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INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

RESTRUCTURING PAPER

ON A

PROPOSED PROGRAM RESTRUCTURING

OF

IMPROVING PRIMARY HEALTH IN RURAL AREAS PROGRAM
APPROVED ON APRIL 24, 2015

TO THE

KINGDOM OF MOROCCO

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

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
CRI	Corporate Results Indicator
CSCA	Centre de Santé avec Module d'Accouchement (Community health center with a delivery unit)
DLI	Disbursement-Linked Indicator
DLR	Disbursement-Linked Result
ENPSF	Enquête nationale sur la population et la santé familiale (National Population and Family Health Survey)
ESSP	Établissement de Soins de Santé Primaires (Primary health care facility)
GOM	Government of Morocco
GRM	Grievance Redress Mechanism
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
IBRD	International Bank of Reconstruction and Development
MEF	Ministère de l'économie et des finances (Ministry of Economy and Finances)
MCH	Maternal and child health
MOH	Ministry of Health
MTR	Mid-Term Review
NCDs	Non-communicable diseases
PDO	Program Development Objective
PforR	Program for Results
SMIPF-SC	Santé maternelle et infantile, planification familiale, et soins curatifs (Information system for maternal and child health, family planning and curative care)

DATA SHEET (MA-Health Sector Support - P148017)

Project ID	Financing Instrument	IPF Component
P148017	Program-for-Results Financing	No

Approval Date	Current Closing Date
24-Apr-2015	31-Dec-2019

Organizations

Borrower	Responsible Agency
MINISTRY OF ECONOMY AND FINANCE (TGR)	Ministry of Health

Program Development Objective(s)

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

Summary Status of Financing

Ln/Cr/TF	Approval Date	Signing Date	Effectiveness Date	Closing Date	Net Commitment	Disbursed	Undisbursed
IBRD-85070	24-Apr-2015	02-Jul-2015	21-Sep-2015	31-Dec-2019	100.00	80.14	19.86

Policy Waiver(s)

Does the Program require any waivers of Bank policies applicable to Program-for-Results operations?

No

I. PROGRAM STATUS AND RATIONALE FOR RESTRUCTURING

Program Background

1. **The Morocco Improving Primary Health in Rural Areas Program for Results (PforR) was approved on April 24, 2015 and became effective on September 21, 2015, with an original closing date of December 31, 2019.** The development objective of the PforR is to expand access to primary healthcare in targeted rural areas in the program area. The expected key results of the PforR are to increase the use of primary healthcare services in targeted rural areas, improve accountability of the health system and establish a health information system in public health facilities. These are accomplished through two results areas: first, improving health at the primary level in rural areas, and second, improving governance in healthcare. This PforR incentivizes progress for these results areas through seven Disbursement-Linked Indicators (DLIs), as shown in Table 1.

Table 1. Disbursement-Linked Indicators of the Program

Results Area 1: Expanding Equitable Access to Primary Care in Rural Areas
DLI 1: Increase in number of pregnant women receiving antenatal care during a visit to a rural primary healthcare facility (ESSP) in the Program Area
DLI 2: Increase in number of deliveries of rural women attended by skilled health personnel in public health facilities in the Program Area
DLI 3: Increase in number of new visits of children under 5 to a rural ESSP in the Program Area for curative care
DLI 4: Increase in number of patients with diabetes diagnosed and treated at a rural ESSP in the Program Area
DLI 5: Increase in number of visits to rural ESSPs in the Program Area
Results Area 2: Improving Health System Governance at the Primary Level
DLI 6: % of rural health centers with delivery services in the Program Area that participate in the main annual quality assessment (concours qualité)
DLI 7: Establishment of the health management information system (HMIS) in one region within the Program Area

2. **The PforR was the first IBRD-funded health operation in Morocco since a small project financed by a trust fund closed in 2008.** At preparation, Morocco suffered from low public health financing, lack of financial risk protection and significant inequality between urban and rural areas in terms of access to health services. The rural areas in particular suffered from poor maternal and child health outcomes associated with low utilization of health services and a lack of an integrated focus on primary care. In addition, the Moroccan health system was also struggling to respond to a dual burden of disease emerging from a significant increase in the burden of non-communicable diseases (NCDs) with limited coverage for the diagnosis and treatment of hypertension. Through the preparation of the operation, the World Bank engaged with the Government of Morocco (GOM) to define the two results areas to strengthen the health system with a focus on benefiting the rural population, by expanding the coverage of maternal and child health services and primary level services addressing NCDs and improving quality assurance and information systems. The process of defining these results areas was an entry point into a sector with limited ongoing policy dialogue, as well as an opportunity to address the constraints related to the building blocks of the health system.

