services de santé de base et Capacité de gestion. Il s'agissait principalement de créer un modèle réplicable de soins de santé de base tout en renforçant la capacité de gestion du MSP. Le projet visait également à acquérir une base de connaissances, particulièrement dans les domaines du financement du secteur et de la gestion hospitalière qui aurait contribué à accroître la pérennité du secteur et à bâtir sur les accomplissements initiaux. Les composantes IEC et approvisionnements en médicaments ont été ajoutées à une phase de préparation ultérieure, et elles sont donc moins bien intégrées dans le concept principal du projet.

8. Le projet tel qu'il a été conçu bien permis d'améliorer les aspects techniques des services de santé de base, et d'améliorer la gestion des programmes. L'effort de planification des services a été issu des équipes provinciales elles-mêmes qui ont identifié leurs problèmes, defini leurs objectifs et planifié leurs activités. Cependant, les liens fonctionnels entre l'entité provinciale en charge des services ambulatoires (Service d'Infrastructure des Actions Ambulatoires Provinciales (SIAPP)), responsable des six programmes centraux soutenus par le projet, la province médicale et les différents départements au niveau central n'ont pas été redéfinis pour assurer la cohérence des objectifs du projet avec la struture organisationnelle. Ceci peut être expliqué par le fait que le MSP était, au moment de l'évaluation, en pleine réorganisation structurelle pour éliminer la dichotomie existante entre les fonctions administratives et techniques. En conséquence, les provinces ont du concentrer leurs efforts sur l'exécution des directives du niveau central, et ce, parfois au détriment de l'approche plus proactive préconisée par le projet dans laquelle elles définissent leurs objectifs et stratégies selon les priorités locales.

9. Au début des années 90, le MSP a subi une autre réorganisation qui a augmenté le nombre de départements tout en les dotant d'une plus grande autonomie. Les provinces se sont donc trouvées face à un nombre accru d'interlocuteurs. Les programmes prioritaires de base étaient à juste titre, fournis par un même personnel médical, et leur supervision, suivi et évaluation étaient administrés par les mêmes personnes au niveau provincial. Néanmoins, les directives des programmes, la formation, le contrôle et le financement demeurent verticales au niveau central, résultant en des chevauchements de responsabilités et parfois des instructions contradictoires, ce qui rend l'intégration et la coordination au niveau provincial plus lourde et difficile. Le transfert de l'Unité de Projet de la Direction des Affaires Techniques (Division de la Planification), à la Direction de la Prévention et de l'Encadrement Sanitaire a créé une distorsion supplémentaire.

10. Enfin, en ce qui concerne la composante relative à l'approvisionnement en médicaments, le projet, dans sa conception, a anticipé l'importance de la participation du secteur pharmaceutique privé, sans cependant introduire dans l'accord de prêt, de mécanismes qui assureraient cette collaboration.

EXECUTION DU PROJET

11. Toutes les composantes du projet ont été réalisées à l'exception de l'Unité d'Approvisionnement en Médicaments et de la Formation et IEC qui n'ont été complétés que partiellement. Plusieurs facteurs ont influencé l'exécution du projet, créant ainsi des retards importants:

a) Insuffisance des fonds de contrepartie : Des allocations budgétaires insuffisantes du fait de la situation économique, des délais dans l'affectation et l'attribution effective des fonds, et une certaine hésitation politique à favoriser ces provinces au détriment des autres, ainsi que la faible capacité du MSP de gérer les engagements et déboursements ont résulté dans d'importants retards dès le début du projet. En particulier, le retard initial entre la présentation au Conseil d'Administration (juin 1985), l'entrée en vigueur du Prêt (juillet 1986) et les premiers déboursements (mars 1987), causé par le manque d'allocation budgétaire, n'a jamais été rattrapé. En conséquence, la date de clôture du Prêt a du être prorogée deux fois (du 31 décembre 1991 au 31 décembre 1993).

b) Changements fréquents au MSP et à la Banque : Les deux institutions ont subi plusieurs réorganisations structurelles et des changements de responsabilité individuelle. Ceci a eu pour résultat des retards supplémentaires, le temps de concevoir de nouveaux mécanismes et que les nouveaux responsables se familiarisent avec le projet avant d'agir. Le transfert de la responsabilité du génie civil du MSP vers le Ministère des Travaux Publics a également causé des retards dans la construction des locaux.

c) Passivité relative de la contribution de la Banque : Les changements fréquents de responsables décrits ci-dessus et les priorités conflictuelles dues à la préparation et l'exécution simultanée du Projet d'Investissement dans le Secteur de la Santé (Prêt 3171) ont conduit à une relative passivité de la Banque. Celle-ci s'est traduite par une absence de commentaires, ou un délai dans leur transmission, sur les deux études (Financement de la Santé et Gestion Hospitalière) entreprises par l'Emprunteur, ou sur la revue à mi-terme du Projet préparée par le MSP. On peut citer également l'exemple du malentendu persistant dans la réalisation de la dernière composante -- amélioration de l'approvisionnement en médicaments -- qui demeure inachevée comme expliqué dans le paragraphe 19.

RESULTATS DU PROJET

12. Services de Santé de base : Cette composante a été exécutée dans sa totalité, tant sur le plan physique qu'opérationnel bien qu'une grande partie des locaux ne soit devenue fonctionnelle qu'à la fin du projet; à ce jour, 29 des 126 centres de santé (plus de 20%) construits restent fermés par manque de personnel. Par contre, la réorganisation de l'offre des services de santé, leurs méthodes de planification et de suivi, ont été mises en place au début du projet et sont bien assimilées par le personnel dans les trois provinces. Comme mentionné dans la revue à mi-parcours et dans l'évaluation finale du projet (voir Annexe) réalisés par le MSP, des progrès ont également été accomplis par les provinces en matière d'évaluation des résultats et des performances.

13. La gestion globale et les méthodes de planification mises en place durant le projet ont permis le déploiement efficace du personnel et, partant, une meilleure couverture de la population dans les trois provinces. Le système de suivi et d'évaluation mis en place dans le cadre du projet a facilité le processus de décision et fournit un certain nombre d'indicateurs de suivi et d'impact. Cependant, comme illustré par le rapport d'évaluation du MSP (voir examples au Tableau 4 de ce RAP) la selection de ces indicateurs ne permet pas toujours d'établir le lien entre couverture et impact.

14. Comme illustré par le tableau ci-dessous, l'accès de la population à un centre de santé a été très amélioré. Le nombre d'habitants par centre a évolué de manière significative pendant la période du projet passant de 75.000 habitants par centre en 1985 à 44.000 en 1992. Dans la même période, le nombre de médecins généralistes a doublé passant de 33 à 61, alors que les personnels para-médicaux n'ont progressés que de 717 à 841.

Pourcentage de la population ayant accès à un centre de santé

	1985	1988	1990	1992
< 3 Km	28	31	33	38
3 to 6 Km	14	15	17	14
6 to 10 Km	22	23	22	23
> 10 Km	36	31	28	25

15. Avant d'être évaluées dans leur totalité, les stratégies de déploiement du système de prestations des services de santé primaire développées dans le projet ont été généralisées à toutes les provinces, avec l'appui de (i) la Banque par l'intermédiaire du Prêt d'Investissement au Secteur de la Santé (Prêt 3171-MOR), et (ii) depuis 1992, la Banque Africaine de Développement (BAD) dans dix provinces. Etant donné l'importance des investissements réalisés, notamment en matière de construction, les accomplissements du projet doivent être évalués en fonction de leur coût-efficacité. Cette analyse devrait (i) distinguer la phase initiale du projet pendant laquelle ces régions ont montré des améliorations dans la couverture sanitaire bien qu'aucune construction de nouveaux centres n'ait encore eu lieu, suggérant que la réorganisation des provinces a à elle seule, grandement contribué aux résultats obtenus; et (ii) calculer la rentabilité des centres construits au delà de la seule période du projet.

16. Renforcement de la Capacité de Gestion du MSP : Le MSP a subi plusieurs réorganisations durant l'exécution du projet qui ne semblent pas toujours avoir été motivées par des objectifs techniques. Dans ces conditions, il est difficile de mesurer jusqu'à quel point le projet a amélioré la gestion centrale tel qu'envisagé (voir para. 4.b). Bien que la gestion des travaux de génie civil ait certainement été améliorée, la passation de marchés, la budgétisation des programmes et le processus d'allocation de ressources demeurent de sérieux problèmes pour le MSP. Ceci est aggravé par la fragmentation des départements du MSP caractérisée à la fois par la dispersion et la superposition des responsabilités, ce qui ne permet pas de mesurer le rendement et l'efficacité, et de promouvoir la responsabilisation.

17. Le système de suivi et d'évaluation des performances a été mis en place dans les provinces, comme décrit au paragraphe 13 ci dessus. Les deux études réalisées sur le financement du secteur de la santé et sur la gestion hospitalière ont eu un impact mitigé :

a) L'étude sur le financement de la santé était de bonne qualité, résultant de recherches et analyses approfondies qui ont généré des discussions expansives. L'étude a servi de base aux discussions sur les réformes de financement de la santé qui ont culminé avec la préparation, par le Gouvernement, avec le soutien de la Banque, d'une proposition de réforme de l'assurance maladie. Cette étude ne s'est cependant pas encore traduite par des résultats concrets au niveau du financement du système. Un bénéfice indirect de l'étude a été le transfert de savoir-faire entre le bureau d'études étranger et l'équipe de consultants locaux, conjointement responsables de sa réalisation. Cette association fructueuse a conduit à l'émergence d'un groupe de jeunes experts marocains qui ont depuis grandement contribué au débat sur les problèmes de santé. Cette étude a également mené à la création, au sein du MSP, d'une Unité d'Economie de Santé.

b) L'impact de l'étude sur la gestion hospitalière est plus difficile à évaluer. La phase diagnostique à laquelle les hôpitaux inclus dans l'étude ont activement participé n'a jamais été suivie par celle devant spécifier et tester les options de réforme. De plus, du fait d'un manque de capacité ou d'un changement dans les priorités du MSP, les résultats de la phase initiale n'ont pas été suffisamment exploités.

18. Les résultats de la composante Formation et IEC sont moins clairs. Seulement 25% des fonds initialement alloués ont été actuellement déboursés. La moitié de ce montant a servi à financer l'équipement du Collège de Santé Publique et le solde a financé la production et dissémination de matériaux IEC. L'insuffisance de décaissements sur cette composante est due à la disponibilité de fonds bilatéraux pour financer les activités de formation. Bien qu'aucun amendement formel n'ait été fait au Prêt, cette composante semble avoir été abandonnée et n'a par conséquent pas été supervisée.

19. Il existe une divergence entre le concept initial de la dernière composante -- Amélioration de l'approvisionnement en médicaments -- décrit dans le paragraphe 4.d, et son exécution, qui reste inexpliquée dans la documentation existante et qui est probablement à l'origine du malentendu entre la Banque et le MSP. Cette ambiguïté a été exarcerbée par le fait que jusqu'à récemment la Banque n'avait par articulé une position claire en matière de politique du médicament. L'UAM a été construite, bien qu'avec trois ans de retard, selon un programme qui ne correspond pas au programme initial plus modeste. Cependant, l'équipement n'a pas encore été acheté et la structure juridique de l'UAM et les termes de sa relation avec le secteur pharmaceutique privé n'ont toujours pas été définis. En dépit de quelques améliorations, l'organisation de la Pharmacie Centrale, les procédures de passation des marchés, la distribution et le contrôle des médicaments restent des préoccupations majeures.

PERENNITE DU PROJET ET FONCTIONNEMENT FUTUR

20. Pérennité Technique : Les méthodes de gestion globale et stratégies de déploiement introduites dans les trois provinces pour offrir les six programmes de santé prioritaires sont devenues parties intégrantes du processus de planification. Cependant, quelques éléments clés de cette stratégie, tel le rôle des infirmiers itinérants, qui ont grandement contribué à l'amélioration de la couverture, sont remis en question, la catégorie de personnel la plus à même d'accepter l'itinérance (agent de santé breveté) ayant été éliminée en faveur d'infirmières plus qualifiées. Il risque donc d'être difficile, particulièrement dans les provinces montagneuses à population dispersée, d'attirer de nouveaux candidats, et des signes de découragement sont déjà ressentis parmi les itinérants, dont les conditions de travail se sont détériorées (manque d'entretien des motocyclettes, retards dans le paiement des indemnités...). De même, à moins que les médicaments et contraceptifs, et moyens de transport pour les équipes mobiles ne demeurent régulièrement disponibles, il est peu probable que les provinces puissent maintenir leur niveau de couverture. Cette situation est des plus critiques, l'attente des populations ayant augmenté avec le niveau d'éducation et la disponibilité des services.

21. Pérennité Financière : Les budgets de fonctionnement incluaient une rubrique spécifique au projet. Cependant, aucune mesure n'a été prise pour assurer un budget approprié après la fin du projet pour financer les médicaments, indemnités journalières, et autres articles consommables nécessaires pour continuer à assurer le fonctionnement des programmes. Les investissements du projet risquent pas conséquent de ne pouvoir être préservés. Les acquis réalisés en termes de couverture de la population ne seront donc pas maintenus à moins qu'un budget suffisant ne soit alloué.

22. Le projet d'Investissement dans le Secteur Santé financé par la Banque mondiale et le projet récent de Santé de Base financé par la Banque Africaine de Développement (BAD) qui incluent le financement des frais de fonctionnement, ont tous les deux échoué à intégrer des mécanismes pour assurer la pérennité progressive du système de santé qui refléterait la priorité donnée aux services de santé de base par le Gouvernement. Au contraire, l'inclusion dans le projet d'Investissement dans le Secteur Santé (Prêt 3171 MOR) d'une composante importante pour l'approvisionnement en médicaments constitue l'implicite acceptation que le financement de ces frais de fonctionnement continuera de dépendre de fonds extérieurs.

23. Le bas niveau de ressources nationales disponibles dans le secteur de la santé publique et la forte dépendance sur les fonds externes pour financer non seulement les investissements, mais de plus en plus, les frais de fonctionnement, limitent considérablement la capacité du MSP à articuler ses priorités opérationnelles et à contrôler l'allocation de ressources. Toutes les ressources sont déjà pré-allouées et pré-dépensées et la marge de manoeuvre est limitée.

PERFORMANCE DE LA BANQUE

24. Durant la période de 15 ans entre l'identification du projet et la clôture du Prêt, la performance de la Banque peut être caractérisée par son irrégularité, en termes de (i) la fréquence de ses missions et communications avec l'emprunteur, et (ii) la qualité et l'emphase de sa contribution et les nombreux changements de responsables de projets, en plus de ses changements structurels. Deux phases peuvent être distinguées:

a) La première phase (préparation - début d'exécution) de 1979 a 1987, durant laquelle le projet était la responsabilité d'un département spécialisé de Population et Ressources Humaines non-régional. Les missions et la correspondance, bien que peu fréquentes, étaient très spécifiques et ont mené à une revue systématique et détaillée de chacune des composantes du projet, une discussion générale de tous les problèmes et un accord sur les actions palliatives et mesures à prendre.

b) La phase suivant la réorganisation de la Banque, qui a dispersé les ressources disponibles. Durant cette période, et plus encore après le commencement du Projet d'Investissement du Secteur de la Santé (Prêt 3171-MOR) qui a éclipsé le premier projet, la supervision est devenue moins systématique, plus courte, concentrée sur un nombre limité de thèmes -- principalement les procédures de déboursement et d'allocations budgétaires qui étaient à juste titre perçues comme des obstacles à une exécution dans les temps impartis. En conséquence, des difficultés dans la réalisation de certaines des composantes sont passées inaperçues ou n'ont pas été abordées qu'avec retard. Les rapports de suivi de la Banque reflète cette situation et l'avancement et les difficultés de certaines composantes ne sont pas documentés. Dans l'ensemble, l'attitude de la Banque durant cette période de supervision a été plutôt passive et un certain nombre d'opportunités ont été manquées d'approfondir le dialogue avec l'emprunteur, comme illustré ci-dessous:

- Le rapport de revue à mi-parcours de l'emprunteur a été reçu mais aucun commentaire n'a été transmis formellement. De même, c'est uniquement après l'insistance du MSP que la Banque a donné ses commentaires sur l'étude de financement de la santé, et il n'y a aucune trace de commentaires formels faits au MSP sur l'étude de gestion hospitalière.

- L'exécution de la composante visant à améliorer l'approvisionnement en médicaments est un autre exemple. Bien que le rapport d'évaluation définisse clairement l'Unité d'Approvisionnement en Médicaments comme unité de "passation de marchés, emballage, distribution et formulation limitée, avec collaboration étroite avec le secteur privé", cette unité semble avoir évolué -- tout au moins dans sa construction -- en une unité de production. Cette évolution, qui n'est pas documentée,

a été une source de malentendus entre le MSP et la Banque. En dépit de sa conviction que procéder avec une unité de production publique n'était pas économiquement justifié compte tenu de l'évolution rapide de l'industrie pharmaceutique privée au Maroc, la Banque n'a pas articulé clairement sa position ni n'a su apporter l'appui nécessaire pour entreprendre une revue complète de la situation afin d'évaluer la viabilité économique de cette unité et élaborer une politique cohérente du médicament. En même temps, en donnant sa non-objection aux documents d'appel d'offres pour la construction et l'équipement de l'UAM, et en donnant des conseils non formels sur son statut, la Banque envoyait le signal contradictoire que la composante pouvait être poursuivie.

PERFORMANCE DE L'EMPRUNTEUR

25. Dans l'ensemble, la performance de l'emprunteur a été excellente quant à l'analyse des problèmes et à la conception du projet. Cependant, le projet a souffert de difficultés dans la mise en oeuvre des mesures définies et la capacité d'exécution du MSP demeure faible de par son organisation structurelle. Durant la seconde partie de l'exécution, le projet semble avoir été mis sur "pilote automatique" et les activités ont continué -- bien que lentement -- sans une revue détaillée de leur impact. C'est d'autant plus surprenant que cette expérience pilote devait préparer le terrain pour de plus grandes réformes nationales, et que les aspects techniques liés à la prestation des services ont été effectivement généralisés.

26. Quant à la réalisation de l'étude sur le financement de la santé, la performance de l'emprunteur a été remarquable. Le rapport a été produit, discuté en détails au sein du secteur de la santé (ateliers, séminaires, etc.) et plus généralement avec le gouvernement. Le MSP a avec succès mobilisé l'appui extérieur (USAID, OMS, etc.) sur le sujet, et a traduit les recommandations et implications de l'étude en projets concrets, tels que le projet d'assurance maladie.

27. Bien que difficile à évaluer en l'absence de documentation, il semble que la performance de l'emprunteur sur l'étude sur la gestion hospitalière n'ait pas été aussi bonne. Les résultats de l'étude n'ont pas été revus avec le bureau d'études et il y a eu très peu de discussions sur le rapport. C'est uniquement avec la préparation du Projet de Gestion Hospitalière que le dialogue avec la Banque dans ce domaine a été renoué.

