OVERVIEW
Morocco’s climate is very diverse, with a warm, Mediterranean climate in the northern coastal region, continental inland areas and semi-arid areas in the south. Morocco has ambitious renewable energy targets and is making political and strategic efforts to conserve biodiversity and to mitigate and adapt to climate change.

Despite positive action, Morocco remains vulnerable to the effects of climate change. The Mediterranean coast and low-lying Moulouya River delta, with their economic and ecological importance are threatened by sea-level rise and subsequent shoreline erosion and saline intrusion. Agriculture, which represents 16% of Morocco’s GDP, is endangered by decreases in annual rainfall increasing the risk of crop failures and malnutrition. Morocco could also face aggravated water scarcity; rising temperatures; severe heat waves; and increased incidence of dengue fever, malaria and schistosomiasis.

SUMMARY OF KEY FINDINGS
• Under a high emissions scenario, mean annual temperature is projected to rise by about 5.5°C on average from 1990 to 2100. If emissions decrease rapidly, the temperature rise is limited to about 1.6°C.
• Under a high emissions scenario, and without large investments in adaptation, an annual average of 187,400 people are projected to be affected by flooding due to sea level rise between 2070 and 2100. If emissions decrease rapidly and there is a major scale up in protection (i.e. continued construction/raising of dikes) the annual affected population could be limited to about 100 people. Adaptation alone will not offer sufficient protection, as sea level rise is a long-term process, with high emissions scenarios bringing increasing impacts well beyond the end of the century.
• Under a high emissions scenario heat-related deaths in the elderly (65+ years) are projected to increase to almost 50 deaths per 100,000 by 2080 compared to the estimated baseline of just under 5 deaths per 100,000 annually between 1961 and 1990. A rapid reduction in emissions could limit heat-related deaths in the elderly to just over 14 deaths per 100,000 in 2080.

OPPORTUNITIES FOR ACTION
Morocco has an approved national health adaptation strategy and is currently implementing projects on health adaptation to climate change. Country reported data (see section 6) indicate there are further opportunities for action in the following areas:

1) Adaptation
• Conduct an updated assessment of climate change impacts, vulnerability and adaptation for health.
• Implement actions to build institutional and technical capacities to work on climate change and health.
• Develop an integrated disease surveillance and response system with climate information included.
• Estimate the costs to implement health resilience to climate change.

2) Mitigation
• Initiate actions for greening the health sector, such as promoting the use of renewable energy.
• Conduct valuation of the co-benefits of health implications of climate mitigation policies.

DEMOGRAPHIC ESTIMATES

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (2013)</td>
<td>33 million</td>
</tr>
<tr>
<td>Population growth rate (2013)</td>
<td>1.4%</td>
</tr>
<tr>
<td>Population living in urban areas (2013)</td>
<td>59.2%</td>
</tr>
<tr>
<td>Population under five (2013)</td>
<td>10.0%</td>
</tr>
<tr>
<td>Population aged 65 or older (2013)</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

ECONOMIC AND DEVELOPMENT INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per capita (current US$, 2013)</td>
<td>3,056 USD</td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP (2013)</td>
<td>6%</td>
</tr>
<tr>
<td>Percentage share of income for lowest 20% of population (2012)</td>
<td>NA</td>
</tr>
<tr>
<td>HDI (2013, +/- 0.01 change from 2005 is indicated with arrow)</td>
<td>0.617 ▲</td>
</tr>
</tbody>
</table>

HEALTH ESTIMATES

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (2013)</td>
<td>71 years</td>
</tr>
<tr>
<td>Under-5 mortality per 1000 live births (2013)</td>
<td>30</td>
</tr>
</tbody>
</table>

b World Bank Data. Agriculture as % of GDP. http://data.worldbank.org/indicator/ NV.AGR.TOTL.ZS
c EMRO 61st Session Regional Committee Meeting. Towards A Public Health Response To Climate Change And Air Pollution In The Eastern Mediterranean Region.
f World Development Indicators, World Bank (2015)
g Global Health Expenditure Database, WHO (2014)
h United Nations Development Programme, Human Development Reports (2014)
i Global Health Observatory, WHO; 2014
The text boxes below describe the projected changes averaged across about 20 models (thick line). The figures also show each model individually as well as the 90% model range (shaded) as a measure of uncertainty and, where available, the annual and smoothed observed record (in blue).ab

a Model projections are from CMIP5 for RCP8.5 (high emissions) and RCP2.6 (low emissions). Model anomalies are added to the historical mean and smoothed.

