Social determinants and health equity in Morocco

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Executive Summary

By the end of the second millennium and after fifty years of independence, Morocco had noticeably improved the average economic, social and health conditions of its population.. Human development in general, life expectancy, literacy and per capita income in particular, increased substantially. However, improvement was uneven and not equally shared by groups from different milieu, regions and/or level of wealth. Indeed, social inequalities and health inequities have persisted or even worsened as indicated by a large urban-rural disparity, discrepancy between developed and less developed regions, and unacceptable gaps between rich and poor. Though reduced at primary school, gender inequality remained at other levels.

At the beginning of the third millennium, Moroccan authorities launched many activities in order to reduce health inequity by acting on the underlying social determinants such as poverty, illiteracy, unemployment and marginalisation. Beside the usual programmes and plans of action undertaken by the government, five main initiatives were launched between 2000 and 2005. The first was devoted to education (the education charter, 2000), the second issue was a study of reflection and debate to evaluate “fifty years of human development in Morocco” (2003), the third important issue was on human rights (Equity and Reconciliation Commission, 2004), the fourth matter concerned the Moroccan Family code (Moudawana, 2004), and the fifth global initiative was dedicated to human development (National Initiative for Human Development, 2005).

Being initiated by the King Mohamed VI as the highest authority in Morocco, all the activities launched were supposed to create a participating and synergic effect involving the government and its regional and local representatives, political parties, academic institutions, civil society organisations and international partners. The commitment of Morocco to the realisation of the Millennium Developments Goals was another incentive obligation.

The preliminary results indicate that the National Initiative for Human Development (NIHD) and other programmes of the government succeeded in reducing the rate of poverty in all Moroccan regions and more particularly in the rural communities with the highest level of poverty. The most disadvantaged populations, which were selected through a targeting strategy, recognise that NIHD projects improved their living conditions. Based on principles such as participation, good governance, proximity, dignity,
confidence and sustainability, the National Initiative for Human Development and similar programmes can improve the living conditions of the most disadvantaged (women, children, population living in rural areas and marginalised districts). More time is, however, needed for a serious and deeper analysis of the impact of NIHD, launched in 2005. Although the national context is reassuring in terms of economic growth, political stability and social solidarity, the problem of inequalities remains a big challenge for the Moroccan policy makers.

As stressed by the Commission on Social Determinants of Health and confirmed by the recent document of UNICEF “narrowing the gaps to meet the goals”, it has now become evident that strategies based on national average indicators like MMR, IMR, life expectancy and the MDGS may reach the goals, expressed as averages, while maintaining or even increasing the gaps between men and women, rich and poor, rural and urban, developed and less developed regions. The Moroccan experience presented here is an illustration of a strategy that reduced the poverty rate and other indicators like IMR and MMR along with an improvement in life expectancy and GNP per capita. But different measurements of inequity (Gini index, Concentration index, relative index of inequality, absolute differences and relative ratios) are used to show the need to deal with gender and socio-spatial inequalities through a pragmatic health equity agenda.

**Stating the problem of inequity**

Although a substantial improvement has been achieved in the average living standard of the whole population, Morocco remained a contrasting country with large disparities between regions, an unacceptable gap between rich and poor, and a rural world lagging far behind the urban cities (Boutayeb, 2006a; Gwatkin et al, 2007; Yaakoubd, 2009; Boutayeb, 2011).

Brief evidence can be provided by analysing data from Demographic Health Survey 2003/04. For instance, the percentage of women who had no antenatal visit reached 60% for all home deliveries and 70% in the poorest quintile; the figures for rural areas were more than 52% and 61% respectively, and 45% and 52% respectively for illiterate mothers. Comparatively, the percentages were 7% (6%) in the richest quintile, 15% (16%) in urban areas and 6.6% (7.6%) for mothers with secondary or higher education. Similar gaps were seen with other indicators (Figure1).
A similar inequity trend is provided by the child mortality rate (U5MR). For example, a child born in the poorest quintile is three times less likely to reach his or her fifth birthday compared to a child born in the richest quintile. For post-neonatal mortality the ratio is nearly 5.