ENSEIGNEMENTS DU PROJET

28. Les conclusions de ce projet devraient être systématiquement prises en compte par le MSP et la Banque lors de la préparation des projets futurs. Bien que cette opportunité n'ait pas été saisie dans le cadre du Projet d'Investissement du Secteur de la Santé (Prêt 3171-

MOR) puisque celui-ci a démarré avant que l'on ait pu dégager les leçons du PDSS, son exécution a permis une meilleure compréhension des problèmes qui devraient être abordés. Une attention particulière devra être portée aux points suivants lors de futures opérations:

a) *Le problème de la pérennité financière du système doit être abordé sans attendre.* Le MSP a déjà intégré cette préoccupation dans son dialogue et a indiqué son intention de procéder avec de nouveaux investissements uniquement lorsque la question de la pérennité du secteur aura été résolue, à savoir, lorsqu'un niveau d'investissement adéquat et plus encore de ressources de fonctionnement (salaires, médicaments, etc.) peuvent être assurés. A cette fin, la préparation du Projet de Financement et de Gestion de la Santé prévu pour l'année fiscale 1996 a été suspendue bien que son objectif soit d'appuyer des réformes de financement de la santé et de gestion hospitalière identifiées par l'intermédiaire des deux études soutenues par le projet. Si le projet de Gestion de la Santé est retardé, la pérennité du secteur de la santé devra être abordée dans le cadre du Programme de Priorités Sociales.

b) *Une évaluation de l'organisation du secteur pharmaceutique et de l'approvisionnement en médicaments du secteur public est nécessaire.* La disponibilité régulière de fonds extérieurs pour financer les médicaments n'a pas encouragé la recherche d'alternatives moins couteuses ni la rationalisation de la fourniture de médicaments. Ceci a été un frein au développement d'une concurrence saine et transparente au sein du secteur privé et très coûteux pour le gouvernement. En effet, le prix des médicaments produits au Maroc est élevé et les devises mobilisées pour financer un produit qui devrait être financé localement. Une analyse détaillée du secteur pharmaceutique et le développement d'une politique du médicament pour le secteur public devrait être entrepris avant tout futur financement de médicaments dans un projet.

c) *Les activités d'un projet ne peuvent pas être séparées de leur structure d'exécution.* L'organisation actuelle du MSP et des provinces médicales est mal adaptée aux objectifs poursuivis et décourage l'efficacité et la responsabilisation. Bien que le MSP soit conscient de ce problème et ait préparé un nouvel organigramme plus proche de ses objectifs, cette organisation n'a toujours pas été mise en place. Les mécanismes et structures d'exécution de projets futurs devraient faire partie intégrante de leur conception et devraient tenir compte de la structure organisationnelle d'ensemble du Ministère, ou intégrer toute modification qui y ait apportée.

d) *L'impact des stratégies mises en place pour assurer les services de santé de base (centres de santé, équipes itinérantes et meilleure organisation) devrait*

être évalué en détail afin de contribuer au développement d'une approche rentable, adaptable aux spécifications de chaque région.

e) *Les conditions ou les mécanismes nécessaires à la bonne réalisation d'un projet devraient faire partie intégrante de leur réalisation, ou, lorsque cela est possible, être des conditions de mise en vigueur du projet.* A titre d'exemple, bien que le projet ait prévu une collaboration étroite entre l'UAM et le secteur pharmaceutique privé, cette coopération ne s'est pas matérialisée. La Banque devant également avoir une attitude plus proactive dans ses commentaires et propositions palliatives (restructuration du projet, accroissement de la supervision des aspects "pilotes/démonstratifs" du projet).

TABLEAU 1: PRETS AFFERENTS DE LA BANQUE

Titre du Prêt	Objectif	Année Approb.	Statut
Opérations précédentes Ce Prêt est le premier Prêt de la Banque dans ce secteur au Maroc. Avant ce Prêt, l'intervention de la Banque dans le secteur de la santé était limité à l'élément schistosomiase du Projet de Développement Agricole de Doukkala (Prêt 1201-MOR) et a un élément de formation de personnel médical dans le Troisième Projet d'Education (Prêt 1220T-MOR) qui consistait de la construction et équipement d'un collège de Santé Publique à Rabat, une école de techniciens médicaux à Casablanca et trois écoles d'infirmières à Oujda, Fes et Agadir.			
Opérations suivantes Projet d'Investissement dans le Secteur Santé (3171-MOR)	Pour soutenir la stratégie du Gouvernement de renforcer (a) la Santé de base; (b) services de consultation, urgence et diagnostic offerts dans les hôpitaux régionaux et provinciaux, et les capacités de construction et de maintenance des équipements biomédicaux; (c) l'administration et la gestion de services offerts par le MSP afin d'augmenter l'efficacité et faciliter l'exécution de réformes administratives désignées à décentraliser la gestion des services de Santé; et (d) les réformes de secteur et de réglementation qui visent les problèmes à long-terme relatifs à l'évolution et la structure des systèmes de Santé publics et privés, mécanismes financiers, et la mobilisation de ressources pour soutenir le secteur.	AF90	Sous supervision. 21% déboursés. Date de clôture: 31 décembre, 1996 (report probable).
Projet de Priorités Sociales	Le projet proposé assisterait le gouvernement dans l'exécution de sa stratégie sociale pour aider les groupes les plus démunis de la société marocaine à jouer un rôle à part entière dans l'économie du pays, contribuant ainsi à augmenter la productivité et une plus grande justice. L'élément de Santé de base et de nutrition du projet soutiendrait l'exécution d'un plan d'action à moyen-terme visant à améliorer l'accès des populations rurales ciblées à un ensemble de services essentiels. A cette fin, un certain nombre d'actions conjointes seraient exécutées: (a) réhabilitation/expansion de l'infrastructure Santé, tout en procurant le matériel et médicaments nécessaires (y compris contraceptifs) et l'équipement; (b) promouvant les stratégies d'atteinte et de demande pour la livraison de services cliniques et de prévention essentiels dans les zones isolées; (c) renforcer et étendre les services de planification familiale, stimulant ainsi la demande pour davantage de services de planification familiale (par exemple les programmes IEC); (d) améliorer le statut nutritionnel des groupes à haut risque et mettre en exécution des programmes pour réduire la prévalence de déficiences micronutritives; et (e) soutenir les actions visant à redéployer et former le personnel médical et paramédical, plus particulièrement pour la supervision et le contrôle au niveau provincial.	Prévu AF96	En Préparation
Projet de Gestion Santé	Le projet soutiendrait les efforts du Gouvernement pour (i) adresser les problèmes majeurs d'efficacité interne des hôpitaux relatifs à la contenance des coûts tout en améliorant la qualité des services; et (ii) introduire de nouvelles réformes de financement de la Santé permettant d'accroître le niveau des ressources disponibles et de promouvoir la justice. Le projet proposé inclurait les éléments suivants: (a) développement de capacité de gestion hospitalière; (b) amélioration de la qualité du service; et (c) développement et exécution de nouveaux mécanismes financiers et de développement institutionnel.	Prévu AF96	En Préparation L'emprunteur a demandé à suspendre la Préparation du projet jusqu'à ce que les problèmes de financement du secteur aient été abordés au niveau gouvernemental.

TABLEAU 2: CALENDRIER DU PROJET

Phases du Cycle des Projets	Date Prévue*	Date Actuelle
Identification	n/a	Septembre 1979
Mécanisme de Financement de la Préparation des Projets (PPF)	Juin 83	
Préparation	n/a	Avril 1980, Juin 1981
Evaluation	n/a	Octobre 1984
Négociations	n/a	Avril 1985
Présentation au Conseil d'Administration	n/a	6 juin, 1985
Signature	Avant Octobre 1985	17 janvier, 1986
Entrée en Vigueur	Octobre 1985	27 juillet, 1986
Revue a mi-terme entreprise par l'emprunteur	Décembre 1987	Novembre 89
Achèvement du projet	30 juin, 1990	**
Clôture du Prêt	31 décembre, 1991	31 décembre, 1993

* Comme présenté dans le résumé du projet pour les phases d'exécution jusqu'à Présentation au Conseil d'Administration, et dans le Rapport d'Evaluation (SAR) pour les phases ayant lieu après Présentation au Conseil d'Administration.

** Tous les éléments ont été complétés à juin 1993 à l'exception de l'unité d'approvisionnement en médicaments qui reste à compléter à ce jour (voir para. 17) et l'élément IEC qui a été annulé.

TABLEAU 3: DEBOURSEMENTS SUR LE PRET: CUMUL ESTIME ET ACTUEL
(millions de $EU)

	AF86	AF87	AF88	AF89	AF90	AF91	AF92	AF93	AF94
Estimation à l'Evaluation	1.3	5.0	10.4	16.4	22.4	26.9	28.4	-	
Actuel	0	0.13	1.13	3.54	7.93	13.98	19.33	23.52	25.84
Actuel (% de l'estimation)	0	0.02	0.1	0.21	0.35	0.52	0.68	0.82	0.90
Date du dernier déboursement	Avril 94								

TABLEAU 4: INDICATEURS CLES

	1985	1988	1990	1992
VACCINATIONS				
- Couverture vaccinale (BCG) (Taux de recrutement des enfants de moins d'un an)	66%	83%	84%	92%
- Incidence des cas déclarés de:				
* Coqueluche	393	11	10	14
* Rougeole	149	120	46	537
* Polio	4	0	0	0
PLANNING FAMILIAL				
* Taux de nouvelles acceptrices pillules	7%	9%	14%	13%
* Taux de nouvelles acceptrices DIU	0.25%	0.56%	0.65%	1.7%
* Taux de prévalence contraceptive*	NA	NA	NA	NA
SERVICES DE SOINS DE BASE				
* Taux d'abandon de traitement anti-tuberculose	26%	16%	7%	4%
SMI				
* % d'accouchements assistés	21%	24%	28%	35%
* % of d'accouchement asssités en centres de santé	22%	26%	32%	45%
* Mortalité infantile**	NA	57‰	52‰	48‰
* Nombre de cas de tétanos néonatal	23	15	2	0
ASSAINISSEMENT				
* % des points d'eau traités	75%	71%	81%	87%
* Incidence de la Typhoide	37	15	12	9

Source: Evaluation du Projet, MSP (Aout 1994).

* L'Enquete ENPS 1992 estime le taux de prévalence national à 41.5 %. Seuls les données sur les nouvelles acceptrices et les CAP ont été recueillies au niveau des provinces du projet.

** Estimations, ne couvrant que deux des trois provinces du projet.

TABLEAU 5: ETUDES INCLUSES DANS LE PROJET

Etude	Objectif	Statut	Impact de l'Etude
1. Contrôle du Service de Santé	Le MSP devait mettre en oeuvre un système de contrôle et d'évaluation complet pour le projet actuel, y compris des programmes de planification familiale comme première étape vers le contrôle du progrès du Plan de Développement de la Santé dans son ensemble. Les données reçues par les centres de Santé devaient être étudiées et complémentées par une recherche opérationnelle et évaluatrice.	Un service contrôlant le système a été mis en place dans les provinces ce qui a facilite la prise de décision et permis la revue à mi-terme et la post-évaluation de ce projet.	La collection des données reste orientée sur les services offerts par les centres et n'est pas souvent en relation avec la population entière. Il n'est pas clair si ces statistiques qui représentent une charge administrative lourde pour le personnel sont utilisées dans le processus de décision.
2. Etude sur le Financement du Secteur Santé	Son but était d'analyser la disponibilité et l'allocation de fonds, ainsi que l'efficacité et la justice des schémas de financement présents et alternatifs.	L'étude fut complétée en octobre 90. Elle fut suivie par plusieurs séminaires et ateliers pour mobiliser le soutien extérieur et a conduit à la création d'une Unité d'Economie de Santé au MSP.	Les recommandations de L'étude sont exécutées, et ont résulté dans le développement d'un plan d'assurance maladie.
3. Etude sur la gestion hospitalière	Puisque les hôpitaux absorbent 72% du budget opérationnel du MSP, L'étude a mis l'emphase sur la performance hospitalière, contenance des coûts et méthodes éventuelles de recouvrement des coûts, selon les alternatives de L'étude sur le financement.	Le diagnostic a été complété en juin 89. L'évaluation a porté sur cinq secteurs: caractéristiques physiques et structurelles du secteur hospitalier au sein du MSP, ressources humaines, ressources financières et organisation structurelle.	Bien que la phase diagnostic a été complétée et a permis une meilleure vue de la gestion hospitalière, la phase prospective qui devait spécifier et tester les options de réforme n'a pas eu lieu. Cette phase est cependant développée dans la préparation du projet de Gestion de Santé.

TABLEAU 6A: COUTS DU PROJET

Description	Estimation à l'Evaluation (M$EU)			Actuel/Dernière estimation[1/] (M$EU)		
	Coûts Locaux	Coûts Etrangers	Total	Coûts Locaux[2/]	Coûts Etrangers[2/]	Total
Développement des services de santé de base	12.5	10.7	23.2	20.7	17.6	38.3
Renforcement de la gestion du MSP	0.8	0.9	1.7	0.7	0.9	1.6
Renforcement de la capacité de Formation/ IEC	0.5	1.1	1.6	0.1	0.3	0.4
Amélioration du système d'approv. médicaments	2.4	4.4	6.8	4.7	8.2	12.9[3/]
Total Coûts de Base	16.2	17.1	33.3	26.2	27.0	53.2
Contingences	7.1	7.2	14.3			
PPF						0.06
Total Coûts du Projet	23.3	24.3	47.6	26.2	27.0	53.3[4/]

1/ Taux de change utilisé: moyenne 1986-1993 (1$EU = 8.4 DH)
2/ Portion des coûts étrangers dans le total, calculée sur la base des estimations d'évaluation
3/ Dépenses estimées à ce jour: 4.8 millions de $EU, élément non complété
4/ Dépenses estimées à ce jour: 41.9 millions de $EU

TABLEAU 6B: FINANCEMENT DU PROJET[1/]

Source	Estimation à l'Evaluation (M$EU)			Actuel/Dernière estimation (M$EU)		
	Coûts Locaux	Coûts Etrangers	Total	Coûts Locaux	Coûts Etrangers	Total
BIRD	4.1	24.3	28.4	1.5	24.0	25.5
Gouvernement	19.2	-	19.2	16.4	-	16.4
Total	23.3	24.3	47.6	17.9	24.0	41.9

1/ Ce tableau reflète les arrangements de financement pour les dépenses déjà encourues. La source de financement nécessaire pour compléter le projet (11.4 millions de $EU) n'a pas encore été déterminée.

TABLEAU 7: STATUT DES AMENDEMENTS LEGAUX

Accord/ Section	Type Amend.	Statut Actuel	Date Exec. Origin.	Date Exec. Révisée	Description de l'Amendement	Remarques
3.02 (a)	7	CP			Etablir et maintenir une unité d'approvisionnement en médicaments responsable d'un programme d'approvisionnement en médicaments inclus dans la Section D du projet.	Seule la construction est terminée. Le statut légal de l'Unité reste à définir et l'équipement à commander.
3.02 (b)	4	CP	Chaque AF	-	Chaque année fiscale, UAM reçoit, par allocations budgétaires séparées, des fonds suffisants pour lui permettre de couvrir les frais estimes pour entreprendre un tel programme.	Les fonds de contrepartie étaient insuffisants pour une exécution dans les temps.
Sc. 5.1a	5	C	-	-	Maintenir et continuer l'opération du PIU.	
Sc. 5.1a	5	C	-	-	DIPC continue ses opérations avec l'assistance de personnel qualifie en nombre adéquat.	
Sc. 5.1a	5	CP	-		DSU reçoit la responsabilité de l'opération d'approvisionnement en médicaments.	
Sc. 5.2a	5	C	31/12/86		Remettre à la Banque les plans d'actions proposés pour renforcer la gestion du MSP.	
Sc. 5.2b	7	C			Exécuter ces plans.	Exécuté en 1990.
Sc. 5.3a	8	C	31/12/85		Etablir et maintenir un comité interministériel pour coordonner l'étude sur le financement du secteur Santé (section B.3b) & revoir les résultats de cette étude.	
Sc. 5.3b	7	C	31/12/86		Remettre a la Banque un rapport détaillé sur le progrès de l'étude.	Rapport terminé en Octobre 1990.
Sc. 5.4a	5	C	31/12/87		Remettre à la Banque un rapport détaillé sur le progrès de l'étude sur la gestion hospitalière (section B.3b).	Repoussé vu retard dans entrée en vigueur du projet. Rapport reçu le 30/6/89.
Sc. 5.5a	7	C	31/12/87		Remettre à la Banque un rapport détaillé sur le progrès de l'exécution du projet, y compris les résultats et recommandations de l'étude du programme de santé (section B.3b).	
Sc. 5.6a	7	NC	au 31/12 de chaque année	annule	Remettre à la Banque un programme détaillé de production et dissémination de matériaux IEC durant l'année calendaire suivant les matériaux sur l'éducation santé (section C.2).	Cet élément du projet a été annulé de par la disponibilité de fonds concessionnels pour les programmes d'éducation santé.
Sc. 5.6b	7	NC			Entreprendre un tel programme.	Voir ci-dessus.
Sc. 5.7a	7	NC			Remettre à la Banque, pour approbation, des programmes de formation de boursiers (sections B, C, D) et listes de candidats proposes pour la formation.	Voir ci-dessus.
Sc. 5.7b	7	NC			Entreprendre de tels programmes.	Voir ci-dessus.

1. Comptes/Expertise
2. Performance Financière/génération de revenus des bénéficiaires
3. Utilisation et Roulement des Fonds du Projets
4. Financement de contrepartie
5. Aspects de gestion du Projet ou de son agence exécutrice
6. Revue de contrôle et rapport
7. Exécution
8. Allocation budgétaire ou autre source sectorielle ou multi-sectorielle
9. Action budgétaire institutionnelle, sectorielle ou multi-sectorielle
10. Autre

Statut: C - Conforme
NC - Non-conforme
CP - Partiellement conforme

TABLEAU 8: RESSOURCES DE LA BANQUE: PERSONNEL

Phase du Cycle des Projets	Prévu		Actuel	
	Semaines	$EU	Semaines	$EU
Jusqu'à l'évaluation	n/a		85.6	
Evaluation - Conseil d'Administration	n/a		79.6	
Conseil d'Administration - Entrée en Vigueur	n/a		n/a[1/]	
Supervision	n/a[3/]		110.8	
Achèvement	n/a		7[2/]	
TOTAL			283	

1/ Période Conseil d'Administration et Entrée en vigueur cumulée avec la supervision.
2/ Estimation
3/ Données sur semaines/personnes prévues n'existent que pour la Période 89-94 et correspondent à 85.5 sp (semaines/personnes), ou une moyenne de 14.2 par an qui équivaut à un temps actuel de 76.2 sp pour cette Période (ou une moyenne de 12.7 par an).