b Observed historical record of mean temperature is from CRU-TSv.3.22; observed historical records of extremes are from HadEX2.

c Analysis by the Climatic Research Unit and Tyndall Centre for Climate Change Research, University of East Anglia, 2015.

d A ‘warm spell’ day is a day when maximum temperature, together with that of at least the 6 consecutive previous days, exceeds the 90th percentile threshold for that time of the year.

Due to climate change, many climate hazards and extreme weather events, such as heat waves, heavy rainfall and droughts, could become more frequent and more intense in many parts of the world.

Outlined here are country-specific projections up to the year 2100 for climate hazards under a ‘business as usual’ high emissions scenario (in orange) compared to projections under a ‘two-degree’ scenario with rapidly decreasing emissions (in green).ab Most hazards caused by climate change will persist for many centuries.
Human health is profoundly affected by weather and climate. Climate change threatens to exacerbate today’s health problems – deaths from extreme weather events, cardiovascular and respiratory diseases, infectious diseases and malnutrition – whilst undermining water and food supplies, infrastructure, health systems and social protection systems.

**EXPOSURE TO FLOODING DUE TO SEA LEVEL RISE**

<table>
<thead>
<tr>
<th>Severity of climate change scenario</th>
<th>RCP2.6 Without Adaptation</th>
<th>RCP2.6 With Adaptation</th>
<th>RCP8.5 Without Adaptation</th>
<th>RCP8.5 With Adaptation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>53,500</td>
<td>100</td>
<td>187,400</td>
<td>100</td>
</tr>
</tbody>
</table>

* Medium ice melting scenario  
** Values rounded to nearest 00

Under a high emissions scenario, and without large investments in adaptation, an annual average of 187,400 people are projected to be affected by flooding due to sea level rise between 2070 and 2100. If emissions decrease rapidly and there is a major scale up in protection [i.e. continued construction/raising of dikes] the annual affected population could be limited to about 100 people. Adaptation alone will not offer sufficient protection, as sea level rise is a long-term process, with high emissions scenarios bringing increasing impacts well beyond the end of the century.


**INFECTIONIOUS AND VECTOR-BORNE DISEASES**

**Mean relative vectorial capacity for dengue fever transmission in Morocco**

Under a high emissions scenario, the mean relative vectorial capacity for dengue fever transmission is projected to increase to 0.33 by 2070 compared to the baseline value of 0.22. If emissions decrease rapidly, the mean relative vectorial capacity could be limited to about 0.29 by 2070.

Source: Rocklöv, J., Quam, M. et al., 2015.

**Estimated number of deaths due to diarrhoeal disease in children under 15 years in Morocco (base case scenario for economic growth)**

In the baseline year of 2008 there were an estimated 4,200 diarrhoeal deaths in children under 15 years old. Under a high emissions scenario, diarrhoeal deaths attributable to climate change in children under 15 years old are projected to be about 10.5% of approximately 1600 diarrhoeal deaths projected in 2030. Although diarrhoeal deaths are projected to decline to just over 600 by 2050 the proportion of deaths attributable to climate change could rise to approximately 14.7%.

Climate change is expected to increase mean annual temperature and the intensity and frequency of heat waves resulting in a greater number of people at risk of heat-related medical conditions.

The elderly, children, the chronically ill, the socially isolated and at-risk occupational groups are particularly vulnerable to heat-related conditions.

Under a high emissions scenario heat-related deaths in the elderly (65+ years) are projected to increase to almost 50 deaths per 100,000 by 2080 compared to the estimated baseline of just under 5 deaths per 100,000 annually between 1961 and 1990. A rapid reduction in emissions could limit heat-related deaths in the elderly to just over 14 deaths per 100,000 in 2080.

Undernutrition

Climate change, through higher temperatures, land and water scarcity, flooding, drought and displacement, negatively impacts agricultural production and causes breakdown in food systems. These disproportionately affect those most vulnerable to hunger and can lead to food insecurity. Vulnerable groups risk further deterioration into food and nutrition crises if exposed to extreme weather events.