These (and other) large and unfair inequalities affected the country at different levels. The four Arab human development reports released between 2002 and 2005 stressed that Morocco has accomplished less than expected in terms of human development globally, and in education, health and social justice in particular (Boutayeb 2006b). Evidence was given by the relatively low human development index (HDI), with a rank of 125 in 2002. In parallel, the targets fixed by the Millennium Development Goals (MDGs) showed that Morocco needed efficient and urgent actions to reduce poverty, gender inequality, maternal and infant mortality as well as adult illiteracy and school dropout rates.

Following the gloomy years of repression and imprisonment, human rights was another field where Morocco needed an urgent action. Voices for freedom and democracy were raised by international bodies and organisations as well as by national civil associations. Social mobilisation expressed regularly the vital need for “the right to a decent life”.

The consequences of a multidimensional transition (economic, demographic, geographic and epidemiological) required actions to deal especially with the marginalisation of the rural world, and its
corollary in terms of rural exodus, unemployment, poverty and insecurity.

**Context by the Beginning of the Third Millennium**

Morocco embarked upon the third Millennium with huge regional disparities, unacceptable gaps between rich and poor, great gender gap, and a rural world lagging far behind its urban counterpart. This multidimensional inequity problem can be illustrated by a multitude of variables and indicators.

On average, 19% of the Moroccan population was living under the national poverty line, with 70% in the rural area. The income/consumption ratio between the richest 10% and the poorest 10% was nearly 12. The estimated earned income of women was less than 40% of that of men and the share of non-agricultural wage employment was 73% for men and 27% for women.

With a national rate of 48%, the urban literacy rate was twice that of rural areas. Urban males were 4.6 more likely to be literate than rural females, and at third level, rich urban males were 7.4 times more likely to be educated than rural poor females. Poor, rural females were struggling under a triple handicap. The rates of enrolment at different levels of education showed gender gaps and large differences between rural and urban areas.

More than 33% of the population was unable to afford necessary medical care. This percentage reached 44 % in rural areas. Households devoted on average 6.5% of their budget to health care; 9% for the poorest quintile, compared to 3.9% for the richest quintile. Morocco had an average of one doctor for 2100 inhabitants but the distribution was unfair since the numbers per region varied from one doctor for 840 inhabitants to one doctor for 4600. A similar regional imbalance was found in the number of health centres.

Nearly 30% of the rural population was living at a distance of 10 km from any health facility. More generally, the rural world had large deficits in terms of basic services and needs like education, jobs, drinking water, electricity and social welfare. Women and children and elderly people were the most affected by remoteness and inaccessibility.

Until the end of the second millennium, government strategies were principally based on a security
Interventions toward the reduction of health inequities and/or regional and geographical disparities were very timid and inefficient. An illustrative example of clear inefficiency was given by the failure to reach the goals at different levels of education. Following up a cohort of 100 pupils enrolled at primary school, only 34% of them completed primary school without repetition while the goal fixed was 90%. For the age category 12-14 years, only 22% completed the college course without repetition instead of 80% expected, and finally 3% successfully finished secondary school while the target fixed was 40% (CSE, 2008). Disadvantaged populations were obviously the most affected by such strategies.

The situation needed urgent interventions and the commitment was made by King Mohamed VI who launched the education charter in 2000, the study of reflection and debate to evaluate “fifty years of human development in Morocco” in 2003, the Equity and Reconciliation Commission and the Moroccan Family code (Moudawana) in 2004, and the National Initiative Human Development in 2005. Government, political parties and civil society organisations were invited to contribute to this movement. In particular, the Ministry of health launched a programme of action 2008-2012. The Ministry of Education called for an urgent plan 2009-2013 following a rather critical report released by the High Council of Education in 2008 after evaluation of the first results of the education charter.