TABLEAU 9: RESSOURCES DE LA BANQUE: MISSIONS
A. PREPARATION

Mois/Année	No. Pers.	No. Jours	Spécialisation	Remarques
- Mars 1979 (identification)	5	11 11 11 11 11	Spécialiste PRH Responsable de Prêt Spécialiste Education Spécialiste PRH Spécialiste PRH UNFDA	
- Septembre 79 Préparation	4	10 10 10 10	Spécialiste PRH Spécialiste Education Responsable de Prêt Spécialiste PRH	
- Avril 80 Préparation	4	11 11 11 11	Spécialiste PRH Economiste Responsable de Prêt Consultant Spécial. PRH	
- 21 juin, 81 Préparation		5	Economiste	
- 19 juin, 83	5	5 10 5 5 5	Economiste (1s) Architecte (2s) Spécialiste PRH (1s) Spécialiste PRH (1s) Spécialiste Exécution (1s)	
- 24 octobre - 5 nov., 83	2	12 8	Spécialiste PRH Spécialiste PRH	
Mars 84	1	20	Spécialiste PRH	
22 juillet, 84 (Pré-évaluation)	1	3	Spécialiste PRH	
Septembre. 84 (évaluation)	9	20 20 20 20 20 20 20 ? ?	Spécialiste PRH Economiste Santé Economiste Architecte Consultant PF Consult Recherche systèmes pharmac. Assistant d'Opérations Chef de Division Responsable de Prêt	
Mars 85	1	7	Spécialiste PRH	Revue du projet et ses implications budgétaires

TABLEAU 9 (SUITE)
B. SUPERVISION

Supervision Mois/Année	No. pers.	No. jours	Spécialisation	Classification du Projet		Problèmes
				Gén.	Dév.	
- Juin 86 (29au 9)	3	12 12 15	Spécialiste PRH Spécialiste PRH Economiste			
Avril 87	3	12 12 12	Spécialiste PRH Assistant d'Opérations Economiste Santé			Révision de la nouvelle structure organisationnelle du MSP et de l'élément IEC, lent à exécuter
- Février 88	1	?a/	Spécialiste Déboursements			Discussion sur l'ouverture d'un compte spécial.
- Août 88	3	8 8 8	Spécialiste Santé Médecin PRH Architecte	2	1	Manque de fonds de roulement. Restructuration du programme tuberculose.
- Octobre 89	4	8 8 8 8 8	Spécialiste Santé Médecin PRH Architecte Spécialiste Educ/Formation	2	1	Revue à mi-terme par le MSP.
- Juin 90	3	5 5 5	Spécialiste Santé Analyste Financier Architecte	2	1	Retard dans les paiements aux entrepreneurs; fonds à déléguer aux provinces. Appels d'offres pour l'UAM trop élevés.
- Novembre 90 b/	2	9 9	Spécialiste Santé Analyste Financier	2	1	Exécution lente. Coûts du projet à réviser.
- Février 91 b/	1	9	Analyste Financier			Rapport sur le financement de la santé à recevoir. Nouveau CPS pour l'UAM révisé.
- Mai 91 b/	3	9 9 9	Spécialiste Santé Analyste Financier Architecte	2	1	Discussion sur la viabilité de l'UAM.

a/ Mission à objectifs multiples. Portion de temps allouée au projet n'a pu être identifiée.
b) A partir d'aout 1988, toutes les missions ont concerné les deux projets santé. Le temps consacré à ces missions a été également réparti entre les deux projets ce qui surestime probablement le temps réellement consacré au PDSS.

TABLEAU 9 (SUITE)

B. SUPERVISION (SUITE)

Mois/Année	No. Pers.	No. Jours	Spécialisation	Classification du Projet		Problèmes
				Gén.	Dév.	
Octobre 91	4	8 8 8 8	Spécialiste PRH Principal Médecin PRH Spécial. Gestion Hospital. Architecte			Problèmes de déboursement -- Manque de fonds de contrepartie. Demande de report de la date de clôture.
- Mai 92	2	5 5	Analyste Financier Spécialiste Exécution	2	1	Allocations budgétaires limitées.
- Novembre 92	3	9 9 9	Analyste Financier Spécialiste Exécution Spécialiste Santé	2	1	Certains centres sont prêts, mais sans personnel. Statut de l'UAM à définir. Négociations avec le secteur pharmaceutique privé.
- Avril 93	2	3 3	Responsable Projet Spécialiste PRH			Equipement et statut de l'UAM.
- Mai 94 (RAP)	1	6	Responsable Projet			---

ANNEX

ROYAUME DU MAROC

MINISTERE DE LA SANTE PUBLIQUE

INSTITUT NATIONAL D'ADMINISTRATION SANITAIRE

EVALUATION DU PROJET DE DEVELOPPEMENT DES SERVICES DE SANTÉ DANS LES PROVINCES D'AGADIR, TAROUDANT ET SETTAT PERIODE 1985-1992

EVALUATEURS

EQUIPES DE LA DELÉGATION DES TROIS PROVINCES
INAS, UGP,
DECEMBRE, 1994

RESUME SYNTHETIQUE DE L'EVALUATION

Le mandat confié à l'INAS est d'évaluer le projet de développement des services de santé dans trois provinces : Agadir, Taroudant et Settat. Ce projet est implanté dans ces provinces depuis 1986 comporte 4 principales composantes :

1- Développement des services de santé au niveau de ces provinces

2- Gestion, recherche et évaluation au niveau du Ministère de la Santé Publique

3- Formation / éducation pour la santé au niveau national

4- Approvisionnement en médicament de base au niveau national.

Le projet touche 2 millions d'habitants et concerne tous les échelons du système. Notre évaluation intéresse essentiellement le premier volet : **Développement des services de santé de base**

L'évaluation a été menée par l'INAS, l'UGP et les équipes des trois provinces concernées. Aucune assistance technique étrangère n'a été apportée. Le budget accordé à cette évaluation est prélevé sur le budget général de l'INAS et n'a dépassé guère 50 000 DH , cette enveloppe a servi au financement de 3 ateliers à Rabat d'une durée 3 jours pour une douzaine de participants.
L'évaluation a pris du retard par rapport aux échéanciers fixés pour des raisons logistiques et humaines (changement des directeurs et des responsables des services de santé provinciaux, insuffisance de compétence des provinces dans le domaine de recherche).

L'évaluation a été accompagnée d'une appréciation de l'état d'avancement en vue de sensibiliser les responsables centraux sur les dysfonctionnements qui ont émergé au cours de cette phase cruciale du projet .
la mise en place de la totalité des composantes infrastructure, équipement budgétaire et surtout l'achèvement du délai de financement du projet ont justifié cette "appréciation administrative " . Les mesures corrective à prendre sont communiqués à l'ensemble des responsables centraux..

La principale limite de cette évaluation réside dans le fait qu'elle ne concerne que la période 1985-1992. Or, en l'an 1992, l'infrastructure nouvellement construite n'est pas totalement fonctionnelle. On s'attend donc à une idée sous estimée du degré de couverture sanitaire en terme d'accessibilité, de disponibilité et d'utilisation.

Pour donner plus de validité à cette évaluation, il est recommandé d'actualiser ces données par une deuxième évaluation en 1996.

Le point fort de cette évaluation réside dans le fait que les équipes locales ont été formées et impliquées dans toutes les phases de l'évaluation, une formation spécifique en méthodologie de recherche a été enseignée à certains animateurs.

La province possède actuellement une base de données informatisée et très détaillée par secteur et par circonscription et qui servira pour la planification des services de santé et la gestion des programmes au niveau local.

Evaluation de la structure :

- Infrastructure :

L'infrastructure dans la zone du projet est passée de 137 à 192 formations de SSB. L'architecture est satisfaisante est très bien appréciée par le personnel et la population.
. Les établissements sont spacieux, mais les logements des infirmiers sont jugés exigus.
. L'analyse du délai d'achèvement de 51 formations sanitaires analysées montre que 50% ont été construits dans un délai d' une année (3 mois à Settat et 4 ans à Taroudant).

- Equipement :

. Toutes les formations sont suffisamment équipées et persistent encore des équipements en stock dans les
magasins provinciaux dans l'attente d'ouverture de nouvelles formations achevées.
. A Settat, il existe des équipements en stocks destinés pour les laboratoire périphériques et qui devraient être redéployé pour le niveau national
. La qualité des équipements est adéquate et appréciée par les professionnels. La radiologie souffre de problèmes sérieux de relation utilisateur - fournisseu (panne, absence de maintenance corrective et problème d'installation).

- Budget :

. Le génie civil et l'équipement ont consommé 60% du budget du PDSS.
En 1992, la part du PDSS dans le budget de fonctionnement varie entre 81% à 18% selon lesrubriques . Ce budget concerne les frais de déplacement, les fournitures de bureau, les produits d'hygiène, le carburant, les médicaments.
La part accordée au zones rurales est prépondérante pour l'ensemble des provinces
. L'unité de gestion de projet (UGP) a produit un rapport de l'évaluation financier du projet..

- Ressources humaines :

Dans les trois provinces on a affecté un total de 134 infirmiers entre 85-92. Le ratio infirmiers par formation SSB (toute catégorie) atteint 4.44% en 1992 alors qu'il a été à 5.25 (en 1985).

L'affectation du personnel ne s'est pas fait en parallèle avec le besoin des 50 nouvelles formations achevées et ouvertes au public en 1992. La situation sera pire si les autres formations achevées seront ouvertes (une vingtaine d'autres dispensaires).

Evaluation de processus :

Les mécanismes d'implantation du projet étaient une expérience pour le Ministère de la Santé Publique. Les structures de gestion ont été mise en place et les termes de référence ont été identifiés et arrêtés à tous les niveaux (central et provincial). Cependant, on a assisté à des problèmes d'incoordination, de dysynchronisation central-périphérique, d'agencement des différentes composantes du projet et de mobilité du personnel opérationnel et des cadres.

Toutes les composantes du projet étudiees ont été implantées selon un ordinogramme qui diffère d'une province à une autre (voir documents des provinces)

Par le fait de la taille du projet et ses exigence la composante gestion est devenue prépondérante par rapport à l'esprit de recherche.

L'étude de ce processus est une leçon pour tous ceux qui veulent envisager un projet similaire. Cette étude du processus est documentée dans les rapports spécifiques de chacune des province.

Evaluation des résultat

Concernant les programmes de santé il y eu une amélioration notable de tous les programmes prioritaires. En 1992, le taux d'achèvement vaccinal est 82%. Le taux de recrutement des femme enconsultation prénatale atteint 38%. L'accouchent en milieu surveillé atteint 35% (45% se font en milieu ambulatoire).
On note l'amélioration de dépistage de la tuberculose et la baisse de l'incidence des 5 maladie cibles dans les 3 provinces .

Tous les indicateurs de ces provinces sont sensiblement supérieures aux indicateurs nationaux.

La mortalité infantile approchée indirectement selon le Service des études information et statistiques du ministère de la santé (SEIS) marquent une fléchissement très significative entre 85 et 92 pour l'ensemble des trois provinces. Cette baisse est similaire de ce qui est au niveau national.

RESULTATS

La couverture sanitaire :

. Accessibilité :

La situation de 1992 démontre, qu'en moyenne, chaque citoyen là où il se trouve peut trouver une formation fixe à moins de 14Km. Cette distance varie d'une province à une autre.

La population a plus de 10km d'un formation fixe est passée de 40% à 28% (les extrêmes varient entre (23% et 37%).

40% des habitants sont couverte par le mode fixe (35% minimum et 48% maximum)

Disponibilité :

Les soins de santé de base (CPN , vaccination, PF, curative, ...) sont disponibles dans la quasi-totalité des formations de SSB.

Le stratégie de couverture :

60% de la population est couverte par le mode le fixe urbain et rural en 1992:
12% par les équipes mobiles
19% par l'itinérant par point de contact (IPDC)
5% par des visites à domicile.

On s'attend à ce que la stratégie fixe prend plus d'emphase sur les autres modes après l'ouverture d'une vingtaine de formations.

La stratégie mobile itinérante présente de difficulté de viabilité, de logistique, de gestion et d'efficacité eu égard des objectifs opérationnelle qu'elle s'est fixées.

Intégration :

Dans tous les centres de santé nouvellement achévés , un modèle d'Intégration des services de santé a été développé et particulièrement pour la SMI/PF/Accouchement. Le même personnel polyvalent assure la prise en charge des bénéficiaires en totalité dans le même espace et pour des besoins différents. Cette expérience comporte toutes les chances de succès. Il est intéressant de l'évaluer après un certain recul.

Efficacité :

Dans la stratégie fixe l'amélioration des moyens de diagnostic, de latechnologie, l'allocation des médicaments essentiels se sont accompagnés d'une amélioration de la prise en charge.

L'utilisation des services de santé :

La sous utilisation est perçu dans l'ensemble des formations sanitaires. Dans certains centres de santé, il est du dessous de toutes normes acceptables malgré la disponibilité des ressources requises. Le TOM de certains modules d'accouchement varie entre 22% a Settat et 42% a Agadir. Ce qui est manifestement faible.

LES AUTRES QUESTIONS DE L'EVALUATION :

1- Les accoucheuses traditionnelles :

L'expérience est positive et reproductible, les limites résident dans la difficulté de maintenir la motivation et d'assurer la continuité de la supervision par l'équipe de santé.

2- Formation continue :

Le programme de la formation continue est actuellement solide au niveau de ces provinces. Les compétences et les attitudes sont améliorées pour l'ensemble du personnel , particulièrement le personnel technique du SIAAP.

La décentralisation du processus de formation a démarré au niveau de ces provinces pour se généraliser au niveau national. Les cadres de ces provinces ont été utilisés pour la conception des modules de formations sur le processus gestionnaire et pour la révision des structures des programmes de santé au niveau national.

3- Les laboratoires périphériques :

Il existe un écart important (sur le plan de performance et rendement) entre l'ensemble des laboratoires implantés. Le problème de ces laboratoires réside dans la supervision et la gestion de ces unités. Le personnel et la population sont satisfaits de cette technologie.

4- La participation communautaire

La population par le biais des collectivités locale et les autorités locales a été informée et sollicitée pour la participation dans la phase de conception du projet. Le rôle réel de la population n'a pas pu être approché dans cette étude.

Il demeure que sa contribution est ponctuelle et consiste surtout à l'affectation des ressources requises (terrain, carburant...) mais non dans le processus décisionnel. Le projet n'a pas identifié une approche réfléchie qui éclairerait les professionnels. Il n'a pas de modèle explicité.

5- La compétence du personnel en gestion :

On assiste à l'amélioration de la capacité managériale et de programmation de tous les cadres du SIAAP et des circonscriptions sanitaires. Cette situation risque de se perdre, voir même de se détériorer si elle ne résiste pas au changement de l'environnement politico-administrative locale (découpage, changement des responsables, mobilité du personnel, démotivation).

RECOMMANDATION :

1- Une deuxième évaluation est requise pour valider la tendance observée et particulièrement pour 1993 et 1994.

2- Les aspect positifs du projet doivent être soutenue par les responsables locales

3- Les dysfonctionnements observés et communiqués aux responsables centraux devront être pris en considération pour ce projet et pour les projets futurs

4- Le financement après projet PDSS doit être estimé pour décider le niveau optimum afin de prévenir la dégradation précipit de l'acquis du projet

5- Tout projet doit être procédé par un évaluation stratégiques.
Les décisions sont sujettes à des modifications tout le long du parcours du projet et jamais considérer que la conception est définitive

6- Assurer la stabilité des personnes-clé du projet tout au moins jusqu'à à la fin de la phase de mise en oeuvre.

7- Le projet de PDSS a développer une culture partagée par les équipes localement et entre le central et le périphérique, un cordon de communication, de lieu et de stimulus. Il véhiculait la philosophie de soins de santé de base auquel toutes les équipes ont adhéré et défendu. Quelle alternatives faut-il créer aujourd'hui à sa place ? Les équipes provinciales parlent déjà de "l'enterrement du projet".

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

Le 1ier septembre 1995

Monsieur Kabbaj
Division des projets financés
Ministère des Finances
Cité Administrative
Rabat, Maroc

Re: MAROC: Projet de développement de la santé (Prêt 2572-MOR)
Rapport final d'achèvement du projet

Cher Monsieur,

J'ai l'honneur de vous remettre ci-joint, à titre d'information, un exemplaire du rapport final (en français et en anglais) tel qu'il a été distribué au Conseil d'administration de la Banque.

Je vous prie de croire, à l'assurance de ma haute considération.

Roger Slade, Chef
Division de l'Agriculture et du développement humain
Département de l'évaluation
rétrospective des opérations

PCR

Pièces jointes

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

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Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

Le 1ier septembre 1995

Monsieur Belouali
Directeur de l'INAS
5 Route de Casablanca
Collège de la Santé
Rabat, Maroc

Re: MAROC: Projet de développement de la santé (Prêt 2572-MOR)
Rapport final d'achèvement du projet

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Pièces jointes

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Cable Address: INDEVAS

Le 1ier septembre 1995

Monsieur Belkoura
Chargé de Mission auprès du Premier Ministre
Responsable de Coordination des relations avec la Banque mondiale
Ministère de l'Incitation de l'Economie
Quartier Administratif (près du Ministère des Transports)
Agdal, Rabat
Maroc

Re: MAROC: Projet de développement de la santé (Prêt 2572-MOR)
Rapport final d'achèvement du projet

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Roger Slade, Chef
Division de l'Agriculture et du développement humain
Département de l'évaluation
rétrospective des opérations

Pièces jointes

Re: MAROC: Projet de développement de la santé (Prêt 2572-MOR)
Rapport final d'achèvement du projet

Son Excellence
Monsieur Ahmed Alami
Ministre de la Santé Publique
Ministère de la Santé Publique
335 Avenue Mohamed V
B.P. 812
Mechanar, Rabat
Maroc

Monsieur Belouali
Directeur de l'INAS
5 Route de Casablanca
Collège de Santé
Rabat, Maroc

Monsieur Belkoura
Chargé de Mission auprès du Premier Ministre
Responsable de Coordination des relations avec la Banque mondiale
Ministère de l'Incitation de l'Economie
Quartier Administratif (près du Ministère des Transports)
Agdal, Rabat
Maroc

Monsieur Kabbaj
Division des projets financés
Ministère des Finances
Cité Administrative
Rabat, Maroc

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

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Le 1ier septembre 1995

Son Excellence
Monsieur Ahmed Alami
Ministre de la Santé Publique
Ministère de la Santé Publique
335 Avenue Mohamed V
B.P. 812
Mechanar, Rabat
Maroc

Re: MAROC: Projet de développement de la santé (Prêt 2572-MOR)
Rapport final d'achèvement du projet

Monsieur le Ministre,

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Roger Slade, Chef
Division de l'Agriculture et du développement humain
Département de l'évaluation
rétrospective des opérations

Pièces jointes

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: May 10, 1995

TO: Susan Stout, OED

FROM: Claire Voltaire, MN1PH CV

EXTENSION: 3-2784

SUBJECT: MOROCCO - HEALTH DEVELOPMENT PROJECT - PCR

1. Thank you again for your very useful comments. I hope I have clarified the paragraphs concerned.

2. As discussed I have added the summary of the Borrower's evaluation of the first component as an annex to the PCR.

3. The addresses of the agencies who should receive a copy of this report are the following:

S.E Monsieur Ahmed Alami
Ministre de la Santé Publique
Ministère de la Santé Publique
335 Avenue Mohamed V
B. P. 812
Mechanar, Rabat
Maroc

M. Belouali, Directeur de l'INAS
5 Route de Casablanca, Collège de Santé
Rabat, Maroc

M. Belkoura, Chargé de Mission auprès du Premier Ministre
Responsable de Coordination des relations avec la Banque mondiale
Ministère de l'Incitation de l'Economie
Quartier Administratif (près du Ministère des Transports)
Agdal, Rabat
Maroc

M. Kabbaj
Division des projets financés
Ministère des Finances
Cité Administrative
Rabat, Maroc

cl. w. & cc: R. Hees

cc: Mmes & Messrs. Ritchie, Costa (MN1DR), Vaurs (MN1CO), Millot, Pierre-Louis, Jarawan, Laederach (MN1HR).

M:\mor\pa074spn\pcr.mem

THE WORLD BANK GROUP

ROUTING SLIP	DATE: June 21, 1995

NAME	ROOM. NO.
Mr. Robert Picciotto	
Thru: Mr. Francisco Aguirre-Sacasa, Director OED FAS	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: MOROCCO: Health Development Project (Loan 2572-MOR)
Project Completion Report

REMARKS:

For your signature prior to printing.
No comments have been received from the Region.

FROM	ROOM NO.	EXTENSION
Roger Slade	T9-045	81293

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: ***Project Completion Report on Morocco Health Development Project (Loan 2572-MOR)***

Attached is the Project Completion Report (PCR) on the Morocco Health Development project (Loan 2572-MOR, approved in FY85) prepared by the Middle East and North Africa Regional Office. Part II was prepared by the Borrower.

