

# Country Cooperation Strategy for WHO and Morocco 2008–2013

# Morocco



World Health  
Organization

Regional Office for the Eastern Mediterranean



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WHO and Morocco  
2008–2013

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**World Health  
Organization**

Regional Office for the Eastern Mediterranean

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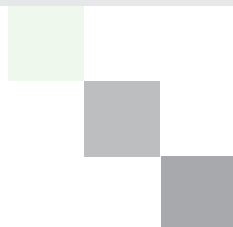
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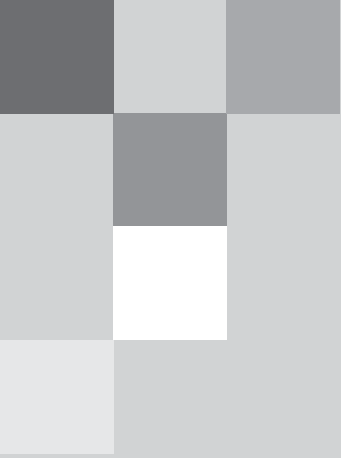
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Section

**1**



**Introduction**







## Section 1. Introduction

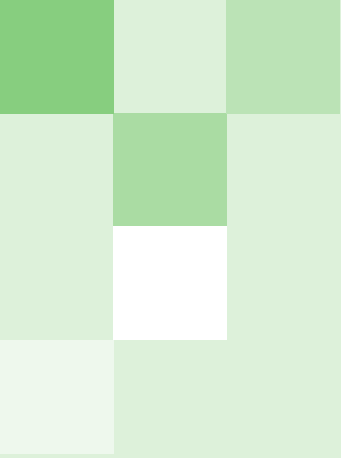
As part of its country focus initiative, WHO has introduced an instrument called the Country Cooperation Strategy (CCS). The CCS is a strategic framework that aims to better adapt WHO support to the specific needs of individual countries. In Morocco, this approach was undertaken for the first time in 2004. Simultaneously, WHO also initiated a results-based management system to support the development of joint WHO/country plans. The development of this new CCS for WHO and Morocco 2008–2013 is to be seen within a specific context, at both global and national levels. At the global level, it coincides with the Organization's launch of the Eleventh General Programme of Work 2006–2015 and the Medium-Term Strategic Plan 2008–2013. It also coincides with the emergence of a new global concern for international health security. At the national level, the development of this second CCS coincides with governmental change and the completion of the sectoral strategy for 2003–2007. Also, today's political environment in Morocco is conducive to undertaking changes needed to speed up economic and social development. His Majesty the King of Morocco has launched a project, entitled the National Initiative for Human Development, and has implemented basic medical insurance coverage as a social project. The CCS is designed to address the issues facing the country and to anticipate upcoming trends in health, while taking into account WHO's medium-term strategy.

For this second CCS, the six-year time frame coincides with the Organization's medium-term strategic plan, spanning three

biennial budgets. This is advantageous in that it enables transitions and reforms that are generally addressed over the longer term to be built into the strategy. However, at national level, a problem caused by the convergence of multi-annual planning by United Nations organizations subsists, with both the commitment to meet the quantified Millennium Development Goals by 2015, and a framework plan for the United Nations (United Nations Development Assistance Framework) scheduled through to 2011. In addition to these are the strategic plans of other partners, such as the World Bank (Country Assistance Strategy) and the European Commission. In the absence of integrated planning, there is a risk of creating a health cooperation strategy operating at different speeds within different UN agencies and organizations.

The development of the current WHO/Morocco cooperation strategy is based on a strategic analysis of the Moroccan health system. Given that the second CCS is a continuation of WHO's support to Morocco, special emphasis will be placed on consolidating the achievements of the first CCS. The CCS is also a framework for coordination within the United Nations Country Team and with the other development partners. Concerted efforts will be required to consolidate and strengthen, through the CCS, the achievement of the Millennium Development Goals and implementation the United Nations Development Assistance Framework in Morocco for the period 2007–2011, developed prior to the current WHO exercise.





Section

2



Country Health and Development  
Challenges



## Section 2. Country Health and Development Challenges

### 2.1 Health determinants

#### 2.1.1 Macroeconomic context

In Morocco, economic growth is variable and highly dependent on climate. It rose from 1.7% between 1990 and 1995 to 4.1% between 1996 and 2004. Strong growth was recorded during 2001–2004 in particular, when the climate was favourable for several consecutive years. During this time, gross domestic product (GDP) grew at an annual rate of 4.8% compared with just 1.5% between 1997 and 2000.<sup>1,2</sup>

#### 2.1.2 Sociodemographic context

In 2004, the year of the general census, Morocco's population was 29.9 million, 600 000 individuals less than the official projections based on the previous census. The growth rate consequently fell more than expected, from 2.04 million between 1982 and 1994 to 1.5 million between 1994 and 2004. The total fertility rate thus fell significantly to 2.5 in 2004. Likewise, the number of the population in the fully active age group (15–59 years) is expected to rise from 56% of the total population in 1994 to 61% in 2010, while the population aged 60 and over will grow more moderately through to 2020, at which time the ageing of the population will accelerate. This pattern means that the demographic transition in Morocco will be completed a little earlier than anticipated.<sup>2,3</sup>

Between 1960 and 2005, the literacy rate rose from 22% to 60%. This gain was accompanied by significant efforts to promote literacy. Despite a school enrolment rate of 90%, 2.5 million children do not finish school and the quality of education provided remains key to real progress in this sector.<sup>1,2</sup>

In 2004, 14.2% of the population was living below the poverty line, i.e. nearly one point less than in the household expenditure and consumption survey conducted in 2000–2001. Gender analysis of the poverty rate shows that women are the most affected in both urban and rural areas. These data are confirmed by the results of the recent actuarial study carried out by the interministerial commission responsible for the implementation of Régime d'Assistance médicale (RAMED), which estimated that the population eligible for RAMED totalled 8.5 million (28.4%), including 4 million absolute poor (13.4% of the general population).<sup>1</sup>

To address this issue, the authorities undertook a number of actions and reforms to foster sustained economic growth, generate jobs and implement the National Initiative for Human Development, aimed at infusing new dynamism into social projects and combating poverty, insecurity and social exclusion.<sup>3</sup>

<sup>1</sup> *50 ans de développement humain and perspectives 2025*. Rabat, Government of Morocco, 2006.

<sup>2</sup> *Haut Commissariat au Plan*. Rabat, Direction de la Statistique, 2006.

<sup>3</sup> *National Initiative for Human Development*. Rabat. Government of Morocco, 2005.

## 2.2 Health situation

### 2.2.1 The reduction of mortality

As a result of the efforts deployed and the health programmes conducted in Morocco since the country's independence, mortality indicators have shown a substantial reduction. Currently, life expectancy at birth is 71 years, compared with 47 years in 1962. The infant mortality rate also fell considerably between 1962 and 2004, from 118 to 40 deaths per 1000 live births, while from 1972 to 2004, the maternal mortality rate fell from 631 to 227 deaths per 100 000 births. However, this apparent improvement is tempered by significant urban–rural disparities. Life expectancy at birth is in fact 6 years higher in urban than in rural areas. The infant mortality rate recorded in rural areas is twice that of urban areas and the maternal mortality rate is 30% higher in rural areas. Compared with other countries with a similar level of development, mortality rates in Morocco remain high. This is a real challenge for the coming years, notably as regards to achievement of the Millennium Development Goals (see Annex 1).

### 2.2.2 The triple burden of disease

The 1992 global burden of disease study confirmed that Morocco has undergone an epidemiological transition, showing that the three groups of diseases described in the International Classification of Disease (ICD-10) co-existed: noncommunicable diseases (56%), communicable diseases and perinatal conditions (33%), and injuries (11%).<sup>4</sup>

The changing disease patterns in Morocco reflect two trends.<sup>1</sup>

- A trend towards the elimination of a number of diseases, especially those targeted by immunization or specific health programmes, such as trachoma, schistosomiasis, leprosy, malaria, neonatal tetanus, diphtheria, poliomyelitis and pertussis
- A trend towards a slight reduction—sometimes persistence—of other diseases, notably: tuberculosis, acute respiratory infections, cerebrospinal meningitis, viral hepatitis (B and C), sexually transmitted infections, HIV/AIDS, foodborne infections, and waterborne diseases

However, there are two main exceptions to these trends.

- The persistent problem of perinatal mortality. At a time when most health indicators are showing a positive trend, rates of maternal and neonatal mortality, respectively 227 per 100 000 live births and 27 per 1000 live births, are influenced neither by the significant progress in the rate of childbirth attendance which reached 63% in 2004, nor by the importance given to the safe motherhood programme
- The emergence and resurgence of a number of diseases that are a threat to international health security and a genuine risk for Morocco because the country has been increasingly opening up to the outside world

<sup>4</sup> WHO Statistical information system, Morocco, 2006 (<http://www.who.int/whosis/en/index.html>, accessed 2 November, 2008).