Planning to reduce poverty and health inequity

The main decision taken to address the problem of poverty and health inequity was the launch of the National Initiative for Human Development (NIHD) as a complementary action supporting sectoral programmes of the government. Theoretically, this initiative was based on the following values: dignity, confidence, participation, good governance and sustainability. Pragmatically, a budget needed to be found and dedicated to a programme with the following priorities (NIHD, 2011a):

- Struggle against poverty in rural areas
- Struggle against social exclusion in urban areas
- Struggle against vulnerability.

A targeting strategy based on poverty-mapping was supposed to identify the urban districts and rural communities most affected by poverty, vulnerability and marginalisation. The Human Development Local
Committees had the task to select, nationwide, the rural communities needing to benefit with priority from the NIHD programme 2006-2010.

In rural areas, priority was to be given to communities with a poverty rate greater than 30% and those with a poverty rate between 22% and 30%. In urban areas, 30 cities were identified and 264 districts were prioritized for receiving benefits from NIHD, with a population of about 2.5 million, representing 22% of the population of the 30 cities and 16% of the whole urban population. The districts were selected on the basis of the following needs: lack of basic social infrastructure, high rate of school drop-outs, unemployment, unfit housing, poverty and insufficient income, high rate of exclusion among women and children and absence of training opportunities.

Before implementation, the organisation of NIDH was conceived on two levels. At the central level, two committees were formed (strategic and piloting) whereas the local level needed local, provincial and regional committees with important roles designated for local actors. This structure was governed by the National Coordination at the central level and by the Social Action Division at the provincial level. The strong point of NIDH was the willingness to facilitate a large participation, including the government and its representatives at different levels, the private sector, civil society, universities and the population at large.

The National Initiative for Human Development planned to secure part of its resources from the main state budget and part from national and international partners. The availability of funds, the political will and the search for rigorous governance based on programmes with clear objectives were supposed to stimulate different groups of the population.

In parallel with NIDH actions, government programmes of action were expected to act in the same direction. Morocco had one of the lowest levels of health insurance in the region and populations were not able to afford the cost of access to health care. Consequently, the government planned to increase the percentage of population with health insurance from 16% to 30% through a compulsory health insurance (AMO) as a first step. In the second step, the poorest 8.5 million people would be covered totally or partially by the “insurance of the poor” (RAMED) (Régime d’assistance médicale aux économiquement démunis).
At the international level, Morocco was engaged to achieve the Millennium Development Goals by 2015. On top of the effort devoted to achieve universal education and reduce poverty and gender inequality, the government devoted substantial attention to the achievement of the MDGs 4 and 5, stipulating the reduction of infant mortality by two thirds and maternal mortality by three-fourth between 1990 and 2015.

**Implementation**

The main philosophy of NIHD was to reduce the socioeconomic deficits by satisfying the fundamental needs of the poor populations. Consequently, four axes were determined for implementation (NIHD, 2011b):

- Struggle against poverty in rural areas
- Struggle against social exclusion in urban areas
- Struggle against vulnerability
- Intersectoral programmes

More precisely, these complementary programmes were dedicated to deal with the following activities:

- Access to basic social services like education, health care, drinking water and sanitation
- Activities generating income, creation of job opportunities and a sustainable income
- Promotion and enhancement of civil society initiatives
- Support to social, cultural and sporting activities
- Realization of project with high impact.

At a central level, a piloting committee was formed by the departments of interior, finance, social development and development planning. This Committee, chaired by the Prime Minister, deals with budget, international cooperation, and monitoring and evaluation of NIHD actions. Its strategies and decisions are validated by another strategic committee, also chaired by the Prime Minister and formed by the members of government and public organisations. A third organization, the National Coordination of NIHD and placed under the ministry of interior, has the task of normalising and following up the NIHD
At a territorial level, the governing principle of NIHD was based on tripartite committees gathering state services, elected members and representatives of civil associations. These committees were conceived as operating at different levels, namely: Regional Committee of Human Development (RCHD), Provincial Committee of Human Development (PCHD) and Local Committee of Human Development (LCHD).