The main objective of the project was to accelerate the transition from an urban based and hospital-oriented health system to a more cost-effective system of primary care services emphasizing outreach in rural areas. To achieve this objective the project was to (a) strengthen primary health care delivery, including family planning, in three provinces; (b) strengthen the capacity of the Ministry of Public Health (MOPH) in planning, training, research, evaluation and health service administration; and (c) improve the supply, distribution and control of drugs.

Implementation of primary health care activities in the three pilot provinces was successful as demonstrated by improvements in the accessibility of services and service utilization. Efforts to strengthen the support system were less successful partly because the MOPH was reorganized several times during project implementation. Moreover, the training and health education activities included in the original project design were absorbed into projects financed by other donors and were not evaluated in the PCR. Studies of hospital management and health financing were delayed, but eventually proved useful to the borrower. The drug supply component was a source of considerable discussion throughout project implementation, and resulted in little apparent impact on drug policy.

The outcome of the project is rated as satisfactory. Improvements in the approach to primary health care delivery piloted under the project are being extended to non-project provinces. However, the financial sustainability of the primary health care approach established by the project is uncertain, and is the subject of a continuing dialogue with the borrower. Sustainability is therefore rated as uncertain. Institutional development is rated as modest as systems for assuring local adaptation of service delivery models remain dependent on continued prodding from the central administration rather than on improved organization and better incentives in regional and local administrations.

The PCR provides an adequate account of project implementation. An audit is planned.

Attachment

RECEIVED

95 JUN 22 PM 12:06

6/23

THE WORLD BANK GROUP

ROUTING SLIP	DATE: June , 1995

NAME	ROOM. NO.
Mr. Robert Picciotto	
Thru: Mr. Francisco Aguirre-Sacasa, Director OED	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: MOROCCO: Health Development Project (Loan 2572-MOR)
Project Completion Report

REMARKS:

For your signature prior to printing.
No comments have been received from the Region.

FROM	ROOM NO.	EXTENSION
Roger Slade	T9-045	81293

OK

RECEIVED
95 JUN -9 AM 10: 25

THE WORLD BANK GROUP

ROUTING SLIP	DATE: June , 1995

NAME	ROOM. NO.
Mr. Robert Picciotto, DGO	DGO
Thru: Mr. Francisco Aguirre-Sacasa, OEDDR	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: MOROCCO: Health Development Project (Loan 2572-MOR)
PROJECT COMPLETION REPORT

REMARKS:

Please find attached, for your approval, the above PCR together with the Project Information Form, a draft Review Note from you to the Board, and a draft memorandum from the Director, OED to the Country Director concerned.

FROM	ROOM NO.	EXTENSION
Roger Slade, Chief, OEDD1	T9-045	81293

6/9

Log 3

THE WORLD BANK GROUP

ROUTING SLIP	DATE: May , 1995

NAME	ROOM. NO.
Mr. Robert Picciotto, DGO	
THRU: Mr. Francisco Aguirre-Sacasa, OEDDR	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: MOROCCO: Health Development Project (Loan 2572-MOR)
PROJECT COMPLETION REPORT

REMARKS:

Please find attached, for your approval, the above PCR together with the Project Information Form, draft Review Note from you to the Board, and a draft memorandum from the Director, OED to the Country Director concerned.

Roger: Another TN which requires considerable work. As in the case of the Argentina Ag Credit II PCR, the objectives statement in this TN is not well handled. Also, the drafting needs to be tightened up. Finally, pls review ratings carefully in light of coreect objectives statement.

JAS 5/31

FROM	ROOM NO.	EXTENSION
Roger Slade, Chief, OEDD1	T9-045	81293

Sussex
We live and learn.
Please handle a.s.a.p. RS 1/6

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: ***Project Completion Report on Morocco Health Development Project (Loan 2572-MOR)***

Attached is the Project Completion Report (PCR) on Morocco–Health Development Project (Loan 2572-MOR) prepared by the Middle East and North Africa Regional Office. Part II was prepared by the Borrower.

The project was to strengthen (a) primary health care delivery, including family planning, in three provinces; and (b) the Ministry of Public Health in planning, staff development, research, evaluation and public health administration at the central and provincial levels.

Implementation of primary health care activities in the three provinces was successful as assessed by improvements in the accessibility of services and service utilization. Efforts to strengthen the support system were less successful. Training and health education activities were absorbed into projects financed by other donors. Support for improved health policy and administration included completion of studies of hospital management and health financing which were delayed, but useful to the Borrower. A drug supply component was a source of considerable discussion throughout project implementation, and resulted in little apparent impact on drug policy.

The outcome of the project is rated as satisfactory. Improvements in the approach to the delivery of primary health care development under the project are being adapted in non-project provinces. However, the financial sustainability of the health system remains uncertain and the subject of future dialogue with the Borrower. Institutional development is rated as partial: systems for assuring local adaptation of service delivery models are dependent on continued commitment at central levels rather than on basic changes in administrative structure and incentives. Bank and Borrower performance during project implementation suffered from flagging interest in later years and competition from the preparation and appraisal of a new health sector investment project.

The PCR provides an adequate account of project implementation. An audit is planned.

Attachment

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: June 12, 1995

TO: Mr. Daniel Ritchie, Director, MN1

FROM: Francisco Aguirre-Sacasa, Director, OED

EXTENSION: 34380

SUBJECT: **MOROCCO: Health Development Project (Loan 2572-MOR)**
Project Completion Report

1. Attached is the Review Note from the Director-General, Operations Evaluation on the above PCR. It is scheduled to be sent together with the PCR to the Print Shop one week from today, for release to the Executive Directors and the President.

2. Based on OED's review of the PCR, we intend to include in the Annual Review database, the following ratings of the operation:

Outcome: Satisfactory

Sustainability: Uncertain

Institutional Development: Modest

An audit is planned. The ratings will be re-evaluated in the course of the audit.

Attachment

S.Stout/pb

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: June 12, 1995

TO: Mr. Daniel Ritchie, Director, MN1

FROM: Francisco Aguirre-Sacasa, Director, OED FAS

EXTENSION: 34380

SUBJECT: **MOROCCO: Health Development Project (Loan 2572-MOR)**
Project Completion Report

1. Attached is the Review Note from the Director-General, Operations Evaluation on the above PCR. It is scheduled to be sent together with the PCR to the Print Shop one week from today, for release to the Executive Directors and the President.

2. Based on OED's review of the PCR, we intend to include in the Annual Review database, the following ratings of the operation:

Outcome: Satisfactory

Sustainability: Uncertain

Institutional Development: Modest

An audit is planned. The ratings will be re-evaluated in the course of the audit.

Attachment

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: June 15, 1995

TO: Mr. Francisco Aguirre-Sacasa, Director OED

FROM: René Costa Acting Director, MN1

EXTENSION: 3.2838

SUBJECT: MOROCCO: Health Development Project (Loan 2572-MOR) - PCR

1. Thank you for your memorandum of June 12 transmitting us OED's Review note on the above project as well as your department proposed rating for this operation.

2. Your assessment of this project concurs with our department's and we have no comments on the text of the Note.

cc: D. Ritchie o/r (MN1DR), R. Hees, C. Voltaire (MN1HR)

CVoltaire:ma
M:\2572last

OPERATIONS EVALUATION DEPARTMENT
PCR REVIEW/AUDIT PROCESS /1

CONTROL SHEET

Project: MOROCCO: Health Development Project
Loan: 2572
PCR Format: Old-Style / New-Style
Evaluating Officer: Susan Stout **Date:**
Approved by: Roger Slade, Chief, OEDD1 **Date:**

	Date (mo/dy/yr)
A. Timetable	
- PCR logged in by Division	02/15/95
- If incomplete, PCR returned to Region	_____
- If PCR is unlogged	_____
In case evaluating officer requests Region to revise draft PCR: /2	
- Memo to Sector Division Chief	_____
- Follow-up memo from Division Chief, OED, to Sector Division Chief, Region, if revision delayed	_____
- Satisfactorily revised PCR received from Region	_____

B. If PCR Returned to Region for Revision

Nature of revision requested (circle one): **minor** **major**

Degree of hassle involved (circle one): **none** **minor** **major**

/1 In the case of a PPAR which does not include the PCR complete section **E** only.

/2 Please attach copy of note to regional task manager and follow-up memos if any.

C. Complete for Old-style PCRs

	YES	NO
Covenant requiring Borrower to prepare PCR /3	___	___
PCR prepared by		
I. Borrower		
- Borrower staff or agencies	___	___
- FAO/CP or consultants /4	___	___
II. Bank		
- Bank staff	___	___
- Some input from Borrower	___	___
- Inadequate/incomplete Borrower PCR	___	___
Use of Borrower PCR in final document /5		
- As final PCR	___	___
- With overview	___	___
- An Annex to Bank PCR	___	___
- On file, Bank prepared its own PCR	___	___

D. Complete for New-style PCRs

Did Borrower complete Part II of the PCR?	___	___
If yes,		
- Part II agrees with Parts I and III	___	___
- Part II disagrees with Parts I and III	___	___

E. OED Staff and Consultants Input

	Days
Staff	3
Consultants	
Total	3

Attachment(s): (See footnote 1, page 1)

/3 Please remember that a standard clause has been included in general conditions since January 1, 1985 (Article IX).
/4 The PCR is clearly identifiable as a consultancy firm product.
/5 Applies to item I.

PCR/PIF COVER SHEET Run Date: 2/16/95

OED ID: L2572 *Division: 1

*Country: Morocco
*Project Description: Health Development
*Sector: 04 / Human Resource
*Subsector: 04.05 / Pop., Health & Nutr.
Lending Instrument Type: SIM
L/C: L2572
Original IDA/IBRD Commitments: 28,400,000 ($US)
Total Cancellations: 2,558,693 ($US)

Key Dates	ORIGINAL	ACTUAL
Approval		6/06/85
Signing/Agreement		1/17/86
Effectiveness	4/17/86	7/29/86
Closing	12/31/91	12/31/93
PCR Receipt in OED		2/15/95

ASSIGNED TO: Susan Stout

SIGNATURE: SS DATE: 2/17/95

Please confirm the "*" fields above, sign this sheet and return a photo-copy to Helen Sioris. Pass this sheet as the PIF cover to the Eval. Officer.

********** TO BE COMPLETED BY EVALUATION OFFICER **********

Date of Review: 4 / 24 / 95 (mm / dd / yy)

Name of Reviewer: SUSAN STOUT

Type of Evaluation: PCR Review [✓] PAR Review [ ]

If this is a PAR Review, are there major differences in the judgements from those made in the PCR Review?

Yes [ ] No [ ]

If Yes, please discuss in detail on page 26 of the PIF

	ORIGINAL	LATEST
Date of Physical Completion	(mm/dd/yy)	5/15/95 (mm/dd/yy)
Total Project Cost ($US mill)	47.6	53.3
Applicable Disbursement Profile: (see note 11 in the PIF, page 31)		
Number of Supervision Missions:	15	

****

OPERATIONS EVALUATION DEPARTMENT

PROJECT INFORMATION FORM (PIF)* 1/

TABLE OF CONTENTS

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* The footnote numbers in the PIF refer to the relevant explanatory notes in OED guideline No. 7.3. [The explanatory notes may be modified depending on treatment of OD's, OM,s, etc.]

II. PROJECT DESIGN

1) Taking into account the country's level of development and the competence of the implementing agency, were the project and its major objectives:

Codes:	1 = Highly	4 = Negligibly
	2 = Substantially	0 = Not Available
	3 = Modestly	blank = Not Applicable

	(1,2,3,4,0, blank)
DEMANDING ON BORROWER/IMPLEMENTING AGENCY:	
Original Project	3
Revised Project	
DEMANDING ON BANK:	
Original Project	3
Revised Project	
COMPLEX: 4/	
Original Project	3
Revised Project	
RISKY:	
Original Project	3
Revised Project	

2) To what extent was the Borrower involved in project design? [0]

3) How appropriate was the design for achieving the project's objectives? [3]

4) How innovative was the project design? [3]

	Yes	No
5) Did the original project design, as presented in the SAR or MOP, include a plan for future project operation?		X
6) Did the original project design include provisions for establishing a M&E system or improving the existing one(s)?	✓	

III. ECONOMIC AND FINANCIAL INDICATORS

III.A. ECONOMIC RATES OF RETURN

1) If an **ECONOMIC RATE OF RETURN** (ERR) was calculated for the project, enter a point or range of estimates (in %) and answer the questions:

	Appraisal Estimate	Re-estimated at Completion
	_____%	_____%
On what percentage of estimated total project costs was the original **ERR** based?		_____%
On what percentage of total projects costs (final/latest estimate) was the re-estimated **ERR** based ?		_____%

2) If an **ERR** was not re-estimated indicate the reason(s):

	(✓)
Project not implemented	☐
Inadequate data	☐
Not relevant for the project	☑
Other (specify): _____	☐

3) If the re-estimated **ERR** differs significantly from the appraisal estimate, indicate the reason(s):

	(✓)
Cost changes	☐
Changes in output price/user charges/terms of trade	☐
Output changes	☐
Output delays	☐
Changes in methodology/analysis	☐
Other (specify): _____	☐

	Yes	No
4) Does the ICR provide enough information to assess the reliability of the re-estimated ERR?	☐	☐
5) Is the re-estimated **ERR** a reasonable measure of this project's overall achievement of objectives?	☐	☐

Explain: _____

_____

III.B. FINANCIAL RATES OF RETURN5/

1) If a **FINANCIAL RATE OF RETURN** (FRR) or another financial indicator (e.g. rate of return on assets) was calculated for the project, enter a point or range of estimates (in %) and answer the questions:

	Appraisal Estimate	Re-estimated at Completion
	_____%	_____%
On what percentage of estimated total project costs was the original **FRR** based ?		_____%
On what percentage of total projects costs (final/latest estimate) was the re-estimated **FRR** based ?		_____%

III.B. FINANCIAL RATES OF RETURN (continued)

2) If a **FRR** (or other financial indicator) was not re-estimated, indicate reason:

	(✓)
Project not implemented	☐
Inadequate data	☐
Not relevant for the project	☐
Other (specify): _____	☐

3) If the re-estimated **FRR** (or other financial indicator) differs significantly from the appraisal estimate, indicate the reason(s):

	(✓)
Cost changes	☐
Changes in prices/user charges	☐
Changes in taxes/trade tariffs	☐
Output changes	☐
Output delays	☐
Changes in methodology/analysis	☐
Other (specify): _____	☐

III.C. INDICATORS OF COST-EFFECTIVENESS6/

1) If an **ERR** was not calculated, but the **COST-EFFECTIVENESS** of the project was estimated in the ICR, was it:

	(✓)
Same or higher than in the SAR	☐
Lower than in the SAR	☐
Information not available	☐

2) For each of the following types of indicators:

	Cost per unit of output	Measures of internal efficiency	Cost per unit of input
Are indicators included in the ICR? (Mark "Y" for "yes"; "N" for "no")	☑	☑	☑
If yes: Provide a clear description of the indicator(s) used, including units of measurement:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Are the indicators used in the ICR evaluation ("Y" or "N")?	☐	☐	☐
Are the indicators measured appropriately ("Y" or "N")?7/	☐	☐	☐

IV. DETAILED RATINGS and UNDERLYING FACTORS

IV.A. FACTORS AFFECTING ACHIEVEMENT OF MAJOR OBJECTIVES

1) Indicate the extent to which the following factors positively(+) or negatively(-) influenced the achievement of **MAJOR OBJECTIVES:**

	Substantial (+ or -)	Partial (+ or -)	Negligible (✓)	Not Available (✓)	Not Applicable (✓)
FACTORS NOT GENERALLY SUBJECT TO GOVERNMENT CONTROL					
World markets/prices	☐	☐	☑	☐	☐
Natural events	☐	☐	☑	☐	☐
Bank performance	☐	⊟	☐	☐	☐
Cofinancier(s) performance	☐	☐	☑	☐	☐
Performance of contractors/ consultants8/	☐	☐	☐	☑	☐
War/civil disturbances	☐	☐	☐	☐	☑
Other (specify):_____	☐	☐	☐	☐	
FACTORS GENERALLY SUBJECT TO GOVERNMENT CONTROL					
Macro policies/conditions	☐	☐	☑	☐	☐
Sector policies/conditions	☐	⊞	☐	☐	☐
Government commitment	☐	⊞	☐	☐	☐
Appointment of key staff	☐	⊞	☐	☐	☐
Counterpart funding	☑	☐	☐	☐	☐
Administrative procedures	☐	☐	☐	☑	☐
Other (specify):_____	☐	☐	☐	☐	
FACTORS GENERALLY SUBJECT TO IMPLEMENTING AGENCY CONTROL					
Management	☐	⊟	☐	☐	☐
Staffing	☐	⊟	☐	☐	☐
Cost changes	☐	☐	☐	☑	☐
Implementation delays	⊟	☐	☐	☐	☐
Use of technical assistance	☐	☐	☐	☑	☐
Monitoring and evaluation9/	☐	⊞	☐	☐	☐
Beneficiary participation	☐	☐	☑	☐	☐
Other (specify):_____	☐	☐	☐	☐	

IV.A. FACTORS AFFECTING ACHIEVEMENT OF MAJOR OBJECTIVES (continued)

2) If there were major increases (+) or decreases (-) in project COSTS, indicate the major reasons(s) with a (+) or (-):10/

	(+, - , blank)
Change in project scope/scale/design	☐
Deficient estimate of physical quantities	☐
Deficient estimate of unit costs	☐
Inadequate price contingencies	☐
Change in exchange rate	☐
Change in prices/tariffs/taxes	☐
Change in time to implement project	⊞
Performance of contractor(s)	☐
Other (specify): _____	☐

3) If there were major increases (+) or decreases (-) in the TIME required to implement the project, indicate the major reasons with a (+) or (-):

	(+, -, blank)
Implementation schedule unrealistic	⊞
Project preparation	☐
Unexpected technical difficulties (specify):_____	☐
Change(s) in project scope	☐
Quality of management	⊞
Selection of staff	☐
Selection of consultants	☐
Receipt of counterpart funds	⊞
Receipt of funds from Bank/cofinanciers	☐
Procurement procedures	☐
Disbursement procedures	☐
Security problems	☐
Natural events	☐
Other (specify): _____	☐

4) If there was a major change in project scope (see Section I, question #1), indicate whether the following were major reasons:

	(✓)		(✓)
Change in project cost	☐	Time delays	☐

INSTITUTIONAL DEVELOPMENT IMPACT and SPECIAL EMPHASES

IV.B. INSTITUTIONAL DEVELOPMENT

	Yes	No
1) Was the project primarily directed at institutional development?	☐	☐
2) If not, did the project contain component(s) with significant institutional development objectives?	☑	☐

3) Rate from 1 to 4 for each of the following aspects of **INSTITUTIONAL DEVELOPMENT:**

Codes: 1 = High. 4 = Minimal relevance, negligible efficacy or impact.
2 = Substantial. 0 = Not Available.
3 = Intermediate relevance, modest efficacy or impact. blank = Not Applicable (not permitted for OVERALL).

