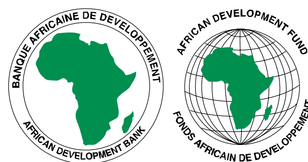
AFRICAN DEVELOPMENT BANK GROUP



MOROCCO

REVIEW OF THE BANK'S ASSISTANCE TO THE HEALTH SECTOR

OPERATIONS EVALUATION DEPARTMENT
(OPEV)

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LIST OF ABBREVIATIONS AND ACRONYMS

ADF	:	African Development Fund
ADB	:	African Development Bank
AIDS	:	Acquired Immunodeficiency Syndrome
BAJ	:	Barnamaj Al Aoulaouaiyat Al Iltimaiya (Social Priorities Programme)
BRD	:	Basic Rural Dispensary
CHC	:	Community Health Centre
CHCD	:	Community Health Centre with Delivery Unit
CSP	:	Country Strategy Paper
DH/DHS	:	Dirham
BHCE	:	Basic Health Care Establishment
GDP	:	Gross Domestic Product
IAEA	:	International Atomic Energy Agency
IEC	:	Information-Education-Communication
NQ	:	Nurses Quarters
LH	:	Local Hospital
DQ	:	Doctors Quarters
NGO	:	Non-Governmental Organization
NICT	:	New Information and Communication Technologies
PARCOUM	:	Medical Cover Reform Support Programme
PIU	:	Project Implementation Unit
PRSSB	:	Basic Health Care Improvement Programme
RD	:	Rural Dispensary
STD	:	Sexually Transmitted Disease
UA	:	Unit of Account (ADB)
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Fund for Population Activities
UNICEF	:	United Nations Children's Fund
UNWDF	:	United Nations Women's Development Fund
USAID	:	United States Agency for International Development
WHO	:	World Health Organization

EXECUTIVE SUMMARY

1. *Objective, Scope and Methodology of the Evaluation.* The evaluation of the Bank's health policy in Morocco aims at examining the Institutions health policy and strategies as well as the performance of its assistance relating to the lending and non-lending activities in the sector. The evaluation makes it possible to learn lessons with a view to strengthening the Bank's policy and strategies and improving the quality of future operations. The study bears on the 1994-2004 period and is based on documentary analysis and interviews conducted with the Bank's experts and with those of Morocco and other development partners during the mission from 11 to 28 April 2005.

2. *Socio-economic Context.* The economic reforms being implemented by the Moroccan Government since the early eighties led to good economic performances, which however did not significantly improve the living conditions of the disadvantaged population. The country is faced with high levels of poverty, unemployment as well as social and regional inequalities. Thanks to the Government's efforts to develop the public health system, the number of basic public health facilities increased from 1,683 to 2,267 between 1992 and 2000, and the number of general and specialized hospitals rose from 98 to 112 over the same period. In 2003, Morocco's population was estimated at 30.6 million inhabitants, 56.8 % of whom were urban dwellers. Life expectancy increased considerably, from 48 years in 1967 to 70.8 in 2003. However, the progress achieved remained inadequate for certain health indicators such as maternal and infant mortality rates, which have remained relatively high. The 2005 Development Report of the United Nations Development Programme ranked Morocco 125th out of 177 countries on the Human Development Index, behind Tunisia and Algeria. Only 15 % of the population enjoys health insurance cover whereas the rural and poor segments of the population find it difficulties to obtain access to health services.

3. Morocco is experiencing a demographic and epidemiological transition characterized by a reduction in communicable diseases – infectious and parasitic – and an increase in non-communicable diseases. Among the non-communicable diseases on the increase are arterial hypertension, cardio-vascular diseases, diabetes, certain types of cancer, emotional and mental disorders, traumatic injuries, etc. The rise in sexually transmissible diseases is due to risky sexual behaviors.

4. *Policy and Strategy of the Government and the Bank.* The Government's policies mainly aim at: a) developing basic health care; b) developing health programmes aimed at reducing infant mortality, introducing birth spacing and improving the nutritional status of the mother and child; and c) expanding health facilities in the rural areas. The demographic changes produced a costly demand for health care, owing to the increase in chronic and degenerative diseases. Access to health care remained limited for the rural population. The Government therefore embarked on a health reform focusing on the expansion of medical cover with a view to reducing the geographical and social inequalities regarding access to health care. The Bank's assistance strategy conformed to priorities defined by the country.

5. *Results of the Evaluation of the Bank's Assistance.* Overall, the Bank's assistance is deemed unsatisfactory. The Bank's financing was channeled mainly towards the realization of construction and infrastructure-development activities. Technical assistance was inadequate and the Bank's contribution to political dialogue was unsatisfactory. Likewise, performance in the area of humanitarian assistance was insufficient. The Bank's assistance contributed significantly to improving health cover in the rural areas. However, the assistance was not efficacious owing to the delay in the construction of health facilities, inadequate quality of the buildings, and lack of medical personnel. The Bank's assistance contributed little to building institutional capacities in the health sector. The Government's maintenance and repair measures are currently inadequate to guarantee enhanced sustainability of the health facilities.

6. *Recommendations to the Government.* The Government should: a) ensure that all the activities envisaged in the lending agreements are carried out with a view to ensuring optimum impact of the Bank's assistance; b) adopt a policy for the planning and management of human resources with significant incentives for health facilities in the rural areas; c) ensure effective maintenance of health facilities and biomedical; d) put in place a system for the treatment of solid waste in all health facilities; e) ensure that all stakeholders are actually involved in the different phases of the health project cycle for enhanced utilization and ownership.

7. *Recommendation to the Bank.* The Bank should: a) improve the quality of its assistance in the social sector, including non-lending activities including technical assistance and sectoral studies; b) before embarking on investments of a certain magnitude, ensure that there are no political changes that might impede the realization of the objectives; and c) improve its performance in humanitarian assistance by rapidly releasing funds to the institution entrusted with its management.

I. BACKGROUND

1.1 Evaluation Objectives

The evaluation of the Bank's assistance to Morocco's health sector aims at examining the Bank's policy and strategies in the sector with a view to appraising their coherence with policies and strategies defined by the Moroccan authorities. It also aims at evaluating the performance of the Bank's assistance in the sector. Finally, it makes it possible to learn lessons from the activities funded, with a view to strengthening the Bank's policies and strategies and improving the quality of future operations.

1.2 Scope and Methodology

1.2.1 The evaluation is based on documents gathered in the Bank and interviews with operations experts. It is equally based on information collated and discussions held by the Bank's evaluation mission to Morocco from 11 to 28 April 2005. These discussions were held with the Moroccan authorities involved in the management of the Bank's funding in the social sector. The evaluation mission also visited three health facilities (a local hospital, a community health centre with a delivery unit and a rural dispensary) constructed with the Bank's funding and situated in the rural area in the *Chefchaouen* province. During the mission, discussion sessions on issues of evaluation were held with the directors of the health facilities. Lastly, the evaluation also took into account documents collected from and discussions held with health development partners in Morocco, including the World Bank, European Union, UNDP, UNIFEM, and UNAIDS.

1.2.2 The report describes the background, including the principal challenges of the health sector, and the Government's health strategy. It describes and analyses the Bank's assistance in the form of lending and non-lending activities, evaluates the performances of the Bank, Government and other stakeholders and finally draws lessons and makes recommendations to the Government and the Bank.

1.3 Socio-Economic Context

1.3.1 Further to the economic reforms, Morocco has recorded satisfactory macro-economic results since the beginning of this new century. However, the country still has high levels of poverty, unemployment, and social and regional inequalities. With a human development index of 0.631 in 2003, Morocco was ranked 124th out of 177 countries, behind Tunisia and Algeria[1]. As regards poverty, it is still a widespread phenomenon in Morocco. It is estimated that about 5.4 million Moroccans – i.e. about 19% of the total population – lived below the poverty threshold in 2001[2]. The appraisal report of the 2000-2004 Five-Year Plan indicated that the 2004 poverty level did not improve in comparison with that of 2002. The anti-poverty policies mainly benefited the urban areas where the poverty rate fell from 12% in 1998 to 9.6% in 2001 whilst, at the same time, that of the rural areas appeared to have worsened, from 27.2 % to 28.8 % over the same period[3].

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[1] HDR 2005, Country Fact Sheets: Morocco.
[2] Set at one American dollar per day.
[3] AfDB/OECD 2004, Economic Prospects for Africa, 2004, to be published.

1.3.2 Employment remains a considerable national concern. The good macro-economic results have not yet led to a reduction of the unemployment rate, which was brought down from 12.5 % in 2001 to 11.6 % in 2002 and subsequently 11.9 % in 2003[4]. Joblessness affects young graduates more than the unqualified, who are less demanding in terms of job opportunities and employment. In 2003, unemployed young graduates accounted for 24 % of the jobless, whilst this rate was 5.7 % for non-graduates. The unemployment rate was higher among women than among men, which accentuated inequalities to the disadvantage of women. The female workforce comprised between 25 and 30 % of women.

1.3.3 The Moroccan Government undertook a series of initiatives to deepen the economic reforms and improve the living conditions of the people, especially the most disadvantaged. In that regard, rural electrification, drinking water supply to rural areas, health care and basic education, roads and feeder roads and the eradication of precarious settlements, were adopted as national priorities.

1.3.4 In the area of health, Morocco is undergoing a quite advanced evolution of its health sector but lags behind other comparable countries. Life expectancy at birth appreciated from 48 years in 1967 to 70.8 in 2002[5]. The increase was the result of improved living conditions but also that of the health programmes which reduced, and sometimes eradicated, some diseases such as malaria, tuberculosis, measles, neo-natal tetanus, diphtheria, etc. The health transition was however accompanied by an increase in the prevalence of some diseases such as arterial hypertension, cardio-vascular diseases, diabetes, certain cancers, emotional disorders, traumatic injuries, etc.

1.3.5 In 2001, about 10% of the population of over 20 years presented signs of diabetes, the prevalence of arterial hypertension in the adult population was around 30 %, and depression accounted for over 15 % of consultations. The total number of motor traffic accidents rose from 24,238 in 1981 to 52,137, that of the injured from 32,224 to 81,365, and that of fatalities from 2,320 to 3,761, i.e. an annual increase of 10.9 % for accidents, 13.2 % for the injured, and 6.9 % for fatalities. Furthermore, exposure to sexually transmissible diseases is on the increase owing to risky sexual behaviour. The first case of AIDS was reported in 1986. In 2004, the prevalence rate of HIV/AIDS in pregnant women was 0.13%, a relatively low rate, but the number of AIDS cases reported each year is on the increase[6].

[4] The 2003 figures show that the unemployment rate seems to be on the decline, going from 12.3% to 10 % between the third quarter of 2003 and that of 2004.

[5] That is equivalent to the developed countries' life expectancy in 1970. Australia: 70.8 yrs., Germany: 70.4 yrs; Finland: 70.8 yrs; United States: 70.9 yrs.

