

# **WHO-Rabat-Morocco**

## **Case study**

**At the confluence of the National Initiative for Human Development and the Basic Development Needs Program: the case of Larache province, Essouaken/Imir Tlek and Doukkala/Boussafi communes**

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## ACRONYMS

AIDS	: Acquired immune deficiency syndrome
AMO	: Compulsory Health Insurance
ANAM	: National Health Insurance Agency
BAJ1	: Social Priorities Project 1
BDN	: Basic Development Needs
BDNP	: Basic Development Needs Program
CDL	: Local development committee
COSEF	: Commission Spéciale Éducation Formation
CPCS	: Comité provincial de coordination et de suivi
CPE	: Cellule Provinciale d'Épidémiologie
Dh	: Dirham (US\$1 = approx. 8.4 Dh)
GTZ	: German Technical Cooperation
HDI	: Human Development Index
IGA	: Income-generating activity
INDH	: National Initiative for Human Development
MPH	: Ministry of Public Health
NGO	: Non-governmental organization
ORE	: Tangier-Tetouan regional epidemiology observatory
PAGER	: National program for rural water supply and sanitation
PNER	: National rural electrification program
Progress	: Projet de gestion régionale des services de santé
RAMED	: Régime d'assistance médicale au profit des démunies
RGPH	: General population and housing survey
SDA	: Social Development Agency
STD	: Sexually transmitted disease
UNDP	: United Nations Development Programme
WHO	: World Health Organization

# CASE STUDY

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# I. CASE STUDY PROTOCOL

## 1. Title

At the confluence of the National Initiative for Human Development and the Basic Development Needs Program: the case of Larache province, Essouaken/Imir Tlek and Doukkala/Boussafi communes

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## 3. Summary

The Basic Development Needs Program (BDNP) in Larache (Morocco) constitutes an embryonic experiment in intersectoral action to promote equity in the areas of health and integrated local development and to address the social determinants of health. This experience is rich in lessons concerning the elements that can hinder or promote the implementation of intersectoral governance. It is promising in that it is part of a sustained, dynamic process to establish this form of partnership at the national level. This process has been undertaken in the context of multiple reforms that have been undertaken to reduce social disparities and exclusion, particularly with respect to the right to receive high-quality, equitable health care. The modest capital developed in the area of intersectoral governance is set to grow considerably with the National Initiative for Human Development (INDH) (National Initiative for Human Development) proclaimed as the foundation for comprehensive societal reforms in 2005. For its part, the BDNP works to consolidate intersectoral action—promoted as a philosophical principle and foundation for community-based initiatives—through more comprehensive intersectoral actions, such as the INDH.

## 4. Introduction

The case studied in these pages is part of a program that was initiated by the WHO and the Ministry of Public Health in 1995 and now encompasses seventeen (17) sites. These sites are distributed across the territory of Morocco, in sixteen (16) provinces and 24 rural communes, with one pioneering experiment in a semi-urban environment (Sahrij Gnaoua in Fez, September 1998). The Larache site was launched on June 20, 2002 (social mobilization). The total population for the four locations is 4,163 (2,868 in the Essouaken/Imir Tlek commune, with 356 families, and 1,295 in Doukkala-Boussafi, with 207 families), for a total of 563 families. The initial budget envelope, made up of WHO funding, is 1,806,500 Dh. The additional amount from other partners concerned or yet to become involved, based on the action plan developed and validated in September 2003, was anticipated to reach 1,858,500 Dh. This amount was to be

provided by eight partners, including six sectoral partners, one private partner and one associative partner, in addition to a contribution from the population. The site (and object of this case study) presents one important and specific characteristic that is linked to its geographic and socio-economic situation in the northern portion of the Kingdom: it has been associated with cannabis production since the days of the Protectorate. Since 2000, major efforts have been made to eradicate the economic and social micro-system that has evolved around this activity, along with parallel efforts to introduce alternative crops, as well as to implement integrated projects and programs within the framework of the INDH. The BNDP is working to establish itself in the province, alongside the INDH, in order to support intersectoral action around community-based initiatives and integrated local development. To this end, the players involved in the BDN process are seeking to consolidate this program and, above all, to relaunch its intersectoral activities, including those related to health and for which the competent government department is a key partner of the INDH. The primary focus of this case study is that very process, which involves the groups highlighted and used to achieve intersectoral and local governance objectives in a parallel fashion. The two other programs mentioned, namely the INDH and the regional health service management project (Progress) are major constituents of the structural process involved in putting in place intersectoral health-sector activities through the BNDP. While the Progress project has generated its own dynamic and has given rise to a nucleus or work team that will be involved in the BNDP, the INDH constitutes a solid foundation that provides the financial stability and government commitment to ensure that the BNDP and, through it, intersectoral health initiatives, will thrive and be sustainable. This case study highlights how, through direct and indirect health-related actions initiated through the BNDP, which constitutes in Morocco an area of enormous lack in terms of meeting the social and health needs of a large population comprising various categories of poor and marginalized citizens [*incomplete sentence – translator*]. Intersectoral action to address the social determinants of health is intended to exert an impact on the social determinants of social inequality. The intervention programs that are developed in this case serve primarily to restore or to institute various forms of social equity. The target population comprises the poorest of the poor and the activities carried out seek to reduce social disparities, as well as to bring about equality of opportunity. Not all of the activities carried out are connected to health; they also encompass efforts to improve incomes, living environments, education, cultural enrichment, etc.