The trend towards a rise in the global disease burden from chronic diseases, such as cancer, cardiovascular diseases (notably hypertension), metabolic diseases and deficiencies (notably diabetes), chronic renal failure and mental disorders, reflects a change in lifestyle and behavioural patterns characterized by the lack of physical activity and the adoption of unhealthy lifestyles, such as smoking and poor dietary habits.<sup>4</sup>

Intentional and unintentional injuries account for 10.8% of the global burden of disease; 51 559 road traffic accidents were recorded in 2005 over the entire road network, resulting in 80 881 casualties, including 3617 deaths. These accidents involve an estimated cost to the community of 2.5% of GDP. The above figures indicate an urgent need for preventive measures to reduce the incidence of injuries.<sup>5</sup>

### 2.2.3 Nutritional issues

Stunting, a symptom of chronic malnutrition among children under 5 years of age, decreased nationwide from 28% (1987) to 18% (2003). During the same period, the prevalence of low weight was reduced by half, from 20% to 10%. However, the increase in acute malnutrition is a cause of concern. Between 1987 and 2003, its rate has increased threefold at national level, from 3% to 9.3% and even up to 11.1% in rural areas. The available data also show a steady downward trend in breastfeeding.<sup>1,6</sup>

Micronutrient deficiencies affect a substantial proportion of the most vulnerable population (children and women of childbearing age). Iodine deficiency affects 22% of school-age children between the ages of 6 and 12; iron deficiency anaemia affects 31.5% of children under 5 years of age, 32.6% of women of childbearing age and 37.2% of pregnant women. Vitamin A deficiency affects 41% of children aged between 6 months and 6 years, and 2.5% of children suffer from radiological rickets.<sup>1,7</sup>

## 2.3 Health system

### 2.3.1 Health care services

Morocco currently has 2552 basic health care facilities, i.e. a ratio of 1 facility per 11 700 population, compared to 1 per 29 500 in 1960. Despite this increase in basic infrastructure, access to care remains difficult, mainly for populations with low resources. 25% of the Moroccan population lives more than 10 km away from a basic health facility. Health care utilization in the public sector remains very limited, with a rate of use of curative services of 0.5 consultations per inhabitant per year, a figure that can be considered low in relation to the needs of the population. In terms of design, planning and monitoring, the network of basic health care facilities does not include the private sector which has nearly 5800 physicians in general medical practice. This reflects a lack of complementarity between these two sectors.

<sup>5</sup> *National health accounts 2001*. Cairo, WHO Regional Office for the Eastern Mediterranean 2008 (<http://www.who.int/nha/country/mar/en>).

<sup>6</sup> *The Moroccan family health survey*. PAPFAM 2003–2004 ([www.papfam.org/papfam/morocco.html](http://www.papfam.org/papfam/morocco.html)).

<sup>7</sup> *Report on the expert group meeting on hospital accreditation*, Cairo, 23–26 September 2002. Cairo, WHO Regional Office for the Eastern Mediterranean, 2003.

With its 128 hospital facilities and 26 250 beds, the hospital network is another challenge in the development of provision of care in Morocco. In addition to funding, hospitals in Morocco need a more modern technical platform and reinforced skills.<sup>4</sup>

### 2.3.2 Quality of care

Despite the efforts made, quality management for health care facilities in both the public and private sectors remains a major challenge. The implementation of basic medical insurance coverage, with a concern to regulate and improve professional practice, reinforces this need for quality assurance and strengthens the case for prioritization.<sup>7</sup>

### 2.3.3 Resource generation

#### Human resources

Human resources have increased substantially over the past 40 years, with the density of human resources having increased by a factor of 6 (1 per 1775 population in 2007 compared with 1 per 12 000 in 1960), at a time when the density of paramedical staff grew from 1 nurse per 2700 population in 1960 to 1 per 1000 in 2007. Despite these efforts, Morocco is one of the 57 countries listed by WHO as suffering from an acute shortage of health personnel. The density of trained birth attendants is below 2.28 per 1000 population, WHO's critical staffing threshold. This shortage is exacerbated by the lack of a proactive and consistent policy for the development of human resources for health.<sup>1</sup>

#### Pharmaceuticals

The Moroccan pharmaceutical industry provides over 6000 direct jobs, with a turnover of more than 4 billion Moroccan dirhams (MAD) in 2000. However, it remains heavily dependent on foreign countries for the supply of raw materials (over 90% of needs). Economic accessibility of medicines remains the main concern of the health system despite the efforts made in recent years by the Ministry of Health in terms of pricing policy, for reduced taxation of some essential medicines, exemption from value added tax (VAT) and the reduction of tariffs for others, as well as in encouraging the manufacture and use of generic medicines.<sup>8</sup>

### 2.3.4 Financing

Total health expenditure in Morocco amounts to approximately MAD 19 billion (i.e. 5% of GDP), of which 51.6% is financed by households and 44.4% by collective financing (taxes, insurance and local authorities). These data show that the Moroccan health system suffers from funding that is both insufficient and lacking in solidarity. Compared to other countries with similar income, Morocco allocates fewer financial resources to health despite its weak health indicators. The Ministry of Health, however, has in recent years seen an increase in its budgetary resources. The health budget currently represents 5% of the state budget. Analysis of health expenditure by type of service shows that 37% of expenditure is devoted to the purchase of medicines and medical supplies, 31% to

<sup>8</sup> Morocco. *Medicine prices, availability, affordability and price components*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2004 (<http://www.emro.who.int/dsaf/dsa944.pdf>).



hospital care, 20% to outpatient care and 3% to prevention.<sup>5</sup>

### 2.3.5 Reform projects

The dynamics of reform in the health sector in Morocco is based on four core areas in which projects for change will generate commitment, partnerships and resources.

#### Regionalization

Since the introduction of a law on regionalization (1996), the Ministry of Health has undertaken a number of regional reorganization initiatives to set up health regions. These efforts led to the development of a model regional organization of health services and the creation of three regional directorates. However, it must be acknowledged that health regions have not yet become operational entities for the planning of health activities and the implementation of national strategies. While the setting up of a regional health structure is essential for the consolidation of decentralization efforts, it is not sufficient to help improve health system performance.

#### Reform of health financing

The health financing reform project began with the development and implementation of basic medical insurance coverage (Couverture Médicale de Base) with its two schemes—AMO (mandatory health insurance) and RAMED (medical assistance scheme), followed by an extended new scheme, INAYA, for coverage of the self-employed and the professions (see Annex 2).<sup>5</sup>

➤ AMO applies to civil servants, private sector employees and persons subject

to the social security system; it already covers 34% of the population

- RAMED, which targets the estimated poor segments of the population, will involve 8 500 000 beneficiaries according to the latest actuarial study, i.e. nearly 30% of the population
- INAYA is considered innovative but is not yet operational. It targets a population of nearly 10 million, i.e. approximately one third of the population, through private mechanisms

#### Hospital reform

Morocco is currently engaged in sweeping and costly hospital reform that has enabled a management framework for hospitals to be set up, based on the first legislation to organize public hospitals. This restructuring effort is supported through three major sectoral projects that also support the reforms mentioned earlier.

- The project for health sector financing and management, which has enabled the Ministry of Health to initiate and implement hospital reform (component 1) and basic medical coverage (components 2 and 3). This project received financial support from the World Bank to the amount of approximately 34 million Euros and has involved five regional hospitals. It was completed in March 2007
- The project to support health sector management (PAGSS), which is primarily a project to support sectoral regionalization and has enabled the setting up of the first regional health directorate in the eastern region.

This project was completed in 2007

➤ The recently launched Morocco-Health III project, which supports the extension phase of the hospital reform, reflecting the commitment to a general deployment of the reform's tools. This project involves 21 provinces distributed across nine regions. The funds devoted to these operations amount to 141.13 million Euros, including a 70 million Euro loan from the European Investment Bank. This project also received a donation of 7.5 million Euros to enable the Ministry of Health to recruit technical assistance for the elements of hospital reform that were not concerned with equipment or construction

These investments made for the restructuring of hospitals reflect the Ministry of Health's determination to improve the provision of care and the image of public hospitals among the population.<sup>5</sup>

### Legal reform

Legal reform has been undertaken on one hand to ensure the implementation and sustainability of the different reform projects and, on the other hand, to ensure the supervision and regulation of the health system as a whole. The past five years have been particularly positive for health system regulation.<sup>9</sup>

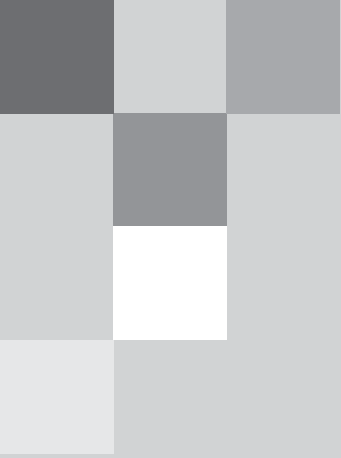
## 2.4 Main challenges

Because of the different transitions undergone by Morocco and the policy steps taken to reduce social deficits and upgrade

the basic infrastructure, it is important to place health sector challenges in the broader context of this dynamic and the interactions that should exist between this sector and other development sectors. Socioeconomic challenges, such as poverty, rural development and employment, have a direct impact on health. Morocco consequently faces the following health challenges.

- health security and globalization
- consolidating achievements made in health protection and in the control of communicable and emerging diseases
- triple burden of disease and the issue of perinatal mortality
- vulnerability of some segments of the population
- lack of consideration for social determinants of health
- lack of access to care as a central obstacle to the development of the health system
- growing role of the private and associative sectors in the financing of health care provision
- shortage of human resources for health
- need for quality assurance as a prerequisite for restoring confidence in the public sector and health system reforms
- improving health system performance through strengthening its functions, particularly governance

<sup>9</sup> Morocco. Country brief. World Bank 2008 (<http://web.worldbank.org/wbsite/external/countries/menaext/moroccoextn/0>).