[6] Ministry of Health, National AIDS Control Strategy, 2005.

1.3.6 In 2002, health expenditures were 4.4% of the GDP as against 5 % in the nineties, and 7% in the sixties 1960[7]. Generally insufficient, the health resources were allocated in an extremely inequitable way within the population. The equity index of health financing drawn up by WHO in its *Report on Health in the World* in 2000, indicates that Morocco ranked 126th out of 191 countries. That implies the existence of considerable disparities and the fact that a large part of the population benefits very inadequately from health expenditure.

1.3.7 Life expectancy increased considerably, but certain health indicators, such as the rate of maternal and infant mortality, lagged. Vaccination was generalized in the whole country but, in the rural areas, access to health services was limited and their quality, mediocre. The health insurance cover catered for only 15 % of the population. Over the period 1990-2002, the rate of infant mortality decreased by more than half, from 101.4 ‰ in 1990 to 42.1‰ in 2002. This rate was slightly lower than that of Algeria (43.9 ‰) and almost double that of Tunisia (23.3 ‰). The maternal mortality rate reduced from 332 to 228 maternal deaths per 100,000 live births between 1990 and 1997[8]. Maternal and infant health programmes undertaken for several years, including in the framework of the Bank's assistance, contributed without doubt to this result.

1.4 Brief Background of Relation between the Country and the Bank

1.4.1 With other donors, the Bank participated in the implementation of projects drawn up by the Moroccan Government, including reform projects with a view to attaining the objectives of its economic and social development policy. The Bank's interventions in Morocco started in 1970 and related to various areas: lines of credit open with local banks for small and medium-sized enterprises, loans to the Treasury to fund the implementation of structural adjustment plans, diversification and improvement of crops in the agricultural sector, improvement of the transport and communications sector, drinking water supply, improvement of access to health and education, and emergency aid during the natural disasters of 2002 and 2004 when the country was afflicted by floods and earthquake.

1.4.2 Cooperation between the Bank and Morocco intensified over the years, and the Bank's net commitments amounted to UA 3,077.5 million in 2003. The closure in 1995 of the regional office in Rabat covering Algeria, Egypt, Libya, Morocco, Sudan, and Tunisia, hampered the Bank's capacity to intervene in policy formulation, definition of the country's development strategies and coordination with the other development partners. It also handicapped some project executing agencies which did not have budgetary allocations to cover the cost of communications with the Bank– expenses hitherto borne by the regional office. The Bank intends to open a field office in Morocco by the end of 2005.

[7] According to WHO, the norm should be 10% of GDP for health expenditure. Averagely, OECD countries spend over 8 % of GDP on health. This percentage is higher than 10 % for the United States, Switzerland and Germany. See OECD, Towards High Performance Health Systems, 2004.

[8] More recent statistics not available.

II. GOVERNMENT POLICIES AND STRATEGIES

2.1 Since its adherence to the "Health for All" approach in 1980, Morocco has developed a health policy mainly focused on basic health care. The economic and social development plans being implemented since that period have geared their actions towards: a) improvement of medical cover in terms of infrastructure and medical personnel; b) improved management; c) deployment of programmes aimed at reducing the level of child mortality; and d) reform of the health system with a view to improving its funding.

2.2 This policy enabled the population, including that of the rural area, to improve access to health care. However, owing to population increase, the health-care offer remained short of demand. Population changes entailed a demand for costly care owing to an increase in chronic and degenerative diseases. Despite the progress made, access to care remained limited for a large part of the population. A 1998-99 household survey revealed that, owing to the high cost of health delivery, over 34% of sick people did not seek medical treatment. This rate was 55 % for a fifth of the population representing the poorest segment.

2.3 Consequently, as part of the 2003-2007 Plan of Action, the Government undertook the reform of the medical cover which provides for the establishment of compulsory health insurance for employees in the private and public sectors and their dependants, and a medical assistance regime for the disadvantaged populations. The plan also aimed at reducing inequalities, improving quality, increasing the basic health services coverage and improving the efficiency of the system.

2.4 The success of these different reform measures is contingent on the removal of a number of constraints: a) the policy of voluntary departures from the civil service, including early retirement, could hamper the operation of the health facilities; b) restrictions on the recruitment of new personnel will compound the workload; c) the current level of public health financing is still inadequate; and d) the Moroccan pharmaceutical industry is prosperous but is largely dependent on the outside world for its supply of raw materials, operating licenses and the transfer of technology.

III. REVIEW OF THE BANK'S ASSISTANCE STRATEGY

3.1 The Bank's Health Sector Policy and Strategy for the Country

3.1.1 The Bank's assistance in the health sector started in 1975 but it was not until 1987 that the institution adopted a health policy to governing its operations. The Bank's policy analyzed the health challenges in Africa and mapped out guidelines for funding the sector. The policy underpinned the need to improve the skills of medical personnel as well as enhance the management of health services. The policy was revised in 1996 to take account of the new health challenges, especially the HIV/AIDS pandemic. The new policy stresses that health programmes were organized and managed vertically and that a considerable part of the funding often went to curative care in the city at the expense of the rural areas. It also stresses that a health policy built on basic health care would be more suitable for improving access to health.

3.1.2 The policy recognizes the importance of the financing of health services in the fight against poverty and advocates the involvement of partners and stakeholders in the design of health projects and programmes, mobilization and utilization of resources.

3.1.3 Despite the Bank's will to prioritize the health sector, the latter was not accorded any special attention. The health sector's share in the assistance did not increase, and varied around 4 % of total assistance over the whole period until December 2004. The same goes for the share of the number of health projects in the total number of projects. The report on the Bank's experience in rural health prepared in 1999 indicated that 80 % of the funding was geared towards the construction of infrastructure. The Bank was not sufficiently influential in the orientation and choice of health policies in the regional member countries.

3.1.4 Until 1996, the Bank Group's assistance to the health sector in Morocco was based on strategies defined in the *Economic Prospects and Country Programming Papers* (EPCP). After that date, it was based on the *Country Strategy Papers* (CSPD). During the period under review, the Bank drew up an EPCP covering the period 1994-1996 and three CSPs covering the periods 1996-1998, 2000-2002, and 2003-2005. The successive strategies of the Bank bore especially on support to the different economic and social reform programmes implemented by Morocco since 1983. In that framework, Morocco accorded greater importance to the enhancement of human resources.

3.1.5 The Bank's strategy advocated an integrated approach based on the complementarity of the social sectors including health, education and the enhancement of the status Women. In line with that vision, the Bank granted Morocco a UA 150 million loan in 1998 to support the implementation of a multi-sector programme referred to as the *Economic and Social Reform Programmes (ESRP)* aimed at improving the economic environment with a view to achieving considerable economic growth and reducing poverty.

3.1.6 The health sector received little assistance which was limited to two lending operations and two humanitarian aid operations. In 1992, the Bank assisted the country to improve the health situation of the populations in 10 disadvantaged rural provinces by expanding the network of Basic Health-Care Facilities (BHCF) and combating certain endemic diseases in the country. In 2000-2002, the Bank supported the Government policy in the reform sector, especially regarding the expansion of health-care insurance.

3.2 Relevance of the Bank's Strategies

The Bank's assistance to Morocco's health sector of was relevant. It supported the country in its efforts geared towards an expansion of the health cover with a view to consequently increasing access to health, particularly in the rural areas. The Bank also supported the country in the reform of the health system with a view to adapting it to the new epidemiological situation characterized by the increase in non-communicable diseases linked to the ageing of the population. The reform also bore on the unequal access to health care arising from the social or geographical situation.

IV. EVALUATION OF RESULTS: LENDING OPERATIONS

4.1 Lending Operations: Composition and Status

4.1.1 The Bank started its social sector operations in 1985 through fundings in the education sector. To date, the Bank has funded eight lending operations in the social sector, six in the form of project loans, one policy-based lending operation in the education sector, and a sectoral adjustment loan in the framework of medical cover reform. The net amount of these operations was UA 328.17 million, i.e. 12.5 % of the Bank's cumulative net commitments at 31 December 2004. As Morocco was no longer eligible for ADF concessional resources since 1998, most of the funding came from ADB resources i.e. a total amount of UA 296.83 million. ADB funding therefore accounted for 90.5 % of all net commitments in the social sector. The first assistance in the health sector dates back to 1992.

4.1.2 The total amount of loans funded in the health sector was of UA 122.1 million, accounting for 4.7 % of the Bank's net cumulative commitments at 31 December 2004, and 37.2 % of net commitments in the social sector. Table 1 sets out the situation of the two operations funded by the Bank.

Table 1
Operations funded by the Bank in the Health Sector

Project	Source of Finance	Lending Instrument	Approval Date UA Million	Completion Date	Amount Approved UA million	Net Amount	Disbursement Rate %
Improving basic health care (PRSSB)	ADF ADB	PL PL	8/24/1992 8/26/1992	31/12/04 30/06/04	18.4 18.5	16.2 13.9	70 76
Medical cover reform support (PARCOUM)	ADB	SL	12/12/2002	31/12/05	92	92	50
Total	-	-	-		128.9	122.1	-

SL= sectoral adjustment loan, PL=Project loan

4.1.3 The deadline for the disbursement of PRSSB was 31 December 2004[9]. As regards PARCOUM, there was a low level of implementation. The first tranche of the funding was disbursed in February 2005. This delay was attributed to the condition relating to the law on the national health system and care delivery in respect of which the Government requested a waiver to carry the conditionality over to the second tranche. Consequently the evaluation mainly bears on the PRSSB, which is already completed.

4.2 Relevance

The Bank's assistance was deemed relevant since it met the priority needs of the country, namely, increase in medical cover and improvement of the quality of health care. These interventions were therefore mainly geared towards the rural areas, which have less medical

[9] Since the Government's completion report is still under preparation, the mission obtained copy of the provisional report from the project implementation unit.

facilities and personnel than the urban areas. They also bore on the expansion of health insurance including for underprivileged persons. These operations thus constituted a factor of equity insofar as they were targeted at the disadvantaged areas and social categories.

4.3 Quality at Entry Point

4.3.1 Generally, the Bank's assistance in the health sector was well prepared. In collaboration with the Government, the different preparation and appraisal missions enabled the Bank to properly identify and select the different sectors of assistance. As regards the PRSSB, the Bank intervened on the basis of the findings of a general in-depth study in the health and population sector carried out by the Government. Nonetheless, this first Bank operation in the health sector did not adequately appraise the various difficulties inherent in the rural health infrastructure.

4.3.2 Indeed, the aim of expanding health cover in the country did not take sufficient account of the lack of medical personnel and the difficulties of rendering the Basic Health-Care Facilities (BHCF) viable in terms of geographical access, water supply, drainage and sources of energy, including electricity. For its interventions, the Bank depended on the Government's commitment to assign to these facilities the required medical and para-medical personnel, a commitment to the Government did not honour. Consequently, the creation of health facilities was not always followed by measures to render them viable or to assign medical staff thereto, which adversely affected the operation of a good number of them. Nor did the Bank take account of certain other aspects such as the treatment of bio-medical waste.