## 5. Methodology

The primary methodological concern that determines the choice of a site or case, as well as the data collection tools and the development and writing process, is the degree of rigour required in order to develop a profound understanding of the process. Since the primary goal was to explore intersectoral governance through the study of a “success story,” the first step consisted of arriving at a definition of what constitutes a “successful” or “exemplary” case in the context at hand. The choice of a site was guided by two key concepts: that of the social determinants of health and that of health equity, both of which are linked to the implementation of intersectoral action in the strategic field of health promotion. It was also understood that these two concepts are intrinsically linked, since health equity is largely dependent on social equity. A number of initial findings were established to determine the “parameters of success” of the case being studied:

1) Action to address social determinants is complex and requires much time, since it seeks to modify a social system, along with deep-rooted sociocultural relationships, power structures, mind-sets, stereotypical practices, etc.

2) the social determinants and social/health equity approach is a process approach that is difficult to quantify and more readily accessible to a progressive and qualitative reading. The reading can then focus on the dynamic set in motion and on the mechanisms and conditions needed to make it sustainable and efficient. The elements of success must therefore be discerned within a range of aspects and criteria, the most important being the outcomes generated. Other elements include the conditions and procedures cited, the decisions taken and the initiatives completed, as well as their relevance, effectiveness and ownership by stakeholders. Focusing on a single site made the case study more illustrative.

The methodology rests on three fundamental tools:

a- an analysis of available reference materials;

b- a field investigation (Rabat, Larache) and interviews with all identified stakeholders;

c- a description of the case in its immediate context (in the field) through the collection of relevant data and documents (follow-up documents, monographs...). The description is meant to be as exhaustive as possible and particular attention has been paid to effective elements of the process, as well as impediments and constraints.

The overall process undertaken with the aid of these various tools consisted of an in-depth study designed to penetrate and understand the thinking of the various stakeholders and to discern the outlines of a model of intersectoral action that is still relatively new. Particularly attention was paid to the mechanisms put in place in support of intersectoral action (IA). To this end, detailed descriptions of the work and cooperation arrangements of the various stakeholders and structures were developed through the interview process.

The approach was designed to be an evaluative one, with emphasis placed on analyzing the strengths, weaknesses and explicit or potential opportunities that characterize the intersectoral action “model” put into effect. Beyond deductions and lessons learned, a question relating to this point was put to every informer in order to measure the degree of self-evaluation, as well as its influence on or interference with potential opportunities to consolidate, sustain or renew intersectoral action.

## II. CASE STUDY RESULTS

### A. National background of intersectoral action

#### *A.1. Morocco: A country undergoing reform*

Morocco's rich human capital currently comprises 30.7 million inhabitants,<sup>1</sup> with urban dwellers representing 55.1% of the total population and rural inhabitants making up 51.4% of the populace. Rural inhabitants present higher rates of illiteracy, with an overall rate of 60.5% (74.5% for rural women), compared to the national rate of 43%. Social insecurity and poverty are still highly prevalent according to the 2004 RGPH, with a poverty rate of 14.2%, as opposed to 16% in 1994. Social disparities are also spatial (with a 22% discrepancy between rural and urban centres), as well as regional and communal in nature.

Under the new King (1999), independent Morocco has been undergoing an economic process that continues to emphasize liberalization but has also sought to be more responsive to social issues since the advent of a system of alternating power in 1998. While the economy remains competitive and focused on growth, it now seeks to address social and human development needs. This project has taken concrete form through the National Initiative for Human Development, launched on May 18, 2005:

Thus, the promotion of social and territorial solidarity has been made a priority, with the ultimate goal being to alleviate poverty and social disparities. The implementation of a social economic dynamic will primarily rest upon the programs of the INDH, to which an initial financial envelope of 10 billion dirhams over five years has been dedicated to cover the first phase. This policy initiative integrates the acquired capital of other programs, such as PAGER. The objectives of the INDH approach are: to act as a corrective to misdevelopment; to foster integrated development and citizen participation; to put an end to the assistance mentality and to ensure social equity. Its basic concepts include the INDH concept itself, as well as capacity and human capital building, and citizen empowerment.

This ambitious societal project is evolving alongside permanent efforts to ensure a stable rate of growth (6.5 in 2001, 5.5 in 2003...). Thus, with a national saving rate representing approximately 26% of GDP, which was estimated to be 128 billion dollars US in 2005, Morocco has established regional economic centres and free-trade zones (EU, USA, Arab nations, Turkey...), and is increasingly emphasizing south/south trade. These developments have spurred investment and made Morocco the 5th largest economy in Africa.

In order to ensure that this economic, social and political movement toward democratization will continue, efforts have been undertaken to establish the foundations of "good governance" through justice system reforms, modernization of administrative systems and, above all, a new concept of authority. The purpose of this new concept is to change the practices, behaviours and mind-sets that underlie the traditional system of governance that has been in place since Morocco first became independent.

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<sup>1</sup> Haut Commissariat au Plan, 2004, General population and housing survey.

“Authority” is henceforth linked to “the protection of public services, local affairs, individual and collective liberties, security and stability, local management and the maintenance of labour peace.”<sup>2</sup>

The new policy direction consists of using authority as a tool to build a society that is based on the rule of law, where local democracy is strengthened in order to reduce the social disparities.