Section

# 3



**Development Cooperation and  
Partnerships**



## Section 3. Development Cooperation and Partnerships

### 3.1 International cooperation in the health sector in Morocco: an overview

Funding of health through international cooperation amounted to MAD 127 million (US\$ 11 million) in 2001, and accounted for approximately 0.7% of total health expenditure and 3% of the overall budget of the Ministry of Health, still the largest recipient of assistance. However, these figures are already outdated and do not cover technical expertise. Consequently, they give only a partial view of the “weight” of cooperation. Significant budgetary support is currently either ongoing or being prepared and is often accompanied by technical assistance, training activities and fellowships. These support the main reforms in the sector: institutional reform and regionalization, reform of funding and hospital reform. Other support in infrastructure and logistics, or of a technical or financial nature, is also provided through cooperation, with procedures, geographic areas and duration that vary from one organization to another.

### 3.2 Action and main partners

Tables produced by the Directorate of Planning and Financial Resources in the Ministry of Health give detailed information of the projects supported by the different cooperation agreements (see Annex 3).

#### The system of UN agencies

The United Nations Development Assistance Framework for 2007–2011 is

based on the national goals for human development in Morocco. It is built around the following five “access portals”.

- management of natural and cultural heritage as essential vectors for policies to combat poverty and promote sustainable development
- decrease in rural vulnerability
- strengthening of human and social capital and improved access to basic social services
- empowerment of women and girls in the political, legal, economic, social and cultural fields
- promotion of human development and democratic governance to support the reduction of poverty and exclusion

The agencies involved in the area of health are mainly WHO, and within the traditional scope of their competence, for reproductive health, the United Nations Population Fund (UNFPA) and for child health, the United Nations Children’s Fund (UNICEF). The International Atomic Energy Agency (IAEA) is actively involved in strengthening the use of nuclear technology in the health sector and in preventing risks of ionizing radiation.

#### Other multilateral cooperation

The World Bank is active through the project for health sector financing and management. The European Union is involved through the project to support

health sector management (PAGSS) and a programme to support the implementation of basic medical insurance coverage. The second phase of these projects is currently being prepared. The African Development Bank is also involved in the support programme for the reform of basic medical insurance coverage (PARCOUM). The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is currently executing its fifth five-year programming cycle in Morocco (HIV/AIDS and tuberculosis).

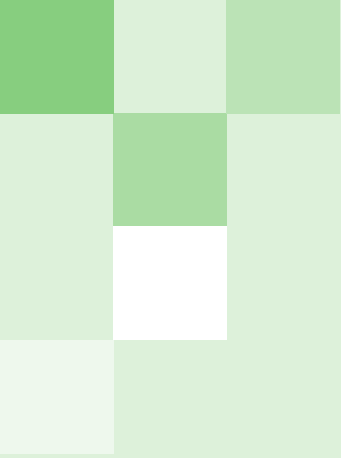
### **Bilateral cooperation**

Several countries, some of which have a long history of cooperation with Morocco, provide valuable assistance: France (notably through the REDRESS programme to support regionalization and the upgrading of basic health care facilities in the regions), Spain, Germany, Italy, United States of America, China and Japan are the main providers. The Ministry of Health has also signed cooperation agreements with a number of African countries covering various areas, notably training, medical evacuation, expertise and twinning between hospitals. It is important to note that though the safe motherhood programme has been receiving a wide range of support for several years, this has had no significant effect on mortality indicators. This is a critical challenge for Morocco and its international partners.

## **3.3 Coordination**

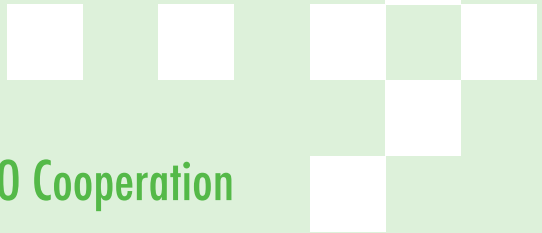
Though external assistance is a vital support for health development in Morocco, it should be part of an overall development strategy and placed under the governance of the national health system, taking into account the comparative advantages of each organization. There is a need to develop the Ministry of Health's leadership to improve the coordination of international aid. A sectoral thematic group has been established under the auspices of the European Commission and the Union's member states. Moreover, as part of the implementation of United Nations reform, several interagency thematic groups have been set up to cover specific fields: reduction of maternal and neonatal morbidity and mortality, promotion of adolescent and youth health and HIV/AIDS prevention and control.

There are currently numerous opportunities for cooperation in the development of the health sector in Morocco. A structured partnership, with clear coordination and collaboration mechanisms is needed to increase aid effectiveness for the benefit of the country itself and as set out in the commitments made by the international community to harmonize and align aid delivery (Paris Declaration).



Section

# 4



Current WHO Cooperation





## Section 4. Current WHO Cooperation

### 4.1 Budgetary allocations

Since Morocco became part of the WHO Eastern Mediterranean Region in 1985 and the WHO Representative's Office was opened in 1986, it has received assistance worth US\$ 22.96 million to support health programmes. As an indication, the average regular biennial budget allocated to Morocco has been approximately US\$ 2 million, compared with an average of US\$ 300 000 when it was part of the European Region. Other activities are funded from extrabudgetary resources. The funds allocated under the regular budget since the opening of the WHO country office, by biennium, are shown in Table 1.

### 4.2 Areas of work and partners

As part of the joint collaborative programme, the budget allocated to Morocco by WHO for the biennium 2006–2007

amounts to US\$ 1 939 000, excluding technical assistance through missions of regional advisers or the participation of national professional officers in intercountry activities. One hundred per cent of the biennial collaborative agreements entered into were in line with the priority directions of cooperation established as part of the 2004–2007 CCS.

The current WHO programme in Morocco includes 20 action programmes and the implementation rate of the joint workplans between WHO and Morocco, at the end of the first year of the biennium, is approximately 61%. Expenditures during this first year were distributed as follows: health system (51%); noncommunicable diseases, lifestyles and health determinants, family and community health (29%); communicable diseases (11%); environment and health (5%); and usable health information and publications for public health (4%).

**Table 1.** History of regular budget allocations as part of WHO cooperation

Period	Budgetary allocations (US\$)
1986–1987	471 200
1988–1989	2 296 000
1990–1991	2 380 500
1992–1993	2 113 843
1994–1995	2 581 900
1996–1997	2 514 200
1998–1999	2 525 973
2000–2001	2 095 200
2002–2003	2 067 000
2004–2005	1 978 000
2006–2007	1 939 000

The performance assessment for the first year of the biennium 2006–2007 shows that training accounts for a large proportion of expenditure, with some 53.5% of the funds used (fellowships and seminars), followed by 41% for the costs of recruitment of consultants (national consultants (22%) and international consultants (19%) and 5.5% for local costs (studies, surveys, subscriptions).

WHO headquarters and the Regional Office have been able to mobilize additional funds for a number of national programmes: tuberculosis, safe motherhood, surveillance of acute flaccid paralysis, leishmaniasis, measles and patient safety. In addition to the Ministry of Health, the WHO country office has for several years extended its cooperation with other partners: the Ministry of Education, the Ministry of Higher Education (faculties of medicine), the state secretariat responsible for women, children and people with physical disabilities, the Department of the Environment and nongovernmental organizations.

Moreover, at the behest of all the agencies and organizations of the United Nations system, the WHO country office is involved in the different work and actions of the UN system, such as the updating of the Common Country Assessment (CCA), the development of the United Nations Development Assistance Framework (UNDAF) and, through the various thematic groups, the development of community-based approaches and local development projects.

### 4.3 Country Cooperation Strategy 2004–2007

The WHO country office in Morocco is committed to WHO's country focus initiative. The CCS 2004–2007 was developed within this framework. This exercise enabled a more effective supervision of programming within the framework of the two joint programme review and planning missions carried out during this period. However, the introduction during the same period of results-based management, and the effort that this required to upgrade and train the technical directorates at the Ministry of Health and programme focal points, disrupted the focus of the strategic agenda set for the CCS 2004–2007. This situation was exacerbated by the fact that the JPRM team, which included Regional Office staff, did not make use of this agenda in selecting and arbitrating between the programmes proposed in the joint workplan.

The implementation of the first CCS also suffered from the conditions created by the change of government and the preparation of a new sectoral strategy for 2003–2007, as the CCS had essentially been based on the priorities defined in the sectoral strategy for 2000–2004. The need for further revision of the CCS should therefore be taken into consideration if there is a major change in health policy directions and priorities.

The value of any CCS is dependent on its appropriation within WHO as a whole (country office, Regional Office and headquarters) and by the Ministry of Health and its partners. The implementation of the current CCS should therefore provide for promotional actions for the CCS and

support to enable appropriation and implementation.

