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Country Cooperation Strategy for WHO and Morocco

2004–2007

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1. INTRODUCTION

Within the framework of the Country Focus Initiative (CFI), aimed at strengthening cooperation between WHO and Member States in support of country needs, WHO is launching the Country Cooperation Strategy (CCS). Formulation of the strategy entails a process similar to other processes within the United Nations system in which Morocco has already been involved, such as in elaboration of the United Nations development assistance framework (UNDAF), the Country Cooperation Framework (CAF) with UNDP, and the Country Assistance Strategy (CAS), with the World Bank.

Development of the CCS was well received by all national partners with WHO in Morocco as a timely step towards enhancing sustainability of programming within the framework of WHO–Morocco cooperation. The period covered by the first CCS (2004–2007) includes two biennia and coincides with the time-frame of the current government programme.

The development of the first CSS occurs in a context of transition and competing challenges. Morocco remains strongly challenged by social development issues such as access to basic education and quality primary health care, elimination of illiteracy, reduction of poverty and social inequality, and increasing training and employment.

Further to the recommendations of the WHO Commission on Macroeconomics and Health, a recent World Bank report on social protection in Morocco has recommended an increase of public health care expenditure with an emphasis on rural programmes, improvement of financing and hospital reform, as well as promotion of health sensitizing initiatives and creation of intersectoral partnerships. Decentralization and modernization of public administration are the major areas of the reform policy adopted by Morocco.

To support the government policy, and more particularly the Ministry of Health, in reform and health sector strategy formulation, namely for the development of primary health care and prevention of emerging risks, WHO cooperation over 2004–2007 will focus on the three following components:

- Developing necessary instruments to health policy planning and orientation;
- Supporting decentralization of the health system aiming at enhancing effectiveness and equity;
- Strengthening technical partnership to consolidate assets, ensure action targeting priority programmes and meet emerging needs.

The identification of these three components is the result of broad consultation with all WHO partners in Morocco. The programmatic framework allowing implementation of this strategy will be the biennium programmes developed during the joint programme review and planning mission (JPRM) exercise.

2. HEALTH AND DEVELOPMENT CHALLENGES IN MOROCCO

2.1 Overview

Morocco is faced with major development challenges at the beginning of the millennium. These include both internal challenges such as political, economic, socio-demographic and epidemiological transition, and external factors related to international policies (i.e. globalization, oil price instability, decrease of tourism).

This situation has given rise a series of reforms aiming to modernize public administration and rationalize public expenditure (regionalization, education reform, financing reform, public expenditure reform, etc). These reforms reflect both strong political commitment towards development and strengthening of the democratization process. However, constraints are faced in relation to irregular economic growth, natural resources degradation (dryness and deforestation) and ongoing monetary poverty.

2.2 Health determining factors

Demographic data

Morocco is undergoing a demographic transition. Its population growth rate and its synthetic fertility index have declined, respectively, from 2.5% and 7 children in 1960 to 1.6% and 3.1 children in 1997. This transition will result in decrease of the number of births and children under 5 years and increase in the number of married women and elderly population.

Demographic analysis also shows strong ongoing urbanization. By 2012, the urbanization rate, currently 55%, is projected to reach 64%. This shift in population entails the development of a new suburban population, particularly vulnerable on the epidemiological level because of its high density and associated risks.

Education level

There has been a renewed interest in education in recent years. The rate of total schooling exceeds 90%, but is estimated at 76% in rural areas. Combined schooling (primary to higher education) is about 52%, which reflects the problem of school drop-out. Literacy remains close to 50% overall, despite an extensive literacy programme for adults.

Socioeconomic level

The socioeconomic situation in Morocco is characterized by irregular economic growth (currently declining). The GDP per capita is estimated at US$ 3546 and the debt servicing at 10% of the GDP. The unemployment rate increase (13.6%), particularly in the cities (20%), and progression of monetary poverty (19%) reinforce the constraints to development. The level of national income remains limited since the GDP per capita does not exceed US$ 1200.

Involvement in health

Morocco dedicates 1.1% of its GDP to public health expenditure, versus 2% to 25% in countries with similar per capita income. This proportion appears insufficient to ensure access to an acceptable level of care for the population. In addition, public health expenditure largely favours urban areas (78% of current expenditures are for urban hospitals and clinics). Moreover, 18% of the population does not have access to drinking water, 25% of rural populations are located more than 10 kilometres from the nearest health facility and 35% of Moroccans do not have access to essential drugs. Some countries with an equivalent or lower GDP per capita, such as Egypt, Georgia, Jordan and Sri Lanka, have better health indicators.

2.3 Health status

In 2002, life expectancy in good health was estimated at 55.4 years in Morocco, while life expectancy at birth is 69 years. The Moroccan health system ranks 151th for reactivity and 125th for financial contribution equity. These indicators show that significant effort will be required to improve health and health system performance.

The other characteristic of the health situation in Morocco refers to its epidemiological transition showing a structural inversion of morbidity burden. According to the burden of disease study in Morocco (*Etude sur la charge de morbidité globale au Maroc*), communicable and peri-natal diseases represent 33% of disability-adjusted life years, versus 56% for noncommunicable diseases and 11% for trauma.

With 228 maternal deaths per 100 000 live births, maternal mortality is still a public health issue in Morocco. The weak improvement of this indicator does not reflect the efforts in recent years in the area of safe motherhood.

With regard to communicable disease, three diseases are being eradicated (diphtheria, poliomyelitis and neonatal tetanus) and the eradication of three other diseases is targeted for 2010 (malaria, schistosomiasis and trachoma). Demand for chronic diseases care is growing, highlighting the problems in access to health care.