## ***A.2. Specific context of intersectoral governance***

Morocco’s system of governance has been undergoing many reforms. These reforms have been consistent with the overall dynamic of change in the country and are linked to the desire to renew the nation’s administrative apparatus so that the various departments of government are equipped to meet the challenges of growth, economic competitiveness, equity and social solidarity, respect for human rights and the dignity of the individual. To this end, a government department was put in place after the system of alternating power was established in 1998, namely the Ministère de la Fonction publique et de la Réforme administrative.

The initial process focused on decentralization/deconcentration, as well as outreach and citizen engagement. The goal of combating corruption has not been overlooked, although it has been only timidly addressed through various efforts to promote morality in public life. The goal has been to replace the “top-down” governance model with a “bottom-up” model (from the central to the regional to the provincial level) which emphasizes good governance, based on national/local, public/private and state/civil society partnership. The political emphasis on democracy and outreach has helped to foster the transfer of administrative and financial responsibilities to local communities and to make elected officials the primary agents of decentralization. This territorial governance model is based on the communal charter of 1976 and is supported by the decree on deconcentration, the delegation of signing authority decree of 1993 and the communal and provincial charter reforms of 2003. This process was supported by an increase in financial resources for local communities from 5.9 billion dirhams in 1988 to 15.7 billion dirhams in 1999-2000 (although the new level was still not sufficient to meet the pressing, vital needs of the populace, particularly in the area of infrastructure). While partnership was now viewed as a dynamic mechanism for facilitating an integrated, participatory approach and promoting local development, based on the principles of operationalization, efficiency and synergy, models and ways of capitalizing on partnership still had to be found. In fact, intersectoral action was still nascent when the INDH came along with its promise to unlock its potential for growth.

As far as past experience with a comprehensive program built on intersectoral partnership (including the private sector, civil society and international partners), the most effective and practical precedent has no doubt been the Basic Developments Needs Program (BDNP) initiated by the WHO and the Ministry of Public Health. In addition to the partnership component (intersectoral action in the context of the BDNP), it addresses a critical social issue in Morocco, namely the role of social determinants, such as poverty and population health.

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<sup>2</sup> Speech delivered by His Majesty King Mohamed VI, October 12, 1999, in Casablanca.

### **A.3. Major social and human development deficits and palliative alternatives**

Social conditions in Morocco have never been satisfactory and for many years they have been neglected in public policy and government budgets, for they were not viewed as a priority, much less as something linked to the overall issue of development. As a result, development has not been social, humane or sustainable. This has generated significant social and spatial disparities within the population. These disparities were exacerbated by the structural adjustment policies introduced in 1983. In addition to the structural causes of vulnerability and poverty, other conjunctural factors—such as repeated droughts—have hindered economic growth (3% between 1980 and 2000) and stability, as well as the creation of social safety nets to offset social deficits and reduce pauperization and vulnerability.

Poverty, including the culture and actual experience of poverty, has taken on a new face and social cohesion is increasingly threatened, the most disturbing manifestations of this being insecure and unsanitary housing conditions, environmental degradation affecting 1.35 million city-dwellers and lack of access to safe drinking water for 2.8 city dwellers.<sup>3</sup> In these precarious communities, illiteracy and school drop out rates are extremely high. Women and girls, made vulnerable by inequalities linked to gender, are rendered more vulnerable still by poverty and are most likely to be illiterate or to drop out of school. Women are also more likely to be unemployed (25.89% of urban women vs. 17.4% of urban men in 2003), which constitutes a major socio-economic problem. It is also women, particularly those in rural areas, who are most affected by health deficits and lack of access to primary care.

Since the 1990s, Morocco has tried in various ways to reduce these deficits and to address the increasingly burdensome consequences of the social divide. This has included conjunctural measures and programs to target the regions that are the most underprivileged and have the more severe social problems, such as lack of access to adequate infrastructures (the BAJ 1 and 2 programs).<sup>4</sup> Other programs first introduced in the 1980s to develop and consolidate rural infrastructures were expanded in the 1990s, particularly PAGER and PNER.<sup>5</sup>

In 1999, a mechanism dedicated to social development was established—the Social Development Agency (SDA). The ultimate mission of this agency is to improve the living conditions of vulnerable persons by funding and supporting local development projects. This concern for social equity became even more explicit through the following five essential developments:

- a- Financially, the portion of the State's budget dedicated to the social sectors was increased from 47.4% in 2002 to 55.5% in 2005.
- b- From a legal standpoint, a number of laws were enacted, including a labour code and a family code that recognizes the equality of the sexes.
- c- Institutionally, various sectors mandated to improve social conditions were created, including: the Ministère du Développement Social et de la Famille et de

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<sup>3</sup>Haut Commissariat au Plan. (2005), Women and Development, in "National human development report 2005."

<sup>4</sup> Social priorities program: 14 target provinces.

<sup>5</sup> National program for rural water supply and sanitation (PAGER) and National rural electrification program (PNER).

la Solidarité, which comprises the Secrétariat d'Etat chargé de la Famille, de l'Enfance et des Personnes Handicapées and the Secrétariat d'Etat chargé de l'Alphabétisation et de l'Education Non Formelle. These departments work to ensure that social initiatives are integrated and built upon a well-coordinated intersectoral partnership.