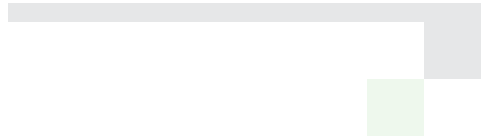
#### 4.4 Technical staff and working conditions

In addition to the WHO Representative, the permanent staff of the WHO country office in Morocco includes one professional staff member and other members of the general services category. A number of people have been recruited under theoretically short-term special services agreement (SSA) or agreements for performance of work (APW), but some of these have been renewed for several years. Technical staff include: 1 national professional officer (3 years in the WHO country office), responsible for programmes; 1 project coordinator (SSA) (8 years in the WHO country office); 1 basic development needs national focal point (SSA) (6 years in the WHO country office); 1 focal point for community mutual health insurance scheme (SSA) (2 years in the WHO Office).

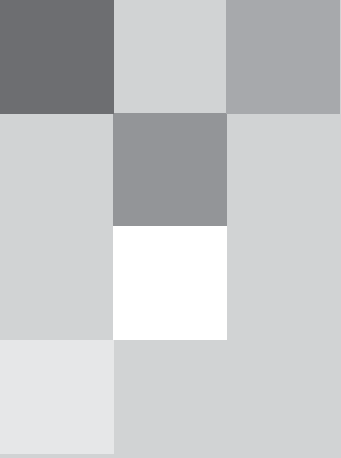
The technical staff are rarely involved in the technical activities of the Regional Office and headquarters, and this complicates the implementation, follow-up and evaluation of the recommendations made by various forums.

For administrative and logistical support, the WHO country office in Morocco has: 1 administrative assistant (6 years in the WHO country office); 1 information and computer technology assistant (2.5 years in the WHO country office); 3 secretaries; 2 drivers; a female cleaner; and a security guard.

A functional analysis of the WHO country office in Morocco in January 2005 showed that of the 22 main functions, 17 were fulfilled and of 11 auxiliary “need-based” functions only four were fulfilled. On this basis, tasks were redistributed and the terms or reference of the staff reviewed. A plan of action to address the functions that are not satisfactorily fulfilled was introduced in the 2006 performance management system.







Section

# 5



**Strategic Agenda for  
WHO Cooperation**



## Section 5. Strategic Agenda for WHO Cooperation

### 5.1 Introduction

The General Programme of Work is a requirement specified in Article 28(g) of the WHO Constitution. The General Programme of Work analyses current health challenges in light of WHO's core functions and sets broad directions for its future work. The core functions as stated in the Eleventh General Programme of Work, covering the period 2006–2015, are as follows.

- Providing leadership on matters critical to health and engaging in partnership where joint action is needed
- Shaping the research agenda, and stimulating the generation, dissemination and application of valuable knowledge
- Setting norms and standards, and promoting and monitoring their implementation
- Articulating ethical and evidence-based policy actions
- Providing technical support, catalysing change and building sustainable institutional capacity
- Monitoring the health situation and assessing health trends

The analysis in the Eleventh General Programme of Work reveals several areas of unrealized potential for improving health, particularly the health of the poor. The gaps are identified in social justice, in responsibility, in implementation and in knowledge. WHO's response is translated

into priorities in the following areas according to its results-based management framework.

- Providing support to countries in moving to universal coverage with effective public health interventions
- Strengthening global health security
- Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health
- Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health
- Strengthening WHO's leadership at global and regional levels and by supporting the work of governments at country level

The Medium-term strategic plan 2008–2013—an integral element in WHO's framework for results-based management—translates the Eleventh General Programme of Work's long-term vision for health into strategic objectives, reflects country priorities (particularly those expressed in country cooperation strategies) and provides the basis for the Organization's detailed operational planning. The strategic objectives provide clear and measurable expected results of the Organization.

The structure of WHO's Secretariat assures involvement with countries.

Headquarters focuses on issues of global concern and technical backstopping for regions and countries. Regional offices focus on technical support and building of national capacities. WHO's presence in countries allows it to have a close relationship with ministries of health and with its partners inside and outside government. The Organization also collaborates closely with other bodies of the United Nations system and provides channels for emergency support.

In developing strategic priorities for collaboration between WHO and the Government of Morocco during the mid-term period 2008–2013, special care has been taken by the CCS mission to ensure that these priorities are in line with the Organization-wide priorities and overall strategic directions during the same period.

## 5.2 Framework

Action in the field of health is so complex and diverse that it is hard to precisely define through a strategy, however relevant. Moreover, there are so many interactions and parties involved that there is a need for proper coordination and regulation. Because of its broad mission to support countries, so that “all peoples attain the highest possible standard of health”, and with limited resources, WHO must invest in “structuring” actions that are concomitant with its core functions, based on its technical expertise and on the approaches and instruments promoted by the Organization. Four principles or criteria have been selected to define the priorities for cooperation between WHO and Morocco.

- Targeting strategic areas that have a “structuring” effect
- The comparative advantages of WHO
- Priority to actions that have a direct effect on the population and on professionals
- The country's commitment at international level, particularly in terms of meeting the targets of the Millennium Development Goals

On this basis and given the development perspectives for the health sector in Morocco as described in Morocco's vision for health for 2020, the United Nations Development Assistance Framework for Morocco (2007–2011) and WHO's strategic objectives as set out in its medium-term strategic plan (2008–2013), four components have been identified for the CCS strategic agenda.

- Public health and health security
- Protection of population groups that are vulnerable or have specific needs
- Advocacy and intersectoral action for health
- Health system capacity-building

The logic underlying this choice also lies in the consistency between components.

- the first component targets public health problems, at the heart of WHO's missions and technical expertise
- the second component aims to reduce health inequities by targeting population groups that are vulnerable or have specific needs for whom coverage is currently insufficient or lacking altogether



- the third component targets health determinants and strengthens health promotion
- the fourth component creates a link between the first three components and the capacity of the health system to implement them. It aims to improve the system's performance by targeting priority functions

Figure 1 below shows the connections between the components in the CCS strategic agenda, the priority health areas in Morocco as defined in the vision for health in 2020, and the objectives of WHO's medium-term strategic plan (MTSP).

## 5.3 Structure

### 5.3.1 Component 1: Public health and health security

Despite the efforts and achievements made in the control of communicable diseases, these diseases continue to weigh heavily on the overall disease burden and are still prevalent. Prevention and control of those communicable diseases that are still prevalent will continue to be core priorities shared by the Organization and the Ministry of Health. As regards the control of diseases targeted by immunization, efforts made in Morocco have been very successful. It is important to consolidate and step up these efforts by introducing new vaccines to contribute to reduce child mortality, as their added value has been proven.

With the new millennium come new threats of pandemics associated with the emergence and reemergence of infectious diseases that recognize no borders and

weigh heavily on international security. All countries are now under obligation to implement the newly adopted International Health Regulations (IHR 2005).

The third millennium also augurs a recrudescence of humanitarian crises and natural disaster, to which Morocco is not immune. Road traffic accidents with their heavy toll of deaths and injuries are a very real public health problem. There is a need for urgent and concerted efforts to reduce their impact in terms of mortality and morbidity.

Finally, the epidemiological transition in Morocco increasingly exposes the country to noncommunicable diseases that are currently central to medical coverage and the whole issue of access to care.

WHO will provide technical support to the Ministry of Health for the implementation of the following priorities.

- Consolidating achievements made in the elimination of specific diseases and maintaining the priority given to the control of communicable diseases that are still endemic
- Continuing to give special emphasis to the national immunization programme, while working to introduce new vaccines in the national immunization schedule in order to reduce the impact of some childhood diseases (pneumococcal disease, rotavirus infection, etc.)
- Maintaining vigilance against emerging and reemerging diseases, particularly those of international concern. The implementation of the

IHR 2005 and the strengthening of the epidemiological surveillance system are two mainstays of this priority

- Reducing the health impact of emergencies and disasters, including violence and injuries. The seriousness of road traffic accidents makes them a priority area for action
- Developing and implementing national strategies for combating noncommunicable diseases while attaching special importance to the control of risk factors that are common to

all these diseases. Only the adoption of healthy lifestyles offers a comprehensive approach to the prevention and control of these diseases at a reasonable cost to the community

### 5.3.2 Component 2: Protection of population groups that are vulnerable or have specific needs

A main focus of work to improve equity in access to care is the targeting of particularly vulnerable segments of the population, such as pregnant women and