3. **Despite challenges, the performance of the Moroccan health system, particularly as it pertains to rural primary healthcare, has been showing positive trends for several years.** This has been done through a concerted effort by

the GOM to increase maternal and NCD service utilization and quality. Analysis of the National Population and Family Health Survey (ENPSF) data from 2011 and 2018 points to an overall increase in skilled birth attendance level, with a significantly faster increase in rural areas from 55 percent to 74 percent (a 35 percent rise), compared to urban areas (rising from 91 percent to 97 percent). Antenatal care visits had a similar trend, with an increase of 27 percent in rural areas, from 63 percent to 80 percent for the same years, compared to 92 percent to 96 percent in urban areas. These trends align with a decline in maternal mortality from 148/100,000 in 2009-2010 to 111/100,000 in 2015-2016 in rural areas, and nationally from 112/100,000 to 73/100,000 for the same period. Similarly, NCD treatment coverage has increased significantly: even though type 2 diabetes prevalence has gone up, coverage for diabetes treatment has accelerated significantly, going up from 625,000 people covered in 2015 to 823,000 in 2017[1] (>30 percent increase) in rural areas of the regions covered by the PforR, resulting in a reduction in unmet treatment needs. Similar improvements were made with hypertension: even as new cases stabilized between 2015 and 2017, the number of those undergoing treatment went up from 663,061 in 2015 to 882,485 in 2017.[2] These changes can also be attributed to increases in health financing since the launch of the PforR: the public per capita health budget in real terms has gone up from US$61 in 2015 to US$69 in 2017,[3] and large increases are reported for 2019 and 2020.[4]

Implementation Progress

4. **Following a level II restructuring in 2017, Program implementation has been satisfactory.** The restructuring approved on July 3, 2017 documented the baseline values (as previously agreed during negotiations) and the list of revised targeted regions. The restructuring also confirmed the achievement of Disbursement-Linked Result (DLR) 7.1 (first year result for 2015) and the revision and implementation of the verification protocol leading to three exercises of verification (indicators for years 2014, 2015 and 2016). Progress towards achievement of the Project Development Objective (PDO) and Implementation Progress are rated Moderately Satisfactory and the program has disbursed US$80.14 million to date at 80.14 percent disbursement rate. This amount includes US$25 million advance which is yet to be recovered. There is no overdue audit.

5. **PforR indicators for the program on expanding equitable access to primary care in rural areas have mostly met or surpassed the targets, attributable to the reallocation of funds to priority areas.** In 2017, antenatal care coverage increased by almost 18 percent against a target of 4 percent, an increase due to improved availability of infrastructure and medical equipment in rural health centers and expanded scope of antenatal care, which now include ultrasound and higher technical capacity. Similarly, proactive outreach by health workers to mothers in remote areas and an increase in the availability of mobile medical units have resulted in this improvement: mobile medical units have been scaled up significantly in the course of the program. In 2018, in rural areas, the units supported a total of 13,745 antenatal care (ANC) visits (about 10 percent of all ANC visits in program regions) and 184,586 outpatient visits for under children under the age of five and 286,011 outpatient visits for those over five years of age. Not only did the

[1] Direction de la planification et des ressources financières, division de la coopération, May 2019. « Programme Pour Résultats du Secteur de la Santé 'PPR-Santé' – Rapport d'Avancement du Programme »
[2] Ibid.
[3] World Health Organization, Global Health Expenditure Database. https://apps.who.int/nha/database
[4] According to the MOH, public health budget increased from around 13.5 billion MAD in 2015 to almost 19 billion in 2020 in nominal terms.

GOM scale-up mobile medical units, but it also improved its investments and prioritized outreach by health workers based in health centers, through offering home-based care for a set of services as well as identifying conditions.

6. **Indicators relating to NCD coverage in rural areas have substantially out-performed the targets.** The GOM's commitment to both prevention and treatment of diabetes and hypertension has seen a dramatic increase since the launch of the PforR. There has been an increase in the number of diabetic patients monitored through diagnostic and therapeutic management in rural primary healthcare facilities (ESSPs) in the program's target regions due to a significant increase in the priority given by the GOM to the diagnosis and treatment of diabetes and hypertension. This was corroborated by improved GOM spending on awareness, drugs and medical equipment. GOM counterparts confirm that the PforR played catalyst role in setting priorities in the diagnosis and treatment of diabetes and high blood pressure in rural areas. The disease burden has increased due to lifestyle factors, especially for type 2 diabetes. The improvement in diagnosis and treatment capacity in rural areas is therefore an important step towards primary and secondary prevention.

7. **The only under-performing DLI under the program on primary care in rural areas has been the deliveries attended by skilled health personnel in public health facilities.** The target for 2017 is a 5.13 percent increase from the baseline, while the realized increase is 0.51 percent. This trend, however, does not necessarily mean that there has not been progress among rural women in receiving this important type of care. In fact, skilled attendance at childbirth for rural women (at any location) has increased from 53 percent in 2011 to 69 percent in 2018 according to the ENPSF, with increases especially in public hospitals (where 50 percent of deliveries for rural women currently take place) and private clinics (which currently supports 4.5 percent of deliveries for rural women). The stagnated number of deliveries among rural women at public facilities may be partly attributable to increased urbanization, declining fertility rates and increased deliveries in private facilities. The total number of pregnancies in rural areas fell from 315,000 in 2015 to 300,000 in 2018, according to GOM projections. This is consistent with the national trend of declining fertility, which has gone down from 2.6 in 2011 to 2.38 in 2018, with a significant decline in rural areas from 3.2 to 2.8 during the same period. At the national level, the rate of deliveries attended by skilled health personnel in public facilities fell from 78 percent in 2015 to 69 percent in 2018. Given that 30% of deliveries are not attended by skilled health personnel in rural areas, targeted efforts may be needed to increase demand for deliveries at public facilities to ensure this service is accessible and available to all women, especially those with financial constraints.