4.3.3 It is important to note that, within the framework of the 1994 hospital reform, the Government altered the architectural design of health facilities after project appraisal. Consequently, a new BHCF typology in the rural area was introduced with areas reduced to a third of those of the former health facilities and administrative quarters. The Bank did not evaluate the impact of the change on the project. The new health facilities consequently proved non-functional since the space available was too small compared to what is required for a proper organization of health-care delivery. Moreover, almost 75 % of Community Health Care Centre (CHC) prototypes proved extremely complicated and the local enterprises found it difficult to construct them.

4.3.4 The design of the buildings had defects and errors in relation to the socio-cultural context. Technically, the design of the buildings did not always take due account of all the aspects required for the smooth operation of a medical service. At the *Bab Taza* hospital in the *Chefchaouen* province, which serves a total population of 62 084, access to the delivery room was so narrow that the gurney that conveys parturient women was unable to enter. The women were therefore obliged to get off the gurney and walk to the room. The X-ray room was also so cramped, and the operator was not insulated against the X-rays. It must equally be noted that the hospital design did not provide for a casualty unit. As regards the socio-cultural aspects, there was no distinction between men's and women's toilets, which constituted a bother for the patients who were obliged to use the same toilet facilities in a region where men and women are separated in public places. These defects imply that medical personnel as well as beneficiary populations were not involved in the architectural design, which could have prevented most of the defects.

4.4 Effectiveness

4.4.1 The Bank's assistance provided for the building of medical infrastructure in rural areas – hospitals, health centres and dispensaries – as well as the construction of official quarters for doctors and nurses. Equally, there were plans to supply the provincial workshops with technical equipment to maintain the vehicle pool, as well as the procurement of 10 mobile maintenance workshops mounted on trucks. Finally, the assistance focused on support to six national disease-control programmes, namely, school and university health-care services, the fight against acute respiratory infections, leishmaniasis control, STI/AIDS control, treatment and prevention of iodine deficiency, and maternal and infant health care.

4.4.2 As indicated in Table 2, the re-evaluation of the number of health facilities to be set up or rehabilitated under the new health policy reviewed the number of these facilities upward from 508 in 1992 to 1,013 programmed for 1994. Table 2 also indicates that the Bank's assistance facilitated the construction of 917 health facilities i.e. 80 % more than the infrastructure provided for at appraisal of the PRSSB, 53 % of which are accommodation for doctors and nurses.

4.4.3 The infrastructure developed comprised 22 local hospitals (LH), 82 Community Health Centres with delivery rooms (CHCD), 182 Communal Health Centres (CHC), 146 Rural dispensaries (RD), 259 doctors' quarters (DQ), and 236 nurses' quarters (NQ). In relation to the projections, 47 facilities were not constructed owing to the abandonment of sites, suspension of works due to bankruptcy of the companies or breaches of contract, and sites that were yet to start operations. Furthermore, the fence walls of some health facilities were not constructed. Regarding equipment, ambulances (52) and motorcycles (166), medico-technical equipment, furniture, drugs and supplies were delivered to the health facilities, outpatient units, provincial maintenance units, as well as to the priority programmes. However, the Government could not establish the system for maintaining the initially-projected health infrastructure and bio-medical equipment since the trucks that should have facilitated upkeep and maintenance works were not procured.

Table 2
BHCF: Projections and Achievements

	Projected	**Modifications**	**Modifications**	**Drawn-up list**	**Built**	**Not Completed**
Type	At appraisal 1992	1993	1994	30-June-04		
RH	12	12	22	22	22	
RHC	18					
CHCD		29	74	90	82	2
RD	48	164	171	168	146	17
DRB	120		9			
CHC		143	192	188	182	1
Sub-total	**186**	**348**	**468**	**468**	**432**	**21**
DQ	43	183	288	271	259	10
NQ	274	356	257	262	236	17
Sub-total	**317**	**539**	**545**	**533**	**495**	**27**
Total	**503**	**887**	**1013**	**1001**	**917**	**47**

Source: PRSSB Implementation Unit, Morocco

4.4.4 The activities covered by the six health programmes concerned, among other things: a) diagnostic and situation-evaluation studies; b) IEC campaigns; c) screening and treatment, including in educational establishments; d) preparation and implementation of a national strategy for sensitization on and treatment of STIs/AIDS; e) improvement of access to anti-retrovirals; and f) improvement of health delivery in reproductive health services, etc. It must be emphasized that, albeit indispensable for capacity building, the training activities were abandoned. The same goes for the initially projected surveys and research activities.

4.4.5 The Bank and Government did not accord sufficient importance to the establishment of a monitoring and evaluation mechanism for the operations. The number of constructed and functional BHCFs is therefore only approximate. The Bank's inventory mission to Morocco from 23 June to 24 July 2004, which covered 78 % of the sites, estimated that 88 % of the facilities were functional. These facilities offered a minimum package of activities according to their type and personnel available. As for the outpatient and mobile services, their operation was ensured by transferring staff from the Centre to the populations, which enabled them reach populations in the most remote areas despite the insufficient number of doctors, nurses and midwives.

4.4.6 In July 2004, the BHCF network covered about 3 346 900 inhabitants. Initially in 1992, the 10 provinces concerned by the Bank's assistance were covered by a network of 374 basic health facilities. The construction of 432 additional health facilities made it possible to expand the network's activities by over 125 %. Before the Bank's assistance, only 52 % of the population was less than 10 km away from a BHCF. This proportion later increased to 72 %. In 2000, the staff population of BHCFs constructed thanks to the Bank's funding accounted for 19 % of the total staffing level of the BHCFs at national level.

4.4.7 For instance, the new infrastructure improved the working conditions of the personnel of the *Bab Taza* local hospital and contributed to giving more prestige to the medical profession and an extremely positive image of medicine, to which the population could have recourse in case of illness and emergencies.

4.4.8 The country is well covered by the BHCFs but was access thereto is sometimes difficult and that limits their attendance. In fact, part of the localities that benefited from the Bank's assistance was situated in mountainous areas to which access is difficult owing to the defective state of the roads and feeder roads and the virtually inexistent means of transport.

4.4.9 The main priority programmes which benefited from the Bank's support are: a) reproductive health; b) malaria control; c) eye diseases; d) the fight against diarrhoeal diseases; e) acute respiratory infections; f) leishmaniasis; g) STIs/AIDS; and h) school and university health care services.

4.4.10 According to health statistics, the prevalence of various diseases targeted by Bank-funded operations considerably reduced and some, such as leishmaniasis, are on the point of being eradicated. This disease developed in 1977 as an epidemic and there was no national programme to control it. At the moment, the situation is under control and the disease no longer constitutes a public health concern. In 2002, the incidence of cutaneous leishmaniasis cases per 10,000 exposed inhabitants was 9.9. For cases of visceral leishmaniosis, the rate of prevalence per 10,000 inhabitants of under 15 years was 2.3.

4.4.11 As regards HIV/AIDS, Morocco currently remains a country with low prevalence but the progression of the pandemic is still a matter of concern despite the considerable achievement in epidemiological surveillance, prevention and patient care, and involvement of civil society. The cumulative number of cases over the period 1986-2002 was 1,113, 26.7 % of whom were women. There has been an increase in the number infected people, especially as from 1993, and women are increasingly affected.

4.5 Efficiency

4.5.1 For diverse reasons, the Bank's assistance was deemed inefficient. These reasons include: a) delays in the construction of infrastructure, b) poor quality of some infrastructure and which are not serviced; and c) problems relating to the operation and utilization of health facilities.

4.5.2 As regards the delays, the construction of health facilities required double the time projected, i.e. 10, instead of 5, years. Despite this long delay, the Government cancelled 25 % of the funding. The quality of the infrastructure was variable depending on the architectural prototype and sites. Most of the works had defects, including poor dosage of reinforced concrete, tiles not well laid and iron rods improperly encased in concrete.[10] Some health facilities have been operating for several years without water, or with a damaged sanitation system. Others did not have energy installations or, if they did, could not use them due to inadequate power. About 4 % of BHCFs were shut down due to lack of medical personnel. The laboratories and X-ray departments were not used owing to lack of skilled personnel, and the admissions unit and kitchen in the local hospitals lacked financial resources to ensure their operation.

4.5.3 Overall, the increase in the number of BHCFs in the country did not result in greater attendance by the population. The number of medical consultations increased from 7.2 million in 1996 to 10.4 million in 2000, i.e. an average growth of 8 % per year. However, as regards the para-medical consultations - services mainly provided by BHCFs, - the number virtually stagnated, going from 17.3 million to merely 17.5 million over the same period. Owing to the high cost of care, drugs and low social security cover, part of the population still prefers renouncing recourse to medical care.

4.6 Impact on Institutional Development

The impact of the Bank's assistance on institutional development was deemed unsatisfactory. The Bank contributed to strengthening the basic health-care-facilities network in the country by constructing and equipping the BHCFs and by supporting the establishment of outpatient and maintenance units. However, the activities carried out did not sufficiently contribute to improving the management capacities of the health sector. Indeed, the Government renounced the implementation of the projected training of medical staff. Nonetheless, the matrix of PARCOUM measures comprised important activities for building the institutional capacity of the Ministry in the organization of health-care delivery, establishment of a drugs policy and establishment of a unified information system.

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[10] Ref. Report of the Bank's inventory mission.

4.7 Sustainability

4.7.1 Maintenance of the constructions and equipment of the BHCFs were ensured, as the case may be, by provincial delegations that resorted to the regional maintenance unit. The geographical dispersion of health facilities was not followed up with a policy to decentralize maintenance services to the provincial delegations. Consequently, the visits by the regional maintenance units were so rare that a health facility could remain paralyzed for a long time by a mere breakdown. Most of the health facilities had no current maintenance system, and this type of service was provided benevolently by the medical and para-medical personnel.

4.7.2 The preservation of buildings was sometimes in a critical state. Some constructions showed signs of advanced disrepair such as cracks in the walls, problems of waterproofing and seeping water, as well as external coating exposed to climatic hazards. Regarding health facilities that were not functional as a result of lack of personnel, the number of positions available each year remained extremely insufficient to bridge the staffing gap accumulated over the years, make up for retirement, and meet the needs of the newly commissioned facilities.

4.8 Consideration of and Impact on Cross-cutting Issues

Gender

4.8.1 The Bank's assistance was considerably beneficial to women, who resort to the medical facilities more than men. This is because a large part of the activities of medical facilities comprised family planning, pre-natal and post-natal consultations, as well as deliveries.