- d- Politically, government at the highest level (Throne speech of May 18, 2005) announced the creation of the INDH, a governmental, partnership and solidarity-based contractual approach to alleviating poverty in disadvantaged and vulnerable social groups and regions. The alignment of these various political interventions and sectoral plans to address major goals and the model adopted (integrated, participatory) is intended to foster intersectoral action that is committed, effective and reflective of solidarity.
- e- Technically and practically, various quantitative and qualitative databases of a macro-economic or social nature, broken down by gender and zone, are now available to support decision making, monitoring and evaluation activities, as well as to establish indicators based on verifiable sources. Morocco conducted a general population and housing survey (2004), and has developed a system to map poverty, human development and social development (2005) that integrates various territorial characteristics (poverty rate, communal human development index, communal social development index, etc.). Moreover, a variety of national surveys, including a survey of consumer and household spending (2000-2001)<sup>6</sup> are now available. Added to these are periodic reports on human and social development in Morocco, as well as reports produced by international organizations, such as the UNDP, the World Bank, etc.
- f- In terms of social protection and the social safety net, the Ministry of Public Health has undertaken health insurance and hospital reforms. This includes a payroll-based health insurance program (AMO) for private and public sector workers, a medical assistance program for the poorest members of society (RAMED) and an insurance scheme for merchants and professionals (INAYA). It has also expanded immunization and maternal/child health programs. Other national social programs include: a program to eradicate shantytowns (Villes Sans Bidonvilles or VSB), programs to provide mortgage loans for affordable housing (FOGARIM, FOGALOGÉ), as well as charters adopted by agreement to guide interventions and reforms, such as COSEF (Special commission for education and training) and PANE (an environmental charter).

#### ***A.4. The INDH: Social goals as national priorities***

The INDH is the expression of the Moroccan government's desire to engage in a strategic, long-term struggle against poverty and social exclusion, in order to promote the social inclusion of the disadvantaged and marginalized, through the latter's engagement, participation and ownership of the vision and methods of local development (capacity building, territorial diagnosis, social engineering...).

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<sup>6</sup> Tools largely developed, documented and implemented by the Haut Commissariat au Plan.

The Human Development Index (HDI) has evolved slowly in Morocco (0.515 in 1975 to 0.642 in 2004)<sup>7</sup> and presents significant gaps related to geography (rural/urban) and gender. Illiteracy, infant and maternal mortality and women's lack of political engagement constitute major impediments to human development.

By focusing on human capital, the INDH aspires to institute responsible community/citizen governance (local democracy). Its ultimate objective is to establish a new social contract and thereby increase social cohesion and avoid the drift toward severe forms of social exclusion which can lead to violence and other forms of vulnerability. Such community governance must be integrated into a system of intersectoral and territorial governance based on partnership and outreach. The aforementioned political will can also be seen in the fact that 10 billion Dh have been allocated for the first stage of the INDH (2006-2010). This envelope includes the contributions of three partners: the State, through its budget (6 million Dh), local communities (2 million Dh) and international partners (2 million Dh). The INDH has also received 250 million Dh to cover urgent and priority programs in the last quarter of 2005; this amount is not part of the 10 billion Dh budget for 2006-2010.

The human, sustainable and equitable development dimension of the INDH is closely tied to gender equality and human dignity, both of which are founding principles of the initiative. Women as a group are targeted for greater inclusion in the nation's economic fabric through income-generating activities (IGAs); in 2005, 60% of IGAs were led by women,<sup>8</sup> vs. 40% by men. By 2007, that proportion for women had risen to 62%. Of particular interest to women are the health sector investments being made through the INDH. The health projects undertaken through the INDH focus on the construction, management and equipping of maternity facilities, the provision of ultrasound equipment to clinics, the purchase and outfitting of mobile health units and the training of traditional midwives. The cost of such health sector initiatives is estimated to be approximately 189.12 million Dh, including 121.45 million Dh for urban communities and 67.67 million Dh for rural communities.<sup>9</sup>

The INDH is currently acting as a triggering mechanism for intersectoral action and, in some cases, as a useful lever for intersectoral initiatives that have already been initiated, such as the BDNP.

The state of local governance, particularly in the area of intersectoral action, is revealed in the case of the Larache BDN project and the manner in which it is being integrated with the INDH... witness the recent training delivered at the WHO office in Rabat, which focused on health issues, sustainable development, the social determinants of health and their sites of interaction. The goal of this exchange was to provide up-to-date information and to foster closer cooperation between local sectoral officials of the INDH and those of the BDN project.

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<sup>7</sup> Haut Commissariat au Plan (2005), Human Development Report. The figure for 2004 is an estimate of the HCP.

<sup>8</sup> Working paper, African Conference on Human Development, April 6-7, 2007. National coordination: INDH, Rabat.

<sup>9</sup> Conference and debate on the theme "Appui de l'INDH au service de santé : réalisations et attentes" chaired by the Ministers of health, social development, families and solidarity, May 17, 2007, Rabat.