8. **The PforR operation has been successful in terms of improving the quality and accountability of the health system and has played a key role in the transition of the Moroccan health system towards an evolving health system through learning; it has also contributed to policy discussions on improving the availability of the health workforce.** The increases in service utilization have been complemented by a focus on improvements in quality of care. The PforR includes a DLI on quality assessments as well as an indicator on the establishment of a grievance redress mechanism (GRM),[5] both of which are operational and enable stakeholders to incorporate feedback from patients in their practice, which would help increase accountability of the health system. These activities have catalyzed a broader

[5] From 2016-2018, the GRM ("Chikaya Santé") has received 4295 calls, mostly related to high waiting times, absenteeism and drug stock-outs. In 2018, a decision was made to collect and address grievances at the decentralized/service delivery level; most regions, districts and hospitals have already established these mechanisms. This process is expected to be completed by the end of 2019.

focus on quality of care, and during the PforR implementation period, the Moroccan health system has made great strides in becoming an evolving health system through learning. The implementation of maternal death audits has been institutionalized, with the results of these assessments[6] being used to address key challenges in quality of care, together with the continuous feedback received from patients. Service packages have been defined for maternal health to ensure improved availability, and trainings have been conducted based on these packages as well as the results of the assessments to ensure continued learning. There has been an increase in the institutionalization of studies similar to maternal death audits. As an example of the institutionalization of learning, two of the program regions have started a pilot of a family medicine model to reorganize care in their districts, where patients have digitized medical records and are assigned a family doctor who is their primary source of contact for all matters related to primary care. Such a model is employed in different countries, and if the results are promising, the model can be scaled up. Another example relates to the scarcity of the health workforce which is a key bottleneck for quality of care in rural areas. Exploring incentives to improve the retention of health workers in rural areas has been identified as a potential way to alleviate the situation. The PforR has supported studies on implementing incentives to improve both the presence and performance of human resources for health. The implementation of the recommendations from these studies hinges upon changes in the legal framework, as currently many civil servants, including health workers, are managed centrally by the civil service directorate, and it is not currently possible to implement differential incentive structures for different civil servants.

9. **Another key improvement in the governance of the health system is the digitization of a health information system that have taken place during the PforR implementation period.** At the launch of the PforR, the GOM did not have a comprehensive strategy with regards to an integrated, digitized health information system, and health data was almost exclusively paper-based. The PforR envisioned the development of building blocks for an integrated information system, as well as piloting an integrated approach in one region. During the process, the GOM completed an urbanization study and a roadmap (masterplan) of an integrated health information system strategy, which were DLRs 7.1 and 7.2. As a first step towards laying down the building blocks of an integrated health system, the GOM has launched an integrated computerized health system for Maternal and Child Health, Family Planning and Curative Care (santé maternelle et infantile, planification familiale et soins curatifs - SMIPF-SC). While the GOM has not achieved original DLRs 7.3 and 7.4, SMIPF-SC is fully operational, comprehensive and digitally available, as of 2017. SMIPF-SC includes all indicators related to maternal, newborn and child health including immunization, nutrition and family planning, information relating to cancers, Human Immunodeficiency Virus (HIV) and sexually transmitted infections, and all curative care interventions including diabetes and hypertension. It should be noted that there is a separate paper-based registry for diabetes and hypertension, which is more comprehensive than the information available on SMIPF-SC. There are plans to fully integrate the diabetes registry with the hypertension registry, and integrate them with the SMIPF-SC, over the next few years. SMIPF-SC was launched in 2010 as a paper-based system, and its scope has expanded significantly from 2015. As of 2017, the system is completely computerized at the hospital level, and all ESSPs send data at the provincial delegation for data entry and reporting to the central level.

[6] Morocco's concours qualité program, involving self-assessment conducted by health facilities and audit by peers, recognizes good work and incentivizes improvement.

10. **Steady progress has been observed on the fiduciary aspects.** The MOH has been addressing the 2018 audit recommendations, particularly those related to stock-outs of medicines and supply chain management, through an action plan. This includes the adoption of three-year framework contracts for supplies, some of which have already been signed. In addition, all health personnel involved in medicine supply chain management has been trained on stock management and quality control through an initiative implemented by the Supply Division of the MOH. In October 2019, it was agreed that the MOH produce interim financial report on a semi-annual basis, which will help consolidate financial information, track spending history and provide more visibility on budget planning. The World Bank will continue to follow up closely with the MOH to: (i) monitor progress and support capacity building efforts; and (ii) use the DLRs for which achievement is yet to be confirmed to justify/account for the initial advance of US$25million disbursed at project effectiveness. Despite the progress made, however, the MOH continues to face complex issues and constraints in procuring essential medicines and strategic public health supplies. This is mainly because the public sector entities responsible for procurement of essential medicines and health commodities are still using inflexible procurement methods and dependent on cumbersome tendering processes, as the existing public procurement decree does not allow for the use of appropriate/specific procurement approaches for the health sector. Furthermore, the media has recently reported governance issues and lack of transparency in the procurement of essential medicines. Therefore, it is essential that the MOH implement and monitor appropriate and good procurement practices in order to ensure timely procurement and good quality of drugs.