**Targeting Strategy**

In urban areas, targeting was based on a number of criteria like unemployment rate, size of the beneficiary population, existence and proportion of unsanitary dwellings, deficit in infrastructure and basic public services, complementary action with local development programmes, and budgetary involvement of partners. A total of 264 districts were identified especially in cities with population over 100,000 inhabitants.

In the rural world, this strategy allowed identification of 403 rural communities where the rate of poverty was around or exceeded 30% (348 had a poverty rate greater than 30% while 55 had a poverty rate between 22% and 30%) on the basis of poverty-mapping established by the High Planning Commission (HPC) in 2004.

Based on the criteria determining poor and vulnerable populations in rural and urban areas, local and regional committees select the priority projects, taking into account technical factors and the readiness of the beneficiary population in terms of participation and follow-up.

**INDH and Social Determinants of Health**

1) About 1350 health projects with a budget of 868 million MDH were provided for nearly 350,000 inhabitants. The actions were supposed to contribute to MMR and IMR reduction by increasing the number of assisted births and improving reproductive health especially in remote areas.

2) A budget of 1.3 billion MDH was devoted to 3150 projects in education, benefiting 800,000 pupils. These projects focused principally on disadvantaged populations and more specifically girls living in remote rural areas.
3) Illiteracy was also a concern, with 329 projects amounting to 41 million MDH and reaching 84,000 men and women.

4) Basic infrastructure attracted 3.28 billion MDH for the realisation of 4546 projects

5) Improvement of access to safe drinking water attracted nearly two billion MDH and benefited 656,000 inhabitants through 2800 projects conducted in a participatory way.

6) About 5000 associations and cooperatives were supported through 6300 projects.

7) Last but not least, some 6300 projects were initiated, creating about 40,000 jobs through income generating activities.

Financial resources

In 2005 NIDH started with a priority programme with a budget of 250 million MDH (about 25 million US dollars). For the period 2006-2010, a budget of 10 billion MDH was dedicated to financing NIDH programmes. This budget was provided by the general state budget (60%), international cooperation (20%) and local communities (20%).

The first part of the programmes (2005) allowed the real launch of work on the site. A total of 1,104 projects were realized, including 570 rural projects, 364 urban projects and 170 projects dedicated to vulnerable populations. The total cost of these projects amounted to nearly 600 million MDH with 59% as a contribution of partners like sectoral departments, national associations and local communities.

For the period 2006-2010, more than 200,000 actions and development projects were initiated with a predominance for intersectoral programmes (9032 projects), followed by rural projects (6756 projects), urban (4069 projects) and vulnerability (2148 projects). The total budget assigned to these projects exceeded 13 billion MDH, of which nearly 6 billion MDH was provided by partners. The 41% contribution of partners is a clear indication of the capacity of INDH to secure additional funds (NIDH, 2011b).

Parallel Government programmes and actions

In parallel with NIHD, different government programmes were devoted to increase accessibility to basic services like education, health, drinking water, and socio-cultural infrastructures. In particular, the MOH adopted the maternal mortality strategy (MMS) in order to: 1) reduce barriers to access to emergency
obstetric services, 2) improve the quality of health care and 3) to improve governance. The national commission appointed in 2008 by the Minister of Health has brought together all stakeholders in the fields of maternity and antenatal care, including UN agencies (UNICEF, WHO, UNFPA, UNDP), professional associations academic community, civil society and representatives of MOH at provincial and local levels.

The institution of the maternal mortality surveillance system (MMSS) was a crucial issue for monitoring and evaluating the MMS. Indeed, in 2009, one year after its establishment, the MMSS recorded 3814 deaths of women aged 15 to 49 years, of whom 436 were maternal deaths. Further analysis allowed the determination of the main causes of deaths (haemorrhage 33%, pre-eclampsia 18%, infection/sepsis 8% and urine rupture 7%). The important findings identified delayed access to care (42%) and inappropriate treatment (44%) as the main determinants of avoidable deaths (MOH & UNFPA, 2011).