## **B. The BDNP program, a model of intersectoral action**

### ***B.1. Morocco's experience with the BDN program***

The introduction of the BDNP in Morocco was made possible by a partnership between the WHO office in Rabat and the Ministry of Public Health (1995). The model put forward by the WHO was seen as especially appropriate by the partners of the Ministry of Public Health, the same partners who would go on to play a leadership role in the process, for macropolitical and economic reasons, as well as for other “micro” reasons linked to the orientations of the Ministry itself. The BDN challenge was taken up at a time when Morocco was beginning to address social issues and to show greater concern for sustainable human development. It then began to reinforce the process of decentralization/deconcentration, as well as regional organization (through legislation enacted in 1997), introducing the communal charter with its new spirit (2003), and calling on the regional governors to become more involved in local development issues (royal letter of January 9, 2002, concerning the issue of investment decentralization), etc. One of the goals established around the issue of decentralization/deconcentration was the adoption of an integrated program approach that would permit the rational optimization of resources, as well as promote intersectoral cooperation. The Ministry of Public Health (MPH) also joined in this trend. It began to promote the new paradigm of “health for all” and to solicit the involvement of other sectors and stakeholders in the dissemination of this new vision and in efforts to improve socio-economic and environmental conditions, so that good health, a precondition for sustained economic growth and prosperity, might indeed be accessible to all.

These converging government and sectoral interests around health issues made it clear that a synergistic effort on the part of all partners would be needed to conduct integrated community and local development projects. The BDN model provided a solution, an approach, as well as philosophical underpinnings that all of the partners viewed as suitable to their community development objectives.

A framework partnership agreement establishing the BDN program was signed on January 24, 2002, by the Minister of Health, the Minister of the Interior, and the WHO representative in Rabat. This is a tripartite partnership in which the two government partners both have a stake in local and community development and in improving the living conditions and well-being of the population.

Establishing the WHO fund and other subsequent funding arrangements to provide micro-credits so that disadvantaged Moroccans for micro-projects might improve their incomes and living conditions would ultimately require the jurisdiction of the highest official in the region, the Governor. This is the first element that justifies the involvement of this department, which is implicitly viewed as playing a regulatory and monitoring role and as being both credible and capable of exercising a form of symbolic “authority” with respect to insolvent recipients in the reimbursement of microcredits. This aspect was seen as all the more important given that local committees would be required to manage these funds, as well as the community fund, without of any legal authority. However, the recent creation of local BDN associations which are legally recognized and registered with the local prefecture would appear to offer a transitional solution leading to the direct management of allocated funds by the community and its representative association. The role of the Ministry of the Interior

(MI) extends beyond regulation into other development areas that require intersectoral action and intersectoral partnership, including:

- a. working alongside the two other partners (WHO Rabat and the MPH) to secure additional funding (in addition to the WHO fund) from local and international partners, particularly UN partners;
- b. contributing to the organizational mobilization of local, sectoral and community partners.

The creation of an appropriate organizational platform required two measures:

- creating organizational program bodies (committees), in partnership with the national or central coordination committee of the BDNP in Rabat;
- strengthening the coordination and partnership frameworks linking the various sectors, NGOs and government organizations operating in the development field.

This led to the establishment of a working agreement which was signed by the Governor of the province in which the site is located, the local representative of the MPH and a representative from the WHO office in Rabat.

The MPH shares some of these roles in a completely transversal manner and is entirely responsible for others, all within a governance framework that, theoretically at least, is meant to be intersectoral. Other sectors are involved, but not in a fixed fashion; instead, they are identified on the basis of the priority needs established by the community, within the context of the community diagnosis and action plan. The action plan is developed with the partners thus identified, based on their commitment to take part and to contribute to some of the measures set out in the plan.

The Ministry of Public Health retains the prerogative of selecting the target site, to ensure that the ultimate objective of improving community and population health will be met. The choice is made on the basis of BDN criteria (the poorest of the poor, an existing or potential core of associations, suitable population demographics), in consultation with the local partners who are directly concerned. In addition to its involvement in the monitoring/evaluation process, the MPH must oversee four fundamental parameters:

- a. reinforcing health services and improving the efficacy and quality of health facilities in BDN localities;
- b. enhancing community involvement in sociocultural activities facilitated by the association or CDL (local development committee); these are activities directly or indirectly related to improving conditions that promote population health and environmental quality;
- c. highlighting the links between development and the determinants of social health for the benefit of all partners, including the community itself, through language, practices and decisions;
- d. raising awareness of the importance of selecting and emphasizing activities and projects that can improve health in the medium or short term.

The involvement of the MPH in the BDN program has been part of an overall health sector dynamic that is progressive and designed to introduce reforms, beginning with hospital reforms. The appropriateness of the health system in place since independence

was to be the central issue in the deliberations of the MPH.<sup>10</sup> The overall assessment was that notable progress had been achieved in terms of expanding health coverage and achieving a decline in infant and juvenile mortality rates, but that Morocco continued to be slow in eliminating inequalities of health between rural and urban communities, and between more affluent and poorer, less advantaged regions. Chief among these were disparities in access and quality of care. Despite Morocco's signing of the Alma Ata declaration in 1978, a commitment that took concrete form with the inclusion of a primary care policy in the five-year plan for 1981-1985,<sup>11</sup> large segments of Morocco's population—particularly the poor, rural inhabitants and women—still lacked adequate access to health services. This situation was exacerbated by a lack of health insurance and other social supports for these populations. Health care funding continued to be gravely inadequate relative to the demand and the reality of growing poverty. Overall health spending was “on the order of 15 billion dirhams (or 4.5% of GDP), 45% funded by households and 40% through collective resources (taxes and insurance).”<sup>12</sup> Inadequate funding, accentuated by a lack of solidarity, called for funding reforms, greater receptiveness to a private/public funding partnership, as well as synergistic intersectoral action and optimization to achieve greater efficiency. The timely creation of a national agency to regulate health funding would give impetus to these changes.