Rationale for Restructuring

11. **The PforR has been successful in building momentum in terms of improved rural primary care and governance in the Moroccan health system.** During the PforR implementation, the GOM has made progress on all the agreed PDO indicators, except for the one regarding skilled birth attendance at public facilities. As highlighted above, the PforR has catalyzed an increase in utilization for key services in rural areas through mobile medical units and improved physical quality of health facilities. Improvements in health system governance have also been achieved through enhancing information systems, collecting evidence on human resources for health retention mechanisms, and focusing on governing for quality of care and institutionalizing quality improvement processes through “quality assessments”. Health budget increased by 10.4% between 2018 and 2019, and even further between 2019 and 2020 at 13.7%, which is a key factor as the GOM moves towards implementing its ambitious Plan Santé 2025, centered on improving quality and service utilization. Even though the program experienced start-up delays and operational bottlenecks, implementation momentum has been building since the mid-term review (MTR).

12. **In order to achieve the Program targets and in line with the MTR recommendations, the Ministry of Health (MOH) through the Ministry of Economy and Finance (MEF) submitted a request for a level 2 restructuring on October 16, 2019. Subsequently, a review of the restructuring request was undertaken in November 2019, and the amendments detailed in the next section were agreed between the World Bank and the GOM.** These amendments are based on two main reasons: (i) the lack of progress on skilled birth attendance for rural women at public facilities, despite commendable progress in all other areas; and (ii) the significant progress made with the operationalization of a national health information system nationwide.

13. **With regards to DLI 2, skilled birth attendance for rural women at public facilities, a review did not find conclusive evidence that the PforR played a role in incentivizing an increase in deliveries at public facilities, unlike other DLIs on antenatal care, diabetes or outpatient consultations, as well as on the improvement of quality of care and accountability mechanisms.** Even though progress was made in expanding the coverage of skilled birth attendance for rural women in general according to the ENPSF, the progress for this DLI has been constantly below targets, and the role of the PforR in this regard is unclear especially in terms of increasing deliveries in public facilities. As highlighted above, even though skilled birth attendance in public facilities has been declining nationally due to an overall decline in the number of expected pregnancies and an increase in deliveries at private facilities, it is difficult to determine that these shifts alone can justify the stagnated delivery rates at public facilities.

14. **As for DLI 7, the GOM has indicated that SMIPF-SC will continue to be their main information system as the country transitions towards operationalizing the integrated data system strategy which was developed through the PforR.** SMIPF-SC forms the main building block for the integrated information system that the GOM is seeking to develop, which would be based on an electronic medical records system at the patient level. Patient data is already collected at every public health facility, including demographic information of patients. The next step in the GOM's strategy is to ensure this patient-level data is captured electronically and can be transmitted easily from one facility to another, from the primary to the secondary and to the tertiary level. There are ongoing efforts to enable computerized data entry in all ESSPs; yet, given the operational and financial constraints, this transition is expected to take time. The GOM has been increasing its budgetary commitments, thanks to upcoming projects financed by the African Development Bank and the European Union. Both the GOM and the development partners indicated that the PforR has served as a catalyst in elevating the profile, attracting interest, and laying down the building blocks for an integrated information system, a process which takes a significant amount of time to complete. Until full digitization takes place under the vision of a fully digitized Morocco by 2030, SMIPF-SC will serve as the main information system of the country.

II. DESCRIPTION OF PROPOSED CHANGES

15. **In light of these contextual observations and deliberations, the following changes were agreed:** (i) revise the 2014 baseline value for DLI 5 to 3,794,877 instead of 3,753,120 to include mobile clinic consultations; (ii) modify DLI 6 as follows: (a) change the name of DLI 6 as "% of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main **biennial** quality assessment (concours qualité); (b) revise the 2014 baseline value for DLI6 from 11.49 percent to 13 percent; (c) reformulate DLRs 6.1, 6.2, 6.3 and 6.4 as "30% of CSCAs in the Program Area participating in the main biennial quality assessment (concours qualité), in CY15", "The guide of self-evaluation of rural health centers has been updated in a manner acceptable to the Bank", "The Borrower, through its MOH, has approved/adopted the guide of self-evaluation of rural health centers updated under DLR#6.2", and "44% of CSCAs in the Program Area have participated in the main biennial quality assessment (concours qualité) and been assessed based on the guide of self-evaluation of rural health centers approved/adopted under DLR#6.3"; (iii) reformulate DLI 7 as follows: (a) revise the name of DLI7 to "Establishment of an HMIS in the Program Area; (b) modify DLR 7.3 to read "The national digitized health management information system on maternal and child health, family planning, and curative care (SMIPF-SC) has been operationalized in the 100% of public health centers of at least 4 regions within the

Program Area"; and (c) modify DLR 7.4 to read "The SMIPF-SC has been operationalized in the 100% of public health centers of all the regions within the Program Area"; (iv) extend the closing date to December 31, 2020 with the disbursement deadline of June 30, 2021. Changes in the baseline value are to record more reliable data and do not impact disbursements already made against achieved results. The end target date for the intermediate results indicator, "Definition of a Human resources (HR) incentive mechanism in rural ESSPs" will also be revised to June 30, 2020.