**Evaluation and Impact**

**Qualitative Assessment: A Perception Survey**

In order to assess qualitatively the impact of INDH on beneficiaries, a survey of perception was conducted among nearly five million people, including 4,867,110 beneficiaries, 19,848 project holders and 3,154 administrators at national, provincial and local levels. The main objectives of the survey were to:

- Assess the outcome of INDH on each beneficiary and on development in general
- Evaluate the social competencies acquired
- Measure the self-efficacy of beneficiaries
- Examine the future perception and perspectives
- Estimate the societal impact of INDH projects.

A stratified sample of 8,257 people was targeted and a final sample of 7,935 people was available for analysis (NIHD, 2011c).
Among the whole population of beneficiaries, scores (rated between 0 and 5) were as follows:

- Social competencies acquired: score 4.3/5
- Evaluation of the self-confidence (self-esteem) before INDH: 2.75, after INDH: 3.47
- Societal impact: score 3.6/5
- Future perspectives: score 3.67/4

Among the beneficiaries of activities generating income (AGI), scores were as follows:

- Motivation and involvement in labour: score 3.97/4
- Labour autonomy: score 3.55/4
- Self-efficacy score 3.45/4
- Projects sustainability: score 4.15/5

**Quantitative Assessment: Impact on Social Determinants of Health**

**Income and consumption**

In monetary terms the rate of poverty is determined by the household consumption budget. This budget shows a huge gap between the richest and the poorest. Table 1 below shows that the consumption ratio urban/rural is nearly 2, while the ratio between the richest 10% and the poorest 10% has increased from 11 in 1991 to 12.6 in 2007. The richest 10% living in urban areas consume 19 times more than the poorest 10% living in rural areas. More generally, the magnitude of inequality in consumption through the whole country can be traced by the well known Gini Index, showing an increasing trend from 0.393 in 1991 to 0.395 in 1999 and 0.407 in 2007.
Table 1: Trend of socio spatial inequalities (HPC, 2010)

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<tr>
<td>% of Consumption by poorest 10%</td>
<td>2.8</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>% of Consumption by richest 10%</td>
<td>30.8</td>
<td>31</td>
<td>33.1</td>
</tr>
<tr>
<td>Ratio urban/rural</td>
<td>2</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Ratio richest 10% / poorest 10%</td>
<td>11</td>
<td>11.9</td>
<td>12.6</td>
</tr>
<tr>
<td>Gini Index</td>
<td>0.393</td>
<td>0.395</td>
<td>0.407</td>
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</tbody>
</table>

Evolution of poverty rate

Nationwide, the poverty rate decreased from 15.3% in 2001 to 8.9% in 2007 (from 7.6% to 4.8% in urban areas and from 25.1% to 14.5% in rural areas). According to the poverty-mappings elaborated in 2004 and 2007 by the Morocco High Planning Commission (HPC), the poverty rate has decreased in all Moroccan regions but the decrease was more noticeable in rural communities targeted by INDH (41%) compared to non-targeted rural communities (28%). However, the decrease in the poverty rate was compensated by an increase in vulnerability affecting almost all regions. Moreover, the disparity between regions is still alarming since the rate of poverty (respectively vulnerability) varies from 3.2% in the most advantaged region to 15.6% in the least advantaged region (respectively from 10.1% to 26.7%) (Figure 3a, b) (HPC, 2010). It should also be stressed that the proportion of poor children (11.3%) is greater than the national poverty rate.
**Figure 3:**

**a) Evolution of poverty rate by regions**

![Evolution of poverty rate by region graph]

**b) Evolution of vulnerability rate by regions**

![Evolution of vulnerability rate by region graph]
**Education**

During the last decade, real progress was achieved in terms of primary school enrolment. Quantitatively, the net rate of enrolment of children aged 6-11 years reached 90.5% in 2008/09. Milieu and gender disparities were noticeably reduced. According to the 2009 MDG national report, the rates registered were: 91% for boys and 90.2% for girls in urban areas compared to 93.2% for boys and 88% for girls in rural areas. This achievement remains, however, insufficient and incomplete when other levels (preschool, college, secondary and university) are considered. For example, huge disparities are seen for children who are supposed to be enrolled at the college (age 12-14). Indeed, only 44% of this age category reaches this level of education, of whom only 16% of rural girls and 22% of rural boys compared with respectively 68% and 65% in urban areas (Figure 4) (UNESCO, 2010).