Morocco ranked 29th in the world in terms of efficiency (WHO). However, the health status of the population rendered this performance rather insignificant, since Morocco also ranked 110th in terms of health funding equity: “The Moroccan health system is good in terms of its efficiency, but not in terms of health status and equity. This may be comforting for a government concerned with efficiency, but is far less so for citizens concerned about health and equity.”<sup>13</sup> That being said, the prospects of achieving greater “health equity” were set to improve when Morocco finally adopted a financial scheme for its health insurance program (presented on January 10, 2007 in Rabat). This has made it possible to establish a health insurance plan for the disadvantaged (RAMED) with an estimated budget of 2.6 million *[should likely read billion–translator]* dirhams, or 18% according to the Primature. This is joint funding in the sense that local communities will invest 587 million Dh (22.5%) and recipients will contribute up to 562 million Dh. The number of indigent people is estimated at 8 million (or 28% of the population, including 4 million who live in abject poverty). In short, the issue is one of finding a formula for solidarity between rich and poor. Public and private sector workers are covered by a compulsory health insurance program (AMO), while craftspersons have another form of coverage (INAYA). These formulas, once completely applied, will cover approximately 60% of the population. In the wake of the numerous reforms undertaken, the Ministry of Public Health has seen its budget rise by 150 million Dh, in part to cover the costs of drugs used in hospitals, the privileged partners of RAMED clients (the relative and absolute poor). A national mechanism has been established to manage these new insurance formulas (AMO and RAMED) in a transparent and equitable fashion: the National Health Insurance Agency (ANAM).

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<sup>10</sup> Belghiti Alaoui, *La réforme de santé au Maroc, pertinence et opportunités*. On line: [http://www.sante.gov.ma/smsm/cmm\\_web/La\\_reforme\\_de\\_sante\\_au\\_Maroc.htm](http://www.sante.gov.ma/smsm/cmm_web/La_reforme_de_sante_au_Maroc.htm) (page consulted April 25, 2007).

<sup>11</sup> Ibid.

<sup>12</sup> Study of Morocco national health accounts (1997-1998), cited by A. Belghiti Alaoui, Ibid.

<sup>13</sup> Ibid, Belghiti Alaoui.

A number of alternative approaches have been implemented to address the inadequacies mentioned earlier, including: the selection of the health region as the locus of integrated development; deconcentration; the operationalization of pre-payment mechanisms in the form of insurance for the underprivileged (AMO, RAMED, etc.); a commitment to implement a system of governance that is based on equity and solidarity, while rationalizing and democratizing access to health care; and, finally, intervention through intersectoral action. The BDNP was to contribute early to this shift.

The Ministry of Public Health and all partners and stakeholders concerned have benefited from technical assistance and support from the WHO, through its local representatives in Rabat. The architecture of the BDN model, codified in an agreement signed on January 24, 2002, varies depending on the site and context and on conditions pertaining to partners' local representation as responsible, physical persons and on the nature of the structures to which they belong. Factors linked to local socio-economic specificities and the conditions that prevail in the community concerned, as well as organizational conditions and aspects of the monitoring/evaluation process can exert a positive or negative influence on the BDNP in general and on intersectoral action in particular.

The Larache site is located in the urban commune of Larache in northern Morocco (87 km from Tangier), which is part of the Tangier-Tetouan region. This region has a population of 472,386 inhabitants, including 219,577 in urban communes/centres, and 256,809 in rural communes. The rate of urbanization is 46.5%, with 52.08% of all households located in urban areas. The province's rate of social development is greater than 15-20%.

Larache comprises four "caïdats" and 17 rural communes, with a total population of 150,000 inhabitants (RGH, 2004). The rural areas of Larache subsist on agriculture, a large part of which consists of cannabis production. Recently (June 2006), a large-scale operation to destroy cannabis crops was undertaken by local authorities in 12 rural communes. Approximately 4,000 hectares of cannabis crops were destroyed. This operation was part of a local development project designed to introduce substitute crops and income-generating activities through a participatory approach involving the communities concerned. Despite this activity, which theoretically generates large revenues, the communes remain poor in terms of basic infrastructures, with a population that is largely illiterate and vulnerable (52.6% in Tazrout and 79.2% in Rissana: BDN site). While the electrification rate in Rissana is 100%, only 6% of Larache province has direct access to potable water, compared to the national average of 18.1%). These projects therefore seek to rehabilitate the communes, creating needed infrastructures and strengthening human capacity through training and functional literacy.

These areas are also known for their ecological fragility, not only in terms of their soil quality and agronomic potential, but also from a health standpoint, due to the presence of swamps, which constitute a risk factor (vector-transmitted diseases). As a result, Larache province has been selected as a target zone for integrated development and a local development plan is currently being developed for it. A variety of local stakeholders have been mobilized around this project. The sectors are cooperating in the areas of funding, field expertise and the like with the Agence de Développement des Provinces du Nord, the Agence de la Promotion Nationale, and the Association Targa-

Aide (action-research). This partnership dynamic is being consolidated as a result of the new impetus provided by the INDH, along with its vision and its financial and logistical contribution.