16. One-year extension provides an opportunity to monitor and capture the trend for the year 2019. While the DLI targets will continue to be for four years (2015-2018), the results framework will be modified to include 2019 data for several indicators. This does not affect past or future disbursements.

17. **Revision of the DLI 6 name, 2013 baseline value for DLI 6 and 2015, 2016, 2017 and 2018 targets** (% of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main annual quality assessment - concours qualité). Due to the implementation schedule of this quality assessment which is every two years with one transitional year, the MOH was only able to complete two cycles for 2014-2015 and 2017-2018. The name of DLI6 is revised to reflect the frequency, biennial rather than annual, and the targets are reformulated to reflect the frequency of these assessments. The baseline value is amended to 13 percent instead of the original 11.49 percent due to the availability of more reliable baseline data.

18. **Regarding DLI 7, as described above, the GOM has made significant progress in operationalizing and scaling up SMIPF-SC, which is going to remain the main integrated information system until the scale-up of patient-level electronic medical records.** The GOM and development partner consultations have demonstrated that this process will take a significantly longer time than anticipated, and in the meantime, the GOM has spent technical, financial and operational resources on scaling up the coverage of SMIPF-SC. Changing the DLRs of this indicator would recognize the progress made to date and support the long-term task of moving towards a comprehensive patient-level integrated information system. In light of this, the DLI name is also revised.

19. **Extension of the closing date to December 31, 2020.** The proposed closing date extension will allow enough time to capture the results achieved for the years 2017 and 2018 as the MOH has faced a delay in publishing its annual health outcomes report "Santé en Chiffre". Most indicators in the results framework are based on this annual report. The verification report of 2017 data has been submitted to the Bank on November 27, 2019. The data for 2018 is expected to be validated and published significantly faster, in the first half of 2020, given the completed transition process of digitized SMIPF-SC. One-year extension will not only ensure that the DLI achievements are captured but also provides an opportunity to monitor the trend for 2019 for service related indicators as well. Verification of these data is not necessary, thus 2019 data will be available during 2020, before the closing date. Finally, the extension also allows additional time for the ongoing activities for the HR incentive mechanism (intermediate results indicator) as well as program action items related to safeguards and fiduciary measures to be completed under the PforR.

20. **The implications of these changes on disbursement are shown in the table below.** This restructuring is likely to result in the GOM to request disbursement for DLRs worth $31.8 million, of which US$25 million will be used to recover the advance.

Disbursement Linked Indicators	Disbursements to date	Disbursements after restructuring and Bank's acceptance of the 2017 data verification report	Disbursements after restructuring and verification of 2018 data
DLI1	$12,100,015	$1,899,985	
DLI2	$1,158,761	$289,488	$289,488 (estimate)
DLI3	$6,496,315	$3,503,685	
DLI4	$20,000,000		
DLI5	$8,894,331	$1,105,669	
DLI6	$1,243,652	$6,000,000	
DLI7	$5,000,000	$5,000,000	$13,750,000
Unrecovered Advance	$25,000,000		
Disbursement Total	$79,893,074*	$ 17,798,827	$ 14,039,488

* Total disbursed under DLIs + $250,000 front end fee=$80.14 million total disbursement to date

III. SUMMARY OF CHANGES

	Changed	Not Changed
Change in Results Framework	✓	
Change in Loan Closing Date(s)	✓	
Reallocation between and/or Change in DLI	✓	
Change in Disbursement Estimates	✓	
Change in Implementation Schedule	✓	
Change in Implementing Agency		✓
Change in Program's Development Objectives		✓
Change in Program Scope		✓
Change in Cancellations Proposed		✓
Change in Disbursements Arrangements		✓
Change in Systematic Operations Risk-Rating Tool (SORT)		✓
Change in Safeguard Policies Triggered		✓

Change in Legal Covenants		✓
Change in Institutional Arrangements		✓
Change in Technical Method		✓
Change in Fiduciary		✓
Change in Environmental and Social Aspects		✓
Other Change(s)		✓

IV. DETAILED CHANGE(S)

LOAN CLOSING DATE(S)

Ln/Cr/TF	Status	Original Closing Date	Revised Closing(s) Date	Proposed Closing Date	Proposed Deadline for Withdrawal Applications
IBRD-85070	Effective	31-Dec-2019		31-Dec-2020	30-Apr-2021

DISBURSEMENT ESTIMATES

Year	Current	Proposed
2015	0.00	0.00
2016	25,000,000.00	25,000,000.00
2017	23,000,000.00	26,243,652.00
2018	25,000,000.00	11,268,797.00
2019	27,000,000.00	17,380,625.00
2020	0.00	6,838,315.00

ANNEX 1: RESULTS FRAMEWORK

Results framework

Program Development Objectives(s)

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

Program Development Objective Indicators by Objectives/ Outcomes

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
The objective of the program is to expand access to primary health care in targeted rural areas							
Increase in number of pregnant women receiving antenatal care during a visit to a rural ESSP in the Program Area (Text)		161 829	0.97% increase from baseline	2.18% increase from baseline	3.88% increase from baseline	5.83% increase from baseline	19% increase from baseline
Action: This indicator has been Revised	***Rationale:*** ***2019 target is added given the one-year extension. This does not affect DLI targets or disbursement.***						
Increase in number of deliveries of rural women attended by skilled health personnel in public health		180 812	1.71% increase from baseline	3.42% increase from baseline	5.13% increase from baseline	7.26% increase from baseline	7.26% increase from baseline