It should also be stressed that illiteracy is still burdening the country. Indeed, according to a national survey conducted in 2006, 38.5% of the population 10 years old and above were illiterate, with great differences according to sex and milieu: 21% for men and 34% for women in urban areas compared with 45% for men and 64% for women in rural areas. For the population aged 15 years and above the rates were: 23% for urban men and 73% for rural women (ENANSD, 2006).

**Economy and activity**

Morocco is a low middle income country. During the last decade, the country achieved an average growth of 4.7% and maintained the level of inflation at about 2%. While these results are judged to be satisfactory especially in a difficult international context, a large disparity is found between the 16 regions since the contribution to GNP of the two most advantaged regions is 40% compared to 6% for the two least advantaged. In 2007, the average GNP per capita was 3.5 times higher in Grand Casablanca (35300 MDH) than in the region of Taza-AlHoceima-Taounate (10191 MDH).

On an other scale, despite the efforts devoted by Moroccan authorities to reach the second MDG, gender inequality is still a challenge at different levels. For instance, in 2010, the rate of economic activity was 25.9% for women compared to 74.4% for men. In 2000, the rates were respectively 28.1% and 78.9%, showing that the gender gap is not being reduced (Figure 5).
Health Care and Accessibility

No doubt that Morocco has significantly improved health conditions of its populations during the last decades. A simple indicator summarising health achievements is given by the average life expectancy at
birth which increased from 59.1 years in 1980 to 74.8 in 2010. Table 2 below confirms that female life expectancy is greater than male life expectancy as is usually the case. It shows also that the difference between urban and rural decreased by two years between 2004 and 2010. However, this trend needs to be considered with caution given the fluctuation between 1980 and 2004.

Table 2: Evolution of life expectancy by sex in rural and urban areas

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>1987</th>
<th>2004</th>
<th>2010</th>
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<tr>
<td></td>
<td>Urb</td>
<td>Rur</td>
<td>Nat</td>
<td>Urb</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>57.6</td>
<td>60.2</td>
<td>71.8</td>
</tr>
<tr>
<td>Women</td>
<td>63</td>
<td>55.4</td>
<td>58.1</td>
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</tr>
<tr>
<td>Men</td>
<td>64</td>
<td>56.5</td>
<td>59.1</td>
<td>69.7</td>
</tr>
<tr>
<td>Total</td>
<td>7.5</td>
<td>5.7</td>
<td>7.6</td>
<td>5.6</td>
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</tbody>
</table>

The difference in life expectancy between men and women living in urban areas and those living in the rural world indicates clearly the influence of the living milieu on the length and quality of life. Considering life expectancy as an outcome generated by daily living conditions, it is sad to notice that poor populations and those living in rural areas have particularly suffered from inaccessibility to basic health services. Comparing reproductive health services like antenatal care, birth assisted by skilled personnel and postnatal visits; or maternal and infant mortality, one is struck by the difference between rural and urban indicators (Annex Tables 3,4).

According to data from the 2003 survey on population, health and family (Enquête sur la population et la santé familiale EPSF2003/04), infant mortality shows great differences according to milieu (urban-rural), well-being quintile, and mother’s level of education (Table 4 Annex). It would have been interesting and fruitful to see the trend according to new data but, unfortunately, the most recent survey conducted by the planning division of MOH with financial support from UNICEF (2009-2010) has not yet
been released!