Environment

4.8.2 Hospital waste management constitutes a serious problem for health authorities. According to the Ministry of Health, the annual volume of waste produced by all sectors, including the pharmaceutical industry, is estimated at around 31,000 metric tons. Public hospitals produce over 50 %, and there is no well-established strategy for hospital waste treatment. The system of incineration of bio-medical waste was abandoned owing to risks of pollution. On the other hand, a system of crushing the waste produced by health facilities is being experimented by the Ministry of Health. Meanwhile, the BHCFs including those put up with the Bank's assistance did not have any waste recycling or treatment mechanism. The processes used were incineration, crushing and sterilization. Sometimes, the waste matter was heaped at the back of the courtyard, burned on the spot or collected by the Municipal services in the localities where these services functioned. The absence of an adequate system for the treatment of bio-medical waste constitutes a hazard for health staff and service users alike as well as for the environment owing to the fact that contaminated injection material is a vector of communicable diseases such as Hepatitis B, HIV/AIDS, tetanus etc. Incineration of waste in the open pollutes the atmosphere, degrades the environment, and constitutes a hazard to residents of the neighbourhood.

Private Sector

4.8.3 In Morocco, the private operators in the health sector include all private medical consultation units as well as private diagnosis or treatment facilities concurrently operating in the public sector. These private medical outfits have considerably developed during the past twenty years but remain concentrated in the major urban areas and in some small towns and centres of average importance, and extremely few in rural areas. The number of private clinics for instance, increased from 4'216 to 6,871 between 1991 and 2002. The private sector accounted in 2002 for 44.6 % of the doctors, and 49.2 % of these private doctors were specialists.

4.8.4 The Bank's assistance strategies accorded greater importance to the private sector considered as the principal engine of the economy and the principal job provider. To that end, the Bank's assistance was mainly geared towards continued economic and sectoral reforms with a view to creating an enabling environment for private-sector development. The Bank's assistance in the health sector was channeled towards the public sector, and direct support to the private sector virtually did not exist.

V. EVALUATION OF RESULTS: NON-LENDING ASSISTANCE

5.1 Non-lending Assistance: Composition and Status

5.1.1 The Bank's non-lending assistance to Morocco was mainly composed of two emergency humanitarian aid operations and activities in the framework of policy dialogue, CSP and portfolio review programmes, seminars etc. It also covered resource-mobilization activities aimed at financing the country's development as well as the improvement of aid coordination.

5.1.2 According to the Moroccan authorities, the Bank's non-lending assistance proved inadequate and unsuitable. Indeed, as a middle-income country, several avenues are open to Morocco for its development funding. Consequently, the reason for resorting to Bank's assistance was the quality of expertise it expected to accompany the lending operations. However, not only was this quality insufficient, but the Bank's interventions were rigid and lacked promptitude, compared with those of other partners such as the World Bank or Arab Funds. The Moroccan authorities consequently became increasingly reticent to resort to the Bank's non-concessionary financings to fund the social sector. They expect from the Bank more technical assistance and grants for the regions and the poorest social segments.

5.2 Emergency Humanitarian Aid Operations

In keeping with its emergency aid guidelines, the Bank funded two humanitarian aid operations of US$ 500 000 each from the resources of the Special Assistance Fund. The first operation was further to the floods of November 2002 and the second concerned the victims of the earthquake of 24 February 2004. The Bank's two interventions were extremely appreciated by the Moroccan authorities in their efforts to assist the stricken populations. However, due to the slowness in the disbursement of the funds, the Bank's funding could not be rapidly available for the emergency requirements. Instead, it was used to meet the needs of the stricken population by purchasing agricultural inputs, renovating schools and buying tents for them.

5.3 Dialogue on Policies and Programmes

5.3.1 The Bank did not carry out studies in the health sector on which to base its assistance. Consequently, it contributed little to the definition of sector policies and strategies. The CSPs did not really constitute instruments for monitoring the Bank's policy in the health sector. Indeed, the multi-sector and global approach advocated in the CSP relating to the enhancement of human resources was taken within the framework of a macro-economic vision which did not directly relate to the Bank's policies and programmes in the health sector.

5.3.2 The participatory process advocated for the CSPs proved contradictory. While the Bank wanted to be selective in its assistance, the participatory process led to a multitude of priorities. During the preparation of the 2002-2005 CSP, the NGOs expressed the desire to see the Bank's assistance strategy, within the framework of its priorities, include issues on literacy, gender and opening up of the regions. In the final analysis, the Bank's strategy focused on reforms.

5.3.3 As regards portfolio review missions, they have been conducted at irregular intervals since 1995. The reviews contributed to improving the Bank's portfolio implementation and management performances, but could not halt on time the drift of an old project such as the PRSSB. The recurrence of management problems in social sector operations testifies to the lack of ownership of the reviews by the national side.

5.4 Resource Mobilization and Co-financing

5.4.1 The health sector benefited from the support of many multilateral and bilateral partners including UN agencies and bodies[11], World Bank, EU, USAID, Japan and the Bank. However, the sector is still confronted globally with inadequate financial resources. In 2002, the vote of the Ministry of Health was no more than 1.2 % of GDP and accounted for only 5.3 % of the State budget against over 7 % during the sixties.

5.4.2 Cooperation between the Government and the development partners is carried out on the basis of jointly established action programmes. Activities generally cover human resource training, expertise, construction of health facilities and procurement of equipment. The breakdown of the capital budget of the Ministry of Health per source of funding indicates that, over the period 1990-2005, the World Bank accounted for 34.5 %, followed by the African Development Bank and the European Union, which respectively accounted for 6.4 % and 4.2 %. The Government's share stood at 55 %. This breakdown did not take account of partners intervening outside the State budget. Thus, for the period 1998-2000 for instance, the United States of America, Spain, Germany, France, Belgium and Italy contributed US$ 12.2 million to funding projects and programmes in the health sector. Among the Bank's interventions, only PARCOUM was co-financed with the European Union. In light of the foregoing, the Bank's contribution to resource mobilization in the health sector was low.

[11] WHO, UNFPA, UNICEF, UNDP and IAEA.

5.5 Aid Coordination, Harmonization and Streamlining of the Results

Co-financing afforded the donors operating in Morocco, an opportunity to develop partnerships and coordinate their assistance. Thus, cooperation between the European Union and the Bank became extremely active during the preparation and appraisal of PARCOUM as well as during the harmonization of the programme monitoring activities. Morocco did not resort to the habitual institutional mechanisms such as advisory groups and sectoral round-table meetings. Generally, it embarked on bilateral negotiation with donors, save for the large-scale programmes where it brought together the principal donors contacted. That was the case in 1996 for the launch of the social priorities programme -*BAJ*-. The rehabilitation of the development plan in 1995 was meant to strengthen the framework of consultation with the different development partners. After the 2000-2004 Five-year Plan, the idea of coordination is still at a fledgling stage and is limited to informal discussions between the different donors.

VI. PERFORMANCE OF THE BANK AND BORROWER

6.1 Performance of the Borrower and Executing Agencies

6.1.1 The Government was at the root of all the initiatives made in health sector investment. It defined its priorities and conducted sector studies. Consequently, its contribution to project identification and preparation was satisfactory. On the contrary, it was unsatisfactory as regards the implementation of the activities. Political decisions entailing changes in the organization of health services hampered the realization of the objectives set by the Bank's assistance. The 1994 hospital reform stopped the activities for almost a year and the modifications resulting from the new medical facilities distribution map led to an alteration of the architectural plans of the infrastructure. The number of infrastructure to be constructed doubled owing to the reduction of the land areas in the said architectural plans and the splitting and/or merging of the provinces concerned by the Bank operations increased the number of beneficiary provinces to thirteen instead of the ten initially projected.

6.1.2 Other factors diminished the level of attainment of the objectives of the assistance and they include: a) implementation of activities which was delayed for six years, after three closing deadline extensions; b) Government's implementation of the construction and equipment-procurement activities while abandoning the training activities as well as the majority of the initially projected seminars.

6.1.3 Furthermore, the execution of the construction works was entrusted to provincial delegations whereas they had no skilled personnel and do not master the procurement procedures regarding the construction of health facilities and the procurement of equipment. The attributions of the implementing unit at central level were reduced to administrative tasks, and the operating budget of the unit, which lacked the appropriate human resources and the requisite financial motivation to manage a project of such magnitude, did not allow it to monitor the activities on the ground. Furthermore, the Coordinating Committee comprising all the contributors was not functional owing to difficulties in planning meetings, obtaining the required quorum, and identifying topics for discussion.

6.1.4 The Government's efforts, too, were inadequate as far as the viability of health facilities was concerned. Indeed, 75 % of the solar panel installations did not function properly. Only 12 % of the BHCFs were connected to the water and electricity networks in the localities. Finally, the authorities were unable to honour their commitment with regard to the assignment of staff to the health facilities built.

6.2 Performance of the Bank

6.2.1 The performance of the Bank in health sector project design was satisfactory, overall. Nonetheless, as indicated above, some problems encountered during the first intervention impacted negatively on performance, namely: a) lack of a participatory approach in project preparation; b) low level of connection of health facilities to public utilities; c) lack of medical personnel to operate the medical facilities; and d) inadequate system for treating solid wastes from health facilities.

6.2.2 As regards the implementation of the activities, the performance of the Bank was deemed unsatisfactory. The Bank was unable to ensure the necessary supervision in such a way as to adopt possible corrective measures in a timely fashion. Consequently, owing to the considerable alterations made during execution of the activities, the results expected from the Bank's assistance were not totally achieved. Furthermore, assistance to the country was insufficient in terms of institutional capacity building, including that of the project implementation unit. Finally, the processing of disbursement and procurement requests was deemed overly rigid, which constituted a real impediment given the high number of infrastructure to be constructed.

6.2.3 As regards non-lending assistance, the Bank's performance was equally inadequate. The Bank was not sufficiently involved in the health sector and did not carry out sector studies to guide its interventions. Concerning emergency aid, the Bank's funding could not be made rapidly available to reach the stricken populations quickly and were consequently channeled to meeting post-disaster requirements.

6.3 Other Stakeholders (civil society, private sector)

The technical assistance, architectural, supply and contracting services were mainly required for the execution of the PRSSB. Technical assistance was not effective, especially as regards supervision and monitoring of activities on the ground. For example, the civil engineer recruited did not possess the requisite skills, the architects' services were unsatisfactory, and the structures handed over by the construction company were sometimes defective. For these reasons, the performance of the stakeholders was, overall, considered unsatisfactory,

VII. OVERALL ASSESSMENT

7.1 Counterfactual Analysis

7.1.1 Counterfactual analysis consisted in examining the contribution of the Bank's assistance in relation to what the situation would have been if the Bank had not intervened. This question always proves delicate to deal with in as far as it remains difficult to imagine the plausible scenarios and/or necessary data - which are not available - for this type of exercise.