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
facilities in the Program Area (Text)							
Action: This indicator has been Revised	***Rationale:*** ***2019 target (maintained at the same level as 2018) is added given the one-year extension. This does not affect DLI targets or disbursement.***						
Increase in number of new visits of children under 5 to a rural ESSP in the Program Area for curative care (Text)		1 013 436	1.50% increase from baseline	2.50% increase from baseline	3.50% increase from baseline	5.00% increase from baseline	7.00% increase from baseline
Action: This indicator has been Revised	***Rationale:*** ***2019 target is added given the one-year extension. This does not affect DLI targets or disbursement.***						
Increase in number of patients with diabetes diagnosed and treated at a rural ESSP in the Program Area (Text)		136 238	4.09% increase from baseline	8.62% increase from baseline	13.1% increase from baseline	17.63% increase from baseline	38% increase from baseline
Action: This indicator has been Revised	***Rationale:*** ***2019 target is added given the one-year extension. This does not affect DLI targets or disbursement.***						

Intermediate Results Indicators by Result Areas

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Expanding equitable access to primary care in rural areas							
Increase in number of visits to rural ESSPs in the Program Area (Text)		3,794,877	1.30% increase from baseline	2.30% increase from baseline	3.30% increase from baseline	4.30% increase from baseline	13% increase from baseline
Action: This indicator has been Revised	***Rationale:*** ***The baseline is revised to take medical units into consideration. 2019 target is added given the one-year extension. This does not affect DLI targets or disbursement.***						
Number of patients with hypertension diagnosed and treated in rural ESSPs (Number)		180,000.00	273,000.00	277,000.00	280,000.00	287,000.00	287,000.00
Action: This indicator has been Revised	***Rationale:*** ***2019 target (maintained the same level as 2018) is added given the one-year extension. Not a large increase is expected from year to year.***						
Establishment of a comprehensive GRM (Text)		GRM not established					Roll out of the comprehensive GRM
Definition of an HR incentive mechanism in rural ESSPs (Text)		Diagnostic not completed	Diagnostic study completed				Implementation mechanism defined, including target indicators, performance criteria, and beneficiaries. Legal documents drafted.

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Action: This indicator has been Revised	***Rationale:*** ***End target date is changed to June 30, 2020.***						
Establishment of an HMIS in the Program Area (Text)		HMIS not established	'Urbanization' process completed	'Master Plan" updated and validated	The national digitized health management information system on maternal and child health, family planning, and curative care (SMIPF-SC) has been operationalized in the 100% of public health centers of at least 4 regions within the Program Area		The SMIPF-SC has been operationalized in the 100% of public health centers of all the regions within the Program Area
Action: This indicator has been Revised	***Rationale:*** ***DLRs 7.3 and 7.4 are reformulated to capture the digitization of SMIPF-SC. DLI name is also modified to reflect these changes.***						
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	181,535.00	363,070.00	544,786.00	726,502.00	908,218.00
Action: This indicator has been Revised	***Rationale:*** ***2019 target is added given the one-year extension.***						

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Number of deliveries attended by skilled health personnel (CRI, Number)		0.00	181,535.00	363,070.00	544,786.00	726,502.00	908,218.00
Action: This indicator has been Revised	***Rationale:*** ***2019 target is added given the one-year extension.***						
Improving health system governance at the primary level							
% of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main biennial quality assessment (concours qualité) (Text)		13%	30% of CSCAs in the Program Area participating in the main biennial quality assessment (concours qualité), in CY15	The guide of self-evaluation of rural health centers has been updated in a manner acceptable to the Bank	The Borrower, through its MOH, has approved/adopted the guide of self-evaluation of rural health centers updated under DLR#6.2.		44% of CSCAs in the Program Area have participated in the main biennial quality assessment (concours qualité) and been assessed based on the guide of self-evaluation of rural health centers approved/adopted under DLR#6.3
Action: This indicator has been Revised	***Rationale:*** ***DLRs 6.1, 6.2, 6.3 and 6.4 are reformulated due to the implementation schedule of this quality assessment which is every two years with one transitional year. The MOH was only able to complete two cycles for 2014-2015 and 2017-2018. The name of the DLI is also revised to say "biennial" instead of "annual" quality assessment.***						

Disbursement Linked Indicators Matrix				
DLI 1	Increase in number of pregnant women receiving antenatal care during a visit to a rural ESSP in the Program Area			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	14,000,000.00	0.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	161,829.00			
CY2015			14,000,000.00	
CY2016			0.00	
CY2017			0.00	
CY2018			0.00	
			0.00	
			0.00	
Action: This DLI has been Revised. See below.				
DLI 1	*Increase in number of pregnant women receiving antenatal care during a visit to a rural ESSP in the Program Area*			
Type of DLI	***Scalability***	***Unit of Measure***	***Total Allocated Amount (USD)***	***As % of Total Financing Amount***
Output	*Yes*	*Text*	*14,000,000.00*	*86.43*
Period	***Value***		***Allocated Amount (USD)***	***Formula***

Baseline	*161,829.00*		
CY2015	*0.97% increase from baseline*	*2,329,331.00*	*See description of DLI*
CY2016	*2.18% increase from baseline*	*2,905,660.00*	
CY2017	*3.88% increase from baseline*	*4,082,333.00*	
CY2018	*5.83% increase from baseline*	*4,682,676.00*	
		0.00	
		0.00	

Rationale:
There is no change to this DLI: details are added in the datasheet.

