Note No. 58         March 2001

Decreasing Social Inequities through Decentralization:
Morocco Social Priorities 1-Health Project

Social Development Best Practice Elements

• Multi-dimensional approach to poverty reduction aimed at enhancing opportunities, capabilities, empowerment, and security of the poor
• Participatory processes in implementation
• Organizational and institutional decentralization
• Ongoing monitoring and evaluation of social development outcomes by the government and community

Despite Morocco’s strides in liberalizing its economy over the past decade, a fifth of its citizens still live in poverty or near-poverty. Although the country’s mortality rate has diminished from 19 persons per 1,000 in the 1960s to 7.3 persons per 1,000 in 1992, performance of other health indicators remains low. The maternal mortality rate is high, averaging 332 deaths per 100,000 women, as compared to 50 in Tunisia and 140 in Algeria. Only 40 percent of all infant deliveries in Morocco take place in a medical setting. Lack of access to health facilities is a major problem for the rural poor, since 53 percent live more than 6 kilometers from a health care facility.

The Morocco Social Priorities Program incorporates three complementary projects, one of which is the Basic Health Project. These projects are being implemented simultaneously in the 14 poorest provinces, in which 27 percent of the total population and 43 percent of the rural population live. The overall objectives of the Social Priorities Project are to assist the government to implement its strategy to increase access of the poor to basic social services, enhance social protection, and create new opportunities for the poor to participate in economically productive activities.

Project Objectives

The specific objectives of the Basic Health Project are to provide better access to essential preventive and curative care, to reduce maternal and neonatal mortality, and to maintain the performance of priority public health programs at the national level. With flexibility in mind, the project was designed to adjust to local circumstances in the 14 provinces. Provincial health officials are responsible to plan, implement, and monitor project activities in their respective provinces.

Securing a Government Commitment

The World Bank worked to convince officials of three successive Moroccan governments that a centralized system to disburse social program funds was inefficient and ineffective, and led to poor outcomes.

This project was recognized as Best Practice in Social Development by the Social Development Family, and received an award for Excellence in Supervision (QSR) from the Quality Assurance Group (QAG). Anne Marie Pierre-Louis is the task team leader. This best practice note was prepared by Kathleen Kuehnast.

The views expressed in this note are those of the author(s) and do not necessarily reflect the official policies of the World Bank.
The Bank advocated decentralization, especially in the health and education sectors. It assisted the government to find an appropriate administrative vehicle and a reliable statistical monitoring system.

During negotiations, agreement was reached on measures and mechanisms to strengthen provincial participation in planning and decisionmaking for health sector activities. At the provincial level, project activities are coordinated by the governor and a board. The central government is responsible for monitoring and assessing impact.

**Social Analysis**

Surveys were conducted in 5 of the 14 targeted provinces to establish the quality of services and to determine the greatest needs. To assist in guiding the strategy during the preparation phase, the various surveys included a beneficiary assessment and a survey of the concerns of medical and paramedical personnel.

A major health care problem identified through this process is the lack of qualified health professionals in rural areas. By mandating that at least 50 percent of newly certified health care providers go to the rural provinces, the government intends to close the gap between urban and rural areas in the delivery of quality health services. Lack of maternal health care in rural areas was highlighted as a concern. As a result, the government has resumed training midwives.

Drug availability was a primary issue raised by survey participants. All three components of the project address this concern. The component to increase access to health care services incorporated access to curative drugs. The component addressing maternal health included financing the purchase of drugs needed in obstetrical emergencies. Vaccines and drugs needed to combat transmissible diseases are provided under the third component.

In addition to social analysis at the preparation stage, ongoing social analysis helped to ensure that the project addressed beneficiary needs. A local consulting firm conducted an impact evaluation survey in the 14 provinces. Interviews were conducted with groups of farmers in villages in which the different elements of the Social Priorities Program have been implemented in combination. After a preliminary report on two provinces, an action plan was developed to adapt and refocus the project as needed.

**Provincial-level Ownership and Supervision**

As decentralization occurred, regional officials such as the Provincial Medical Officers (PMOs) in the field became the points of stability for the project. During project preparation, PMOs were involved in defining and planning activities to be financed by the project in their provinces through regional workshops held to discuss project objectives and priority activities.

PMOs collaborated with the Bank to select specific districts in the targeted provinces as priority intervention areas. The selection criteria were demographic data, existing access to health services, coverage, epidemiological profile, and use of services. Most of the districts chosen were rural. PMOs also were involved in matching districts in their provinces with the relevant types of health care coverage, such as health centers, mobile teams, and outreach health workers.

Through the project, the PMOs have been empowered to make decisions about resource allocations to address the specific needs of their provinces. Since low morale and high turnover have plagued rural health workers, involving medical personnel in both the strategy development and implementation phases of the project has been a critical element of success.

Capacity building is ongoing. PMOs meet every six months to review issues and to create linkages among the provinces, the central government, and the periphery. PMOs have found that these bi-annual meetings enable them to identify and share common concerns, thus increasing their influence on the central government.

By simultaneously implementing the Basic Health project with the Basic Education project and the Co-ordination, Employment and Monitoring project, the Social Priorities Program aims to achieve more significant and sustainable results than by using isolated sectoral projects. Flexibility in implementation has fostered local ownership. The application of social analysis and participation is improving social development outcomes.