7.1.2 Even if only the data collected at the *Bab Taza* local hospital is used for the counterfactual analysis, it can be observed that, since the opening of the hospital in 2000, all the indicators of access to health care improved. Between 2000 and 2003, the total number of patients increased by 51 %. Post-natal consultations increased by 52 %, and pre-natal consultations by 45 %. Still under the same period, assisted deliveries were multiplied by 2.6 and there was a 19 % increase in family planning. Handling of delivery complications and post-partum by the hospital improved significantly from under 10 % to over 50 %, delivery of health care in respect of risky pregnancies also improved and the referral of this type of pregnancy reduced from 95 % to fewer than 10 %. Vaccination also increased to cover 95 % of children and 85 % women between 15 and 45 years.

7.2 Overall Assessment

The assessment of the Bank's assistance to the health sector yielded an unsatisfactory rating. The Bank's financing was mainly channeled towards the realization of construction activities and procurement of equipment without it being accompanied with sufficient technical assistance from the Bank. The Institution's contribution to policy dialogue including sectoral dialogue was considered inadequate. The performance of humanitarian aid operations was also inadequate. At operational level, the Bank's assistance contributed significantly to improving health cover in the rural areas. Nonetheless, it was not efficient owing, among other things, to the delay in the construction of health facilities, the questionable quality of the structures built and delivered as well as the lack of staff for their operation. The Bank's assistance also contributed little to institutional capacity building in the health sector. The upkeep and maintenance measures adopted by the Government are currently inadequate to guarantee the viability of health infrastructure.

Table 3
Summary of Assessment

	Assessment criteria	Rating	Interpretation
A	Evaluation of the Bank's assistance strategy	3.5	Satisfactory
B	Evaluation of lending operations	2.6	Unsatisfactory
C	Evaluation of non-lending assistance	1.9	Extremely unsatisfactory
D	Evaluation of the Bank's performance	2.5	Unsatisfactory
E	Evaluation of the performances of the Borrower, implementing agencies and other operators	2.3	Unsatisfactory
	Overall Rating	**2.5**	**Unsatisfactory**

VIII. LESSONS AND RECOMMENDATIONS

8.1 Lessons Learned

8.1.1 In an environment conducive to the mobilization of non-concessional resources as in the case of Morocco, the added value of a development Bank lies especially in the quality of policy dialogue and technical assistance. Consequently, assistance solely in the form of loans is insufficient for the social sector which is not always immediately profitable. *(ref. 6.1.2).*

8.1.2 To produce maximum efficiency, assistance for the construction of basic health care facilities must take sufficient account of other aspects that supplement the construction of infrastructure, such as connecting the health facilities to public utilities, recruiting the necessary personnel for their operation, and ensuring the availability of an adequate system for treating bio-medical wastes *(ref. 5.3.3, 5.5.2, 5.7.1, 5.7.2, 7.2.1, 8.2.1).*

8.1.3 The participation of the different stakeholders – including medical personnel and beneficiary populations – in the design of health project ensures that the technical and cultural aspects are taken into due account in the architectural plans, and fosters an enhanced utilization and ownership of the constructions *(ref. 5.3.4).*

8.1.4 Political decisions that change the change the ground on which the operation were designed are liable to significantly hamper the realization of objectives. In the same vein, the non-implementation some activities, such as training not carried out impacts negatively on performance *(ref. 5.3.3, 5.4.5, 5.6.1, 7.1.1, 7.1.2).*

8.2.5 Considering that the Bank does not have much expertise in emergency aid operations, its performance in this area depends on the rapidity with which the beneficiary populations are provided with the funds *(ref. 6.2.1, 7.2.3) 7.1.2).*

8.2 Recommendations and Follow-up Measures

Recommendations to the Government

8.2.1 To ensure a smooth functioning and improved viability of health facilities, the Government should: a) take measures to assign medical personnel to the health facilities that have been shut-down, and to the local hospitals whose laboratories as well as X-ray and admissions units are not functioning; b) ensure the maintenance of the health infrastructure and bio-medical equipment; and c) set up a system for the treatment of solid wastes in all the health facilities *(ref. 5.3.3, 5.5.2, 5.7.1, 5.7.2, 5.8.2, 7.2.1, 8.2.1).*

8.2.2 The Government should adopt a human-resource management policy more conducive to the operation of health facilities in rural areas. In so doing, the authorities could put in place a system of staff rotation within and between the provinces and equally provide for more incentives, including premiums and allowances for personnel working in rural areas *(ref. 7.1.4).*

8.2.3 Considering the increasingly-important role played by the beneficiary populations and medical personnel regarding the operation and upkeep of the basic health care establishments, the Government must ensure that all stakeholders are actually involved in the design of health projects, including the architectural plans, with a view to better integrating the technical and cultural parameters into the design. This would foster improved operation and utilization of the health facilities *(ref. 5.3.4, 5.7.1)*.

8.2.4 The Government should ensure that all the activities provided for in the loan agreements are carried out so as to maximize the impact of the Bank's assistance. In that regard, it is important not to introduce changes likely to hamper the attainment of objectives *(ref. 5.3.3, 5.4.5, 5.6.1, 7.1.1, 7.1.2)*.

Recommendations to the Bank

8.2.5 To improve the competitiveness of the Bank, a strategy for non-lending assistance must be devised to enable the Bank to ensure greater added value within the framework of its fundings. To do so, the Bank must take further initiatives to propose non-lending activities that better respond to the country's concerns, including technical assistance and sector studies. The initiative: *Strengthening the Bank's Support to Middle-Income Countries*[12] responds to this concern *(ref. 6.1.2)*.

8.2.6 The Bank's sector strategy and its application to the social sector, and in particular the health sector, should be more explicit in the CSP. Hence, it should be based on the analysis of the principal evolutions, challenges and constraints in the sector so as to clearly map out sector strategy guidelines *(ref. 6.3.1)*.

8.2.7 The Bank's health sector projects with a component on the construction of health care establishments, should adopt an integrated approach by taking due account of the different aspects such as rendering the constructions serviceable, securing the human resources necessary for their operation, and ensuring that there is an adequate system for the treatment of bio-medical waste *(ref. 5.3.3, 5.5.2, 5.7.1, 5.7.2, 7.2.1, 8.2.1)*.

8.2.8 In case of a change in the sector policy at project start-up, the Bank should carry out a timely evaluation of the impact of the change on project objectives and cycle, with a view to taking the appropriate measures *(ref. 5.3.3, 7.1.1)*.

8.2.9 In order to guarantee a better quality at completion and greater sustainability for the health infrastructure constructed with the Bank's funding, it is necessary to promote the involvement of all stakeholders, including civil society and the medical personnel. In that regard, the Bank's assistance could also anticipate measures for building the capacities of the beneficiaries, including training *(ref. 5.3.4, 5.7.1)*.

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[12] African Development Bank, Strengthening the Bank's support to middle-income countries, ADB/BD/WP/2005/12/Rev.1, 25 April 2005.

8.2.10 To improve its performance in emergency aid operations, the Bank should expeditiously put the funds earmarked for financing emergency aid operations at the disposal of the institution it would have identified for managing such funds *(ref. 6.2.1, 7.2.3)*.

Rating of Strategies and Operations

(in accordance with the Bank's evaluation criteria)

KEY:

4	=	***Very satisfactory***
3	=	***Satisfactory***
2	=	***Unsatisfactory***
1	=	***Extremely unsatisfactory***

A-Evaluation of the Bank's assistance strategy

	Evaluation criteria	Rating	Justification
1	Relevance and conformity with the Bank's health policy	4	The Bank's assistance was in keeping with its vision and health policy aimed at promoting sustainable economic growth and poverty reduction in Africa by investing in the development of human capital, including health.
2	Conformity with policies and strategies of the Moroccan Government's strategies	4	The Bank's assistance responded to Morocco's priorities, which laid emphasis on basic health care.
3	Complementarity with the other development partners in Morocco	3	The Bank's strategy accorded greater importance to co-financings. PARCOUM was co-financed with the EU, as well as the other partners.
4	Coherence with the needs of the populations	3	The Bank's assistance was coherent with the needs of the population consisting in enhanced access to health services. However, the adoption of a participatory approach in the CSP did not necessarily imply that the beneficiaries' arguments were actually taken into account in the formulation of the Bank's strategy.
Rating: Section A		**3.5**	**Overall, the Bank's assistance strategy in the health sector in Morocco was satisfactory.**

B-Evaluation of Non-lending Assistance

	Evaluation Criteria	Rating	Justification
1	Relevance (conformity with Moroccan priorities and the Bank's strategies)	**4**	The Bank's assistance constituted an appropriate response to the Moroccan Government's will to expand the country's health cover and increase equity in access to health care, especially to the benefit of the rural population and destitute population.
2	Quality at entry point	**3**	Quality at entry was considered satisfactory, overall. However, the Bank did not properly appraise the existence of certain problems, including lack of human resources, viability of health training and management.
3	Effectiveness (production of physical inputs, realization of objectives)	**3**	Most of the activities were carried out. However, some activities were abandoned, including trainings and seminars as well as the setting up of provincial maintenance units.
4	Effects and impacts (development of the health sector, poverty reduction, MDG, for the beneficiaries)	**3**	The Bank's assistance significantly contributed to expanding health cover in rural areas. The 468 additional health care facilities equipped and provided with supplies and drugs made it possible to extend the capacity of the health-care network by more than 125 %. About 88 % of the facilities are functional, but access is still not easy for the populations owing to the difficulty of access to the mountainous zones and the dispersal of settlements. The Bank's assistance led to an improvement of staff working conditions and contributed to improving the demographic and health indicators.
5	Consideration/Impact on cross-cutting aspects	**3**	Women and children benefited from Bank assistance more than men, since the former used the health facilities more. As regards the environment, the issue of the treatment of hospital wastes was not dealt with.
6	Effectiveness (profitability, cost-benefit ratio, operational performance,)	**2**	The operations-implementation performance was extremely low. It took twice the time estimated for implementation and a considerable part of the financing activities was cancelled. (ref. training not carried out). Moreover, the infrastructure was not of any great quality. About 10 % of health facilities are not functional. The attendance rate was equally low.
7	Impact on institutional development	**2**	The Bank's assistance did not have significant impact on institutional development. Training and seminars were abandoned by the Government. The implementation of PRSSB did not make it possible either to strengthen national project-management capacities.
8.	Sustainability (technical, financial, social and institutional; permanent nature of results)	**1**	Most health facilities did not have a current maintenance system. The medical and para-medical personnel benevolently performed the maintenance tasks. The buildings sometimes had signs of considerable degradation. Part of the health facilities was not functional for want of personnel. The Government did not formulate a strategy make up for the problem of unequal distribution of human resources in the country.
Rating Section B		**2.5**	**Overall, the results of project assistance were unsatisfactory. Although the relevance of the objectives was satisfactory overall, the delays and implementation performance highly reduced the realization of the objectives, efficiency, institutional impact and sustainability of the Bank's assistance.**