2.4 Health system development challenges

Health service delivery

Coverage of primary health care has expanded greatly. Currently there are more than 2347 primary care facilities, versus 394 in 1960. The ratio of the number of facilities per 10 000 inhabitants is estimated at 0.8 (1 for every 12 400 inhabitants). Despite these figures, more than 25% of the rural population is still located more than 10 kilometres from a health facility (31% in 1996). Usage of primary health services has increased but remains strongly marked by the disparity between urban and rural areas.

Along with this gap in access to care, the health care system suffers from under-utilization of services. Medical consultations are estimated at 0.4 contacts per capita per

annum, i.e. an average of 18 medical consultations per physician per working day. Coverage of preventive care services are 59% for contraceptive usage, 56% for peri-natal care, 46% for childbirths in attended centres and 87% for immunization.

The public hospital network has been slow to evolve. It currently numbers about 120 facilities, with a total bed capacity of 24 360 beds (i.e. less than 1 bed per 1000 inhabitants). Hospital capacity increased by more than 8000 beds between 1960 and 1997, but has not kept pace with overall population growth. Indeed, between 1990 and 1997, the average number of patients by bed declined by 14 points. In addition, the allocation of beds shows a great inequity among areas and social classes. Nearly 6 000 000 people attend public hospitals annually (i.e. 0.2 contacts/capita/year). More than half of these contacts are emergencies. Despite their insufficient numbers, hospital beds are under-utilized, with a 56% average occupancy rate.

The hospital network is being strengthened within the context of the hospital reform, which aims to modernize hospitals and develop their autonomy. This action is supported by an important health sector financing and management project financed by an IRDB loan.

Coverage by the private sector is often limited to urban areas and large cities. It covers two-thirds of primary health care services and 20% of the national bed capacity. Private sector development is less regulated by medical authorities.

At the level of health services organization, the decentralization process is being expanded within a regional framework. Indeed, since the creation of a local authority at the regional level in 1996, the health sector has initiated a number of activities and projects aimed at strengthening regionalization. One such project is PROGRESS, financed by USAID and aimed at supporting health programmes in two regions: Souss–Massa Draa and Tangier–Tetouan. Another is the PAGSS project in the eastern region, financed by the European Commission and aiming to develop a regional organization pattern for health care.

The administrative and technical organization at the regional level have also been strengthened, particularly through the nomination of a delegate in the main city of each region and regional coordinators and the creation of regional epidemiological observatories.

Financing

The overall health expenditures in Morocco are about MAD 15 billion (i.e. 4.5% of GDP), of which 54% is financed by households and 41% by collective financing (taxes, insurance and local municipalities). Thus, the Moroccan health system suffers from insufficient and fragmented financing. This is exacerbated by expensive care and drugs and limited purchasing power. Compared to other countries with similar income, Morocco allocates fewer funds to health, despite the weakness of its health indicators.

Public hospitals (SEGMA and CHU) generate insufficient receipts due to delays in implementing the medical coverage code, inadequacy of tariffs and lack of management

capacities. Receipts for these public hospitals represent less than 30% of their operating budget (MAD 206 000 000 for 2001).

The national health system dedicates more than 37% of funds for drugs and medical supplies, 31% for hospital care and 20% for ambulatory care. With the epidemiological transition and expansion of basic medical coverage, this structure is likely to be altered. The budget of the Ministry of Health is insufficient. It represents barely MAD 175 per capita (5% of the overall state budget). 47% of this budget goes to hospitals and 38% to the basic health care network.

Financial flow analysis of medical insurance, which contributes to 16.4% in total health expenditures, shows that only 6% of the expenditures go to public hospitals, despite the fact that these hospitals provide 80% of the national bed capacity.

To mitigate the under-financing of the health sector, it is planned, within the framework of the new code of basic medical coverage, to implement two new financing mechanisms: mandatory medical insurance (AMO) and an medical insurance assistance scheme (RAMED). Medium-term projections envisage doubling the population covered by medical insurance to 32%. The RAMED financing share is not yet given.

Human resources for health

The centres of health professional staff training are represented by the faculties of medicine (currently four), the National Institute of Medical Administration (*Institut national d'administration sanitaire*), the training institutes for health careers (*Instituts de formation aux carrières de santé*) and the training institutes for health techniques (*Instituts de formation aux techniques de santé*). The advent of a new law on higher education reform will help support reorganization of these facilities, which are increasingly less able to meet the needs of a health system in transition.

More than 200 facilities of the health care network are currently closed due to lack of human resources. Although the proportion of specialists is average for the Maghreb, the demand for gynaecologists/obstetricians, anaesthetists and nephrologists is pressing. In addition to the absence of tools such as medical charts or regional care services diagrams, there is a quasi-absence of planning for health staff. The training centres' key role will be to adapt training to the health system needs and develop a national policy for human resources management.

General administration

Administration of the public health care system is strongly centralized with low capacity for services regulation and coordination of the health system stakeholders (partnership and intersectoral collaboration). The legal framework of the health system remains inadequate regarding institutionalization and sustainability.