The Larache BDNP site, which was established in 2002-2003, has provided an opportunity to consolidate the process undertaken, through the direct involvement of the community, which had previously been difficult to reach, given the economic conditions described above.

The health delegation, approached by the national coordinating committee in Rabat to oversee the BDNP in Larache province, proved to be highly receptive to the proposal and quickly suggested sites that might be targeted. This favourable response was linked to five key factors:

- a. The health priorities identified in the region, particularly in Larache province (maternal mortality and significant under-utilization of health services for mothers and their babies; water-borne infections, diseases linked to unsanitary practices and vector-borne diseases; absence of sewage systems, etc.) were of direct concern to the community.
- b. The affected rural population was poor, isolated, illiterate and lacking in infrastructures (drinking water, roads, etc.).
- c. The local health delegate had tried out the BDN approach in another locality (Chefchaouen) and was aware of its impact in terms of improving living conditions, health parameters and basic care.
- d. The chief medical officer of CIAP, who had performed outreach in the area and listened to the concerns of citizens, seized on the BDN concept as an opportunity to increase the involvement of the community and other partners.

Adoption of the BDNP took place in the context of the newly created Tangier-Tetouan health region, the result of decentralization-deconcentration. Those working in the field showed a willingness to undertake a regional management project, which led to the creation of the regional Tangier-Tetouan team, as part of the Ministry of Public Health (thirty-odd individuals). Moreover, as part of the decentralization process, as well as the 2000-2004 economic and social plan, a Cellule Provinciale d'Épidémiologie (CPE) and the Tangier-Tetouan regional epidemiology observatory (ORE) were established by the MPH. The basic work of epidemiological mapping would ensure better epidemiological surveillance and intersectoral action, when such action was required. The mechanisms put in place were also useful in terms of targeting BDN sites and promoting the establishment of an intersectoral governance project in these fields. This attempt to implement intersectoral action, based on health needs and the determinants of health, was launched in a phase that preceded the BDNP. The process was initiated in 2002 but was terminated soon after, although a way to relaunch it was subsequently sought, first under the BDNP and, ultimately, under the current INDH. Despite the major constraints that affected its sustainability, this phase was beneficial to both the BDNP and the BDN project, providing a new opportunity to keep up the pace in addressing health priorities.

In short, the first catalyst of intersectoral action in matters of health was the *Projet de gestion régionale des services de santé (Progress)*, carried out in cooperation with GTZ, around the time the Ministry was adopting the national policy of decentralization-deconcentration. This project, which was based on a decentralized approach to health

programming, was designed to achieve two major objectives: partnership development and community participation. It was launched through a series of forums, with the Larache forum taking place on March 28, 2002. The Larache forum was successful in securing the participation of all potential partners: local communities, elected officials, representatives of various government ministries (national education, youth and sports, agriculture), national NGOs, local and village neighbourhood associations and the provincial team of the Ministry of Public Health. The goals of the forum were to give impetus to intersectoral governance, as well as to develop a shared vision and policies around decentralization and community participation, in order to promote “health for all” through an effective and efficient process. The debate revolved around five key points:

- 1: identifying and defining the province’s health problems;
- 2: establishing an order of priority for these problems;
- 3: proposing suitable, achievable solutions;
- 4: identifying potential partners and defining their contribution;
- 5: proposing mechanisms and arrangements that would enable the various partners to coordinate their efforts.<sup>14</sup>

These points demonstrated a desire to see intersectoral governance implemented and to support the process in another forum: the regional “population health” symposium. The symposium was seen as an additional opportunity to mobilize partners and to initiate a regional partnership approach. At the 2003 symposium, cooperation coalesced around key elements of intersectoral action, namely:

- creating a space for consensus-building and formal discussions on the roles and responsibilities of the various partners;
- definition of priorities;
- identifying opportunities and complementarities between the various partners;
- promoting synergistic effort;
- establishing a basis for institutional cooperation at the regional level.

This process was undertaken with considerable enthusiasm by the partners, who were interested in the potential of intersectoral governance. As a result, consensus was achieved around the province’s most important problems, which were identified as:

- 1) environmental problems;
- 2) inadequate facilities;
- 3) inadequate material and human resources (workforce numbers and qualifications);
- 4) socio-economic problems, including those related to education.<sup>15</sup>

The second concrete result was the proposal to create mechanisms that would enable the partners to coordinate their efforts, in the form of a provincial coordination and monitoring committee, supported by local cells. In forum workshops, solutions were proposed to address the priorities identified and the contributions and responsibilities of the various partners were defined. A “horizontal” solution was retained, placing emphasis on the participation and contribution of civil society to the various other solutions adopted.

These mechanisms remained in operation for one agonizing year, essentially ending when funding from the partner (GTZ) came to an end. However, this investment in human capital did generate some positive, lasting outcomes that proved to be an asset

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<sup>14</sup> Soudi B. (2002), Mission report for March 26-30, 2002. GTZ, Progress, Activity II, C.3, GTZ, Progress, Rabat (Internal document/consultant).