C- Evaluation of Non-lending Assistance

	Evaluation Criteria	Rating	Justification
1	Economic studies and sector policy support	**1**	The Bank did not carry out sectoral studies to guide its interventions in the health sector.
2.	Advisory services including policy dialogue	**2**	The Bank's contribution to policy dialogue aimed at defining sectoral development strategies was inadequate. The country did not benefit from sufficient Bank expertise in the choice of sectoral policies. The CSP did not constitute a real instrument for monitoring the Bank's policy in the health sector.
3	Humanitarian assistance operations	**2**	The Bank's performance was inadequate owing to the slowness in the disbursement of funds. The Bank's financings were not rapidly available for emergency needs.
4	Aid coordination (Bank's initiatives regarding capacity building for national aid coordination as well as, co-financing initiatives)	**2**	The Bank made considerable effort to ensure coherence of its assistance with those of the other donors. Its interventions accorded greater importance to co-financings. There was high demand for the creation of a formal coordination framework in Morocco.
4.	Portfolio review	**2**	The pace of portfolio review has increased since 1999. Four reviews were organized between 1999 and 2002. These reviews contributed to improving the Bank's portfolio review performance However, PRSSB remained confronted with generic management problems.
Rating: Section C		**1.9**	**The Bank's performance was considered inadequate. The country expected the Bank to provide more technical assistance and grants for financing the social sector, especially the poorest regions and social segments. The assistance instruments are currently not diversified enough.**

D - Evaluation of the Performance of the Bank

	Evaluation Criteria	Rating	Justification
1.	Preparation (quality of sectoral and context studies)	**3**	The Bank was actively involved in the preparation of its assistance but on the basis of sector studies conducted by the Government and other donors.
2.	Ex-ante evaluation (quality of economic, financial, social analysis etc.)	**3**	The evaluation of operations was generally based on the preparatory activities conducted by the Government and the other development partners.
3.	Monitoring and supervision	**2**	Supervisions and mid-term reviews were inadequate. The country complained about delays in disbursement and non-objection notice, as well as rigidities in the Bank's procedures.
4.	Ex-post evaluation	**2**	The Bank accorded little importance to ex-post evaluation.
Rating: Section D		**2.5**	**The Bank's performance was deemed unsatisfactory.**

E- Evaluation of the Performances of the Borrower, Executing Agencies and Other Contributors

	Evaluation Criteria	Rating	Justification
1	Identification (ownership and participation of political decision-makers and beneficiary populations)	**4**	The country's performance in project identification was satisfactory. Morocco was able to define its health priorities. The needs also corresponded to a priority for the beneficiary populations.
2	Preparation (design, risk analysis and alternatives, consideration of lessons learned from similar operations, involvement of the populations concerned)	**2**	Morocco actively participated in the different interventions of the Bank. It however did not provide the Bank with the necessary material to enable it carry out a proper evaluation of the costs. The quality of the architectural programmes proposed was inadequate. The beneficiary populations and medical personnel were not sufficiently involved.
3	Implementation (capacity to carry the development programmes through).	**2**	The Government's implementation performance was inadequate. There was much delay in programme implementation. Generic problems of management, especially non-compliance with the Bank's rules of procedure, were recurrent. The Government abandoned some activities, such as training. Health facilities were not sufficiently serviced and connected to the utilities. The required personnel have still not been assigned to get the constructed health facilities to operate in the best conditions
4	Performances of the other contributors (technical assistants, consultants, companies, suppliers, NGO, etc.)	**2**	The performance of the other contributors was deemed unsatisfactory. The technical assistance anticipated has not always been effective. Hence, the tasks entrusted to technical assistance were not performed effectively. The architectural plans have still not been adapted to the context; 48 sites were abandoned, and the quality of the works was sometimes inadequate.
5	Monitoring and supervision (utilization of follow-up data and supervision to improve the implementation of projects and programmes)	**2**	The project monitoring mechanism was generally ineffective. The required resources were not provided to the PIU to ensure follow-up. Consequently, the PIU was relegated to administrative tasks. The activities were decentralized at the provincial delegations, which did not have the relevant skills.
6	Aid coordination (Borrower's initiatives and capacities in coordinating the assistance of donors)	**2**	Morocco did not resort to the normal mechanisms such as advisory groups and sector round-table meetings. Generally, it negotiated bilaterally with donors. The request for coordination desired by donors did not appear to correspond to a requirement for the Government.
Rating: Section E		**2.3**	**Overall, the performance of the Borrower and implementing agencies was deemed unsatisfactory.**
Overall Rating		**2.6**	**Overall, the Bank's assistance was deemed unsatisfactory.**

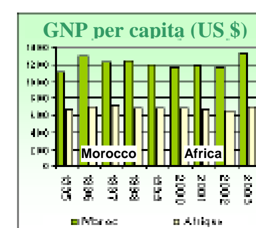
Matrix of Recommendations and Follow-up Measures

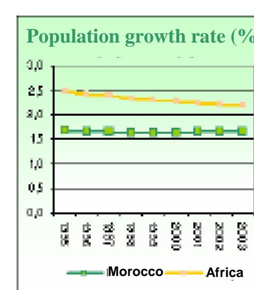
Observation and Conclusion	Recommendations	Responsibility
According to the Moroccan authorities, the Bank's non-lending assistance was insufficient and un suitable. The country was increasingly reticent to resort to the Bank's non-concessional resources to fund operations in the social sectors.	Improve the Bank's competitiveness in the country by proposing non-lending activities that better correspond to the country's concerns: technical assistance and sector studies.	Bank
The multi-sector and global approach advocated in the CSP related to the enhancement of human resources as per the macro-economic vision which did not highlight the Bank's policies and programmes in the health sector.	The Bank's sector strategy in the social sector, including health, should be more explicit in the CSP and be based on the analysis of the principal evolutions of the challenges and constraints of the sector so as to clearly map out the sectoral strategic guidelines.	Bank, Operations Department
The Bank did not adopt an integrated approach for its assistance in the health sector.	The health projects bearing mainly on the construction of health infrastructure should have adopted an integrated approach taking due account of all the important aspects such as viability of achievements, human resources, and an adequate system for treating bio-medical waste.	Bank, Operations Department
The 1994 hospital reform modified the architectural programme of health facilities. The land areas were reduced to a third, and the number of projected facilities doubled. The new health facilities subsequently proved ineffective due to their smallness. The construction of 75 % of the Community Health Centres (CHC) was extremely complicated. The project was stalled by policy changes for a year, and the decentralization o f the implementation increased the number of contracts to be awarded.	It is important for the Bank to seek sufficient information on short and medium-term reforms that can be implemented, before getting involved in major investments	Bank, Operations Department

Observation and Conclusion	Recommendations	Responsibility
For want of personnel, almost 5 % of the BHCFs were shut down, and the laboratories, X-ray and admissions departments in the local hospitals were not functional. Part of the BHCFs is not yet serviced, and there is no system for treating wastes.	The necessary personnel should be assigned to the health facilities; service the health facilities that are yet to be serviced; maintenance of health infrastructure and bio-medical equipment should be ensured. A solid-waste treatment system should be established in all health-facilities.	Government
	A policy should be devised for active planning of human resources management more suitable for the operation of health facilities in rural areas.	Government
The architectural plans did not take due account of the technical aspects necessary for the organization of health activities as well as the customs of the populations.	It must be ensured that all stakeholders are actually involved in the design of health projects to foster enhanced ownership and utilization of health facilities.	Government/Bank
The Government made considerable modifications to the initially projected activities and the establishment of ten provincial maintenance units.	It must be ensured that all the activities projected in the loan agreements are carried out so as to maximize the impact expected from the Bank's assistance.	Government/Bank
The Bank's funding of humanitarian aid operations could not be rapidly available for emergency needs, and its utilization was deferred to meet the needs of the afflicted population	Enhance emergency aid performance by expeditiously making the funds available to the institution identified and selected to manage them.	Bank

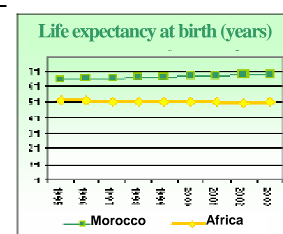
MOROCCO: COMPARATIVE SOCIO-ECONOMIC INDICATORS

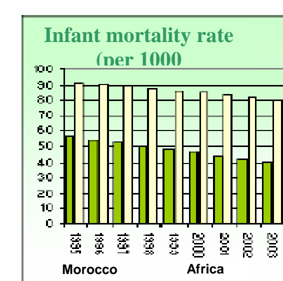
Basic indicators	Year	Morocco	Africa	Developing country	Developed country
Area ('000 Km²)		447	30 061	80 976	54 658
Total population (millions)	2003	30.6	849.5	5 024.6	1 200.3
Urban population (% of Total)	2003	56.8	39.2	43.1	78.0
Population density (perKm²)	2003	68.4	28.3	60.6	22.9
GNP per capita (US$)	2003	1 330	704	1 154	26 214
Labour force participation - Total (%)	2003	41.4	43.3	45.6	54.6
Labour force participation - Female (%)	2003	35.1	41.0	39.7	44.9
Gender-related development index value	2002	0.604	0.476	0.655	0.905
Human Development Index (rank among 174 countries)	2002	125	n.a.	n.a.	n.a.
Population living below $ 1 a day (%)	1995	…	46.7	23.0	20.0
Demographic Indicators					
Population Growth Rate - Total (%)	2003	1.6	2.2	1.7	0.6
Population Growth Rate – Urban (%)	2003	2.9	3.8	2.9	0.5
Population < 15 years (%)	2003	31.9	42.0	32.4	18.0
Population >= 65 years (%)	2003	4.5	3.3	5.1	14.3
Dependency rate (%)	2003	56.0	86.1	61.1	48.3
Sex ratio (males per 100 females)	2003	100.3	99.0	103.3	94.7
Female population 15 - 49 years (%)	2003	27.6	24.0	26.9	25.4
Life expectancy - together (years)	2003	69.0	50.7	62.0	78.0
Life expectancy - Female (years)	2003	70.8	51.7	66.3	79.3
Crude birth rate (per 1000)	2003	22.9	37.0	24.0	12.0
Crude death rate (per 1000)	2003	6.0	15.2	8.4	10.3
Infant mortality rate (per 1000)	2003	40.7	80.6	60.9	7.5
Mortality rate under 5 years (per 1000)	2003	50.0	133.3	79.8	10.2