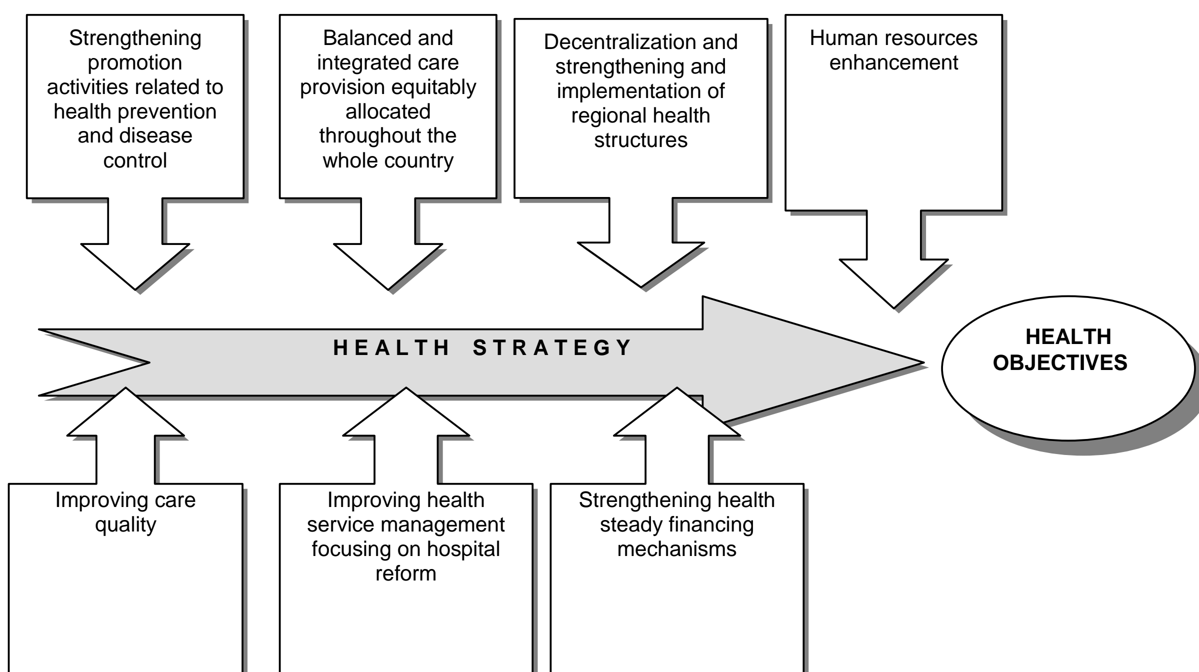
The general administration also suffers difficulty in absorbing development aid within the context of major changes brought about by the reform process. The Ministry of Economy and Finance recently launched a reform of public expenditures that includes a) globalization of loans; b) outsourcing by the central administration and decentralized public services; and c) development of health partnerships. Implementation of these mechanisms will provide the central administration with a legal framework to control its relations with the decentralized services and with civil society and the private sector. Concerning health care regulation, regional care provision diagrams are being developed to give impetus to regionalization. This tool is currently being piloted in the eastern region.

Within the decentralization process, the Ministry of Health is currently reviewing its administrative organization both to support the creation of health regions and to re-centralize the administration in terms of health system control and regulation. A technical and organizational audit is currently being conducted in this regard. The General Inspection Department of the Ministry of Health is also undergoing reorganization within the framework of a cooperation project with the French government. The project is intended to create a branch of medical inspectors and revise the organization of the General Inspection Department in order to enhance its mandate and possibly expand its activities. Beyond these sector dimensions, improvement of governance has become a priority in government policy, as well as for development assistance programmes (e.g. UNS, IRDB, EC).

2.5 Health priorities in Morocco

Health in the economic and social development plan

Within the 2000–2004 economic and social development plan, the Ministry of Health developed a sectoral strategy based on seven priority areas (Figure 1).



Source: DPRF, Ministry of Health, Morocco 1999

Figure 1. Main components of the 2000–2004 health sector strategy

This strategy constitutes the political and budgetary framework of the health system reform. Health system reform is supported by two sectoral projects: the PFGSS, which is funded by an IRDB loan, and PAGSS[1], funded by the European Community. The reform is based on four essential components:

- Financing reform: aims to improve financing through the implementation of two new financing mechanisms, mandatory medical insurance (AMO) and medical insurance assistance scheme (RAMED).
- Hospital reform: a prelude to financing reform that aims to modernize public hospitals (non CHU) and strengthen their managerial autonomy.
- Institutional strengthening: aims to ensure the success of the two prior reforms through ministry of health capacity-building for policies formulation and new legal framework for the health system.
- Organization of services and balance of the health care network: This area, mainly implemented by PAGSS, aims to improve regulation of services through the implementation and development of resource allocation criteria and planning tools for health care provision.

National health charter

Along with health system reform, the Ministry of Health has initiated, with WHO support, a process intended to lead to the adoption of a national health charter, setting the basic directions for health policy in Morocco. The first stage of the process consisted of analysing the health status trends and sectoral orientation. This stage focused on seven thematic issues: the right to health, health status and trends, health care provision, drugs and medical supplies, health system governance, health financing and research and development.

Health and government policy

More recently, new health needs were underlined in government policy. These new needs are particularly related to diabetes and chronic renal insufficiency. The response to these new needs could generate an update of the 2000–2004 health sector strategy. On the whole, this evolution shows that a quasi-consensus has been established on the goals and priority fields of interest. However, this consensus still remains to be translated in terms of suitable resources development and implementation of effective strategies. It requires dialogue with all health sector development partners in Morocco, and more specifically civil society, the private sector and development organizations and agencies.

[1] PFGSS: Health sector financing and management project (*projet de financement et de gestion du secteur de la santé)* ; PAGSS: Support project for health sector management (*projet d'appui à la gestion du secteur de la santé*).

3. DEVELOPMENT ASSISTANCE

3.1 Importance of development assistance in Morocco

Resources structure analysis of the health system shows that international cooperation funding remains weak (1% of total health expenditures). International assistance to the health sector is estimated at approximately US$ 15 million/year, of which 62% is invested in maternal and infant health.