	RELEVANCE of outcomes cf. country/sector objectives		EFFICACY of outcomes cf. project objectives, original or revised	Estimated IMPACT
	original	revised	(1, 2, 3, 4, 0, blank)	
NATIONAL CAPACITY				
Economic management	☐	☐	☐	☐
Civil service reform	☐	☐	☐	☐
Financial intermediation	☐	☐	☐	☐
Legal system	☐	☐	☐	☐
Poverty alleviation	☐	☐	☐	☐
Support to private sector	3	☐	3	4
Environment & natural resources	☐	☐	☐	☐
Sectoral capacity	☐	☐	☐	☐
Other (specify): _____	☐	☐	☐	☐
AGENCY CAPACITY				
Planning/policy analysis	2	☐	2	0
Management	2	☐	2	0
Skills upgrading	2	☐	2	0
Personnel management	3	☐	3	0
Management information systems (incl. budgeting, auditing)	2	☐	2	2
Agency restructuring	☐	☐	☐	☐
Other (specify): _____	☐	☐	☐	☐
OVERALL INSTITUTIONAL DEVELOPMENT	2	☐	2	3
copy to:	page 1		pages 1	page 26

IV.B. INSTITUTIONAL DEVELOPMENT (continued)

4) Indicate if any of the following modalities were used:
(insert + for items having a positive impact, - for a negative impact, and ✓ for modalities used but for which the impact is not available in the ICR).

	Local (+,-,✓,blank)	Expatriate (+,-,✓,blank)
Studies	☒	☐
Twinning	☐	☐
Short-term consultants	☐	☑
Long-term consultants	☐	☑
Training	☐	☑
NGO participation	☐	☐
Other (specify): _____	☐	☐

5) Indicate which, if any, of the following supported institutional development:

	(✓)
Joint or parallel co-financing	☐
Non-project specific advisers	☐
Other Bank funded operations	☐
Other non-Bank operations	☐
Grant or trust funds	☐

6) What percentage of TOTAL PROJECT COST was committed to institutional development?

30 %

OF WHICH:
the Bank 50 %
the borrower 50 %
other sources of local funding ____ %
co-financiers ____ %
other contributors ____ %

(if no information is available, enter NA.)

assume that 30% of "Development of Basic Health Services" was institutional development

IV.B. INSTITUTIONAL DEVELOPMENT (continued)

7) Was the design of the institutional development component mapped out completely in advance (blueprint) or left to evolve within agreed rules (process) approach, or a mixture of the two?

	(✓)
Blueprint	☐
Process	☐
Mixed	☑

8) Indicate whether any of the following factors had a positive (+) or negative (-) influence on the overall achievement of institutional objectives:

	(+, -, blank)
Borrower commitment	☐
Quality of preparation, including institutional development sector work	☐
Design (including blueprint vs. process)	☐
Supervision	⊟
Establishment of a new organization	☐
Elimination of an existing organization	☐
Restructuring/privatizing/strengthening of an organization	⊞
Regulatory changes	☐
Number and/or complexity of financing arrangements	☐
Monitoring and evaluation	⊞
Exogenous factors (eg. wars, civil disturbances, terms of trade shocks, etc.) specify:_____)	☐

IV.C. PUBLIC POLICY REFORM[11]/

1) Did the project objectives include reform of **PUBLIC POLICIES** (other than institutional development: see page 7)?

	Yes (✓)	No (✓)
	☐	☑

If yes, rate from 1 to 4 for each of the following **PUBLIC POLICY** objectives:

Codes: 1 = High.
2 = Substantial.
3 = Intermediate relevance, modest efficacy or impact.
4 = Minimal relevance, negligible efficacy or impact.
0 = Not Available.
blank = Not Applicable.

	RELEVANCE of outcomes cf. country/sector objectives		EFFICACY of outcomes cf. project objectives, original or revised	Estimated IMPACT
	original	revised	(1, 2, 3, 4, 0, blank)	
Planning public investments/ expenditures	☐	☐	☐	☐
Budget process	☐	☐	☐	☐
Tax system	☐	☐	☐	☐
Monetary reform	☐	☐	☐	☐
Debt management	☐	☐	☐	☐
Exchange rate management	☐	☐	☐	☐
Trade/tariff/etc.	☐	☐	☐	☐
Banking/financial sector reform	☐	☐	☐	☐
Regulation of private sector	☐	☐	☐	☐
Public enterprises	☐	☐	☐	☐
Procurement policies	☐	☐	☐	☐
Labor legislation	☐	☐	☐	☐
Civil service reform	☐	☐	☐	☐
Other (specify):				
_____	☐	☐	☐	☐
OVERALL	☐	☐	☐	☐
	(	copy to page 1	)	

IV.C. PUBLIC POLICY REFORM (continued)

2) Indicate whether the following factors had a positive(+) or negative(-) influence on the achievement of **PUBLIC POLICY REFORM** objectives:

	(+, -, blank)
Project preparation/design	☐
Government/borrower commitment	☐
Legal framework	☐
Bank staff effectiveness	☐
Borrower/Implementing agency effectiveness	☐
Consultant(s) effectiveness	☐
Other (specify): _____	☐

IV.D. SOCIAL CONCERNS (answer question #4 in all cases)

	Yes (✓)	No (✓)
1) Did the project target specific **SOCIAL GROUPS?**	☐	☑

If yes, what characterized these groups?

	(✓)
a. Socio-economic status (i.e. poverty)12/	☐
b. Gender (i.e., men, women, girls)13/	☐
c. Ethnicity (i.e. indigenous or tribal peoples)14/	☐
d. Community type or locale (e.g. resettlement)15/	☐
e. Other (specify): _____	☐

2) Indicate whether the following factors had a positive(+) or negative(-) influence on the achievement (see below) of **SOCIAL** objectives, and identify the group(s) affected using the above letter(s):

	(+, -, blank)	
Quality of project preparation/design	☐	( ) ( )
Government/borrower commitment	☐	( ) ( )
Effectiveness of NGO participation	☐	( ) ( )
Effectiveness of beneficiary participation	☐	( ) ( )
Bank staff effectiveness	☐	( ) ( )
Borrower/Implementing agency effectiveness	☐	( ) ( )
Other (specify): _____	☐	( ) ( )

IV.D. SOCIAL CONCERNS (continued) - answer question #4 in all cases

Codes: 1 = High.	4 = Minimal relevance, negligible efficacy or impact.
2 = Substantial.	0 = Not Available.
3 = Intermediate relevance, modest efficacy or impact.	blank = Not Applicable.

3) Rate from 1 to 4 for each of the following **SOCIAL** objectives:

	RELEVANCE of outcomes cf. country/sector objectives		EFFICACY of outcomes cf. project objectives, original or revised	Estimated IMPACT
	original	revised	(1, 2, 3, 4, 0, blank)	
Community development/ Beneficiary participation	☐	☐	☐	☐
Poverty alleviation/protection of vulnerable groups	☐	☐	☐	☐
Gender related issues	☐	☐	☐	☐
Equity enhancement	☐	☐	☐	☐
Improved access to services	☑ 2	☐	☑ 2	☐
Improved quality of services	☑ 2	☐	☑ 2	☐
Nutrition and food security	☐	☐	☐	☐
Settlement/Resettlement	☐	☐	☐	☐
Skills development	☐	☐	☐	☐
Health improvement	☑ 2	☐	☑ 0	☐
Other (specify): _____	☐	☐	☐	☐
OVERALL	☑ 2	☐	☑ 2	☐
		(copy to page 1)		

4) Did the project have significant unintended/unexpected positive or negative effect(s) on special **SOCIAL GROUPS**, regardless of the project's objectives?

Positive ☐ Negative ☐ No ☑

Explain: _____

IV.E. ENVIRONMENTAL CONCERNS16/ (answer questions #1 & #4 in all cases)

1) Did the project objectives include enhancement or protection of the **ENVIRONMENT**?	Yes (✓)	No (✓)
	☐	☑

If yes, in what area(s):	(✓)
Natural resource management	☐
Biological Diversity	☐
Air/water/soil quality	☐
Global warming/ozone depletion	☐
Natural disaster prevention/reduction	☐
Noise Control	☐
Preservation of cultural heritage17/	☐
Urban environmental quality	☐
Other (specify): _____	☐

2) Indicate whether the following factors had a positive(+) or negative(-) influence on the achievement of **ENVIRONMENTAL** objectives:

	(+, -, blank)
Project preparation/design/environmental assessment	☐
Government/borrower commitment	☐
Legal framework	☐
Bank staff effectiveness	☐
Borrower/Implementing agency effectiveness	☐
Consultant(s) effectiveness	☐
Consistency with National Environmental Action Plan	☐
NGOs	☐
Beneficiary participation	☐
Other (specify): _____	☐

IV.E. ENVIRONMENTAL CONCERNS (continued) - answer question #4 in all cases

Codes: 1 = High.	4 = Minimal relevance, negligible efficacy or impact.
2 = Substantial.	0 = Not Available.
3 = Intermediate relevance, modest efficacy or impact.	blank = Not Applicable.

	RELEVANCE of outcomes cf. country/sector objectives		EFFICACY of outcomes cf. project objectives. original or revised	Estimated IMPACT
	original	revised	(1, 2, 3, 4, 0, blank)	
3) Rate from 1 to 4 for the **ENVIRONMENTAL** objectives	☐	☐	☐	☐
		(copy to page 1)		

4) Did the project have significant unintended/unexpected positive or negative effect(s) on the **ENVIRONMENT**, regardless of the project's objectives?

Positive ☐ Negative ☐ No ☐

Explain:

_____

_____

_____

IV.F. PRIVATE SECTOR DEVELOPMENT[18]

1) Did the project include objectives to enhance/strengthen the role of the **PRIVATE SECTOR**?

	Yes (✓)	No (✓)
	☐	☑

Codes: 1 = High.
2 = Substantial.
3 = Intermediate relevance, modest efficacy or impact.
4 = Minimal relevance, negligible efficacy or impact.
0 = Not Available.
blank = Not Applicable.

If yes, rate from 1 to 4 for each of the following **PRIVATE SECTOR DEVELOPMENT** objectives:

	RELEVANCE of outcomes cf. country/sector objectives: original	RELEVANCE of outcomes cf. country/sector objectives: revised	EFFICACY of outcomes cf. project objectives, original or revised (1, 2, 3, 4, 0, blank)	Estimated IMPACT (1, 2, 3, 4, 0, blank)
Improvement in legal or incentive framework designed to foster PSD (e.g. trade, pricing)	☐	☐	☐	☐
Restructuring/Privatization of public enterprises	☐	☐	☐	☐
Financial sector development	☐	☐	☐	☐
Direct government financial and/or technical assistance to private sector	☐	☐	☐	☐
Other (specify): _____	☐	☐	☐	☐
OVERALL	☐	☐	☐	☐

(copy to page 1)

2) Indicate whether the following factors had a positive(+) or negative(-) influence on the achievement of **PRIVATE SECTOR DEVELOPMENT** objectives:

	(+, -, blank)
Project preparation/design	☐
Government/borrower commitment	☐
Legal framework	☐
Bank staff effectiveness	☐
Borrower/Implementing agency effectiveness	☐
Consultant(s) effectiveness	☐
Private sector interest	☐
Other (specify): _____	☐

OUTCOME AND SUSTAINABILITY

IV.G ASSESSMENTS OF OUTCOME

(1,2,3,4)[a]

1) Considering the project objectives (original or revised) and the extent of their achievement, give your **ASSESSMENT OF THE OUTCOME** (or likely outcome) of the project (copy to page 26): ☑ (2)

If the assessment is marginally SAT or UNSAT, mark here: (✓) ☑

2) Does this assessment differ from that in the ICR? Yes ☐ No ☑

Explain:

---

[a] **DEFINITIONS OF OUTCOME RATINGS**

1 = **Highly Satisfactory**
Project achieved or exceeded all its major relevant objectives and has achieved or is highly likely to achieve substantial development results, without major shortcomings.

2 = **Satisfactory**
Project achieved most of its major relevant objectives and has achieved or is expected to achieve satisfactory development results with only a few shortcomings.

3 = **Unsatisfactory**
Project failed to achieve most of its major relevant objectives, has not and is not expected to yield substantial development results and has significant shortcomings.

4 = **Highly Unsatisfactory**
Project failed to achieve any of its major relevant objectives and has not and is not expected to yield any worthwhile development results.

Notes: (1) An ERR of 10% or more for a major portion of the total investment, or other significant unquantified benefits (net of costs) if the ERR was less than 10%, is necessary to meet the minimal requirements for a "Satisfactory" project. Projects with an ERR of more than 10% might be "Unsatisfactory" if major policy/institutional objectives were not met or if significant unquantified costs (net of benefits) are omitted. Where ERRs are not estimated, the overall performance rating is made on the basis of cost-effectiveness in achieving project objectives. (2) The "Relevance" concept (in #4 below) includes an assessment of the realism of the objectives.

3) Is the **BORROWER'S VIEW** of this project significantly different from the view recorded by this PIF? Yes ☐ No ☐ NA

Explain:

IV.G. ASSESSMENTS OF OUTCOME (continued)

Codes: 1 = High.
2 = Substantial.
3 = Intermediate.
4 = Minimal relevance, efficacy, or efficiency.

4) Taking into consideration, among other factors, the answers you gave to questions I.2; II.3 and 4; and IV.I.1, give your assessment of the **RELEVANCE (assessment of outcomes in relation to country and sector assistance strategies)** of the project. (1,2,3,4) [2]

5) Taking into consideration, among other factors, the answers you gave to questions I.2, IV.C.1, IV.D.3, IV.E.2, IV.F.2, and IV.L, give your assessment of the **EFFICACY (assessment of outcomes in relation to project objectives)** of the project. (1,2,3,4) [3]

6) Taking into consideration, among other factors, the answers you gave to questions III.A, III.B, IV.A, IV.C.2, IV.D.2, IV.E.3, IV.F.2, and IV.J, give your assessment of the **EFFICIENCY (assessment of outcomes in relation to project inputs)** of the project. (1,2,3,4) [3]

7) Is this is an outstanding project, for one or more of the following reasons?

	(✓)
Project has exceeded all of its major objectives	☐
Project highly innovative	☐
Project success highly replicable	☐
Other (specify): _____	☐

IV.H. SUSTAINABILITY

	Likely (✓)	Unlikely (✓)	Uncertain (✓)
1) To what extent is the project likely to maintain the achievements generated, or expected to be generated in the operational plan (copy to page 26)	☐	☐	☑

2) Indicate which of the following factor(s) will have a positive(+) or negative(-) influence on the likelihood of **SUSTAINABILITY:**

	(+ or - or blank)
Government commitment	☐
Policy environment	☐
Institution/management effectiveness	☐
Economic viability	☐
Technical viability	⊞
Financial viability	⊟
Environmental viability	☐
Social impact/local participation	☐
Other (specify): _____	☐

	Yes (✓)	No (✓)	Not available
3) Does the ICR include a plan for future operations? (assessment of the quality of such plan is discussed on page 29, under QUALITY OF ICR)	☐	☑	
IF YES:			
Does the plan make the appropriate technical, financial, commercial and institutional arrangements to ensure smooth project operation?	☐	☐	
Does the plan define the performance indicators for judging proper operation?	☐	☐	
Does the plan include provisions for operating an appropriate M&E system?	☐	☐	
4) Has the Borrower made alternative provisions to support the infrastructure, services, or institutional investments made under the project?	☐	☐	☑
5) Does/did the project have a follow-on project which continued or expanded activities in this project?	☑	☐	

PERFORMANCE IN PROJECT CYCLE PROCESS

IV.I. UPSTREAM ACTIVITIES: IDENTIFICATION, PREPARATION, & APPRAISAL

Codes:	1 = Highly Satisfactory.	4 = Highly Unsatisfactory.
	2 = Satisfactory.	0 = Not Available.
	3 = Unsatisfactory.	blank = Not Applicable (not permitted for OVERALL).

1) **Assess** the quality of BANK performance in the **IDENTIFICATION** of the project: 19/

	(1,2,3,4,0,blank)
Involvement of government/beneficiaries	3
Project consistency with Government development strategy priority	2
Project consistency with Bank strategy for country	2
Project innovativeness	2
Other (specify): _____	
	(1,2,3,4,0)
OVERALL (copy to page 26)	2

Comments: _____

_____

_____

IV.I. UPSTREAM ACTIVITIES: IDENTIFICATION, PREPARATION, & APPRAISAL (continued)

2) Assess the quality in the following areas of:

Codes:		
	1 = Highly Satisfactory.	4 = Highly Unsatisfactory.
	2 = Satisfactory.	0 = Not Available.
	3 = Unsatisfactory.	blank = Not Applicable (not permitted for OVERALL).

	PREPARATION by the Borrower/ Implementing Agency (1,2,3,4,0,blank)	Bank support for PREPARATION (1,2,3,4,0,blank)	APPRAISAL by the Bank 20/ (1,2,3,4,0,blank)
Physical/technical	0	0	2
Financial	0	0	2
Economic	0	0	0
Commercial	0	0	0
Institutional	0	0	2
Sociological	0	0	0
Environmental	0	0	
Other (specify):	0	0	
	(1,2,3,4,0)	(1,2,3,4,0)	(1,2,3,4,0)
OVERALL copy to page 26	0	0	2

3) Indicate whether the following factors had a positive(+) or negative(-) influence on the above OVERALL quality assessment of the Bank's performance in:

	PREPARATION (+, -, blank)	APPRAISAL (+, -, blank)
Degree of Bank involvement	+	
Economic and sector work		
Bank staff quantity	+	+
Bank staff quality (skill mix, continuity, ...)	+	+
Performance of consultant(s)	+	+
Coordination with other donors		
Other (specify):		

IV.I. UPSTREAM ACTIVITIES: IDENTIFICATION, PREPARATION, & APPRAISAL (continued)

Codes:	1 = Highly Satisfactory.	4 = Highly Unsatisfactory.
	2 = Satisfactory.	0 = Not Available.
	3 = Unsatisfactory.	blank = Not Applicable (not permitted for question #5).

4) Assess the quality of APPRAISAL by major subject(s) using the codes above:

(1,2,3,4,0,blank)

Appraisal of commitment of government/implementing agency/ beneficiaries	2
Appraisal of borrower/agency implementing capacity	2
Realistic project design	2
Identification/control for project risks/key variables21/	2
Adequacy of implementation plan/performance indicators	2
Suitability of lending instrument	2
Adequately taking into account past experience	
Other (specify): _____	

(1,2,3,4,0)

5) Considering the identification, preparation, and appraisal processes discussed above, use the codes above to rate the quality of the project at the time of Board Approval (QUALITY AT ENTRY): ☐

IV.J DOWNSTREAM ACTIVITIES: IMPLEMENTATION & SUPERVISION

Codes:	1 = Highly Satisfactory.	3 = Unsatisfactory.
	2 = Satisfactory.	4 = Highly Unsatisfactory.
		0 = Not Available.

1) Using the codes above, rate the Borrower/Implementing Agency performance in **IMPLEMENTATION** of the project: (copy to page 26) (1,2,3,4,0,blank) [2]

2) Indicate whether the following factors had a positive(+) or negative(-) influence on the OVERALL quality of project **IMPLEMENTATION**:

	(+ or - or blank)
Management quality and continuity	[-]
Bank staff quantity	[ ]
Bank staff quality (skill mix, continuity, ...)	[ ]
Borrower/Agency staff quantity	[-]
Borrower/Agency staff quality (skill mix, continuity, ...)	[-]
Performance of contractor(s)	[ ]
Performance of consultant(s)	[ ]
Government commitment	[-]
Absence of government interference	[ ]
Project monitoring & evaluation	[+]
Level or timeliness of counterpart funding	[-]
Other (specify): lack of coordination between pharmaceutical management and technical leadership in MOH	[-]

IV.J. DOWNSTREAM ACTIVITIES: IMPLEMENTATION & SUPERVISION (continued)

3) Assess the quality of Bank performance in project **SUPERVISION** in these areas: 22/

Codes:	1 = Highly Satisfactory.	4 = Highly Unsatisfactory.
	2 = Satisfactory.	0 = Not Available.
	3 = Unsatisfactory.	blank = Not Applicable (not permitted for OVERALL).