Without considerable efforts made to improve climate resilience, it has been estimated that the risk of hunger and malnutrition globally could increase by up to 20 percent by 2050.

In Morocco, the prevalence of child malnutrition in children under age 5 was 3.1% in 2011.

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*a* Country-level analysis, completed in 2015, was based on health models outlined in the Quantitative risk assessment of the effects of climate change on selected causes of death, 2030s and 2050s. Geneva: World Health Organization, 2014.

*b* World Food Project 2015. [https://www.wfp.org/content/two-minutes-climate-change-and-hunger](https://www.wfp.org/content/two-minutes-climate-change-and-hunger)

CURRENT EXPOSURES AND HEALTH RISKS DUE TO AIR POLLUTION

Many of the drivers of climate change, such as inefficient and polluting forms of energy and transport systems, also contribute to air pollution. Air pollution is now one of the largest global health risks, causing approximately seven million deaths every year. There is an important opportunity to promote policies that both protect the climate at a global level, and also have large and immediate health benefits at a local level.

OUTDOOR AIR POLLUTION AND SHORT LIVED CLIMATE POLLUTANTS

KEY IMPLICATIONS FOR HEALTH

Outdoor air pollution can have direct and sometimes severe consequences for health. Fine particles which penetrate deep into the respiratory tract subsequently increase mortality from respiratory infections, lung cancer and cardiovascular disease.

Short-lived climate pollutants (SLCPs) such as black carbon, methane and tropospheric ozone are released through inefficient use and burning of biomass and fossil fuels for transport, housing, power production, industry, waste disposal (municipal and agricultural) and forest fires. SLCPs are responsible for a substantial fraction of global warming as well as air-pollution related deaths and diseases.

Since short lived climate pollutants persist in the atmosphere for weeks or months while CO₂ emissions persist for years, significant reductions of SLCP emissions could result in immediate health benefits and health cost savings, and generate very rapid climate benefits - helping to reduce near-term climate change by as much as 0.5°C before 2050.

In Morocco, it is projected that a reduction in SLCPs could prevent almost 2,000 premature deaths per year from outdoor air pollution, from 2030 onwards (Source: Shindell, D., Science, 2012).

*Through implementation of 14 reduction measures: 7 targeting methane emissions and the rest, emissions from incomplete combustion. See source for further detail.

HOUSEHOLD AIR POLLUTION

MOROCCO

Percentage of population primarily using solid fuels for cooking (%), 2013

<table>
<thead>
<tr>
<th></th>
<th>RURAL AREAS</th>
<th>URBAN AREAS</th>
<th>NATIONAL TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morocco</td>
<td>6</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

Source: Global Health Observatory, data repository, World Health Organization, 2013

Percent of total deaths from ischaemic heart disease, stroke, lung cancer, chronic obstructive pulmonary disease (18 years +) and acute lower respiratory infections (under 5 years) attributable to household air pollution, 2012

Total Deaths:

<table>
<thead>
<tr>
<th></th>
<th>58,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attributable to household air pollution</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: Global Health Observatory, data repository, World Health Organization, 2012

KEY IMPLICATIONS FOR HEALTH

Air pollution in and around the home is largely a result of the burning of solid fuels (biomass or coal) for cooking.

Women and children are at a greater risk for disease from household air pollution. Consequently, household air pollution is responsible for a larger proportion of the total number of deaths from ischaemic heart disease, stroke, lung cancer and COPD in women compared to men.

In Morocco, 5% percent of an estimated 2,900 child deaths due to acute lower respiratory infections is attributable to household air pollution (WHO, 2012).


Health co-benefits are local, national and international measures with the potential to simultaneously yield large, immediate public health benefits and reduce the upward trajectory of greenhouse gas emissions. Lower carbon strategies can also be cost-effective investments for individuals and societies.

Presented here are examples of opportunities for health co-benefits that could be realised by action in important greenhouse gas emitting sectors.