As a result of the international economic situation and relative improvement of national health indicators, Morocco is among the less eligible countries for external assistance. For UNFPA, Morocco is ranked among class B countries, which can benefit from only 35% of external assistance. Such considerations penalize the rural sector in Morocco, which suffers from systematic inequity with regard to health compared to the urban sector. USAID, which provided significant support reproductive health and, more specifically, family planning (US$ 120 million in 30 years), has decided to phase out of the health sector in Morocco and re-orient its funding to support “economic growth”. Likewise, the support pattern of other organizations is increasingly oriented towards rural development projects and partnership with civil society based on multisectoral approaches.

In addition, it is important to note that development assistance within bilateral cooperation has become increasingly active. In recent years, the Government of Morocco has signed major conventions with the Governments of Belgium, France, Germany and Japan.

Table 1 shows that the average annual contribution from international assistance is about US$ 19 million. This amount represents 3.8% of the Ministry of Health budget, estimated at US$ 500 million. Compared to the 1998 health national accounts data, international aid increased from US$ 15.4 million in 1998 to US$ 19 million in 2001. In terms of proportion of the budget, this aid appears to have been reduced compared to the 5% (12% out of salaries) reported by the national health accounts. This is explained by the fact that the state budget has significantly increased during this period.

Table 1 also shows that the main international donors are USAID, European Union and Japan, with more than half of international assistance (56%). The contribution of United Nations organizations represents more than 17%. WHO support accounts for 5% of the international assistance for health. With the withdrawal of USAID from the health sector, the financial structure of international assistance change, especially because the cooperation with Japan more recent and could experience fluctuations.

Moreover, and according to the national health accounts, international aid service activities represent 31% of (against 40% for fixed assets and 23% for drugs and medical supplies). In this proportion, WHO support is about 15%. The WHO permanent and regular role remains fundamental to orient international aid as regards health. Bilateral cooperation mobilizes many more funds, but remains related to economic factors.

Table 1. International assistance allocation in the field of health according to financing source

International organization or agency	Amount (US$ million)	Period	Annual average contribution (US$ million)	%
Belgium	4.1	1999–2002	1.03	5%
China	0.35	1998	0.35	2%
European Union	30.44	1996–2003	3.80	20%
France	1.0	2002	1.00	5%
Germany (GTZ)	3.7	2001–2005	0.74	4%
Italy	1.45	1999–2001	0.48	3%
Japan	11.0	2002–2004	3.66	19%
Luxembourg	1.45	2000	1.45	8%
Spain	0.8	1999–2001	0.27	1%
United States (USAID)	15.0	1999–2003	3.00	16%
UNDP	0.7	2002–2006	0.14	1%
UNFPA	9.0	2002–2006	1.80	9%
UNICEF	1.7	2002–2006	0.34	2%
WHO	2.0	2002–2003	1.00	5%
Total	–	–	19.05	100%

Source: Comptes nationaux de la santé, 1997/1998

3.2 Main cooperative programmes in the field of health

UNFPA

UNFPA supports mainly reproductive health and health planning activities. Its support includes several components (training, equipment and purchase of contraceptives, information, education, communication and information system support) and covers 13 provinces, representing 20% of the Moroccan population.

United States Agency for International Development (USAID)

In Morocco, USAID supports the following four programmes:

- Decentralization efforts in two regions through the PROGRESS project. These activities are related to MCH and reproductive health programmes, information system, ongoing training, quality assurance, partnership with civil society.
- National nutritional strategy (micronutrients).
- Commercial market strategies project (CMS); this project concerns the commercial contraceptive products promotion by the private sector.
- Capacity-building of general physicians through training in IUD insertion in partnership with the Moroccan Association of General Physicians and through the introduction of a family medicine course and ongoing training sessions for general physicians (private and public sectors) in partnership with the Faculty of Medicine of Marrakesh.

UNICEF

UNICEF actions prioritize children and women and are mainly related to the following fields:

- Access to care and essential drugs
- Integrated management of childhood illnesses
- National nutrition strategy: iodine and vitamin A deficiency
- Vaccine independence initiative.

UNDP

Main health support areas of UNDP are provision and maintenance of hospital equipment and STD/AIDS control and prevention.

European Union

Three projects have been implemented:

- Control and prevention STD/AIDS in 15 provinces
- Maternal and neonatal health
- Combating drug addiction.

Two other projects are currently being implemented, the support project for health sector management (PAGSS) and support for medical coverage code implementation.

Japan International Cooperation Agency (JICA)

The Government of Japan funds a major investment project in the field of safe motherhood.

Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

- Health services decentralization support in a northern region.
- Technical training in dental prosthetics.
- Project on maternal health and family planning in a pilot province in southern Morocco.

Government of France

Cooperation with the Government of France focuses on the following fields:

- Ongoing training for specialists (orthopaedics, psychosomatics, emergencies, child psychiatry).

- Care techniques development: organ transplant (kidney, cornea, spinal chord), traumatology, neonatal resuscitation, open heart surgery, ionizing radiation, transfusion, haemodialysis and support to laboratories.

- Support for creation of a branch of hospital and inspection management specialists, maintenance policy, mobile emergency service (SAMU) development in Morocco, medical fluids normalization and drug policy.
- Epidemiological monitoring.
- Support for the role of the National Hygiene Institute (INH) laboratory in quality control for other laboratories.

Government of Belgium

The Government of Belgium is funding two projects: health care funding in 2 southern provinces and control and prevention of STD/AIDS (in the Casablanca area).