	(1,2,3,4,0,blank)
Reporting of project implementation progress	2
Identification/assessment of implementation problems	3
Attention to likely development impact	0
Attention to likely social impact	0
Advice to implementing agency	2
Adequacy of follow-up on advice/decisions	2
Enforcement of loan covenants/exercise of remedies	3
Flexibility in suggesting/approving modifications	3
Other (specify): _____	3
	(1,2,3,4,0)
OVERALL (copy to page 26)	3

4) Indicate whether the following factors had a positive(+) or negative(-) influence on the OVERALL quality of Bank **SUPERVISION**:

	(+, -, blank)
Supervision plan	
Timing of supervision missions	-
Sufficiency of time in field	-
Bank staff quantity	-
Bank staff quality (skill mix, continuity, ...)	-
Performance of consultants	
Country implementation reviews	
Other (specify): lack of specialist skills in pharmaceutical management	-

IV.K. OPERATIONAL DIRECTIVES

Indicate significant lack of compliance with applicable ODs:

No.	Subject
1.	
2.	
3.	
4.	
5.	

IV.L. COMPLIANCE, BORROWER/IMPLEMENTING AGENCY PERFORMANCE

Codes:	1 = Full Compliance.	4 = Negligible Compliance.
	2 = Substantial Compliance.	0 = Not Available.
	3 = Modest Compliance	blank = Not Applicable (not permitted for OVERALL).

1) To what extent did the Government/Implementing Agency **COMPLY** with major loan covenants/commitments:

		Was compliance belated?		
		Yes	No	Not avail.
	(1,2,3,4,0,blank)	(✓)	(✓)	(✓)
Macro policies	☐	☐	☐	☐
Sector policies	☐	☐	☐	☐
Institutional changes	☐	☐	☐	☐
Management of social aspects	☐	☐	☐	☐
Effective management	2	☐	☐	☑
Appropriate staffing	2	☐	☐	☑
Financial improvements (tariffs, user charges, etc.) 23/	☐	☐	☐	☐
Provision of counterpart funds	3	☑	☐	☐
Increased efficiencies/cost reductions	☐	☐	☐	☐
Procurement 24/	2	☐	☐	☑
Progress reports	2	☐	☐	☑
Accounts and Audits 25/	3	☐	☐	☑
Use of technical assistance 26/	☐	☐	☐	☐
Monitoring and evaluation	☐	☐	☐	☐
Studies	2	☐	☐	☑
Other (specify): _____	☐	☐	☐	☐
	(1,2,3,4,0)			
OVERALL	2	☐	☐	☑
	(copy to p. 26)			

2) Did the Borrower/Implementing Agency satisfy the letter of some major covenants but violate their spirit?	Yes (✓)	No (✓)	Not avail. (✓)
	☐	☑	☐

Explain: _____

V. RATINGS SUMMARY AND LESSONS DRAWN

1. PERFORMANCE BY PROJECT CYCLE PROCESSES

Codes: 1 = Highly Satisfactory. 3 = Unsatisfactory.
2 = Satisfactory. 4 = Highly Unsatisfactory.
0 = Not Available.

(1,2,3,4,0)

IDENTIFICATION	- of the project by BANK (from p. 20)	2
PREPARATION	- by BORROWER/AGENCY (from p. 21)	0
	- assistance by BANK (from p. 21)	0
APPRAISAL	- by BANK (from p. 21)	2
IMPLEMENTATION	- by BORROWER/AGENCY (from p. 23)	3
SUPERVISION	- by BANK (from p. 24)	3

2. COVENANT COMPLIANCE

Codes: 1 = Full Compliance. 3 = Modest Compliance
2 = Substantial Compliance. 4 = Negligible Compliance.
0 = Not Available.

(1,2,3,4,0)

The extent that the BORROWER/IMPLEMENTING AGENCY has complied with major loan covenants/commitments (from p. 25): 2

3. INSTITUTIONAL DEVELOPMENT

Codes: 1 = High. } To be described as "Substantial" impact in Director's memo to Region
2 = Substantial. }
3 = Modest impact.
4 = Negligible impact.
0 = Not Available.

(1,2,3,4,Blank)

The impact of meeting INSTITUTIONAL DEVELOPMENT objectives (from p. 7): 3

4. PROJECT SUSTAINABILITY

	Likely	Unlikely	Uncertain
The probability of maintaining the achievements generated, or expected to be generated in the operational plan for the project (from p. 19):	☐	☐	☑

5. OUTCOME

Codes: 1 = Highly Satisfactory. 3 = Unsatisfactory.
2 = Satisfactory. 4 = Highly Unsatisfactory.
0 = Not Rated.

(1,2,3,4,0)

The assessment of the OUTCOME (or likely outcome) of the project (from p. 17) considering the project objectives (original or revised) and the extent of their achievement: 2

6. LESSONS DRAWN

1) **If there are any significant positive or negative LESSONS DRAWN from the success or failure of the project that were not mentioned in the ICR, please list them:**

a. Significant organizational change in MOH during implementation can

b. _____

c. _____

VI. COMMENTS*

* Comments are encouraged, especially to clarify ambiguities in the ratings or important issues not brought out in the ratings, and also to indicate where the OED reviewer questions the judgments of the ICR. These comments can capture qualitative aspects of the project's story not captured in the ratings. Comments of a confidential nature should be made in a separate note to the Division Chief.

VII. QUALITY OF ICR
(to be completed for every project)

Codes: 1 = Highly Satisfactory; No significant qualifications.
2 = Satisfactory; Some qualifications but generally acceptable.
3 = Unsatisfactory; Significant qualifications which would have been readily susceptible to improvement.
4 = Highly Unsatisfactory; Significant qualifications which would not have been readily susceptible to improvement.
0 = Not Available.

A. ICR

1) Rate the quality of the ICR by the following characteristics:

	(1,2,3,4)
Coverage of important subjects	2
Availability of key data	2
Soundness of judgments:	
• internal consistencies	2
• evidence complete/convincing	2
Adequacy of analysis including Lessons Learned	2
Consistency with SAR/revised project	2
Presentation	2
Plan for Future Project Operation (refer to page 19)	3
Performance indicators for the projects operation's phase	3
Evaluation of monitoring & evaluation achievements	3
Aide-memoire of the ICR mission	0
Other (specify): _____	
OVERALL	2

Explain: _____

_____

_____

VII. QUALITY OF ICR (continued)

2) Are the following borrower inputs included in the ICR?	Yes (✓)	No (✓)
Summary evaluation of project implementation	☑	☐
Plan for future project operation	☐	☑
Borrower comments on draft ICR	☐	☑

If no, give reason(s):

summary is annexed

comments on Parts I + II not received at time of completion of ICR

If yes, are there significant differences between Bank and Borrower views? ☐ ☑

If yes, explain:

C. OED DATABASE

1) Identify key data in the ICR (including relevant Annexes) which are missing, incorrect or dubious and indicate whether they should be included, qualified, corrected or excluded from the OED database:

Original data in ICR	Problem with data and suggested treatment in the OED database
eg. *Completion date = 6/30/94.*	*Date is unrealistic. Should use 12/31/95 instead.*

VIII. PRIORITY OF PROJECT FOR PAR AND IMPACT EVALUATION*

A. PERFORMANCE AUDIT

1) The priority of the project for PERFORMANCE AUDIT is:

High ☐ Medium ☑ Low ☐

2) If the priority is HIGH or MEDIUM, indicate reason(s):

	(✓)
Project is an adjustment operation	☐
Project is the first of its type in the subsector in the country	☑
Project is part of a series of projects which are suitable for packaging in a combined audit	☐
Project is large and complex	☐
Project has especially innovative and unusual features	☐
Project was highly successful in a difficult sector/ country	☐
ICR was incomplete/not satisfactory	☐
Project is likely to have high priority for impact evaluation	☐
OED and Operations disagree on performance rating	☐
An Executive Director has proposed audit	☐
Project is or is likely to be of considerable public interest	☐
Audit is required for special studies	☑
Other (specify): _____	☐

3) If the priority is high or medium, what are the major issues on which the audit should focus?

a) Pharmaceutical policy

b) use of monitoring + evaluation at local levels

c) _____

---

* To be completed for every ICR.

VIII. PRIORITY OF PROJECT FOR PAR AND IMPACT EVALUATION (continued)

B. IMPACT EVALUATION

1) The preliminary priority of the project for IMPACT EVALUATION is:

High ☐ Medium ☑ Low ☐

2) If the priority is HIGH or MEDIUM, indicate the reason(s):

	(✓)
*Project has a high or medium priority for performance audit or a satisfactory ICR	☐
*A satisfactory data/monitoring and evaluation system for the project exists	☑
Project gives high priority to special emphases (e.g., public sector reform, social concerns, environment, private sector development)	☐
Project is reasonably representative for sector/ subsector	☑
Project has experimental/innovative features	☐
Project is large and complex	☐
Project has considerable indirect costs and benefits/externalities	☐
Project is likely to be in operation at time of impact study	☐
Project sustainability is uncertain	☐
Project is part of a series of projects which are suitable for packaging in a combined evaluation	☐
Evaluation is required for special studies	☑
Project is or is likely to be of considerable public interest	☐
Project type not well covered by previous impact evaluations	☐
Other (specify): _____	☐

* These criteria are requisites for impact evaluation.

Attachment to OED Guideline No. 7.3
Last Revised: January 1994

EXPLANATORY NOTES
for the
PROJECT INFORMATION FORM (Form 7.3)

1. The purpose of the Project Information Form (PIF) is to evaluate the project and abstract relevant findings and conclusions for use in OED's Annual Reviews. It standardizes and classifies most answers to facilitate data entry in a computerized form for easy aggregation (Bankwide, by region, country, sector, lending instrument, etc.). It is a core PIF, intended to capture important information generic to most sectors, and may be supplemented by sector-specific forms as determined by each Division. The PIF is to be completed for each project both for ICRs and Performance Audits.

2. This includes only projects which have been restructured following a formal agreement between the borrower and the Bank that has been approved by or reported to the Executive Directors.

3. See relevant Country Brief or Country Strategy Paper; for SALs, see Policy Framework Paper.

4. Complexity is determined by such factors as the range of policy and institutional improvements, the number of institutions involved, the number of project components and their geographic dispersion, the number of cofinanciers, etc.

5. OD 10.50 deals with Financial Analysis and Management.

6. Indicators of cost-effectiveness may be sub-sectoral specific. For education and PHN sectors, use the following guidelines.

   Cost per unit of output: In education, ideally, recurrent cost per graduate of a specific level or type of training supported by the project. In absence, cost per student year (in shorter training courses, cost per trainee hour may have to be used). In PHN, center operating costs per client visit; recurrent cost of treating a case of a given disease. In all cases provide clear description of the measure(s) used including units of measurement.

   Measures of internal efficiency: In education, e.g., student-teacher ratios, dropout rates, repetition rates. In PHN, client-doctor/nurse ratios, client visits per extension worker per period.

   Cost per unit input: In education, e.g., construction cost per classroom or per unit floor space, average cost of textbooks. In PHN, construction cost per primary health center or (eg for hospitals) per floor space, cost per standard package of drugs/medicines, cost per unit of contraceptives.

7. Eg., indicators should reflect the cost of underutilization, should allow comparison with SAR figures, etc.

8. OD 11.10, Annex F deals with the Evaluation of Consultant Performance and OD 11.13 with Reporting of Consultants' Performance.

9. OD 10.70 deals with Project Monitoring and Evaluation.

10. OD 6.50 deals with Project Cost Estimates and Contingency Allowances.

11. OD 5.00 deals with Public Sector Management and OD 5.10 with Public Enterprise and Divestiture.

12. OD 4.15 deals with Poverty Reduction; OD 10.40, Annex E with Estimating the Poverty Impact of Projects.

13. OD 4.10 deals with Women in Development.

14. OD 4.20 deals with Indigenous People.

15. OD 4.30 deals with Involuntary Resettlement.

16. ODs 4.00, 4.01, and 4.02 deal with Environmental Policies, Assessment and Action Plans.

17. OD 4.25 deals with Cultural Property.

18. OD 5.20 deals with Private Sector Development.

19. OD 10.00 deals with Project Generation and Preparation.

20. OD 10.10 deals with Project Appraisal and ODs 10.20-40 deal more specifically with Technical, Sociological, Institutional and Economic criteria.

21. OD 10.40, Annex C deals with Risk and Sensitivity Analysis.

22. OD 13.05 deals with Project Supervision.

23. OD 6.00 deals with Cost Recovery and the Pricing of Public Goods.

24. ODs 11.00, 11.02 and 11.03 deal with Procurement.

25. OD 13.10 deals with Borrower Compliance with Audit Covenants.

26. OD 8.40 deals with Technical Assistance.

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

Pilar 2
keep with
Morocco file
S.

DATE: February 8, 1995

TO: Mr. Hans-Eberhard Köpp, Director-General, OED

THROUGH: Mr. Daniel Ritchie, Director, MN1

FROM: Roslyn G. Hees, Division Chief, MN1HR

EXTENSION: 32778

SUBJECT: MOROCCO - Health Development Project (Loan 2572-MOR)
Project Completion Report (PCR)

1. Attached is the Project Completion Report for the above referenced-project. The report was prepared by the Task Manager who supervised the project and comments received from previous task managers were incorporated. The report was cleared by the acting MN1 Project Adviser, and the Legal and Loan Departments.

2. While the last mission for this project occurred in May 1994, therefore prior to the enforcement of the new guidelines, this report tried to follow as much as possible the guidelines and format of ICRs.

3. Since the Ministry of Health was carrying out an extensive evaluation of the first component of the project, we postponed distribution of the PCR. However, the format of MOPH report which was just received, is not suitable for inclusion as attachment to the PCR and no summary has been provided. We have not yet received the Moroccan authorities' comments on Parts I and III of the PCR, which will be taken into account once we receive them.

4. This report was prepared in accordance with the guidelines for preparing PCRs published June 7, 1989.

Attachment: PCR

Cleared and cc: Mmes./Messrs: Vaurs (MN1CO); Dupuy (LEGMN), Van Praag (LOAEL); Voltaire (MN1HR)

Distribution:

Mmes./Messrs: Bouhabib, Husain (2) (MNAVP); Murli (MNACA); Picciotto, Donaldson (DGO); Heyneman (EMTHR); Sood (EMTDR); Baudouy (MN2HR); Costa, Underwood, Ettori, Gress (MN1DR); de Wulf, Vaurs (MN1CO); Sinha (MN1NE); Al-Khafaji (MN1PI); Hees, Wolff, Ezzine, Hakim, Millot, Laederach, Pierre-Louis, Jarawan, Sulllivan (MN1PH); Project BB, Mena files.

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PROJECT COMPLETION REPORT

KINGDOM OF MOROCCO

HEALTH DEVELOPMENT PROJECT

Loan no. 2572-MOR

January 30, 1995

DO NOT MODIFY DATES

Human Resources Division
Country Department I
Middle East & North Africa Region

CURRENCY EQUIVALENTS

At appraisal:

US$1 = Dirham (DH) 9.47
DH1 = US$0.106

1986-1994 Period Average

US$ 1 = DH 8.4
DH 1 = US$ 0.120

FISCAL YEAR OF BORROWER

January 1 - December 31

ABBREVIATIONS AND ACRONYMS

ADB	African Development Bank
FP	Family Planning
IEC	Information, Education and Communication
GDP	Gross Domestic Product
MCH	Maternal and Child Health
MOPH	Ministry of Public Health
PPF	Project Preparation Facility
SIAAP	Service d'Infrastructure des Actions Ambulatoires Provinciales (Division in charge of ambulatory services at provincial level)
UAM	Unité d'Approvisionnement en Médicaments (Drug Supply Unit)

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please review accuracy after printing text.

PROJECT COMPLETION REPORT

KINGDOM OF MOROCCO

HEALTH DEVELOPMENT PROJECT (LOAN No. 2572-MOR)

Preface

This is the Project Completion Report (PCR) for the Health Project in the Kingdom of Morocco, for which loan 2572-MOR in the amount of US$28.4 million equivalent was approved on June 6, 1985 and made effective on July 29, 1986.

The loan was closed on December 31, 1993 after two extensions from its original closing date of December 31, 1991. Final disbursement took place on April 12, 1994, at which time a balance of US$ 2.6 million was canceled.

The PCR was prepared by Claire Voltaire, MN1HR of the MENA region and reviewed by Roslyn G. Hees, Division Chief, MN1HR, and René Vaurs, Acting Project Adviser, MN1DR.

Preparation of this PCR was begun during the Bank's final completion mission in May 1994. It is based on material in the project file, on the Borrower's financial completion report and on its impact evaluation of the basic health component which was carried out by the three pilot provinces and the Institut National d'Administration Sanitaire (See Annex).

KINGDOM OF MOROCCO
HEALTH DEVELOPMENT PROJECT
Loan no. 2572-MOR

Evaluation Summary

Project Objectives and Description

1. The project aimed at accelerating the shift from an urban-based hospital-oriented health system to a more cost-effective system of primary care emphasizing outreach activities in the rural areas. To that end, the project included four components which aimed at improving: (i) primary care delivery in three pilot provinces by strengthening the infrastructure and equipment as well as the logistics and monitoring of the programs delivery, and the training of medical staff; (ii) the management capacity of the Ministry of Public Health (MOPH) at both central and provincial levels, in terms of planning, training, research and evaluation, and health service administration; (iii) training and IEC programs; and (iv) the supply of basic drugs by establishing a coordinated system for the procurement, storage, formulation, packaging, distribution and control of drugs for the public system.

Summary of Findings

2. The project results are mitigated. Two of the four components were completed:

a. The Primary Health Care component was fully implemented in its physical and "software" aspects though a large share of the new facilities only became functional at the very end of the project; to date 29 health facilities out of the 126 (more than 20%) built remain closed due to insufficient staff to man them. In contrast, reorganization of service delivery, planning, supervision and monitoring methods were put in place at the start of the project and are well assimilated by staff in all three provinces. The project has indeed permitted to improve population coverage.

b. It is difficult to measure the extent to which the project has strengthened MOPH management capacity as the ministry underwent several reorganizations during project implementation. While management of civil works certainly improved, procurement, program budgeting and resource allocation remain serious issues for the MOPH. The outcome of the two studies on the financing of the health sector and on hospital management which were carried out is uneven: (i) the health financing study was of good quality and served as a basis to the discussions on health financing reforms which have culminated with the preparation by the Government, with Bank support, of a health insurance reform proposal; (ii) the Hospital Management Study output is more difficult to assess as its diagnostic phase was never followed by the prospective one that was intended to specify and test the options for reform.

c. Training and IEC Component: Only 25% of the funds allocated to this component were disbursed, due to the availability of bilateral funds to finance training activities.

d. Improvement in the supply of basic drugs: This component remains incomplete. Equipment for the drug Unit built under the project has yet to be purchased and, despite some improvements, the Central Pharmacy organization, procedures for the procurement and distribution of drugs remain an issue for the MOPH.