DLI 2	Increase in number of deliveries of rural women attended by skilled health personnel in public health facilities in the Program Area			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	14,000,000.00	0.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	180,812.00			
CY2015			14,000,000.00	
CY2016			0.00	
CY2017			0.00	

CY2018		0.00	
		0.00	
		0.00	

Action: This DLI has been Revised. See below.

DLI 2	*Increase in number of deliveries of rural women attended by skilled health personnel in public health facilities in the Program Area*			
Type of DLI	***Scalability***	***Unit of Measure***	***Total Allocated Amount (USD)***	***As % of Total Financing Amount***
Output	*Yes*	*Text*	*14,000,000.00*	*8.28*
Period	***Value***		***Allocated Amount (USD)***	***Formula***
Baseline	*180,812.00*			
CY2015	*1.71% increase from baseline*		*3,297,521.00*	*See description of DLI*
CY2016	*3.42% increase from baseline*		*3,297,521.00*	
CY2017	*5.13% increase from baseline*		*3,297,521.00*	
CY2018	*7.26% increase from baseline*		*4,107,437.00*	
			0.00	
			0.00	

Rationale:
There is no change for this DLI: details are added in the datasheet.

DLI 3	Increase in number of new visits of children under 5 to a rural ESSP in the Program Area for curative care			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	10,000,000.00	0.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	1,013,436.00			
CY2015			10,000,000.00	
CY2016			0.00	
CY2017			0.00	
CY2018			0.00	
			0.00	
			0.00	
Action: This DLI has been Revised. See below.				

DLI 3	*Increase in number of new visits of children under 5 to a rural ESSP in the Program Area for curative care*			
Type of DLI	***Scalability***	***Unit of Measure***	***Total Allocated Amount (USD)***	***As % of Total Financing Amount***
Output	*Yes*	*Text*	*10,000,000.00*	*64.96*
Period	***Value***		***Allocated Amount (USD)***	***Formula***
Baseline	*1,013,436.00*			

CY2015	*1.50% increase from baseline*	*3,000,000.00*	
CY2016	*2.50% increase from baseline*	*2,000,000.00*	
CY2017	*3.50% increase from baseline*	*2,000,000.00*	
CY2018	*5% increase from baseline*	*3,000,000.00*	
		0.00	
		0.00	

Rationale:
There is no change for this DLI: details are entered in the datasheet.

DLI 4	Increase in number of patients with diabetes diagnosed and treated at a rural ESSP in the Program Area			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	20,000,000.00	0.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	136,238.00			
CY2015			20,000,000.00	
CY2016			0.00	
CY2017			0.00	
CY2018			0.00	

		0.00	
		0.00	

Action: This DLI has been Revised. See below.

DLI 4	*Increase in number of patients with diabetes diagnosed and treated at a rural ESSP in the Program Area*			
Type of DLI	***Scalability***	***Unit of Measure***	***Total Allocated Amount (USD)***	***As % of Total Financing Amount***
Output	*Yes*	*Text*	*20,000,000.00*	*100.00*
Period	***Value***		***Allocated Amount (USD)***	***Formula***
Baseline	*136,238.00*			
CY2015	*4.09% increase from baseline*		*4,639,818.00*	*See description of DLI*
CY2016	*8.62% increase from baseline*		*5,138,968.00*	
CY2017	*13.1% increase from baseline*		*5,082,246.00*	
CY2018	*17.63% increase from baseline*		*5,138,968.00*	
			0.00	
			0.00	

Rationale:
There is no change for this DLI: details are entered in the datasheet.

DLI 5	Increase in number of visits to rural ESSPs in the Program Area			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	10,000,000.00	0.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	3,794,877.00			
CY2015			10,000,000.00	
CY2016			0.00	
CY2017			0.00	
CY2018			0.00	
			0.00	
			0.00	
Action: This DLI has been Revised. See below.				

DLI 5	*Increase in number of visits to rural ESSPs in the Program Area*			
Type of DLI	***Scalability***	***Unit of Measure***	***Total Allocated Amount (USD)***	***As % of Total Financing Amount***
Output	*Yes*	*Text*	*10,000,000.00*	*88.94*
Period	***Value***		***Allocated Amount (USD)***	***Formula***
Baseline	*3,794,877*			

CY2015	*1.30% increase from baseline*	*3,023,257.00*	
CY2016	*2.30% increase from baseline*	*2,325,581.00*	
CY2017	*3.30% increase from baseline*	*2,325,581.00*	
CY2018	*4.30% increase from baseline*	*2,325,581.00*	
		0.00	
		0.00	

Rationale:
The baseline is updated to take mobile units into account.

DLI 6	% of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main annual quality assessment (concours qualité)			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Percentage	8,000,000.00	0.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	11.49			
CY2015			8,000,000.00	
CY2016			0.00	
CY2017			0.00	
CY2018			0.00	

		0.00	
		0.00	
Action: This DLI has been Revised. See below.			