Other partners

The Governments of Spain, Italy and Luxembourg contribute to the health sector, support equipment funding and provide technical assistance on demand; however this aid remains irregular. Assistance from the Government of China has been formalized through a bilateral convention in the field of medical human resources and equipment.

3.3 Trends

Among the programmes that seem to benefit most from international cooperation are safe motherhood and the STD/AIDS prevention and control programmes. In the first programme, international assistance reaches US$ 10 million per annum, i.e. more than half of international aid in the field of health. The Ministry of Health mobilizes the same amount within its general budget. For STD/AIDS, international funding is estimated at more than US$ 600 000 per annum, i.e. 31% of the total amount mobilized for the STD/AIDS programme. This support will continue to increase with the advent of the Global Fund to fight AIDS, Tuberculosis and Malaria. On the whole, this shows the need to reinforce Ministry leadership with regard to international cooperation in order to enhance coordination of activities.

In addition, and within the framework of UNDAF operationalization, WHO must be involved, through the interagency working group, in supporting actions to reduce poverty and strengthen food safety through a common strategy between the agencies and organizations of the United Nations system focused on fostering local governance and participatory approach, namely through implementing local development projects (i.e. adopting the basic development needs approach).

4. CURRENT WHO PROGRAMME

4.1 Overview

The basic agreement between WHO and Morocco related to technical assistance, currently force, was signed on 15 September 1961. This agreement replaced the previous one

adopted on 30 April 1953. The WHO Representative’s Office in Morocco opened in 1986. The credits granted under the regular budget since the opening of the WHO office, by biennium, are as follows:

1986–1987	US$ 471 200
1988–1989	US$ 2 296 000
1990–1991	US$ 2 380 500
1992–1993	US$ 2 113 843
1994–1995	US$ 2 581 900
1996–1997	US$ 2 514 200
1998–1999	US$ 2 525 973
2000–2001	US$ 2 095 200
2002–2003	US$ 2 067 000

Since 1986, more than US$ 19 million has been mobilized by WHO for Morocco, excluding extrabudgetary resources and regional activities resources.

4.2 Areas of work and partners

Within the framework of the joint cooperation programme, the budget granted to Morocco by WHO for 2002–2003 amounts to US$ 1 975 000, excluding technical assistance through regional advisers, technical missions or Moroccan participation in intercountry activities.

The current WHO programme in Morocco includes 19 action programmes. Compared to the previous two years, this number has been reduced by 30%, i.e. from 28 programmes for the 2000–2001 to 19 currently (Annex 2). This confirms the trend, started in the past biennium, of opting for consistent integrated programmes across different structures rather than several small programmes.

At the end of the first year, the implementation rate of the joint cooperation programme between WHO and Morocco is about 50%, showing significant improvement over the previous biennium. The 19 action programmes are allocated under four work areas.

Work areas	Number	Budget %
Health policy and management	3	16
Health system and service development	5	20
Health promotion and protection	6	34
Integrated fight against diseases	5	30

Among the 19 programmes, the following 6 mobilize 60% of the credits allocated for the biennium:

- Basic development needs programme

- Health policy formulation programme
- Integrated care of childhood illness programme
- Adult respiratory health programme
- Epidemiological monitoring development programme
- Human resources management and planning programme.

By components, the implementation assessment for the first working year of the 2002–2003 biennium shows that training occupies the first area of expenditures, with approximately 50% of the loans used (grants and seminars), followed by printing expenses (guides, didactic and educational material) with 13%, equipment (including more than 50% for computer equipment) with 75%, local contracts to perform specific work with 7%, and local costs (studies and surveys) with 55%.

Technical assistance and expertise were provided in 12 international consultant missions to Morocco in 2002.

Consultation field	Number of missions
Health policy and management	2
Health system and service development	4
Health promotion and protection	3
Integrated fight against diseases	3

In addition, WHO headquarters and the Regional Office contributed significantly, particularly in joint review meetings on several important national programmes leading to the development of action plans, some of which are currently being implemented:

- combating tuberculosis
- epidemiological monitoring
- safe motherhood
- pharmaceutical sector
- injection safety
- national programme on chronic diseases monitoring.

For the past 3 years, the joint collaboration programme identifies partners other than the Ministry of Health and management of the budgets allocated to them; these partners currently represent 10% of the regular budget. The situation is the same for nongovernmental organizations (1.5% to 2%)

The Ministry of National Education, the Ministry of Higher Education (Faculties of Medicine), the Ministry in charge of Women’s Condition, Family Protection, Childhood and Integration of Handicapped, the Department of Environment, some NGOs will remain, along with the Ministry of Health, as WHO partners for the 2002–2003 biennium.

In addition, like other United Nations agencies and organizations, the WHO Office contributes to the different system studies and activities such as the Country Common

Assessment, UNDAF as well as to community steps development and local development projects through the permanent working group.

The WHO Representative has headed, for the past 4 years, the UNAIDS–Morocco theme group that contributed to the development of the national strategic plan against AIDS and the country coordination mechanism (CCM) included in a successful funding proposal to the Global Fund to Fight AIDS, Tuberculosis and .Malaria.

4.3 Technical staff and work conditions

In addition to the Representative, technical staff of the WHO office in Morocco include an administrative assistant (2 years in the WHO office) and a project coordinator (SSA) (5 years in the WHO office). Working conditions have improved significantly since the WHO office moved to new premises.