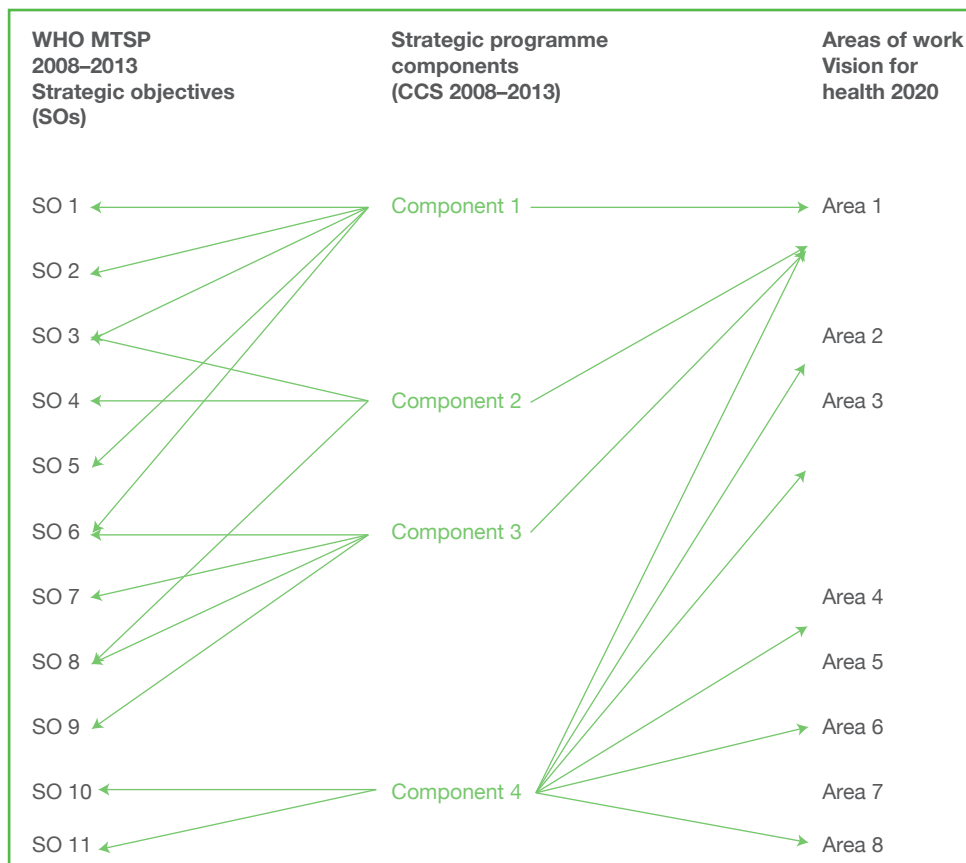


Figure 1. WHO's strategic objectives and health priorities in Morocco

newborn infants, or groups of population with specific needs: people with physical disabilities, older people, children, young people and adolescents. Maternal and infant mortality rates remain unacceptably high in Morocco, despite the resources invested in “targeted” programmes such as safe motherhood programme. With the demographic transition that the country is currently experiencing, the young and elderly populations are going to increase and will have an increasing influence on social, health and economic dynamics. Morocco has embarked upon a policy to step up democratization and reinforce human rights, especially for sectors of the population, such as people with physical disabilities (5.12% of the population<sup>10</sup>) and victims of violence should not be left out of health coverage.

WHO will support the Ministry of Health in the following priority actions.

➤ Women and newborn infants: developing/ revising mother and child health strategies and plans to support an evidence-based maternal and neonatal mortality reduction initiative through:

- conducting evidence-based analysis/ studies to identify the causes of maternal and neonatal mortality from the start of pregnancy to the monitoring of newborn babies, including why previous efforts have not been successful and the impact of shortcomings within and outside the health care system to reduce mortality

- developing strategies/plans to remedy gaps within the health system for the reduction of maternal and neonatal mortality
  - preparing promotional and advocacy approaches, strategies and plans to minimize the causes of maternal and neonatal mortality that are outside the health system
  - strengthening existing national surveillance systems, including instituting a national maternal mortality committee to review and monitor maternal deaths to identify mortality and morbidity trends among mothers and newborn babies in order to adopt evidence-based interventions, including community-based interventions
  - mobilizing political leadership and resources for improving reproductive health with specific focus on maternal and newborn health
- People with physical disabilities: upstream action on the prevention of physical disability. Apart from its more general support with regard to health determinants (see component 3), WHO will provide targeted support for the prevention of physical disabilities from perinatal risks, childbirth and contracted diseases. WHO will provide support as part of the national strategy for the prevention of physical disabilities

<sup>10</sup> State secretariat responsible for families, children and people with physical disabilities. National strategy for the prevention of disabilities: strategic directions and preventive measures, 9 February 2007.

- Older people: documenting morbidity and defining a strategy for the care of older persons. Training will be of central importance in this strategy, with special emphasis on training for general practitioners and nurses
- Young people and adolescents: emphasizing the ability to listen and to inform. This will be addressed as part of school and university health promotion programmes
- Women and child victims of violence: coordinating and integrating activities. In the initial phase, WHO will facilitate the development, by the concerned ministries, of a national strategy integrating the role of the health sector. Responsibility in this sector encompasses both provision of care by health services and subsequent referral to appropriate facilities

Civil society is particularly active in providing support to vulnerable populations. The actions developed in this area will help strengthen partnerships with nongovernmental organizations. However, in view of the number of parties involved in this area, there is a need for WHO to work with the Ministry of Health and the other ministries, and to consult with partners to ensure more alignment and harmonization in the activities.

### 5.3.3 Component 3: Advocacy and intersectoral action for health

Intersectoral advocacy is the main way forward to mobilize concerted action on health determinants. It underlies partnerships within the government, between public and private

sectors, between cooperation partners and with the civil society. This advocacy is based on WHO's definition of health, and gives a central role to the involvement of individuals, communities and all sectors concerned in the health development process. The issues that underlie health inequity, such as the development of rural communities, the fight against poverty and the promotion of the rights of women and children are paths that can be followed to initiate and strengthen health advocacy. There is currently an urgent need to reposition the health sector as an important sector for economic development and also for social development and enhancement of human rights.

In this respect, and in light of the introduction of the National Initiative for Human Development, the epidemiological transition and the law on the protection of the environment, WHO's action in health promotion will focus on three main areas: ensuring that the social determinants of health are addressed; protecting the environment; and promoting healthy lifestyles and nutrition.

This component involves supporting actions that adopt a different approach to health determinants, repositioning health as an intersectoral issue, and that seek to mobilize new partnerships for health. Community and intersectoral participation will be a key vector for this work. The basic development needs approach promoted by WHO should now be integrated into current socioeconomic development initiatives in Morocco, in particular those promoted as part of the National Initiative. There will be a special focus on projects concerning health, and on training provincial delegates

and directors of health regions to address the issues of community and intersectoral participation.

#### 5.3.4 Component 4: Strengthening health system capacity and performance

The various health promotion and protection programmes can only have the desired impact if health systems that represent the platform required for all health actions are strengthened. Therefore, it is important to invest in such strengthening. This is the most “structuring” component of this strategic programme. It calls on the sovereign functions of the State and aims to improve the major functions of the health system (service provision, financing, resource, governance and leadership). To be capable of assuming its stewardship role and ensuring that the health system is adequately regulated, the Ministry of Health must be able to improve its ability to organize and supervise health actions, and implement the reforms initiated, ensuring their sustainability.

Health system financing is a function that requires special attention because of the major reforms undertaken by the Government in the field of health protection, through the extension of health insurance coverage. It remains important to generate more information about equity and the catastrophic expenses related to health care.

A special effort is required in the area of human resources, an essential component of the health system, through a strategic, long-term review process. Reforms should address the production, management and

evaluation of human resources. This will call for institutional strengthening, better coordination between the different bodies involved in training and capacity-building at the different levels of intervention.

The performance of the health system should be measured and monitored in order to identify strengths and weaknesses and to be capable of adapting to the new challenges. Performance assessment and monitoring will be supported by the use of the analytical tools promoted by WHO, particularly burden of disease measurement and national health accounts. The findings of analytical studies and concomitant action-research should be used as input to political debate at national level, and provide a framework for this debate. In this general framework, WHO’s support in Morocco will specifically focus on the following aspects.

- Generation of evidence-based information on the health system
- Strengthening the national health information system at all levels of the pyramid of service provision to promote the collection and analysis of morbidity and mortality data, notably as input to the Ministry of Health’s planned study of disease burden
- Exerting a special effort in the area of epidemiological research and research on the health system and services to gain fuller knowledge of the health system
- Undertaking an analysis of the actual determinants of maternal mortality

## Provision of services

Efforts will focus on improving access to health services and coverage by the various health protection and promotion programmes, through two types of priority initiatives: supporting further decentralization to ensure proper implementation; and improving service quality and enhancing patient safety.

## Human resource development

Low staffing numbers and poor geographical distribution make human resources one of the main priorities for health development in Morocco. WHO's support will aim to:

- Ensure the preparation of a national strategy spanning various aspects of this issue, including strategic planning, the production of the required workforce, the management of personnel and performance evaluation
- Improve training at basic curriculum, further training and refresher levels
- Ensure good coordination with the other partners concerned, and with the departments of education, higher education and professional associations

## Governance

This important function should be strengthened by actions to:

- Develop norms and quality standards for services provided, health legislation and inspection in all technical and administrative areas

- Implement the tools needed to manage the public–private mix and produce the health map. The Ministry of Health should be able to use the analytical tools for performance assessment in this area, namely burden of disease analysis, national accounts analysis and the utilization of scenarios for long-term strategic planning
- Strengthen the coordination function both within the department and with the main national and international partners
- Develop a function for analysing health policy implementation. A forum might also be developed around a national health system observatory to facilitate the monitoring of the reforms undertaken by the ministry and other agencies

## Financing

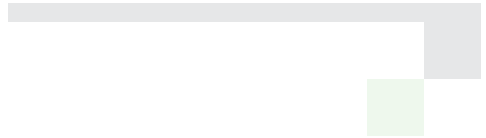
WHO's priority is to provide technical support for the reform to extend compulsory health insurance coverage. Activities will address the generation of information on funding levels and structure by measuring the fair financing index, the level of catastrophic health care expenditure and the risks of increasing poverty caused by morbid events within the household. The national health accounts tool will be more fully adapted to the Ministry's requirements in order to generate the data needed for decision-making. The Ministry of Health will be supported in the efforts initiated in the analysis of costs of health services and cost accounting.