- **Household heating, cooking and lighting**: Household air pollution causes over 4.3 million premature deaths annually, predominantly due to stroke, ischaemic heart disease, chronic respiratory disease, and childhood pneumonia. A range of interventions can both improve public health and reduce household emissions: a transition from the inefficient use of solid fuels like wood and charcoal, towards cleaner energy sources like liquefied petroleum gas (LPG), biogas, and electricity could save lives by reducing indoor levels of black carbon and other fine particulate matter; where intermediate steps are necessary, lower emission transition fuels and technologies should be prioritized to obtain respiratory and heart health benefits; women and children are disproportionately affected by household air pollution, meaning that actions to address household air pollution will yield important gains in health equity; replacing kerosene lamps with cleaner energy sources (e.g. electricity, solar) will reduce black carbon emissions and the risk of burns and poisoning.

- **Transport**: Transport injuries lead to 1.2 million deaths every year, and land use and transport planning contribute to the 2–3 million deaths from physical inactivity. The transport sector is also responsible for some 14% (7.0 GtCO₂e) of global carbon emissions. The IPCC has noted significant opportunities to reduce energy demand in the sector, potentially resulting in a 15%–40% reduction in CO₂ emissions, and bringing substantial opportunities for health: A modal shift towards walking and cycling could see reductions in illnesses related to physical inactivity and reduced outdoor air pollution and noise exposure; increased use of public transport is likely to result in reduced GHG emissions; compact urban planning fosters walkable residential neighborhoods, improves accessibility to jobs, schools and services and can encourage physical activity and improve health equity by making urban services more accessible to the elderly and poor.

- **Electricity generation**: Reliable electricity generation is essential for economic growth, with 1.4 billion people living without access to electricity. However, current patterns of electricity generation in many parts of the world, particularly the reliance on coal combustion in highly polluting power plants contributes heavily to poor local air quality, causing cancer, cardiovascular and respiratory disease. Outdoor air pollution is responsible for 3.7 million premature deaths annually, 88% of these deaths occur in low and middle income countries. The health benefits of transitioning from fuels such as coal to lower carbon sources, including ultimately to renewable energy, are clear: Reduced rates of cardiovascular and respiratory disease such as stroke, lung cancer, coronary artery disease, and COPD; cost-savings for health systems; improved economic productivity from a healthier and more productive workforce.

- **Healthcare systems**: Health care activities are an important source of greenhouse gas emissions. In the US and in EU countries, for example, health care activities account for between 3–8% of greenhouse gas (CO₂-eq) emissions. Major sources include procurement and inefficient energy consumption. Modern, on-site, low-carbon energy solutions (e.g. solar, wind, or hybrid solutions) and the development of combined heat and power generation capacity in larger facilities offer significant potential to lower the health sector’s carbon footprint, particularly when coupled with building and equipment energy efficiency measures. Where electricity access is limited and heavily reliant upon diesel generators, or in the case of emergencies when local energy grids are damaged or not operational, such solutions can also improve the quality and reliability of energy services. In this way, low carbon energy for health care could not only mitigate climate change, it could enhance access to essential health services and ensure resilience.

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a For a complete list of references used in the health co-benefits text please see the Climate and Health Country Profile Reference Document, at: http://www.who.int/globalchange/en/
EMISSIONS AND COMMITMENTS

Global carbon emissions increased by 80% from 1970 to 2010, and continue to rise. Collective action is necessary, but the need and opportunity to reduce greenhouse gas emissions varies between countries. Information on the contribution of different sectors, such as energy, manufacturing, transport and agriculture, can help decision-makers to identify the largest opportunities to work across sectors to protect health, and address climate change.

A 2°C upper limit of temperature increase relative to pre-industrial levels has been internationally agreed in order to prevent severe and potentially catastrophic impacts from climate change. Reductions are necessary across countries and sectors. In order to stay below the 2°C upper limit it is estimated that global annual CO2-energy emissions, currently at 5.2 tons per capita, need to be reduced to 1.6 tons per capita.

The most recent greenhouse gas emissions data for Morocco is from 2000. At that time, carbon emissions were increasing across sectors, with the largest contributions from the agriculture, energy industries sectors and ‘other’ sectors. Through intersectoral collaboration, the health community can help to identify the best policy options not only to eventually stabilize greenhouse gas emissions, but also to provide the largest direct benefits to health.

Source: UNFCCC Greenhouse Gas Data Inventory, UNFCCC [2015].