5. GLOBAL AND REGIONAL WHO DIRECTIONS

5.1 General programme guidelines 2002–2005

The WHO general programme of work has adopted four areas of strategic action for the 2002–2005 period:

- Reducing mortality, morbidity and disability, especially in poor and disadvantaged populations

- Promoting healthy lifestyles and reducing risk factors to health related to environment, economic and social context and behaviour

- Developing health systems that equitably improve health outcomes, and respond to the people’s legitimate expectations, and are financially fair

- Designing a basic policy and an institutional framework in the health sector and promoting awareness on health issues to social and economic partners, as well as in the field of environment and development.

5.2 Regional WHO priorities

The following 10 areas of work are considered priority areas within the Eastern Mediterranean Region.

- Human resources development
- Basic development needs approach to reduce poverty and enhance health development
- Communicable disease control and safe blood transfusion
- Healthy life behaviour promotion, Tobacco-Free Initiative, aged people health promotion and nutrition promotion
- Noncommunicable disease prevention
- Maternal and child health

- Access to and rational use of essential drugs
- Health systems and services development
- Promotion of technology transfer, health information material and capacity-building in health research
- Environmental health, water sanitation and safety.

5.3 WHO functions at country level

To define its action at country level, WHO has identified the following five functions.

Function 1: Supporting sustainable implementation of routine activities.

Function 2: Facilitating and catalysing the adoption and adaptation of strategies, tools and technologies.

Function 3: Supporting research and development in the field of health, as well as activity monitoring of health system performance.

Function 4: Sharing and disseminating knowledge and information on health, providing options on general policies, norms and standards, advocacy.

Function 5: Providing advice on specific policies; serving as a broker, supporting health policies, actions and financing.

According to these functions, and taking into account the overall functions of the health system, the WHO Morocco action programmes are allocated as shown in Table 2. This analysis shows that with 54% of the activities, the function related to catalysing and adopting strategies, tools and technologies remains predominant in the current WHO programme, thus favouring the health system delivery function. Moreover, these results are confirmed through the activity implementation assessment during the first year, which showed that training ranks first for expenditures, with 50% of spent credits.

Table 2. Allocation (in %) of the current programme activities according to the WHO functions at the national level

Overall health system functions	F1	F2	F3	F4	F5	Total
General administration		1	4		11	16
Service delivery	10	50	7	3	3	73
Resource generation	3	3	3	3	1	13
Financing	–	–	–	–	–	–
Total	13	54	14	6	15	100

6. STRATEGIC AGENDA FOR MOROCCO

6.1 National partner expectations

Preliminary consultations led by WHO among its different Moroccan partners as well as discussions held with the Ministry of Health officials show that the national and international partners are expecting WHO to develop its activities in Morocco in the following seven priority areas:

- Formulating and implementing health policies, more specifically developing tools for planning and decision-making.
- Epidemiological monitoring and care of prevalent morbidity.
- Strengthening health safety and monitoring
- Developing management skills and capacities in human resources
- Enhancing general health system administration
- Developing the health information system
- Developing targeted and concerted research.

6.2 Challenges to be met

Care and service delivery

The challenge is to strengthen the capacity of health authorities to overcome four major obstacles:

- disparity in the access to care
- transition of care demand
- under-utilization of resources
- low integration among the different delivery levels and the public and private sectors.

To meet this challenge, decentralization of management must be strengthened.

Financing

Along with care organization and issues of equity in provision, under-financing remains the main obstacle to health system development in Morocco. Health reform cannot be fully implemented without improving financing and the equity of financial allocations.

Resource generation

With the exception of the pharmaceutical sector, which produces more than 80% of the country drug demand, the biomedical technology market remains very limited and is far from meeting the hospital technical renewal or development needs scheduled within the planned hospital reform.

At the level of human resources production, and despite the initial training autonomy for the different health staff categories, the system continues to suffer from an imbalance between supply and demand.

General administration

In terms of health sector administration, the primary obstacle is the strong health system centralization, which contrasts with a weak regulatory capacity and weak cost control. Moreover, to guide the health system transition, efforts to generate information on health status and system performance need to be maintained and strengthened in order to provide an evidence base to guide decision-making and better pilot the current reforms.

6.3 Cooperation strategy with Morocco

The Moroccan health system is in a critical phase. Given the national priorities and new WHO guidelines, WHO–Morocco cooperation aims at enhancing efforts to address the challenges facing the health of the population and performance of the health system in Morocco. It will also aim at promotion of sustainable development and achievement of the Millennium Development Goals.

WHO support will take into account the main policy and strategy choices made in the health sector and upon which consensus has been reached. The priorities identified by WHO in the medium term are to reinforce the reforms launched by the government while ensuring the continuity of WHO technical support targeting priority health programmes.

Thus, the 2004–2007 CCS will include three main components: developing necessary tools for health policy planning; supporting decentralization of health system management; and supporting the development of technical expertise.

1) Developing necessary instruments for health policy planning and guidelines

This component addresses the common concern of generating information useful to strategic decision-making and facilitating the adoption and adaptation of necessary tools to design or assess health policies. The choice of the instruments to be developed is dictated by the actions planned in the reforms that have been launched. Priority will be thus given to the actions that allow:

- Health status measuring: study on disease burden, surveys on health status, risk factors, etc.; these studies and surveys will enable assessment of health priorities.
- Health system performance measuring: national heath accounts, system reactivity measuring, sectoral governance analysis, joint programme reviews, development of performance indicators, etc.
- Regulation: priority will be given to human resources planning and basic training adequate to health needs, health mapping development, improvement of access to primary health care and essential drugs.