Demographic indicators	Year	Morocco	Africa	Developing country	Developed country
Maternal mortality rate (per 100000)	1995	372	661	440	13
Synthetic fertility index (per female)	2003	2.7	4.9	2.8	1.7
Women on contraceptives (%)	1997	58.4	40.0	59.0	74.0
Physicians (per 100000 habitants)	1997	48.8	57.6	78.0	287.0
Nurses(per 100000 habitants)	1997	105.0	105.8	98.0	782.0
Births assisted by skilled personnel (%)	1994	40.0	44.0	56.0	99.0
Access to Safe Water (% of population)	2002	80.0	64.4	78.0	100.0
Access to Health Services (% of population)	1991	62.4	61.7	80.0	100.0
Access to Sanitation (% of population)	2000	75.0	42.6	52.0	100.0
% of HIV/AIDS positive adults between 15 and 49	2003	0.09	6.4	1.3	0.3
Incidence of Tuberculosis (per 100000)	2000	96.6	109.7	144.0	11.0
Child immunization against Tuberculosis (%)	2003	92.0	81.0	82.0	93.0
Child immunization against Measles (%)	2003	90.0	71.7	73.0	90.0
Underweight children below 5 years (%)	1992	9.5	25.9	31.0	…
Daily Calorie supply	2002	3 052	2 444	2 675	3 285
Public expenditure on health (in % of GDP)	1998	1.2	3.3	1.8	6.3
Education Indicators					
Gross enrolment ratio (%)					
Primary school - Total	2001	107.0	88.7	91.0	102.3
Primary school -Girls	2001	101.0	80.3	105.0	102.0
Secondary school - Total	2001	41.0	42.9	88.0	99.5
Secondary school -Girls	2000	36.0	41.3	45.8	100.8
Primary School Female Teaching Staff (% of total)	1998	37.7	46.3	51.0	82.0
Adult illiteracy Rate - Total (%)	2003	48.4	36.9	26.6	1.2
Adult illiteracy Rate - Male (%)	2002	36.7	28.4	19.0	0.8
Adult illiteracy Rate - Female (%)	2003	60.7	45.2	34.2	1.6
Percentage of GDP spent on Education	1998	5.0	5.7	3.9	5.9





Source: Compiled by Statistics Division from Data bases of ADB; UNAIDS; World Bank Live Database and United Nations Population Division. Notes: n.a. = Not Applicable ….= Data not Available

Evolution of the Principal Health Indicators at National Level: 1992-2000 Period

Indicator	1992	1993	1994	1995	1996	1997	1998	1999	2000
1-Demography									
Synthetic Fertility Rate (SFR)	4.2	4.1	4.0	3.6	3.6	3.1	3.1	3.1	3.1
Crude Birth Rate (1 000)	27.3	26.6	24.2	23.9	23.6	23.2	22.8	22.4	21.9
Crude Mortality Rate (1 000)	7.2	6.8	6.7	6.6	6.5	6.3	6.2	6.1	5.9
Rate of demographic growth (100)	2.2	2.0	2.0	1.7	1.7	1.7	1.7	1.6	1.6
Infant mortality rate (100)	57.3	54.7	52.2	66.0	66.0	36.6	36.6	36.6	36.6
Juvenile mortality rate (100)	20.0	17.3	15.0	19.9	19.9	9.8	9.8	9.8	9.8
Infanto-Juvenile mortality rate (1 000)	76.1	68.9	62.4	84.6	84.6	45.8	45.8	45.8	45.8
Neo-natal mortality rate (1 000)	31.4	34.0	36.8	36.8	36.8	19.7	19.7	19.7	19.7
2-Population (in thousands)									
Total population	25823	25474	26074	26386	26848	27310	27775	28223	28787
Urban population	13001	12909	13415	13684	14100	14524	14954	15383	15897
Rural population	12822	12565	12659	12702	12748	12786	12821	12890	12890
Births	721	697	696	695	692	636	644	651	662
Children < 1 year	677	657	655	653	649	600	607	619	630
Children < 12-23 months	626	647	644	642	637	601	589	581	592
Children < 5 years	3355	3201	3162	3099	3045	2987	2986	2979	3038
Population between 5-14 years	_	_	6439	6465	6470	6455	6411	6357	6289
Population between 15-59 years	_	_	14490	14943	15420	15905	16393	16893	17345
Population >60 years	_	_	1835	1879	2115	1948	2029	2029	2084
Population of child-bearing married women (15-49yrs	3680	3722	3502	3540	3725	3746	4782	4782	4106
Population of child-bearing women (15-49 years)	6919	7087	6606	6821	7047	7137	7787	7787	7791
3-Health resources									
3.1-Health delivery									
Number of BHC facilities*	1683	1724	1772	1764	1857	1949	1980	2138	2267
Number of hospitals	98	98	104	105	106	107	109	112	112
Number of para-medical consultations (in thousands)	19560	239994	23623	25146	17543	19478	19781	20979	17348
Number of medical consultations (in thousands)	6678	9027	9535	10728	7242	8491	28	10139	10390
Inhabitant per BHC facility	15343	14776	14714	14958	14458	14048	14028	13201	12685

Indicator	1992	1993	1994	1995	1996	1997	1998	1999	2000
3.2- Human Resources									
3.2.1- l Medical personnel									
Number de physicians (all specialties) Public sector	3779	4371	4422	4158	4007	4193	4567	5476	5812
+including BHC doctors (all specialties)	2013	1273	1273	1329	1454	1641	2024	2294	2568
Number de physicians (all specialties) Private sector	3324	3881	4416	4787	5390	5730	6204	6431	6620
Number of Public Sector pharmacies	16	21	16	20	24	28	26	35	39
Number of Private Sector pharmacies	1746	2214	2470	2675	2907	3132	3573	4386	5197
Number of Private Sector Dentists	60	72	73	65	89	105	127	150	162
Number of Private Sector Dental Surgeons	932	1132	1292	1521	1630	1797	1964	2111	2299
Inhabitant per physician (all specialties) all sectors	3636	3087	2950	2950	2857	2759	2479	2370	2313
Rate of medical supervision (all specialties) Public sector	6	5	6	6	6	6	6	5	5
3.2.2- Para-medical staff									
Number of Nurses (all categories)	23748	23992	24471	24959	25536	25693	25641	26239	26174
Including:									
Number of Nurses working in BHCN (all categories)	9280	9022	_	9896	10026	9998	1007	10081	10172
Number of Nurses working in HOSPN (all categories)	10226	7971	_	11951	12305	12607	12755	13161	13051
Inhabitant per Nurse	1087	1062	1066	1057	1051	1063	1083	1076	1099
3.3-Financial resources (DH million)									
3.3.1- Operating budget	**2002**	**2161**	**2358**	**2416**	**2621**	**2902**	**2967**	**4048**	**1787**
Personnel	1396	1423	1590	1676	8999	2102	2167	_	_
Equipment	606	737	767	739	359	800	800	_	_
3.3.2-Capital budget	**552**	**552**	**691**	**500**	**548**	**720**	**800**	**925**	**516**
Curative	143	277	307	163	83	_	_	_	_
Preventive	224	212	296	237	106	_	_	_	_
Other Capital expenditures	183	63	86	98	41	_	_	_	_
3.3.3- Overall health budget	**2554**	**2713**	**3048**	**2915**	**3169**	**3622**	**3767**	**4973**	**2303**

Source: Ministry of Health/Department of Studies and Health Information, *Health in figures 2001*, Kingdom of Morocco, 2001

Ongoing Bank Group Operations for the 1994-2004 Period

Project	**Sector**	**CoCd**	**LnT**	**Approval Date**	**Signature Date**	**Date of Effectiveness**	**Completion Date**	**Approved Amount**	**Net Amount**	**Disburs. Rate**	**Status**
SECOND TRANCHE OF *GHARB* IRRIGATI0N	Agriculture	ADB	PL	05/29/1979	10/01/1979	10/21/1982	06/30/1994	8 000 000	7 999 163	100	Completed
TENSIFT INTEGRATED POULTRY COMPLEX	Agriculture	ADB	PL	04/28/1981				10 000 000	0	0	Completed
INTEGRATED RURAL DEVELOPMENT. PROVINCE OF *SETTAT*	Agriculture	ADB	PL	03/12/1985	12/23/1985	04/10/1987	12/31/1997	41 630 000	8 689 397	100	Completed
ORMVAL OF LOUKKOS	Agriculture	ADB	PL	10/26/1987	03/10/1988	11/19/1990	12/21/1999	21 600 000	20 975 468	100	Completed
AGRICULTURAL SECTOR ADJUSTMENT PROGRAMME	Agriculture	ADB	SA	12/14/1987	03/10/1988	09/30/1988	06/30/1994	117 000 000	117 000 000	100	Completed
NATIONAL RESOURCE CONSERVATION PROJECT.	Agriculture	ADB	PL	05/14/1990	10/31/1990	01/27/1994	12/31/1997	8 330 000	3 156 917	100	Completed
NATURAL RESOURCE CONSERVATION PROJECT.	Agriculture	ADB	PL	05/14/1990	11/30/1990	01/27/1994	12/31/1998	3 794 734	3 147 321	100	Completed
NATURAL RESOURCE CONSERVATION PROJECT	Agriculture	ADB	GA	05/14/1990	10/31/1990	12/29/1992	12/31/1998	2 440 788	2 439 199	100	Completed
PASTORAL & STOCKBREEDING DEVT. – EAST. REGION.	Agriculture	ADB	PL	05/14/1990	10/31/1990	09/22/1992	12/31/2001	5 460 000	3 042 162	100	Completed
PASTORAL & STOCKBREEDING DEVT. – EAST. REGION	Agriculture	ADB	PL	05/14/1990	11/30/1990	09/28/1992	12/31/2001	15 473 674	8 271 254	100	Completed
PASTORAL & STOCKBREEDING DEVT. – EAST. REGION	Agriculture	6450	PL	12/19/1990	05/27/1991	12/31/2001	12/31/2001	10 850 000	10 850 000	0	Completed
DOUKKALA IRRIGATION PROJECT	Agriculture	ADB	PL	10/29/1991	03/05/1992	07/08/1994	06/30/2000	130 000 000	75 373 222	100	Completed
EL-HACHEF DAM	Agriculture	6540	PL	02/17/1992	02/17/1992	12/31/1996	12/31/1996	3 324 512	5 000 000	0	Completed
GHARB AREA IRRIGATION STUDY (GRANT)	Agriculture	ADB	GA	08/31/1993	11/19/1993	05/06/1996	12/31/1999	2 440 788	1 349 122	100	Completed
TELECOMMUNICATIONS DEVELOPMENT PROJECT	Communications	ADB	PL	12/14/1993	06/06/1994	11/27/1995	12/31/1997	42 750 000	13 591 758	100	Completed
P & T SECTOR ADJUSTMENT PROGRAMME	Communications	ADB	SA	12/09/1998	05/10/1999	05/31/1999	12/31/2002	81 401 950	95 096 200	100	Completed
DEVELOPMENT OF THE INFRASTRUCTURE & INFO SECTOR.	Communications	ADB	SL	04/04/2001	10/04/2001	06/06/2002	12/31/2003	66 490 246	100 000 000	50	Completed
Total Communications		ADB						190 642 195	208 687 958		
LINE OF CREDIT (IV)	Finance	ADB	LC	11/24/1981	02/16/1982	12/14/1983	06/30/1994	10 000 000	9 595 341	100	Completed
AGRICULTURAL LINE OF CREDIT III	Finance	ADB	LC	06/17/1986	06/25/1986	02/27/1987	06/30/1994	62 400 000	62 400 000	100	Completed
LINE OF CREDIT (V)	Finance	ADB	LC	09/24/1986	12/18/1986	03/07/1988	12/31/1996	50 000 000	49 996 958	100	Completed
IV CNCA LINE	Finance	ADB	LC	10/16/1989	02/22/1990	12/28/1990	06/30/1994	56 160 000	56 160 000	100	Completed
LINE OF CREDIT TO- B.C.P.; B.C.M.E; B.C.M	Finance	ADB	LC	10/29/1991	03/05/1992	01/08/1993	12/31/1996	30 000 000	30 000 000	100	PIPE
LINE OF CREDIT TO- B.C.P.; B.C.M.E; B.C.M	Finance	ADB	LC	10/29/1991	03/05/1992	04/26/1993	12/31/1996	25 000 000	13 352 595	100	PIPE
LINE OF CREDIT TO CIH	Finance	ADB	LC	10/29/1991	03/05/1992	11/09/1993	12/31/1996	10 000 000	5 026 499	100	Completed
LINE OF CREDIT TO B.C.P.; B.C.M.E; B.C.M	Finance	ADB	LC	10/29/1991	03/05/1992	08/25/1993	12/31/1996	25 000 000	7 871 218	100	Completed
LINE OF CREDIT TO SGMB	Finance	ADB	LC	05/06/1993	05/13/1993		06/30/1997	20 000 000	0	0	ABAN
SIXTH LINE OF CREDIT TO BNDE	Finance	ADB	LC	05/06/1993	05/13/1993	11/18/1993	06/30/1997	70 000 000	43 406 330	100	Completed
FIFTH LINE OF CREDIT TO CNCA	Finance	ADB	LC	10/20/1993				70 000 000	0	0	ABAN
FINANCIAL SECTOR SUPPORT PROGRAMME - 4	Finance	ADB	SA	12/12/2002	12/17/2002		12/31/2005	117 699 426	137 500 000	100	APVD