NATIONAL RESPONSE

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>Morocco ratifies the UNFCCC</td>
</tr>
<tr>
<td>2002</td>
<td>Morocco ratifies Kyoto Protocol</td>
</tr>
<tr>
<td>2009</td>
<td>Morocco’s national plan against global warming</td>
</tr>
<tr>
<td>2010</td>
<td>Law on the national agency for the development of renewable energy and energy efficiency</td>
</tr>
<tr>
<td>2030</td>
<td>Morocco’s commitment to reduce GHG emissions 32% by 2030 compared to the “business as usual” projected emissions</td>
</tr>
</tbody>
</table>

---

MOROCCO ANNUAL GREENHOUSE GAS EMISSIONS (metric tonnes CO₂ equivalent)

The annual greenhouse gas emissions for Morocco from 1994 to 2000 are shown in the diagram. The largest contributions were from the agriculture, energy industries sectors and ‘other’ sectors. Through intersectoral collaboration, the health community can help to identify the best policy options not only to eventually stabilize greenhouse gas emissions, but also to provide the largest direct benefits to health.

Source: UNFCCC Greenhouse Gas Data Inventory, UNFCCC [2015].

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c Pathways to deep decarbonization, Sustainable development Solutions Network, 2014 report.


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1995

MOROCCO RATIFIES THE UNFCCC

2002

MOROCCO RATIFIES KYOTO PROTOCOL

2009

MOROCCO’S NATIONAL PLAN AGAINST GLOBAL WARMING

2010

LAW ON THE NATIONAL AGENCY FOR THE DEVELOPMENT OF RENEWABLE ENERGY AND ENERGY EFFICIENCY

2030

MOROCCO’S COMMITMENT TO REDUCE GHG EMISSIONS 32% BY 2030 COMPARED TO THE “BUSINESS AS USUAL” PROJECTED EMISSIONS
The following table outlines the status of development or implementation of climate resilient measures, plans or strategies for health adaptation and mitigation of climate change [reported by countries].

### GOVERNANCE AND POLICY

<table>
<thead>
<tr>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country has identified a national focal point for climate change in the Ministry of Health</td>
<td>✔</td>
</tr>
<tr>
<td>Country has a national health adaptation strategy approved by relevant government body</td>
<td>✔</td>
</tr>
<tr>
<td>The National Communication submitted to UNFCCC includes health implications of climate change mitigation policies</td>
<td>✔</td>
</tr>
</tbody>
</table>

### HEALTH ADAPTATION IMPLEMENTATION

<table>
<thead>
<tr>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country is currently implementing projects or programmes on health adaptation to climate change</td>
<td>✔</td>
</tr>
<tr>
<td>Country has implemented actions to build institutional and technical capacities to work on climate change and health</td>
<td>✗</td>
</tr>
<tr>
<td>Country has conducted a national assessment of climate change impacts, vulnerability and adaptation for health</td>
<td>✓</td>
</tr>
<tr>
<td>Country has climate information included in Integrated Disease Surveillance and Response (IDSR) system, including development of early warning and response systems for climate-sensitive health risks</td>
<td>✗</td>
</tr>
<tr>
<td>Country has implemented activities to increase climate resilience of health infrastructure</td>
<td>✔</td>
</tr>
</tbody>
</table>

### FINANCING AND COSTING MECHANISMS

<table>
<thead>
<tr>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated costs to implement health resilience to climate change included in planned allocations from domestic funds in the last financial biennium</td>
<td>✗</td>
</tr>
<tr>
<td>Estimated costs to implement health resilience to climate change included in planned allocations from international funds in the last financial biennium</td>
<td>✗</td>
</tr>
</tbody>
</table>

### HEALTH BENEFITS FROM CLIMATE CHANGE MITIGATION

<table>
<thead>
<tr>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>The national strategy for climate change mitigation includes consideration of the health implications (health risks or co-benefits) of climate change mitigation actions</td>
<td>✔</td>
</tr>
<tr>
<td>Country has conducted valuation of co-benefits of health implications of climate mitigation policies</td>
<td>✗</td>
</tr>
</tbody>
</table>

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*a* Supporting monitoring efforts on health adaptation and mitigation of climate change: a systematic approach for tracking progress at the global level. WHO survey, 2015.