For nearly two decades (1985-2005), maternal mortality constituted a real problem for Moroccan health authorities. It seems that, at last, the government strategy devoted to this important issue has given reassuring results (MOH & UNFPA, 2011). Focusing on facility deliveries and antenatal care, especially in hospitals and primary care facilities, the strategy allowed increasing the proportion of births attended by skilled personnel from 61% in 2004 to 83% in 2009. Consequently, and according to the last HPC figures, the MMR is estimated at 112 deaths per 100 000 lives births (148 in rural areas and 73 in urban areas). In 2003-2004, the MMR was 267 and 187 in rural and urban areas respectively. While applauding this achievement as an average, one needs also to assess the strategy in terms of inequality reduction. Indeed, the 2003-2004 data showed huge differences in access to health services either between rural and urban areas or according to well being quintiles (Figure 6a). Researchers are looking forward to the release of data from the recent survey in order to evaluate the magnitude and trend of inequalities. For maternal mortality a comparison in time shows that the ratio Rural/Urban rose from 1.43 in 2003 to 2.03 in 2010 (Figure 6b).

**Figure 6: a) Home delivery: Concentration index=-0.412 b) MMR in rural and urban areas**

![Graph showing Concentration Index of home delivery and Trend of MMR in rural and urban areas]

**Follow-up and lessons learned**

Being initiated by the King Mohamed VI as the highest Moroccan authority, the NIHD was implemented
in co-ordination with the government departments, the local communities, the civil associations and NGOs and the population (beneficiaries).

The preliminary results seem to be in favour of the strategy in terms of poverty and vulnerability reduction as perceived by the beneficiary population. Indeed, according to a survey conducted by the ONDH in 2009, about 50% of households say that INDH projects improved their living conditions. It is however, too early to evaluate the proper impact of NIDH in terms of poverty and inequality reduction. More time is needed for a serious and deeper analysis.

It is obvious that when you start with high levels of poverty, vulnerability and marginalisation and in a situation where populations are suffering from lack of basic services like education, health care, job opportunities and human respect in general, activities like those launched by NIHD are likely to make a straightforward difference. But two main questions will need convincing answers. The first is about sustainability and the second concerns the cost-benefit of the NIHD strategy which is dealing with an important budget.

During more than fifty years of independence, Morocco could not get rid of the dualism between developed and less developed regions. Unbelievable gaps exist between the 16 regions at nearly all levels (GNP, health structures, education institutions, vulnerability, poverty, etc...). On top of the already mentioned regional gaps in poverty and vulnerability rates, one can hardly admit that 40% of GNP per capita and 50% of all physicians practicing in Morocco are found in two regions (Grand Casablanca and Rabat-Salé-Zemmour-Zaer).

With the adoption of a new constitution in June 2011, Morocco is expected to be governed by a less centralised administration. The reshaped regions will have more autonomy for local governance but the least advantaged will need a transfer of funds and technology in order to reduce the gap and catch up with the advantaged regions. Failing to solve the regional deficit would leave very few chances for any initiative to tackle the structural problem of socio-spatial inequalities.

As indicated by the recent Common Country Assessment report (UN, 2011), gender and socio-spatial inequalities constitute a real challenges for Morocco. Populations living in rural areas and shantytowns are still experiencing large deficits in terms of basic services (education, health, employment, housing and a general decent life). Among these populations, women and children are the most vulnerable and
necessitate particular attention.

The Moroccan experience presented here is an illustration of a strategy that reduced the poverty rate and other indicators like IMR and MMR along with an improvement in life expectancy and GNP per capita. In this way, similar experiences may well be implemented in other developing countries. However, the main lesson learned is the more and more recurrent need for a pragmatic equity-focused approach.
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ANNEX

Table 3: Infant and child mortality rates by socio economic characteristics

<table>
<thead>
<tr>
<th>Socio-economic characteristics</th>
<th>Neonatal mortality</th>
<th>Post-neonatal mortality</th>
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<th>Under five mortality</th>
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<td>33</td>
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Table 4: Women and health services by socio economic characteristics

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<th>Socio-economic characteristics</th>
<th>% of women who had no antenatal care</th>
<th>% of women who had no post natal visit</th>
<th>% of births given home</th>
<th>% of deliveries assisted by traditional midwives</th>
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