Project	Sector	CoCd	LnT	Approval Date	Signature Date.	Date of Effectiven.	Complet. Date.	Approved Amount	Net Amount	Disburs. Rate.	Status
Total line of credit								546 259 426	415 308 941		
INVESTMENT PROPOSAL- LOAN TO CAROGUA S.A.	Ind/Mini/Quar	ADB	PL	12/16/1991				919 094	0	0	Completed
STUDY OF THE MINING DEVELOPMENT PLAN -	Ind/Mini/Quar	ADF	GA	06/23/1993	11/19/1993	01/29/1996	03/31/2000	1 657 894	1 638 964	100	Completed
SAP.	Multisector	ADB	SL	08/22/1989	09/11/1989	10/02/1989	06/30/1994	100 000 000	100 000 000	100	Completed
CONSOLIDATION OF SAP.	Multisector	ADB	SL	09/01/1993	09/23/1993	12/08/1993	12/31/1994	100 000 000	99 999 998	100	Completed
FINANCIAL SECTOR ADJUSTMENT PROGRAMME II	Multisector	ADB	SA	11/22/1995	11/30/1995	12/22/1995	12/31/1998	150 000 000	150 000 000	100	Completed
INSTITUTIONAL SAVINGS DEVELOPMENT PROGRAMME	Multisector	ADB	SA	11/19/1997	05/28/1998	06/16/1998	12/31/2000	68 705 998	80 264 408	100	In progress
INSTITUTIONAL SAVINGS DEVELOPMENT PROGRAMME	Multisector	ADB	SA	11/19/1997	05/28/1998	06/16/1998	12/31/2000	59 002 114	88 738 000	100	In progress
ECONOMIC AND SOCIAL REFORM PROGRAMMES - ESRP	Multisector	ADB	SL	12/09/1998	05/10/1999	07/23/1999	12/31/2002	152 628 655	178 305 374	100	In progress
Total Multisector								632 913 755	698 946 743		
HYDRO-ELECTRIC MICRO POWER STATIONS	Energy	ADF	TI	06/18/1986	01/14/1987	03/31/1988	06/30/1994	787 499	787 473	100	Completed
HYDROELECTRIC PROJECT OF *MATMATA*	Energy	ADB	PL	10/18/1988	02/07/1989	03/20/1990	12/31/1996	51 000 000	49 088 736	100	Completed
ELECTRICITY VII	Energy	ADB	PL	03/23/1989	04/28/1989	01/18/1990	12/31/1994	39 000 000	37 950 021	100	Completed
RENEWAL OF. ELECT. TRANSMISSION NETWORKS VIII	Energy	ADB	PL	12/15/1994				65 000 000	0	0	ABAN
RENEWAL OF ELECT. TRANSMISSION. & DISTRIB. NETWORKS	Energy	ADB	PL	10/14/1997	05/28/1998		12/31/2001	21 662 290	0	0	ABAN
INTERCONNECTION OF ELECTRICITY NETWORKS	Energy	ADB	PL	11/13/2002	05/06/2003		12/31/2007	68 479 666	80 000 000	69	In progress
Total Energy								245 929 455	167 826 230		
INTENSIFICATION OF PROFESSIONAL TRAINING	Social	ADB	PL	12/11/1985	12/23/1985	04/07/1987	12/31/1997	25 500 000	17 665 218	100	Completed
INTENSIFICATION OF PROFESSIONAL TRAINING.	Social	ADF	PL	12/12/1985	12/23/1985	04/08/1987	12/31/1998	9 210 520	7 850 965	100	Completed
REFORM OF THE EDUCATION SYSTEM	Social	ADB	SA	11/27/1986	01/14/1987	04/21/1988	06/30/1994	60 000 000	60 057 428	100	Completed
BASIC EDUCATION	Social	ADB	PL	03/23/1989	08/11/1989	07/17/1990	06/30/1997	31 000 000	26 913 522	100	Completed
EDUCATION IN RURAL AREAS	Social	ADB	PL	10/29/1990	05/08/1991	11/10/1994	12/31/1999	37 000 000	10 016 646	100	Completed
IMPROVING HEALTH IN RURAL AREAS - 10 PROV	Social	ADF	PL	08/24/1992	01/25/1993	10/27/1994	06/30/2004	18 421 040	16 241 040	70	In progress
IMPROVING HEALTH IN RURAL AREAS - 10 PROV	Social	ADB	PL	08/26/1992	01/25/1993	10/27/1994	06/30/2004	18 500 000	13 880 000	76	In progress
EDUCATION V PROJECT	Social	ADB	PL	11/24/1993	03/13/1995	12/04/1998	12/31/2003	30 000 000	7 400 000	55	In progress
EDUCATION V PROJECT	Social	ADF	PL	11/24/1993	03/13/1995	12/04/1998	12/31/2003	10 130 000	7 240 000	37	In progress
EDUCATION GENERALIZATION SUPPORT PROJECT	Social	ADB	PL	11/30/2000	05/30/2001	09/17/2001	12/31/2007	47 616 269	47 616 269	5	In progress
DEVELOPMENT OF SCIENTIFIC AND TECHNOLOGICAL EDUCATION	Social	ADB	PL	11/30/2000	05/30/2001	09/17/2001	12/31/2007	21 549 489	21 549 489	14	In progress
MEDICAL COVER REFORM SUPPORT - PARCOUM)	Social	ADB	SL	12/12/2002	04/25/2003		12/31/2005	94 159 541	94 159 541	0	APVD
EMERGENCY HUMANITARIAN AID TO FLOOD VICTIMS	Social	SRF	RF	05/26/2003	06/04/2003		12/31/2004	332 451	332 451	0	APVD
Emergency Humanitarian Aid (Earthquake)	Social	SRF	RF	03/04/2004	03/10/2004		12/31/2004	332 451	332 451	0	APVD

Project	Sector	CoCd	LnT	Approval Date	Signature Date	Date of Effectiven.	Completion Date...	Approved Amount	Net Amount	Disburs. Rate.	Status
SECONDARY - TERTIARY ROADS (PERST)	Transport	ADB	PL	12/11/1985	12/23/1985	11/03/1987	12/31/1994	49 000 000	48 824 353	100	Completed
TRANSPORT SECTORAL PROGRAMME	Transport	ADB	SI	11/25/1987	03/10/1988	01/18/1990	12/31/1998	94 000 000	93 235 896	100	Completed
SECOND ROAD PROJECT	Transport	ADB	PL	06/11/1990	12/05/1990	02/25/1992	12/31/1996	25 750 000	21 604 845	100	Completed
AIRPORT REHABILITATION PROJECT	Transport	ADB	PL	12/14/1992	04/06/1993	10/12/1993	08/31/2001	70 000 000	43 288 674	100	Completed
THIRD ROAD PROJECT	Transport	ADB	PL	12/15/1994	05/19/1995	11/05/1997	08/31/2001	60 000 000	29 374 240	100	In progress
RAILWAY REHABILITATION PROJECT	Transport	ADB	PL	12/02/1996	05/20/1997		12/31/2002	60 410 000	0	0	In progress
RAILWAY REHABILITATION PROJECT	Transport	ADB	PL	12/16/1998	03/08/1999	04/06/2001	12/30/2004	54 189 550	81 500 000	52	In progress
AIRPORT IMPROVEMENT AND CAPACITY BUIDLING	Transport	ADB	PL	04/18/2001	01/06/2002	09/18/2002	12/31/2006	66 596 475	77 800 000	20	In progress
Total Transport		ADB						479 946 025	395 628 008		
TANGIERS DWS (*CHARF EL AKAB*)	Potable water	ADB	PL	08/18/1987	03/10/1988	12/21/1989	12/31/1996	7 950 000	6 571 202	100	Completed
EL HACHEF DAM	Potable water	ADB	PL	05/21/1991	11/29/1991	10/09/1992	12/31/1996	44 000 000	22 047 660	100	Completed
FIFTH RADEEF DRINKING WATER SUPPLY PROJECT -	Potable water	ADB	PL	03/23/1992	05/13/1992	09/28/1994	06/30/2001	4 200 000	2 684 951	100	PIPE
FIFTH DRINKING WATER SUPPLY PROJECT (ONEP)	Potable water	ADB	PL	03/23/1992	05/13/1992	01/27/1994	08/31/2001	55 800 000	47 910 852	100	Completed
SIXTH DRINKING WATER SUPPLY PROJECT	Potable water	ADB	PL	05/26/1994	07/20/1994	06/25/1996	12/31/2001	30 000 000	15 816 565	100	Completed
DRINKING WATER SUPPLY AND SANITATION PROJECT	Potable water	ADB	PL	06/09/1999	12/13/1999	08/01/2001	12/31/2004	21 528 295	14 080 000	87	In progress
WATER SECTOR STRUCTURAL ADJUSTMENT	Potable water	ADB	SA	12/03/2003	10/14/2004		12/31/2006	184 039 102	215 000 000	0	APVD
Total Drinking Water Supply								347 517 397	324 111 229		
OVERALL								**2 879 787 113**	**2 484 946 124**		