2) Supporting decentralization of care system management

Support for decentralization is a general policy choice in Morocco. There has been renewed interest in decentralization since the promulgation of the law on regionalization. To consolidate this national direction, it is proposed that WHO action is set pragmatically within the decentralized management strategy of the health care system. Integrated programmes such as access to health care, service organization and integrated management of childhood illness will be dealt with primarily within the decentralization framework. Accordingly, three work areas will be strengthened:

- Skills development through basic and ongoing training in the areas of health service management and operational research development, etc.
- Management tool development to facilitate delegation of responsibility and service management transparency. In this area, WHO will support initiatives to implement control mechanisms such as outsourcing (contracting), quality control, accreditation and internal audit.
- Programme integration and intersectoral collaboration. Decentralization consolidates the intersectoral collaboration possibilities and participation opportunities at the community level to manage health problems. From this point of view, community-based initiatives, and particularly the basic development needs programme, will go on, particularly in the form of technical collaboration, either with the Agency for Social Development or with any other agency with a similar mission. Decentralization is also an opportunity to ensure more integration in health care provision and in programme management, i.e. supporting the integrated management of childhood illness programme, health sector organization, district team problem-solving (DTPS) and promotion of public–private sector partnership.

3) Technical expertise development

All stakeholders have underlined the invaluable role of WHO in specific technical fields. The two components mentioned above will be supplemented by specific actions in WHO regional and global key areas. These actions will have the following goals:

- Consolidating the WHO–Morocco cooperation by updating traditional technical programmes such as immunization, tuberculosis and malaria; supporting structuring activities such as the national health information system and training at the national institute of health administration, and strengthening information dissemination and sharing support.
- Reinforcing, in a targeted way, some key Ministry of Health programmes such as epidemiological monitoring, maternal health, safe motherhood and STD/AIDS prevention and control.
- Preparing and developing a national response to emerging problems which will need structured priority programmes in the future, i.e. activities aimed at the reduction of

health risks, chronic disease management and care, health and safety and adolescent health promotion.

In order to answer to partner expectations and implement the programmes developed under this strategic agenda, the WHO role in Morocco must be strengthened, especially as USAID will withdraw from the health sector during the period covered by the present CCS. The importance of USAID support (around 50% of international assistance), its focus of activities in maternal health, which constitutes a national and regional priority, and the increased risks for rural populations as a result of this withdrawal are added impetus for WHO to strengthen its role in advocacy and in mobilization of additional resources for health within bilateral and multilateral cooperation. The CCS will be a major support to guide this advocacy and reinforce collaboration with development agencies and civil society.

7. IMPLICATIONS FOR THE WHO OFFICE

Implementation of the CCS will have an impact on the WHO office in terms of its technical staff, work organization and financial programming. Strengthening the representation in international health cooperation and CCS implementation is linked to the assignment of additional technical staff in the WHO country office.

At the programme level, CCS implementation will entail reinforcement of the functions of general administration and resource generation and a reconsideration of the activities supporting care provision. Resource re-deployment will also be necessary to strengthen the WHO country-level F2 function (facilitate and catalyse the adoption and adaptation of strategies, tools and technologies) and F5 function (provide advice on specific policies). This deployment would take into account the intervention of other partners and the comparative advantage of WHO in terms of expertise (Table 3).

To ensure better monitoring of the cooperation programmes and their overall integration in the health sector, institutionalization of a yearly WHO–Morocco joint programme review may be considered. Financial programming should be adapted in order to support the CCS actions. WHO will mobilize consequent extrabudgetary resources within the context of international cooperation in order to support the CCS goals. Tales 4 and 5 show a synopsis of the WHO–Morocco strategic agenda and a list of CCS actions according to WHO and health system functions, respectively.

Table 3. Relative importance of WHO actions in Morocco (in 2004–2007)

Health system functions	WHO functions at the national (country) level				
	F1	F2	F3	F4	F5
General administration	+	++	+++	+	++
Service delivery	++	+++	++	++	++
Resource generation	+	++	–	–	–
Financing	–	–	++	–	–

Table 4. WHO–Morocco cooperation strategic agenda (synopsis)

Component 1 **Developing the necessary instruments to plan and guide the health policy**	**Component 2** **Supporting the care system decentralized management**	**Component 3** **Technical expertise**
1.1. Health status measuring Morbidity burden Surveys on risk factors Surveys on health status	2.1. Skills development Training Action-research Operational research Experience sharing	3.1. Assets consolidation Updating traditional programmes (immunization, tuberculosis, malaria, trachoma, water-borne diseases) SNIS National Institute of Health Administration (INAS) Information dissemination and sharing supports (CDS, WHO office web site)
1.2. System performance measuring System responsiveness National health accounts Governance Joint national programmes reviews Performance indicators	2.2. Management tools development Contracting Internal audit Accreditation Quality control	3.2. Targeted interventions in priority programmes Epidemiological monitoring Safe maternity STD/AIDS Water and environment
1.3. Offer regulation Human resources planning Adaptation of basic training to health needs (re-definition of profiles and curricula, trainers' training) Health mapping Access to drugs Primary health coverage	2.3 Integrating programmes and intersectoral collaboration DTPS Children diseases integrated care programme (PCIME) BED and other community-based initiatives Organisation de la filière de soins (hospital-primary health care relation) Public-private sectors partnership	3.3. Response to emerging needs Health safety Health risks reduction (tobacco, lifestyles) Chronic diseases management and care Mental health Vulnerable groups, namely adolescents

Table 5. CCS actions according to WHO functions at the country level and health system functions