## Health technology

The goals of the vision for health for 2020 focus on the key role of affordable access to quality medicines and their rational use. WHO will focus on: implementing a survey to determine the price structure of medicines and to measure the degree of penetration of generics on the market in Morocco; and developing standard treatment regimens for selected common diseases.

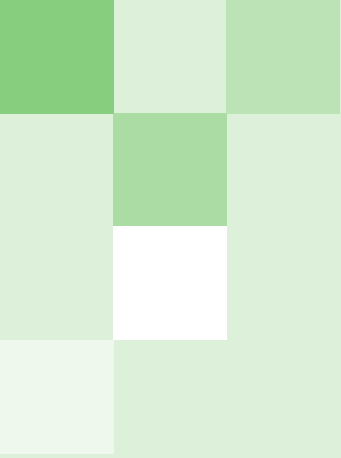
The four major thrusts of this strategic agenda are interdependent, yet complementary. WHO will strive to favour synergies and collaboration, both at country level and within the Secretariat. Moreover, the Moroccan experience provides a wide range of valuable new information for the international community.

Morocco is also seeking to collaborate with other players in the search for solutions to the increasingly complex problems of human development, and to learn from the experience of other countries with similar contexts. A number of global and regional initiatives can benefit from Morocco's contribution. WHO will strive to promote intercountry cooperation, including south–south cooperation and cooperation between countries within the Maghreb. It will encourage the contribution of Moroccan centres of excellence and the use of Moroccan expertise at international level.









Section

# 6



**Implementing the Strategic Agenda:  
Implications for WHO**



## ❖ Section 6. Implementing the Strategic Agenda: Implications for WHO

### 6.1 WHO positioning in Morocco: strategic support to the Ministry of Health and promotion of effective partnerships

The main implications for WHO of the formulation of its CCSs derive from the Organization's country focus policy. These implications concern the country office, the support it receives from the Regional Office and headquarters, the other forms of WHO's presence in the country, and the interactions with partners. The specific implications in Morocco are presented here in the form of supportive interventions required to implement this CCS.

In a country such as Morocco, currently experiencing a number of transitions (demographic, epidemiological, political, etc.), with major ongoing health reforms, the WHO country office should have a strategic position. WHO's institutional support in Morocco, as mentioned in Section 6 above, should cover ongoing reform projects. The formulation of the CCS and the Joint Programme Planning and Review Missions that monitor it are opportunities to put stronger emphasis on these directions and reinvigorate the Organization's area of action and expertise.

WHO, with its expertise and reputation, has a responsibility to provide leadership in the coordination of international support for health. WHO plays a very active role in the United Nations agencies' thematic meetings. A number of themes

have already been prioritized: HIV/AIDS control, reduction of violence, youth and adolescent health and community-based initiatives. However, all of these areas lack harmonization. Consequently, WHO should support the Ministry of Health and step up its role in these coordination mechanisms and with other partners particularly active in the health field, in order to promote alignment and complementarity. Here, the sector-wide approach (SWAp) could be used as a platform to unify approaches and objectives.

Complementary action might be to use partnership networks and develop national alliances for health. Just as in WHO headquarters, this would involve initiating and supporting alliances on specific issues. The alliances would include governmental and nongovernmental organizations, international agencies, health stakeholders and patient associations seeking solutions to specific health problems. The context in Morocco favours this type of mobilization, enabling the fostering of civil society participation and health promotion. In this respect, there appears to be a strong case for forging national alliances for tobacco control, and improving the social determinants of health or patient safety, as such alliances would reflect the priorities of the country and the Region.

### 6.2 Implications for the country office

The WHO country office in Morocco plays a key role in technical cooperation

and supervision in the health sector. It fulfils advisory functions in health policy and technical support, information, public relations, advocacy, management and administration. Until now, the country office has been capable of meeting the expectations and needs of national partners. It has a National Professional Officer recruited as recommended in the first CCS, who fulfils technical functions and who has developed very good collaboration and coordination relations with national partners. It also has an Administrative Assistant who fulfils the administrative management function properly and a Secretariat adequately staffed to address the Office's needs. In terms of information technology (IT), the Office has an Assistant Computer Technician who manages information flow and security and ensures that the IT equipment is working properly and well maintained. A United Nations volunteer, recently seconded by United Nations Development Fund (UNDP), is responsible for the follow-up of the thematic groups on safe motherhood and HIV/AIDS. From the point of view of connectivity, the Office has VSAT (very small aperture terminal) and ADSL (asymmetrical digital subscriber line) lines and has no shortfalls in this area.

As part of the collaboration with United Nations agencies and development partners, notably concerning the generation of awareness and the relationship between health and development, the country office plays an active role. This is particularly true in the development of views of the UN development groups intended for national partners and in the development of communications. In fact, WHO is leading the

UN Thematic Group on Safe Motherhood; it is a very active member of the UN Thematic Group on AIDS, which it chaired efficiently for several years; it serves as vice-chairman of the country coordinating mechanism (CCM), the body responsible for managing the projects of the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis. It is also an active member of the UN Thematic Groups on Youth and Adolescents and Migration, as well as the European Commission's Thematic Group on Health.

An organizational audit of the country office with an in-depth assessment of its administrative and management capacities was conducted in 2005. It revealed a number of shortcomings, notably in terms of staff development and resource mobilization.

The implementation of the CCS, and the advocacy and coordination efforts needed for the selected strategic components will have implications in terms of capacities for the WHO country office in Morocco. The national authorities recognize the technical quality and neutrality of WHO's support, but expect less compartmentalized and more coherent assistance. The Organization should align its activities with the national development processes, favouring upstream commitment and integration of the activities of the different programmes and partners. The strengthening of the representation role in the coordination of international cooperation in health and dialogue between partners continues to be dependent on the development of its capacities in terms of communication, advocacy, sectoral approaches and sustainable development. To mobilize all national and international partners active in the health sector, and

foster collaboration between the different programmes, there is a need to build up the capacities of the country team to enable it to better support health systems development, have a more strategic involvement with partners and support the coordination and development of partnerships more efficiently. In this connection, there is a need to recruit a full-time WHO Technical Officer to effectively assist in aid coordination and building partnership for health. WHO support in aid coordination also requires better administrative systems and the delegation of authority enabling WHO to work efficiently at country level. There is also a need to improve the mechanisms whereby the country office can be responsible for the mobilization and management of financial resources.

To better implement the recommendations of the CCS and more efficiently execute the operational plans derived from it, the staff of the country office should be more involved in regional activities and those at headquarters level. They would also benefit from exchanging visits and sharing experience with other WHO country offices.

To ensure improved monitoring of cooperation programmes it would also be desirable to maintain and institutionalize the joint annual review of WHO programmes in Morocco. This is an annual meeting between the WHO Representative and its national partners aiming at a mid-term assessment of the biennial programme of work. The results of this meeting will, inter alia, help reprogramme activities and reallocate financial resources for the second year of the biennium. This will not be new

programming and no new project is to be reintroduced in this review.

As for financial programming, it should be geared to appropriate supervision of CCS actions. WHO should work to mobilize the extrabudgetary resources required, within the framework of international cooperation, in order to support the CCS goals. The aim is also to improve the credibility of the Organization, which for each biennium plans the amounts of the regular budget and extrabudgetary funds for supporting its activities.

Financial support for the operation of the country office is also required to best meet the expectations of the national partners. This budgetary support will help to finance a number of useful facilities and equipment for the office.

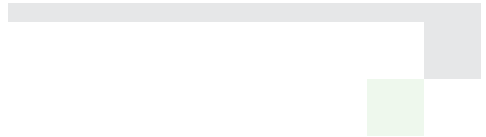
### 6.3 Implications for the Regional Office and headquarters

The strategic programme presented in the previous section shows the different areas to which the Regional Office and headquarters will be requested to contribute. Timely mobilization of technical support and high-level expertise by the appropriate units at the Regional Office and headquarters, particularly in areas such as health system financing and resource mobilization, will be important. To provide faster and more efficient technical support to address the needs expressed by Morocco, there will be a need to develop new capacities at regional and subregional levels. The availability of documentation and international guidelines, as well as the conducting of workshops in French, should be promoted.

## 6.4 Other forms of WHO presence in Morocco

As indicated in Section 6, the development of human resources in Morocco, the quality of the expertise available, the deployment of a strong infrastructure and the level reached by the training structures will be enhanced by WHO and be taken advantage of by the Organization in intercountry cooperation, platforms, forums and international networks.

Finally, the world's economic situation, health security issues and the limits reached by traditional forms of cooperation should encourage particular attention to be given to WHO collaborating centres as a means of strengthening cooperation with Morocco and building up the capacities of its health system. In Morocco, WHO collaborating centres do not appear to receive enough recognition to fulfil their role in the national health system and assume their status as collaborators with the Organization. Morocco is in a period of transition and is at a regional crossroads, hence, the need to review and revive this form of collaboration.