4. Several factors adversely affected project implementation, and in particular: (i) the lack of counterpart funds as a result of the economic situation, delays in allocation and release of funds and the weak capacity of MOPH to manage commitments and disbursements; (ii) frequent organizational and staff changes in the MOPH which resulted in a lack of continuity of the dialogue; and (iii) the relative passivity of the Bank contribution in its comments to studies and progress reports and in proposing remedial actions. The main findings of this post-evaluation are the following:

a. The financial sustainability of the system needs to be addressed without delay. The MOPH has already integrated this lesson in its dialogue and indicated its intention to proceed with new investments only when the sustainability of the sector has been addressed i.e, when adequate investment and more importantly recurrent resources can be secured. To that end, the preparation of the proposed FY96 Health Management and Financing Project has been halted. If project does not proceed, the health sector sustainability should be addressed through the FY96 Social Priorities Project.

b. The overall organization of the pharmaceutical sector and the provision of drugs to the public sector need to be reviewed. A thorough review of the pharmaceutical sector and the development of a drugs policy for the public sector should be carried out prior to any further financing of drugs in a project.

c. The policies and project activities cannot be divorced from their implementation structure: The current organization of the MOPH and of the medical provinces is ill-adapted to the objectives pursued by the MOPH and discourage efficiency and accountability. While MOPH is fully aware of this issue and has prepared a new organizational chart more in line with its objectives, it has not yet been implemented. Implementation arrangements for future projects should be an integral part of their design and should take into account the overall organizational structure of the Ministry, or should not proceed without addressing needed changes.

d. The impact of the strategies deployed to deliver basic services (fixed facilities outreach techniques and better organization) should be assessed carefully to facilitate the development of a cost-efficient approach, adaptable to the specificities of each region.

e. The Bank should have a more pro-active attitude in its comments and proposals for remedial actions (ie. restructuring of the project, increasing the supervision of "pilot/demonstrative" aspects of the project). The preparation of new projects should not start before the results of the previous project can be built on, and lessons learned so as to be integrated into the new design.

5. Overall assessment: The project is partly satisfactory. The improved approach to the delivery of primary health care is being adopted in non-project provinces, although the financial sustainability of the approach remains uncertain and is being examined as part of the Bank's dialogue in the country.

PROJECT COMPLETION REPORT
KINGDOM OF MOROCCO
HEALTH DEVELOPMENT PROJECT (Loan 2572-MOR)

BACKGROUND

1. In the late 1970s, Morocco faced major economic and financial difficulties. While the population was increasing rapidly, GDP growth slowed down, fiscal and external imbalances reached peak levels, in particular after the 1979 drought and unemployment increased, varying between 22 to 30 percent. In 1980, with Bank and IMF support, the Government adopted an ambitious plan for recovery aimed at liberalizing the economy and redressing fiscal imbalances. The prospect of a period of financial constraints resulting from these reforms induced the Government to examine the possible impact of dwindling average family income and food availability on the population health status. At the time, Maternal and Child Health (MCH), Family Planning (FP) and nutrition programs reached less than one-third of the target population, transportation costs for outreach activities were soaring and budgetary allocations for drugs were grossly insufficient. The MOPH endeavored to review its strategy, placing emphasis on the expansion of primary health to the entire population. Such strategic thinking was integrated in the 1981-85 National Economic Plan.

2. The Government's medium- and long-term objectives for the population, health and nutrition sectors, of which the project objectives stemmed, were derived, included from

   a. in *population*, to control demographic growth so as to limit size to 30 million or less by 2000 by stepping up population activities and raising contraceptive prevalence;

   b. in *health and nutrition*, to minimize the biological impact of the economic crisis on the population, to improve MOPH's management and hospital performance, and identify cost-effective alternatives to the health and nutrition programs. The Government's long-term objectives were to secure an adequate financing scheme for health care activities and eliminate pockets of malnutrition by raising domestic food production.

PROJECT OBJECTIVES AND DESCRIPTION

3. The project objectives, as defined in the Staff Appraisal Report, were to assist the Ministry of Public Health (MOPH) in strengthening and accelerating its on-going shift from an urban-based hospital-oriented health system to a more cost-effective system of primary care emphasizing outreach activities in the rural areas.

4. The project consisted of four components which aimed at:

   a. *strengthening primary health care* in three provinces as a means to test a new delivery scheme before its implementation countrywide. Special attention was

given to six core programs: immunization, FP, MCH, nutrition, front-line curative care and basic sanitation. The organization of the system was conceived to deliver these programs through polyvalent purpose staff, according to several types of strategies adapted to local conditions (terrain, population density..) by using a different mix of types of facilities, outreach techniques and staff. To achieve this objective, the following activities were to be implemented: upgrading and expanding the physical infrastructure; providing equipment; training of health staff; improving logistics and monitoring implementation to allow continuous adjustments. To that end, the project financed construction and rehabilitation of buildings, equipment, drugs, per-diems and vehicles;

b. *strengthening the management capacity of MOPH* at central and provincial levels. The objectives were to improve capacities in terms of health sector planning, staff training, research and evaluation, and public health service administration, as a necessary condition for a large scale extension of the health care delivery experience to the rest of the country. Specifically, this component was to: (i) strengthen the planning capacity of the MOPH Infrastructure and Planning Department, in which the Project Unit was based; (ii) improve MOPH administration in particular in the areas of program budgeting and resource allocation, procurement and bidding procedures, civil works and maintenance, and management of personnel; and (iii) support the implementation of a health services monitoring and evaluation system and the realization of two studies on the financing of the health sector and hospital management. To that end, the project financed technical assistance and expert services, training and equipment;

c. *strengthening training and IEC programs*; specifically this component was to: (i) strengthen the capacity to train paramedical personnel by completing the pedagogic equipment of a college of public health which had been financed under the Bank Third Education Project; and (ii) increase the capacity of the MOPH Health Education unit to produce IEC materials by providing audio-visual, printing and graphic equipment as well as technical assistance and fellowships for the production and dissemination of IEC materials; and

d. *improving the supply of basic drugs* by (i) improving procedures and establishing a coordinated system for the procurement, storage, formulation[1], packaging, distribution and control of drugs for the public health system; and (ii) redefining the respective roles of the Pharmacie Centrale, the National Drug Control Laboratory and the Drug Supply Unit (UAM) to be created

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1/ Formulation is the final stage of drug production, from intermediate ingredients to final or finished form. It consists of simple mechanical operations such as mixing, solving or dispersing and fragmentation into dosage forms.

under the project. Disbursements on this component were conditioned upon the creation of the structure in charge of managing this unit. To this end, the project was to finance the construction of storage, packing and shipment space, a packaging unit and a small formulation laboratory as well as the related equipment, training and technical assistance.

5. Clarity of Objectives. Overall, the project objectives were well defined and were an integral part of the Government objectives which were also supported by other donors and international organizations involved in Morocco (UNICEF, USAID, WHO). They were consistent with the Bank assistance strategy in the social sectors which included improving basic social services in rural areas and encouraging a shift from capital and foreign exchange intensive hospitals to expanding basic health services.

6. The degree of Government commitment to the project varied between components:

a. The extensive preparation work carried out by the MOPH over the period 1979-1984 for the Primary Health component with the support of a project preparation facility (PPF), ensured a good understanding of the concepts and a strong ownership especially at provincial levels;

b. The second component -- Management -- responded to the perceived needs of the MOPH and was meant to support its on-going structural reorganization. With regards to the studies, addressing sector financing and hospital management issues was rightly perceived by the Borrower as a means to develop a sustainable system in the medium and long term.

c. The third component --Training and IEC-- aimed at completing activities started in the Third Education Project (Loan 1220T-MOR), and as such its objectives were not reassessed and its implementation not expected to be problematic.

d. While the objectives of the last component -- the improvement of the supply of basic drugs - were shared by all involved, the means to achieve them seem to have been ambiguous from the on-set of the project. Though fully justified from a public health perspective, the economic viability of the creation of the drug unit and the scope of the reorganization of the drug supply system seem to have evolved early in the project.

PROJECT DESIGN

7. This first Bank project in the health sector in Morocco initially included two components: basic health services and management capacity. Its design aimed mainly at creating a replicable model of basic health care while at the same time, strengthening the MOPH management capacity. It was also aimed at building a knowledge base, in particular

in the areas of sector financing and hospital management which would have helped increase sector sustainability and would have permitted to build on initial achievements. The IEC and drugs supply components were added at a later stage of preparation, and their integration in the main concept of the project was not as strong.

8. The design of the project aimed successfully at improving the technical aspects of basic health care delivery, but underestimated the importance of the organizational structure. While the health planning activity which took place was a bottom-up effort in which each province defined its problems, goals and monitoring tools, the administrative and structural organization at the provincial level was not addressed. The functional links between the provincial entity (Service d'infrastructure des actions ambulatoires provinciales, SIAAP) in charge of ambulatory care and inter alia of the six core programs supported by the project, the medical province and the different departments at the central level were not analyzed. This may be explained by the fact that the MOPH was at the time under-going a structural reorganization to eliminate the existing dichotomy between the administrative and technical functions. The provinces concentrated their efforts in implementing as best as they could, directives from the central level sometimes to the detriment of the more pro-active approach preconised by the project, in which they defined their objectives and strategies according to local priorities.

9. In the early 1990s, the MOPH underwent another reorganization which increased the number of departments at central level and provided them with increased autonomy. The provinces found themselves faced with an even greater number of interlocutors. Basic core programs were rightly being delivered by the same multi-purpose medical staff, and their supervision, monitoring and evaluation done by the same persons at provincial level. Nevertheless, at central level, program guidelines, training, monitoring and financing remained vertical, creating some overlaps and/or conflicting messages which made integration and coordination at the provincial level more difficult and cumbersome. The transfer of the Project Unit from the Direction des Affaires Techniques (Division de la Planification), to the Direction de la Prévention et de l'Encadrement Sanitaire created an additional discrepancy between functions and structure.

10. Finally, with regard to the drug supply component, the project design foresaw the need for a close collaboration with the pharmaceutical private sector. However, it failed to set in place the mechanisms which would have ensured its collaboration.

PROJECT IMPLEMENTATION

11. All project components were completed with the exception of the Drug Supply Unit and of the Training and IEC component which were executed only partially. Several factors influenced project implementation, causing significant delays:

a. *Lack of counterpart funds*: Insufficient budgetary allocations as a result of the economic situation, delays in allocation and release of funds, political

resistance to favor these provinces over others, and weak capacity of MOPH to manage commitments and disbursements, resulted in important delays from the project inception. In particular, the initial lag between Board presentation (June 1985), loan effectiveness (July 1986) and the first disbursements (March 1987), which was due to the lack of budgetary allocation, was never caught up. As a result, the loan closing date had to be extended twice (from December 31, 1991 to December 31, 1993).

b. *Frequent changes in the MOPH and in the Bank*: Both institutions encountered several structural reorganizations and changes in individual responsibility. This resulted in additional delays as new mechanisms had to be designed and new managers had to become familiar with the project before taking action. This loss of momentum affected the levels of funds allocated to the project, as "lobbying" for the project was weaker. The transfer of responsibility for civil works from the MOPH to the Ministry of Public Works also caused delays in the construction of facilities.

c. *Relative passivity in the Bank's contribution*: The frequent changes in task management described above and the conflicting priorities due to the simultaneous preparation and implementation of the Health Sector Investment Project (Loan 3171) led to a relative passivity of the Bank. It was slow or even silent in commenting on the two studies (Health Financing and Hospital Management) carried out by the Borrower, or on the project mid-term review prepared by the MOPH. The persistent misunderstanding in the realization of the last component -- improvement of the supply of drugs, which remains incomplete is another example, as explained in paragraph 19.

PROJECT RESULTS AND OUTCOME

12. Primary Health Care. This component was fully implemented in its physical as well as its "software" aspects though a large share of the new facilities only became functional at the very end of the project; to date 29 health facilities out of the 126 (more than 20%) built, remain closed due to insufficient staff to man them. In contrast, reorganization of service delivery, planning, supervision and monitoring methods, were put in place at the start of the project and are well assimilated by staff in all three provinces. As illustrated by the MOPH mid-term review and final evaluation of the component, progress has also been achieved by the provinces in evaluation of outputs and outcomes.

13. The global management and planning methods put in place during the project have enabled the efficient deployment of staff which in turn permitted an improved population coverage in the three provinces. The Health service monitoring system put in place as part of the project has facilitated the decision process and provided a number of monitoring and impact indicators. However, as illustrated by the MOPH evaluation report (see examples in

Table 4 in Annex to this PCR) the selection of these indicators does not always seem to link coverage and impact.

14. As shown in the table below, access to a health facility has been greatly improved. The ratio of population to health facility has evolved greatly during the project period for 1 basic center for 75,000 in 1985 to 1 for 44,000. While the number of general practitioners allocated to the project area doubled during the 1985-92 period (from 33 to 61), the number of para-medical staff only progressed for the same period from 717 to 841.

Percentage of Population with access to a health facility in the project area

	1985	1988	1990	1992
< 3 Km	28	31	33	38
3 to 6 Km	14	15	17	14
6 to 10 Km	22	23	22	23
> 10 Km	36	31	28	25

15. Before being fully assessed, the deployment strategies for basic health care delivery developed in the project have been generalized to all provinces, with external support from: (i) the Bank through the Health Sector Investment Project (Loan 3171-MOR), though with an evolution of the six core programs supported and, (ii) since 1992, the African Development Bank (ADB) in ten provinces. While the project's achievements cannot be disputed, it remains true that the investments realized are important and call for a full assessment of their cost efficiency. This analysis should take into account the fact that: (i) these regions showed improvements in service coverage early in the project (prior to the construction of new centers), suggesting that the reorganization of the provinces alone contributed to a large extent to the results obtained; and (ii) the cost-efficiency of the centers constructed cannot be assessed over the period of the project alone.

16. Strengthening of MOPH Management Capacity. The MOPH underwent several reorganizations during project implementation which did not always seem to be technically motivated. The project design did not take into account the then upcoming reorganization. Under these conditions, it is difficult to measure the extent to which the project improved central management as it was intended (see para. 4.b). While management of civil works certainly improved, procurement, program budgeting and resource allocation remain serious issues for the MOPH. This is compounded by the "balkanisation" of the MOPH Departments characterized by overlapping and scattered responsibilities which prevent measuring output and efficiency, and promoting accountability.

17. The health service monitoring system was put in place in the provinces, as described in para 13 above. The outcome of the two studies on the financing of the health sector and on hospital management which were carried out, is uneven:

a. The health financing study was of good quality, considering the lack of information available at the time. It resulted in a thorough data collection and analysis. The study served as a basis to the discussions on health financing reforms which have culminated with the preparation by the Government, with Bank support, of a health insurance reform proposal. This study has however not yet translated into concrete results in the financing of the system. An indirect benefit of the study was a transfer of know-how between the foreign firm and the teams of local consultants, jointly in charge of its realization. This fruitful association led to the emergence of a group of young Moroccan experts who has since then contributed significantly to the debate on health issues. This study also led to the creation, within MOPH, of a Health Economics Unit.

b. The Hospital Management Study output is more difficult to assess. The diagnostic phase to which each hospital included in the study actively participated, was never followed by the prospective one that was intended to specify and test the options for reform. Also, due to a lack of counterpart capacity or a shift in MOPH priorities, the results of the initial phase were insufficiently discussed.

18. The results of the Training and IEC component are less clear. Only 25 percent of the funds initially allocated were actually disbursed. Half of this amount financed the equipment of the College of Public Health and the balance financed the production and dissemination of IEC materials. The lack of disbursements on this component is due to the availability of bilateral funds to finance the training activities. Though no formal amendment to the loan agreement was made, this component seems to have been dropped and was therefore not supervised.

19. There is a discrepancy between the initial design of the last component - Improvement of the drug supply - described in paragraph 4.d, and its actual implementation, which remains unexplained by existing documentation and is probably at the origin of the misunderstanding between Bank and the MOPH. This was compounded by the fact that, until recently, the Bank's position with regard to drug sector policy was unclear. The UAM was built, though with three years delay, and with a design which does not correspond to its initial more modest concept. However the equipment remains to be purchased and, more importantly, the legal structure of UAM and the terms of its relationship with the private pharmaceuticals sector are still undefined. Despite some improvements, the Central Pharmacy organization, procedures for the procurement, distribution and control of drugs still need to be improved.

PROJECT SUSTAINABILITY AND FUTURE OPERATION

20. Technical Sustainability. The global management methods and deployment strategies developed in the project to deliver the six core health programs have become an integral part of planning practice and are unlikely to disappear. However, some of the key features of this strategy, such as the travelling nurse who greatly contributed to the increase in population coverage, are being put in question as this category of staff who is more likely to accept this function has been eliminated in favor of more qualified nurses. It may therefore prove more difficult, especially in the mountainous provinces with dispersed population, to attract new candidates. Signs of low morale are already evident in this category of staff, whose working conditions have deteriorated (lack of maintenance of motorcycles, delays in payment of per diem,..). Similarly, unless drugs and contraceptives, and means of transportation for the mobile teams remain regularly available, it is unlikely that the provinces will be able to maintain their coverage level. This situation is the more problematic that the population expectations have risen with the educational level and the previous availability of services.

21. Financial Sustainability. No provision has been made in the budget to ensure an appropriate level of operating budget after project closing to continue financing the drugs, per diems, and other consumable items necessary to ensure the functioning of the programs. It is therefore expected that the project investments will not be preserved and that the achievements realized in terms of population coverage will not be sustained, unless a sufficient allocation for recurrent costs is maintained.

22. Both the Bank's on-going Health Sector Investment Project and the ADB recent Basic Health Project which finance operating costs, have equally failed to integrate mechanisms to ensure the progressive sustainability of the health system which would reflect the priority given to basic health services by the Government. On the contrary, the inclusion in the Health Sector investment Project (Loan 3171-MOR) of a significant component for the provision of drugs was an implicit acceptance that the financing of these operating costs would continue to depend on external financing.

23. The low level of national resources available in the public health sector and the related heavy reliance on external funds to finance not only investments but, increasingly, operating expenditures, considerably limit the MOPH capacity to articulate its operational priorities and control allocation of resources. All resources are already pre-allocated and pre-spent and the margin of maneuver is limited.

BANK PERFORMANCE

24. During the 15-year period between project identification and loan closing, the Bank performance can be characterized by its irregularity, in terms of (i) the frequency of its missions and exchanges with the Borrower, and (ii) the quality and emphasis of its

contribution and of the high turnover of its project managers, compounded by its organizational changes. Two phases can be distinguished:

a. The first phase (preparation - early implementation) from 1979 to 1987, during which the project was handled by a specialized non-regional PHN Department. Field visits and correspondence, although infrequent, were very focussed and led to a systematic and thorough review of each of the project components, a broad discussion of all issues and agreement on the remedial actions and next steps.

b. The post-Bank's reorganization phase, which scattered available health specialist resources. During this period, and even more after the start of the Health Sector Development Project (Loan 3171-MOR) which overshadowed the first project, supervision became less systematic, of shorter duration, concentrating on a limited number of themes -- mainly disbursement procedures and budgetary allocations -- which were rightly perceived as obstacles to timely implementation. As a result, difficulties in the realization of some of the components remained unseen or unaddressed for a long time. Bank documentation reflects this situation and progress and difficulties on some of the components remained unreported. Overall, Bank's attitude during the supervision period was rather passive and resulted in a number of missed opportunities to deepen the dialogue with the Borrower as illustrated by the following examples:

- The Borrower's mid-term review report of the project was received but not commented on. Similarly, it is only after the strong insistence of the MOPH that the Bank commented on the study of health financing and there is no record on any written comment made to the MOPH on the hospital management study.

- The implementation of the component aiming at improving the supply of drugs is another case in point. While the appraisal documentation clearly defines the drug Supply unit as a "procurement, packaging, distribution and limited formulation unit, with a close collaboration with the private sector", this unit seems to have evolved -- at least in its building design --into a full production unit. This evolution which is not documented in the files, has resulted in a misunderstanding between the MOPH and the Bank. Despite its skepticism that a public production unit was economically justified considering the rapid evolution of the Moroccan private pharmaceutical industry, the Bank failed to clearly state its position or to provide the necessary support to: (i) undertake a full assessment of the economic feasibility of this unit; and (ii) develop a coherent drug policy. At the same time, the Bank sent opposite signals that the component could proceed by giving non-

objection to the procurement documents for the construction and equipment of the UAM, and providing informal advice on its status.