DLI 6	*% of rural health centers with delivery services (CSCAs) in the Program Area that participate in the main biennial quality assessment (concours qualité)*			
Type of DLI	***Scalability***	***Unit of Measure***	***Total Allocated Amount (USD)***	***As % of Total Financing Amount***
Output	*Yes*	*Text*	*8,000,000.00*	*15.55*
Period	***Value***		***Allocated Amount (USD)***	***Formula***
Baseline	*13%*			
CY2015	*30% of CSCAs in the Program Area participating in the main biennial quality assessment (concours qualité), in CY15*		*2,000,000.00*	
CY2016	*The guide of self-evaluation of rural health centers has been updated in a manner acceptable to the Bank*		*2,000,000.00*	
CY2017	*The Borrower, through its MOH, has approved/adopted the guide of self-evaluation of rural health centers updated under DLR#6.2.*		*2,000,000.00*	
CY2018	*44% of CSCAs in the Program Area have participated in the main biennial quality assessment (concours qualité) and been assessed based on the guide of self-evaluation of rural health centers approved/adopted under DLR#6.3*		*2,000,000.00*	
			0.00	

		0.00	

Rationale:
DLRs 6.1, 6.2, 6.3 and 6.4 are reformulated due to the implementation schedule of this quality assessment which is every two years with one transitional year. The MOH was only able to complete two cycles for 2014-2015 and 2017-2018. The name of the DLI is also revised to say "biennial" instead of "annual" quality assessment.

DLI 7	Establishment of the HMIS in one region within the Program Area			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	24,000,000.00	0.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Not established			
CY2015			24,000,000.00	
CY2016			0.00	
CY2017			0.00	
CY2018			0.00	
			0.00	
			0.00	

Action: This DLI has been Revised. See below.

DLI 7	Establishment of an HMIS in the Program Area			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	23,750,000.00	21.05
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Not established			
CY2015	Urbanization process complete		5,000,000.00	
CY2016	Master Plan updated and validated		5,000,000.00	
CY2017	The national digitized health management information system on maternal and child health, family planning, and curative care (SMIPF-SC) has been operationalized in the 100% of public health centers of at least 4 regions within the Program Area		7,000,000.00	
CY2018	The SMIPF-SC has been operationalized in the 100% of public health centers of all the regions within the Program Area		6,750,000.00	
			0.00	
			0.00	

Rationale:
DLRs 7.3 and 7.4 are reformulated to capture the digitization of SMIPF-SC. DLI name is also modified to reflect these changes.

ANNEX 2: PROGRAM ACTION PLAN

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement	Action
Finalize the POM by incorporating the new procedures of the National Plan for Medical and Pharmaceutical Waste Management.			Client	Due Date	31-May-2016		No Change
The responsible persons in the seven targeted regions will ensure follow up of environmental aspects according to regulation (decret 2009).			Client	Due Date	31-Dec-2018		Revised
Proposed The responsible persons in the seven targeted regions will ensure follow up of environmental aspects according to regulation (decret 2009).	Environmental and Social Systems		Client	Due Date	30-Jun-2020	---	
Creation of a budgetary line in the annual Budgetary of MoH regional directorate and of MoH delegations to externalize the medical and pharmaceutical waste management at the ESSP levels			Client	Due Date	30-Mar-2018		No Change
The seven target regions implement the			Client	Due Date	31-May-2019		Revised

externalization of the medical and pharmaceutical waste management.							
Proposed The seven target regions implement the externalization of the medical and pharmaceutical waste management.	Environmental and Social Systems		Client	Due Date	30-Jun-2020	---	
The diagnosis of the current GRMs, the strategy and the draft GRM implementation manual are completed.			Client	Due Date	31-Dec-2015		No Change
The pilot GRM was completed and the GRM is scaled up is at national level.			Client	Due Date	30-Dec-2016		No Change
The pilot GRM is evaluated and the implementation manual is reviewed.			Client	Due Date	31-Dec-2017		No Change
The GRM is rolled out at the regional level.			Client	Due Date	31-Dec-2021		Revised
Proposed The GRM is rolled out at the regional level.	Environmental and Social Systems		Client	Due Date	30-Jun-2020	---	
Audit: 1) Setting up of internal audit and management control functions at the central and regional levels of the MoH. At the			Client	Due Date	31-Dec-2019		Revised

regional levels, these functions will be located within the Regional directorate of Health.							
Proposed Audit: 1) Setting up of internal audit and management control functions at the central and regional levels of the MoH. At the regional levels, these functions will be located within the Regional directorate of Health.	Fiduciary Systems		Client	Due Date	30-Jun-2020	---	
Audit: 2) Agree on improved terms of reference for audit, including procurement and governance.			Client	Due Date	09-Jun-2017		No Change
Support to the implementation of the new PFM framework and organic finance law. This involves support in the preparation of a multi-year budget and a draft performance plan, contracting and monitoring and evaluation system.			Client	Due Date	31-Dec-2019		Revised
Proposed Support to the implementation of the new PFM	Fiduciary Systems		Client	Due Date	30-Jun-2020	---	

framework and organic finance law. This involves support in the preparation of a multi-year budget and a draft performance plan, contracting and monitoring and evaluation system.							