### Annex 1

#### Members of the CCS mission

##### Members of the WHO CCS team for Morocco

Dr Said Youssef, WHO Representative, Morocco

Dr Jouad Mahjour, Director, Communicable Diseases, EMRO

Dr Belgacem Sabri, Director, Health Systems, EMRO

Dr Carol Landon, Public Health Officer, Department of Country Focus, HQ

Mr Jaafar Jaffal, Technical Officer, Planning Monitoring and Evaluation, EMRO

##### Members of the national team met by the CCS team

Dr Mustapha Ismaili Alaoui, General Inspector, Ministry of Health

Mr Jilali Hazim, Director of Planning and Financial Resources, Ministry of Health

Mr Ahmed Ait Malek, Head of Cooperation, Ministry of Health

Ms Sanaa Cherqaoui, Head of International Cooperation Service

Mr Hassan Akhadam, Head of Planning, Ministry of Health

Dr Abdelali Alaoui Belghiti, Director of Directorate of Hospitals and Ambulatory Care, Ministry of Health

Dr Mimoun Ennaciri, Head of Hospitals Division, Ministry of Health

Dr Amina Sahel, Head of Ambulatory Services, Ministry of Health

Dr Nouredine Chaouki, Director of Epidemiology and Diseases Control, Ministry of Health

Dr Abdelwahab Zerrari, Acting Director of Population Affairs

Mr Mohamed Madi, Head of Communication Services, Ministry of Health

Dr Hamid Chekli, Head of Child Health Services, Ministry of Health

Dr Ali Bensalah, Head of Maternal Health Services, Ministry of Health

Dr Abdelaziz Agoumi, Director of Medicines and Pharmaceuticals, Ministry of Health

Mr Elhachmi Bouzbib, Directorate of Medicines and Pharmaceuticals

Ms Laila Hakkou, Head of Laboratory Services, Ministry of Health

Ms Khadija Meshak, Director of Directorate of Legal Issues, Ministry of Health

Mr M'hamed Benelkadi, Director of Human Resources, Ministry of Health

Mr Mohamed Zaari Jabiri, Head of Training Division, Ministry of Health

Mr Abdelhai Laghmam, Director of Equipment and Maintenance, Ministry of Health

Ms Touria Sefrioui, Head of Equipment Services, Ministry of Health

Mr Radouane Cherkaoui, Division of Equipment and Maintenance Staff

Dr Mohamed Hassar, Director of Pasteur Institute

Dr Rajae El Aouad, Director of National Institute of Hygiene

Professor Abderrahmane Maaroufi, Director of the National Institute of Health Administration

Dr Noufissa Benchemsi, Director of National Blood Transfusion Centre

Dr Mohamed Tazi Saisout, Director of National Radiation Protection Centre

Mr Bouchaib Mouijane, National Health Insurance Agency Staff

Dr Mohamed El Menzhi, Regional Director of Casablanca, Ministry of Health

Dr Mohamed El Jazouli, Delegate from the Ministry of Health, Fez

Mr Hicham Sbai, Officer in charge of Cooperation, University Hospitals Centre

Dr Naima Amrani, Officer in charge of Cooperation, Faculty of Medicinal Pharmacy, Rabat

Mr Abdenbi Elkamar, Officer in charge of Cooperation, University Hospital Centre

Ms Nadia Rammal, University Hospital Centre Officer

Mr Abdelkrim Largab, Officer in charge of Cooperation, Faculty of Medicine

Dr Ouadia Elkandoussi, Officer in charge of Cooperation, University Hospital Centre, Fez

Dr Chakib Nejari, University Hospital Centre Fez

Dr Mohamed Said Belkadi, Director of Mohamed V Hospital, Marrakesh

Ms Laila Barny, Minister of Environment Staff

Mr Chirif Rfiqi, Staff of Secretaries in charge of family, children and the handicapped

Ms Ghita Hamzaoui, Staff of the Social Development Agency

Dr Farid Afkarr, Pan African Organization for the Prevention of AIDS

Ms Amina Arroub, Association of the Prevention of AIDS

### Members of the UN country team

Dr Georgi George, UNFPA Representative

Dr Redouane Belouali, Officer in charge of Health/UNFPA

Dr Ahmed Laabid, Officer in charge of Health/UNICEF

Mr Houssain Elghilani, Monitoring and Evaluation Officer, UNAIDS



## Representatives of selected donor agencies and embassies

Ms Corine Boulet, Social Programme Officer, European Commission

Mr Nicolas Frelot, Cooperation Officer, Embassy of France

Mr Manuel Couffignal, Health Programme Officer, Spanish Cooperation

Ms Sati Sayah, Technical Consultant, GTZ

Ms Li Jia, Cooperation Officer, Embassy of China

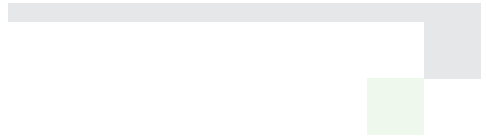
Mr Delrivero Jame, Programme Officer

Mr Sartori Damiano, Programme Officer

## Professional staff in the WHO Country Office

Dr Zoulikha Faraj, National Professional Officer

Mr Ahmed Chahir , Programme Coordinator



## Annex 2

## Country profile

**Table 1. Urban and rural population, Morocco, 1960–2004**

Year of census	Population			Growth rate (%)
	Urban	Rural	Total	
1960	3 389 613	8 236 857	11 626 470	–
1971	5 409 725	9 969 534	15 379 259	2.8
1982	8 730 339	11 689 156	20 419 555	2.6
1994	13 407 835	12 665 882	26 073 717	2.1
2004	16 463 634	13 428 074	29 891 708	1.4

**Table 2. Demographic indicators**

Indicator	
Crude birth rate (per 1000 population)	20
Crude death rate (per 1000 population)	5.5
Population growth rate (%)	1.5
Dependency ratio (%)	57
Population under 15 (%)	33.5
Total fertility rate (per woman)	2.5

**Table 3. Sociocultural indicators**

Indicator	(%)
Adult literacy rate	60
Female literacy	38.3
Women as a percentage of workforce	34.9
Primary school enrolment ratio	90
Primary education, pupils (% female)	45.6
Urban population	56.8

**Table 4. Economic indicators**

Indicator	
Poverty rate (%)	13.7
Gross domestic product (US\$)	1667
Gross domestic product per capita (US\$)	1546
Gross domestic product growth per capita (US\$)	1.55
Unemployment rate (%)	10.8
External debt as a percentage of GDP (%)	51.54
External balance on goods and services (% GDP)	-4.34

**Table 5. Health indicators**

Indicator	
Life expectancy at birth (years)	70.3
Infant mortality rate (per 1000 live births)	40
Neonatal mortality rate (per 1000 live births)	27
Child mortality rate (per 1000 live births)	47
Maternal mortality ratio (per 100 000 live births)	227
Percentage of newborn infants with normal weight	97
Prevalence of stunting (%)	8.9

**Table 6. Health resource indicators**

Indicator	
Population per basic health care facility	11 904
Population per hospital bed (public sector)	1144
Medical consultations per inhabitant	0.5
Paramedical consultations per inhabitant	1
Population per physician	3704
Population per physician (private sector)	4168
Population per physician (all sectors)	1782
Percentage of specialists	47.4
Percentage of specialists (private sector)	51.2
Percentage of specialists (all sectors)	51.9
Population per nurse (public sector)	1115
No. of beds per nurse (public sector)	1
Population per primary health care physician	9272
Beds per hospital physician	6

**Table 7. Financial resource indicators**

Indicator	(%)
Total health budget as percentage of total state budget	5.44
Health operating budget as a percentage of state operating budget	5.49
Health investment budget as a percentage of state investment budget	5.24
Overall Ministry of Health budget as a percentage of GDP (current prices)	1.25

## Annex 3

### Medical coverage (insurance) schemes

#### 1. Compulsory health insurance (AMO)

AMO is a basic medical coverage (insurance) scheme that became compulsory in 2002 under law No 65-00 on basic medical coverage, which is the basis of social health protection in Morocco. AMO is based on the principle of contributions and the pooling of risk. Its implementation was undertaken with the signature on 4 January 2005 of a charter by the government and social partners.

The beneficiaries of AMO are:

- Officials and civil servants of the state, local authorities, public health facilities and corporations under public law
- Persons subject to the social security scheme in force in the private sector
- Pensioners in both the private and public sectors

AMO is supposed to cover nearly one third of the Moroccan population. Currently, there are over 8 600 000 beneficiaries, excluding former resistance fighters, students, etc.

- 4 600 000 in the private sector, including 2 800 000 managed by the Caisse nationale de Sécurité Sociale (CNSS) (National Social Security Fund); and 1 800 000 managed by private insurance companies
- 4 000 000 in the public sector, including 3 200 000 managed by the

Caisse nationale des Organismes de Protection Sociale (CNOPS) (National Fund for Social Welfare Bodies); and 800 000 by the Royal Armed Forces

AMO is managed by the CNSS for private sector employees and the CNOPS for public sector employees. There are more than 6 000 000 members. The regulatory body is the ANAM (Agence Nationale de l'Assurance Maladie [National Health Insurance Agency]).

For insured persons and dependent family members, AMO guarantees the coverage of risks and the cost of health care associated with disease or accidents, maternity and physical and functional rehabilitation.

For both the public and private sectors, AMO's package of care covers:

- Childbirth
- Medical/surgical hospitalization, including day care services
- Management and follow-up care of long-term conditions and long and expensive conditions
- Monitoring of pregnancy, delivery and postpartum
- Well child care up to the age of 12
- Medical devices and implants required for the different medical and surgical procedures
- Refundable prosthetic devices and braces
- Refundable medicines required for the above care

For the public sector, the package also includes outpatient care and examinations (medical consultations, laboratory tests, medical imaging and functional explorations, medicines) to which patients are entitled.