BORROWER PERFORMANCE

25. Overall, Borrower's performance was excellent with regards to analyzing issues and conceptualizing strategies. However, the project suffered from difficulties in operationalizing the policies defined and the implementation capacity of the MOPH remains weak as a result of its structural organization. During the second half of implementation, the project seems to have been put on "automatic pilot" and activities were being carried out -- though at a slow pace-- without a thorough review of their impact. This is the more surprising that this pilot experience was meant to lay the ground work for broader reforms countrywide, and that the technical aspects of service delivery were indeed generalized.

26. With regards to the realization of the health financing study, the Borrower's performance was commendable. The report was produced, discussed extensively within the health sector (through workshops, seminars...) and more generally in the Government. The MOPH was very successful in mobilizing external support (USAID, WHO..) on the topic, and translating the study's recommendations and implications into operational activities, such as the health insurance proposal.

27. Although difficult to assess in the absence of records, the Borrower's performance on the Hospital Management Study was not as good. Counterparts do not seem to have reviewed the study's findings with the consulting firm and very few discussions of the report took place. It is only with the preparation of the Hospital Management Project that the dialogue with the Bank on that subject was renewed.

KEY LESSONS LEARNED

28. Both the Bank and the MOPH should make more systematic use of the findings of this project to build on their future operations. Though a good opportunity was missed with the on-going Health Sector Investment Project (Loan 3171-MOR), since it started before the lessons of the previous one could be fully drawn, its implementation has permitted a better understanding of the issues which should be addressed. The areas of focus of future operations should be:

a. <u>The financial sustainability of the system needs to be addressed without delay</u>. The MOPH has already integrated this lesson in its dialogue and has indicated its intention to proceed with new investments only when the sustainability of the sector has been addressed ie. when adequate investment and more importantly recurrent resources (staff salaries, drugs...) can be secured. To that end, the preparation of the proposed FY96 Health Management and Financing Project has been halted although it attempted to support health financing and hospital management reforms identified through the two studies

supported by the project. If the Health Management project does not proceed, the health sector sustainability should be addressed through the FY96 Social Priorities Project.

b. The overall organization of the pharmaceutical sector and the provision of drugs to the public sector need to be reviewed. The continued financing of drugs through external funds has been a disincentive to exploring more cost-effective alternatives and to rationalizing the procurement of drugs. This has been ultimately detrimental to the development of a fair and transparent competition within the private sector and very costly for the Government, as the prices of drugs produced in Morocco are high and foreign exchange is mobilized to finance what should be local costs. A thorough review of the pharmaceutical sector and the development of a drugs policy for the public sector should be carried out prior to any further financing of drugs in a project.

c. The policies and project activities cannot be divorced from their implementation structure: The current organization of the MOPH and of the medical provinces is ill-adapted to the objectives pursued by the MOPH and discourage efficiency and accountability. While MOPH is fully aware of this issue and has prepared a new organizational chart more in line with its objectives, it has not yet been implemented. Implementation arrangements for future projects should be an integral part of their design and should take into account the overall organizational structure of the Ministry, or should not proceed without addressing needed changes.

d. The relative impact of the strategies deployed to deliver basic services (fixed facilities, outreach techniques and better organization) should be assessed carefully to facilitate the development of a cost-efficient approach, adaptable to the specifications of each region.

e. The Bank should ensure that appropriate mechanisms are included in the project design or, whenever possible, implemented prior to effectiveness to meet intended objectives. While the project design clearly stated that UAM should collaborate with the private sector, this failed to happen. The Bank should also have a more pro-active attitude in its comments and proposals for remedial actions (ie. restructuring of the project, increasing the supervision of "pilot/demonstrative" aspects of the project). The preparation of new projects should not start before the results of the previous project can be built on, and lessons learned so as to be integrated to the new design.

TABLE 1: RELATED BANK LOANS

Loan Title	Purpose	Year of Approval	Status
Preceding Operations			
This loan was the first Bank loan in the sector in Morocco. Prior to this loan, Bank involvement in the health sector was limited to a schistosomiasis component in the agriculture development Doukkala I Project (Loan 1201-MOR) and to a health manpower training component in the Third Education Project (Loan 1220T-MOR) which consisted in the construction, furnishing and equipping of a college of Public Health in Rabat, a school of medical technicians in Casablanca and three nursing schools in Oujda, Fes and Agadir.			
Following Operations			
Health Sector Investment Project (Ln 3171-MOR)	To support the Government strategy to reinforce (a) basic health; (b) referral, emergency and diagnostic services provided at regional and provincial hospitals, and building and biomedical equipment maintenance capabilities; (c) administration and management of services provided by the MOPH in order to increase efficiency, and facilitate the implementation of administrative reforms designed to decentralize the management of health services; and (d) sector and policy reforms which address longer term issues related to the evolution and structure of the public and private sector health services delivery systems, financing mechanisms, and the mobilization of resources in support of the sector.	FY90	Under supervision. 21% disbursed. Closing date: December 31, 1996.
Social Priorities Project	The proposed project would assist the Government in the implementation of its social strategy to help the least advantaged groups of Moroccan society play a full role in the country's economy, thus contributing both to increased productivity and enhanced equity. The basic health and nutrition component of this project would support the implementation of the medium-term action plan aiming at improving access of the target rural population to a package of essential services. To that end it would implement a number of intertwined actions: (a) rehabilitating/expanding the health infrastructure, while providing the necessary material, drugs (including contraceptives) and equipment; (b) promoting outreach and demand promotion strategies for the delivery of essential clinical and preventive services in remote areas; (c) strengthening and expanding FP services, and stimulating further demand for FP services (e.g. IEC programs); (d) improving the nutritional status of high risk groups and implementing programs to reduce the prevalence of micronutrient deficiencies; and (e) supporting actions aimed at redeploying and retraining the medical and paramedical personnel, in particular in the area of supervision and monitoring at the provincial level.	Planned FY96	Under Preparation
Health Management Project	The project would support Government efforts to (i) address major hospital internal efficiency issues to contain costs while improving quality of services; and (ii) introduce new health financing reforms, able to increase the level of resources available and promote equity. The proposed project would include the following components: (a) development of hospital management capacities; (b) improvement of service quality; and (c) development and implementation of new financing mechanisms and institutional development.	Planned Fy 96	Under preparation Borrower asked to delay project preparation until sector financing issues have been addressed at the Governmental level.

TABLE 2: PROJECT TIMETABLE

Steps in Project Cycle	Date Planned*	Date Actual
Identification	n/a	September 1979
Project Preparation Facility (PPF)	June 83	
Preparation	n/a	April 1980, June 1981
Appraisal	n/a	October 1984
Negotiations	n/a	April 1985
Board Presentation	n/a	June 6, 1985
Signing	Before October 1985	January 17, 1986
Effectiveness	October 1985	July 27, 1986
Midterm review carried out by the Borrower	December 1987	November 89
Project completion	June 30, 1990	**
Loan closing	December 31, 1991	December 31, 1993

*As provided in Project Brief for processing steps up to Board Presentation, and in the Staff Appraisal Report (SAR) for steps occurring after Board Presentation.

**All components were completed by June 1993 with the exception of the Drugs supply unit which remains incomplete to date. (see para. 19) and the IEC component which was dropped.

TABLE 3: LOAN DISBURSEMENTS: CUMULATIVE ESTIMATED AND ACTUAL (US$ million)

	FY86	FY87	FY88	FY89	FY90	FY91	FY92	FY93	FY94
Appraisal Estimate	1.3	5.0	10.4	16.4	22.4	26.9	28.4	-	
Actual	0	0.13	1.13	3.54	7.93	13.98	19.33	23.52	25.84
Actual as % of estimate	0	0.02	0.1	0.21	0.35	0.52	0.68	0.82	0.90
Date of final disbursement	April 1994								

TABLE 4: SELECTED MONITORING AND IMPACT INDICATOR IN THE PROJECT AREA

	1985	1988	1990	1992
IMMUNIZATION				
- Vaccinal Coverage (BCG) (Recruitement rate of children less than one year old)	66%	83%	84%	92%
- Incidence of declared cases				
* Whooping-cough	393	11	10	14
* Measles	149	120	46	537
* Polio	4	0	0	0
FAMILY PLANNING				
* Rate of new acceptors (pills)	7%	9%	14%	13%
* Rate of new acceptors (IUD)	0.25%	0.56%	0.65%	1.7%
* Contraceptive prevalence rate *	NA	NA	NA	NA
BASIC HEALTH SERVICES				
* Drop-out rate for tubercolosis treament	26%	16%	7%	4%
MCH				
* % of assisted deliveries	21%	24%	28%	35%
* % of assisted deliveries occurring in BHC	22%	26%	32%	45%
* Infant Mortality **	NA	NA 57‰	NA 52‰	NA 48‰
* Number of neonatal tetanus cases	23	15	2	0
SANITATION				
* % Water points created	75%	71%	81%	87%
* Incidence of Typhoid	37	15	12	9

Source: MOPH Project Evaluation Report (August 1994).. + prevalence rate at 41.5% at province level -

* The 1992 DHS estimates the natural rates were monitored
Only new acceptors and resumption

** Estimates, for two of the 3 provinces

TABLE 5: STUDIES INCLUDED IN PROJECT

Study	Purpose	Status	Impact of Study
1. Health Service Monitoring	MOPH was to implement a comprehensive monitoring and evaluation system for the present project, including family planning programs as a first step toward monitoring the progress of the Health Development Plan as a whole. Data collected by health facilities was to be processed and complemented by operational or evaluative research.	A service monitoring system was put in place in the provinces which has facilitated the decision process and permitted the mid-term review and post-evaluation of this project.	Data collection remains oriented towards services provided by the centers and is not often related to the total population. It is unclear whether these statistics, which represent a heavy administrative burden for the staff are fully utilized in decision making.
2. Study on the Financing of the Health Sector	Its purpose was to analyze the availability and allocation of funds, and the efficiency and equity of the present and alternative financing schemes.	Study completed in October 90. Was followed by several seminars and workshops to mobilize external support and led to the creation of a Health Economics Unit within MOPH.	The study's recommendations are being implemented, and have resulted in particular in the development of a health insurance scheme.
3. Study on Hospital Management	Since hospitals absorb 72% of MOPH's operating budget, the study focused on hospital performance, cost containment and possible methods of cost recovery, in accordance with the alternatives of the study on financing.	Diagnostic completed in June 89. The assessment focussed on 5 areas: Structural and physical characteristics of the hospital sector within MOPH, human resources, financial resources and organizational structure.	While the diagnostic phase was carried out and provided insight on hospital management the prospective phase intended to specify and test options for reform was not carried out. This phase is however expected to be developed as part of the Health Management project preparation.

TABLE 6A: PROJECT COSTS

Item	Appraisal Estimate (US$M)			Actual/latest estimate (US$M) 1/		
	Local costs	Foreign costs	Total	Local costs 2/	Foreign costs 2/	Total
Development of basic health services	12.5	10.7	23.2	20.7	17.6	38.3 3/
Strengthening of MOPH Management	0.8	0.9	1.7	0.7	0.9	1.6
Strengthening of training and EIC Capacity	0.5	1.1	1.6	0.1	0.3	0.4
Improvement of drug supply system	2.4	4.4	6.8	4.7	8.2	12.94/
Total Baseline Costs	16.2	17.1	33.3	26.2	27.0	53.2
Contingencies	7.1	7.2	14.3			
PPF						0.06
Total Project Costs	23.3	24.3	47.6	26.2	27.0	53.3 5/

1/ Exchange rate used corresponds to 1986 - 1993 average (US$ 1 = DH 8.4)
2/ Share of foreign costs in total calculated on the basis of appraisal estimates.
3/ Increase in cost of this component is due to the cumulative effects of:
(i) an increase in the number of centers built;
(ii) delays in implementation; and
(iii) increase in the square footage of the center following the adoption of modular plan.
4/ Estimated cost of completing component. Expended to date : US$ 4.8M.
5/ Estimated cost of completing the project. Expended to date: US$ 41.9M.

TABLE 6B: PROJECT FINANCING 1/

Source	Appraisal Estimate (US$M)			Actual/latest estimate (US$M)		
	Local costs	Foreign costs	Total	Local costs	Foreign costs	Total
IBRD	4.1	24.3	28.4	1.5	24.0	25.5
Government	19.2	-	19.2	16.4	-	16.4
Total	23.3	24.3	47.6	17.9	24.0	41.9

1/ This table reflects the financing arrangements for expenses already occurred. Financing source to complete the project (US$ 11.4M) has not yet been determined.

TABLE 7: STATUS OF LEGAL COVENANTS

Agree./Sect.	Coven. Type	Present Status	Original Fulfill. date	Revised fulfill. date	Description of covenant	Comments
3.02 (a)	7	CP			Establish & maintain a drug supply unit to undertake responsibility for the carrying out of the drug supply program included in Part D of project.	Only construction was completed. The legal status of the unit remains to be defined and equipment to be ordered.
3.02 (b)	4	CP	Each FY	-	Each fiscal year DSU is provided, through separate annual budgetary allocations, with funds sufficient to enable it to meet the estimated expenditures required for the carrying out of such a program.	Counterparts funds were insufficient for timely implementation.
Sc. 5.1a	5	C	-	-	Maintain & continue to operate PIU.	
Sc. 5.1a	5	C	-	-	DIPC continues to carry its operations with assistance of qualified staff in adequate numbers.	
Sc. 5.1a	5	CP	-		DSU is vested with responsibility for drug supply operation.	
Sc. 5.2a	5	C	12/31/86		Furnish to Bank proposed action plans for strengthening MOPH management.	
Sc. 5.2b	7	C			Thereafter carry out such plans.	Implemented 1990.
Sc. 5.3a	8	C	12/31/85		Establish & maintain thereafter an interministerial committee to coordinate study on health sector financing (part B.3b) & review results of the study.	
Sc. 5.3b	7	C	12/31/86		Furnish to Bank detailed report on progress in carrying out study.	Report completed October 1990.
Sc. 5.4a	5	C	12/31/87		Furnish to Bank detailed report on progress in carrying out study on hospital management (part B.3b)	Delayed by delay in project effectiveness. Report received 6/30/89.
Sc. 5.5a	7	C	12/31/87		Furnish to Bank detailed report on progress implementation of project, including findings and recommendations of health program study (part B.3b).	
Sc. 5.6a	7	NC	by 12/31 of each year	dropped	Furnish to Bank detailed program of production and dissemination of IEC material during the year following calendar year of health education materials (part C.2).	This project component has been dropped because of the availability of concessional funding for health education programs.
Sc. 5.6b	7	NC			Thereafter carry out such a program.	See above.
Sc. 5.7a	7	NC			Furnish to Bank for approval proposed programs of fellowship training (parts B, C, D) and lists of proposed candidates for training.	See above.
Sc. 5.7b	7	NC			Thereafter carry out such programs.	See above.

Status

C - Complied with
NC - Not complied with
CP - Complied with Partially

1. Account/audit
2. Financial Performance/generate revenue from beneficiaries
3. Flow and utilization of Projects funds
4. Counterpart funding
5. Management aspects of the Project or of its executing agency
6. Monitoring review and reporting
7. Implementation
8. Sectoral or cross-sectoral budgetary or other resource allocation
9. Sectoral or cross-sectoral budgetary/institutional action
10. Other

TABLE 8: BANK RESOURCES: STAFF INPUTS

Stage of project cycle	Planned		Actual	
	Weeks	US$	Weeks	US$
Through appraisal	n/a		85.6	
Appraisal - Board	n/a		79.6	
Board - Effectiveness	n/a		n/a[1/]	
Supervision	n/a[3/]		110.8	
Completion	n/a		7[2/]	
TOTAL			283	

1/ Period Board & effectiveness cumulated with supervision.
2/ Estimate
3/ Data on planned staffweeks only exist for the period 89-94 and correspond to 85.5 sw (or average of 14.2 per year) which compare to an actual time of 76.2 sw for that period (or 12.7 average per year).

TABLE 9: BANK RESOURCES: MISSIONS
A. PREPARATION

M/Y	No. persons	Days in Field	Skills	Comments
- March 1979 (Identification)	5	11 11 11 11 11	PH Specialist Loan Officer Education Specialist PH Specialist PH Specialist UNFDA	
- September 79 Preparation	4	10 10 10 10	RH Specialist Education Sp. Loan Officer PH Specialist	
- April 80 Preparation	4	11 11 11 11	PH Specialist Economist Loan Officer PH Sp. Consultant	
- June 81 Preparation		5	Economist	
- June 83	5	5 10 5 5 5	Economist 1w Architect 2w PH Specialist 1w PH Specialist 1w Imp. Specialist 1w	
- October 24 - Nov. 5, 83	2	12 8	PH. Specialist PH. Specialist	
March 84	1	20	PH. Specialist	
July 84 (Pre.appraisal)	1	3	PH. Specialist	
Sept. 84 Appraisal	9	20 20 20 20 20 20 20 ? ?	PH. Specialist Health Economist Economist Architect PF. Consultant Pharmac. Syst. Consultant Research Assistant Division Chief Loan Officer	
March 85	1	7	PH. Specialist	Review of project timetable and its budgetary implications

TABLE 9 CONTINUED
B. SUPERVISION

M/Y	No. persons	Days in Field	Skills	Project Rating		Problems
				Overall rating	Dev. rating	
- June 86 (29 to 9)	3	12 12 15	PH. Specialist PH. Specialist Economist			
April 87	3	12 12 12	PH. Specialist Operations Assistant Health Economist			Reviewed new organizational Structure of MOP & IEC component slow to start
- February 88	1	? 1/	Disbursement Officer			Discussions on opening of Special Account
- August 88 2/	3	8 8 8	Health Specialist PH. Physician Architect	2	1	- Lack of operating resources - Restructuration of tuberculosis program
- January 89	4	8 8 8 8	PH. Specialist PH. Physician Pop. Specialist Hospital Ad. Sp.	2	1	
- October 89 2/	4	5 5 5 5	Health Specialist PH. Physician Architect Education/Training Sp.	2	1	- Mid-term review carried out by MOPH
- June 90 2/	3	5 5 5	Health Specialist Financial Analyst Architect	2	1	- Delays in payments to contractors; funds to be delegated to provinces - Bids for UAM to high
- November 90 2/	2	9 9	Health Specialist Financial Analyst	2	1	- Slow implementation - Projects costs to be updated
- February 91 2/	1	9	Financial Analyst			-Health Financing report received - New TPS for UAM reviewed
- May 91 2/	3	9 9 9	Health Specialist Financial Analyst Architect	2	1	-Discussion on feasibility of UAM

1/ Multi purpose missions. Share of time allocated to project not available.

2/ Starting August 1988, all missions covered both the Health Development Project and the Health Sector Investment Project. Mission time has been apportioned equally to each project which is likely to overestimate time actually spent on the first project.

TABLE 9 CONTINUED

B. SUPERVISION (LTD)

M/Y	No. persons	Days in Field	Skills	Project Rating		Problems
				Overall rating	Dev. rating	
October 91	4	8 8 8 8	Sr. PHN Specialist PH. MD Hospital Administ. Sp. Architect	2	1	- Disbursement Issues - lack of counterpart funds - Request for postponement of closing date
- May 92	2	5 5	Financial Analyst Implementation Specialist	2	1	- Limited budget allocations
- November 92	3	9 9 9	Financial Analyst Implementation Specialist Health Specialist	2	1	- Some centers ready but not staffed - Status of UAM to be defined - MOPH Negotiating with the Pharmaceutical private sector
- April 93	2	3 3	Project Officer PH Specialist	2	1	UAM equipment and status
- May 94 (PCR)	1	6	Project Officer	-	-	———