Health system functions	WHO functions at the national (country) level				
	F1	**F2**	**F3**	**F4**	**F5**
General administration	SNIS	Human resources planning Health mapping Contracting	Burden of morbidity Risk factor surveys Health status surveys System responsiveness National health accounts Governance	Accreditation and quality assurance	Basic health coverage National programme joint reviews Performance indicators
Service delivery	Updating traditional programmes (vaccination, tuberculosis, malaria, trachoma, water-borne diseases) Epidemiological monitoring Training	Contracting Internal audit Accreditation Health quality DTPS Integrated management of childhood illness (PCIME) Health network organization (hospital–primary health care relationship) Public–private sector partnership	Supporting referral laboratories Action-research Operational research	Information dissemination and sharing supports (CDS, WHO web sites) Experience sharing	Access to drugs BDN and other community based initiatives Safe maternity STD/AIDS Water and environment Health safety Health risks reduction (tobacco, lifestyles, etc.) Chronic diseases management and care Mental health Vulnerable groups, namely adolescents
Resource generation	National Institute of Health Administration (INAS)	Adapting basic training to health needs (profiles and curricula re-definition, trainers' training) National Institute of Health Administration (INAS)			
Financing	–	–	Rationalizing resource allocation (criteria development for resource allocation, development of gain of productivity tools)	–	–

Annex 1

COUNTRY PROFILE

General

Country name:	Morocco		
Capital name:	Rabat		
Total land area:	710 850 km2		
Official language:	Arabic		
Currency:	Dirham (MAD)	Exchange rate in US$	9.75

Demographic indicators 2002

Total population	29 637 000
Urban: rural ratio	56
Male: female ratio	50.2
Under 1 year (%)	2.1
1 – 4 years (%)	10.1
5 – 14 years (%)	20.8
15–49 years (%)	21.7
Over 65 years (%)	5.0
Population growth rate (%)	1.6
Crude birth rate (%)	21.0
Dependency ratio (%)	62
Total fertility rate	2.9
Population density	40 (inhabitants/km2)

Socioeconomic indicators

Indicator	Year	Total	Male	Female
Adult literacy rate (15+ years)	01–02	52	66	38
School enrolment ratio (first level)	00–01	85	88	81
School enrolment ratio (second level)	00–01	28	30	26
Percentage of regular smokers	00	17.7	34.5	1.6

Per capita GNP	1360 US$ (1999)
Unemployment	12.5 (2001)
Main natural resources	
Main exports	
Ethnic groups	

Budgetary resources indicators in 2000

National health expenditure as % of GDP	3.8
Allocated resources to MOH from total government budget (%)	5.3 (2003)
MOH expenditures as % of GDP	1.9 (2002)
Annual budget of MOH (per capita)	17.5 US$ (2002)
National expenditures on health (per capita)	50 US$ (2000)

Percentage of population with access to local health services

Total	85

Urban	100
Rural	65

Human and material resources indicators (rate per 10 000 population)

Physicians	5.3
Dentists	0.74
Pharmacists	1.77
Nursing and midwifery	10.0
Hospital beds	10.9
PHC units or centres	2.7

Percentage of infants fully immunized in 2002 with

BCG	90
DPT	95
OPV	95
Measles vaccine	96
Hepatitis B vaccine	92

Percentage of total population with access to:

Safe drinking water	77
Adequate excreta disposal facilities	72

Other indicators

Pregnant women attended by trained personnel	56
Deliveries attended by trained personnel	49
Infants attended by trained personnel	62
Married women (15–49) using any form of contraceptives	59

Health status indicators

Indicator	**Year**	**Value**
Newborn with birth weight at least 2.5 kg.	2000	97
Children with acceptable weight for age	1997	91.1
Infant mortality rate	1999	36.6
Probability of dying before reaching 5th birthday	1999	45.8
Maternal mortality rate	1997	22.8
Life expectancy at birth (total)	1999	69.5
Male	1999	67.5
Female	1999	71.5

Selected morbidity indicators (reported cases in 2002)

Cholera	0
Malaria	104
Poliomyelitis	0
Measles	4703
Pulmonary tuberculosis	16 576
Diphtheria	0
AIDS	150
Meningococcal meningitis	120

Annex 2

ALLOCATIONS OF THE 2000–2001 BIENNIUM, BY PROGRAMME

Programme title	Allocated budget (in US$)	%
4.3 Sustainable human development – Basic development needs approach	430 000	21.72
1.1 Health policy formulation	260 000	13.13
7.2 Child and adolescent health – Service for children victims of violence.	181 500	9.17
10.1 Adult respiratory health	176 000	8.89
11.1 Epidemiological monitoring	120 000	6.06
2.1 Human resources policy management, planning and formulation	107 500	5.43
1.4 Preparation to emergency situations and risk management	100 000	5.05
6.1 Promotion of healthy lifestyles, health at school and health education targeting youth.	90 000	4.55
5.1 National drugs policy based on essential drugs – Pharmacy monitoring and monitoring medical treatments used in health programmes.	75 000	3.79
5.3 Implementation of assurance quality programme in the laboratories supporting health programmes	66 500	3.36
4.1 Care quality approach development	65 500	3.31
10.3 National programme against STD and AIDS	55 900	2.82
2.2 Supporting medical teaching	50 000	2.53
4.2 Strengthening the re-adaptation community-based programme targeting the handicapped	45 000	2.27
7.1 Supporting the safe maternity strategy, genesis health and family planning	44 600	2.25
1.3 Supporting research on health systems	38 000	1.92
8.4 Assessing health risks related to environment	35 000	1.77
1.2 Reinforcing health legislation	20 000	1.01
6.5 Food hygiene	19 500	0.98
Subtotal	1 980 000	100.0

Extrabudgetary funds US$ 72 000
Total US$ 2 052 000

Note. Excludes intercountry financing, such as participation in intercountry meetings and headquarters and EMRO technical support represented by visits from regional advisers and by planning missions (JPRM).