Funding is equally shared between employer and employee contributions up to a fixed ceiling. Care is billed on the basis of national reference fees and tariffs set by an agreement or a regulatory framework.

## 2. RAMED: Medical Assistance Scheme

RAMED is a basic medical coverage scheme intended for deprived groups of the population. It is based on the principle of national solidarity. It was introduced in 2002 under law No 65-00, which is the basis of social health protection in Morocco. Today, the population eligible to RAMED receives free care upon presentation of a certificate of indigence.

The following are eligible for RAMED.

- Persons not covered by a basic AMO scheme and without sufficient resources to meet the costs of medical care and their spouse(s)
- Their dependent, non-wage earning children aged up to 21 and not covered by the basic AMO scheme. This age limit may be extended up to 26 in the event of prolonged studies with adequate justification
- Their children with physical disabilities irrespective of age, who are totally and permanently unable to fulfil a remunerated activity as a result of a physical or mental incapacity

- Residents of charitable institutions, orphanages, hospices, or rehabilitation facilities and any non-profit public or private care facility accommodating abandoned children or adults with no family

- Prisoners

- Persons who have no permanent place to reside

For the purposes of defining the RAMED threshold and eligibility criteria, an actuarial study was conducted and estimated the eligible population at 8.5 million, including 4 million in absolute poverty.

The medical assistance scheme covers medically required care offered in public health care and hospital facilities.

The managing and regulatory body is ANAM.

Funding comes from contributions of the state and local-level authorities (“collectivités locales”).

Payment method is through state subsidy for health care and hospital facilities.

## 3. INAYA or health insurance for self-employed professionals

INAYA is a scheme currently being introduced by the government to complete the existing medical coverage provided by AMO and RAMED. It is being set up to provide coverage to the self-employed and freelance professions. The texts regulating INAYA are in the process of endorsement. The proposed draft law will introduce an obligation for all self-employed professionals

and their families who are not eligible for RAMED to have health insurance.

The INAYA scheme covers:

- The self-employed: craftsmen and retailers with or without business premises and their assistants
- Freelance professions

The population targeted by this scheme is estimated at 10 million (for whom the scheme would be compulsory), i.e. one third of the population of Morocco.

Currently, 700 000 craftsmen and their assistants are registered under this scheme through CHIFAA ASSASSI and AL AMANE ASSASSI products currently being marketed.

The package may vary according to the products identified by the insurers and their partners. It should however be noted that the INAYA scheme includes three types of products:

1. Basic products currently represented by CHIFAA ASSASSI and AL AMANE ASSASSI

2. Products equivalent to AMO currently represented by CHIFAA MOUTAKAMIL
3. Premium products represented by CHIFAA CHAMEL

The INAYA scheme mobilizes new players in the implementation of health insurance. These include.

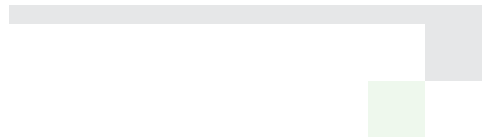
- Microcredit associations representing craftsmen (AL AMANA, ZAGORA, FONDEP, etc.)
- Insurance companies: Wafa-assurance, MCMA
- Companies responsible for marketing the products: Barid Al maghreb, Al AMANA

Managing body: Not yet identified

Regulatory body: Not yet identified

Funding: Contributions of beneficiaries

Payment method: Capitation



## Annex 4

## Data on international cooperation in the health sector in Morocco

Table 1. Funding situation in each area of financial cooperation									
Funded programmes and projects	Areas	Funding from donors (in million Euros except where otherwise noted)					Total	Remarks	
		WB	EIB	ADB	EC <sup>1</sup>	AFD <sup>2</sup>			
Project to Support Health Sector Management (PAGSS)	Hospital reform Institutional reform Upgrade of basic health care facilities and hospitals in the eastern region				20		20	The Moroccan Government contributes € 2.6 million The disbursement rate is 90.13% as at end June 2007	
Project for Health Sector Financing and Management (PFGSS)	Hospital reform Institutional reform Reform of financing (AMO and RAMED)	US\$ 38.10					US\$ 38.10	Status in June 2007: € 32.85 million, i.e. 86.22% of the loan has been disbursed The amount actually cancelled out amounts to € 1.5 million	
Programme to support the reform of Basic Medical Coverage (CMB) (PARCOUM)	Funding reform and accompanying measures			110			110	50% of the amount has been disbursed, i.e. € 55 million	
Programme to support CMB implementation	Funding reform and accompanying measures				50		50	In June 2006, disbursement reached 54% of the donation, i.e. € 43 million	
GAIN programme (donation)	Strengthening of the maternal and child health programme		2.9				2.9	–	
REDRESS programme	Regionalization Upgrade of basic health care facilities in three regions					25	25	MAD 38 was disbursed in 2006, i.e. € 3 327 496	

Source: Directorate of Planning and Financial Resources, Ministry of Health

<sup>1</sup> All European Commission contributions are in the form of donations.

<sup>2</sup> Agence Française de Développement (French Development Agency)



Table 2. Funds mobilized within the framework of multilateral cooperation

Project	Partners	Period	Overall cost of project (US\$)	Ministry of Health contribution (US\$)	Partner contribution (US\$)
1. Support for health programmes (20 programmes)	WHO	2006–2007	1 939 000	–	1 939 000
2. Support for the reproductive health programme (obstetric care, youth health, IEC, STIs, AIDS and information system) at central level and in two regions Marrakech Tensift Al Haouz and Tadia Azilal	UNFPA	2002–2006	9 000 000	1 000 000	4 500 000
3. Basic health: Consolidate priority achievements (immunization, nutrition); access to quality health care for children and mothers; availability of medicines, reduction of nutritional deficiencies; STI, AIDS	UNICEF	2002–2006	2 000 000	–	2 000 000
4. National youth survey	UNICEF/UNFPA/ WHO/MOH	2006–2007	314 000	80 000	234 000
5. Support for the implementation of the national strategic plan for HIV/AIDS control	Global Fund	2003–2007	9 230 000	–	9 230 000
6. Strengthening the use of nuclear techniques in the health sector; and prevention of risks from ionizing radiation	IAEA	2005–2006	723 751	36 288	687 463

**Table 3. Funds mobilized within the framework of multilateral cooperation (2007–2012)**

Project	Period	Partners	Overall cost of project (US\$)	MOH contribution (US\$)	Partner contribution (US\$)
Support for health programmes (20 programmes)	2008–2009	WHO	1 942 000		1 942 000
Support for integrating reproductive health in the health reform	2007–2011	UNFPA	6 265 000	1 765 000	4 500 000
Child and women's health	2007–2011	UNICEF	4 025 000		4 025 000
Support for AIDS and tuberculosis control programmes in Morocco	2007–2012	Global Fund	30 611 710		30 611 710
“Implementation of PET scan tomography in clinical practice in oncology and cardiology” and “Quality control and assurance of radiopharmaceutical medicines produced locally or imported”	2007–2008	IAEA	0 200 300	10 015	210 314

Table 4. Funds mobilized within the framework of bilateral cooperation 2005–2006

Project	Partners	Cost of project	Partner contribution
Project for the decentralization of the reproductive health system in the TAT region	Germany	€ 1.6 million	€ 1.6 million
FSP* project on hospital maintenance	France	€ 1 500 000 (2005–2008)	€ 1 500 000 (2005–2008)
FSP project for training hospital managers and executives of the General Inspectorate	France	€ 850 000 (2003–2006)	€ 850 000 (2003–2008)
Technical support: AMO projects, hospital accreditation and conduct of seminars	France	€ 450 000 (2005–2006)	€ 450 000 (2005–2006)
Support for the national programme for STI/AIDS prevention and control in the Casablanca region	Belgium	MAD 15 85 000 (2003–2006)	MAD 9 230 000
Donation of 15 ambulances	Andalusian International Cooperation Agency	€ 500 000 (2005)	MAD 15 885 000 (2003–2006)
Construction of a communal health centre with a delivery module and physician accommodation in Aoumra	Spain	MAD 1 562 536 24 (2005)	MAD 1 562 536 24 (2005)
Construction of an urban health centre at Ksar El Kébir	Spain	MAD 1 547 358 48 (2005)	MAD 1 547 358 48 (2005)
Construction of an urban health centre in Larache	Spain	MAD 1 121 243 50	MAD 1 121 243 50
Donation of medical and surgical instruments and medicines	China	MAD 6000 (2005)	MAD 6000 (2005)
Donation of medical and surgical instruments and medicines	China	MAD 1 600 000 00 (2006)	MAD 1 600 000 00 (2006)
Support for maternal health care in rural areas	Japan	MAD 72 106 459 00 (2006)	MAD 72 106 459 00 (2006)
Purchase of two ambulances for two health centres in El Kelaâ Sraghna and Azilal	Japan	MAD 516 608 00	MAD 516 608 00
Donation to detection programme for avian influenza	USA	US\$ 625 000	US\$ 625 000

\*FSP: Fonds de solidarité prioritaire (Priority Solidarity Fund)





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