<sup>15</sup> Ibid.

for the BDNP, almost a corollary to Progress (2002-2003). These positive outcomes included:

1. the emergence of leaders in the form of the Larache health delegation and the “legal person” of the chief medical officer of the CIAP (still in place);
2. the emergence of a liaison capability (communication: the “health pages” which have survived in the form of a newsletter entitled Info-santé du Nord (Spanish cooperation).
3. the survival of an informal core, in the form of work team within the delegation which continues to pursue intersectoral activities, particularly with national education authorities (health education), etc.
4. an order of priority was established for the problems to be addressed;
5. a greater receptiveness to and awareness of the vital contribution that intersectoral partnership can make.

The core group mentioned above recently became smaller following the resignation or retirement of certain delegation members who had been active players within the informal group. The team survived, thanks to strong leadership (the chief medical officer) and the impact of Progress in terms of providing a new working method and additional know-how in the area of intersectoral governance. The same core group would go on to adopt the BDNP and to participate in its community diagnosis, community mobilization and action plan development phases. It also took part in activities organized by the BDN associations created in the two rural communes selected to be BDN sites. These sites were selected because the major problems affecting the province were identified there, including problems relating to the environment and other issues directly affecting the communes of Essouaken and Doukkala, in addition to difficulties linked to inadequate medical infrastructures and facilities. The population (4,171 inhabitants, 563 households) affected by the BDN initiative was living in an environment that was harmful to human health in a variety of ways:

- the water table was polluted with waste and the rodent and mosquito populations were exploding;
- wastewater was not being treated and no sewer system was present;
- insects were pullulating in humid, swampy areas and stagnating waters;
- wells and water sources were left untreated and unmaintained.

The two communes were also concerned about maternal mortality rates and the under-utilization of services for mothers and babies. Five deaths were recorded in 2002 and prenatal services were found to be wanting. In 2002, prior to the launch of the BDN initiative, only 27 pregnancies received prenatal attention (7%), 12 high-risk pregnancies were identified (5%), with fewer than one visit per woman on average and only 17 births had occurred in a supervised environment (4.4%).<sup>16</sup> The community diagnosis linked this situation to a number of factors, including: the enclavement and remoteness of certain douars (villages) from health centres; a shortage of ambulances; the absence of female doctors due to a deeply rooted traditionalist culture; rural women’s resistance to being examined by male doctors; lack of midwifery training; a high illiteracy rate; and an overall lack of public awareness. The latter point was linked to the fact that mobile nursing/medical resources were inadequate (the health structure alone could not cover all villages), in addition to enclavement and the absence

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<sup>16</sup> Data presented on May 3, 2006, on the occasion of the BDN Forum in Fez, WHO and Ministry of Public Health. Paper of the Larache health delegation. These data have been locally confirmed (Essouaken centre).

of mobile vehicles to travel to remote but relatively accessible villages. Other factors included the aforementioned environmental problems, and the population's vulnerability owing to an economy based on subsistence farming (which is dependent on rainfalls), a high rate of unemployment and the marginalization that enclavement induces (lack of viable roads). The needs identified were of concern to a number of local and sectoral stakeholders and the issue became one of granting micro-credits for small income-generating concerns in the area of livestock production, a sector of local importance, which explains the presence of the Ministry of Agriculture as a partner.

Contributions were solicited from local communities and the Ministry of Equipment and Transport to create new roads and thereby improve physical accessibility. The national education and national mutual assistance sectors, as well as a number of non-governmental partners, were invited to contribute to literacy and awareness activities.

## ***B.2. Intersectoral action - BDN Larache***

In order to take up the challenge of intersectoral action based on the BDN model, it was necessary to establish BDN associations and local development committees (CDL) in the two communes. Once these community-based organizations had been established, the community was able to take its place as a stakeholder/partner and interlocutor within the framework of structured intersectoral initiatives. The creation of a BDN association in Doukkala commune was doubly laudable since few formal community organizations were based there, although solidarity-based cultural practices already existed (Touiza). However, an associative structure was present at the Essouaken commune: the Association Oued El Makhazin de développement social, culturel et sportif (1999). The more active members of this association (licenced graduates) joined the BDN association and participated in the creation of the BDN local development committee (CDL BED) (2003-2004). This time around, the community incorporated the gender dimension. Women were represented on the CDLs of both communes, and a female member of the BDN association office in Essouaken was put in charge of the literacy program. The latter, who was recruited from the neighbouring city of Ksar El Kébir, came with considerable associative experience and an interest in functional literacy (hygiene). The image she projected of an active educated woman provided a role-model for rural women and those participating in the literacy program.

The other partners would perform two different types of roles: an active one (Ministry of Public Health and the WHO) and a passive one, which was expressed as a potential to intervene and to contribute to intersectoral actions, which materialized rather late as it turns out.

Still, as a result of the notable mobilization efforts of the BDN associations and their almost daily monitoring activities, as well as the support of health sector leaders, who provided advice to association members on an ongoing basis, a number of activities contained in the action plan were carried out or are currently in the process of being carried out. The commune in Essouaken, with its highly active BDN association, played a large role in these achievements. Three large-scale coordinated projects were undertaken: road construction, particularly in Doukkala where the community contributed workers and 100,000 Dh; the electrification of certain villages in cooperation with the Agence de Développement du Nord (400,000 Dh); and the renovation of schools to improve learning conditions for students (130,000 Dh). Rural schools in Essouaken, Imir Tlek, Ouled Jmil and El Ouamra were renovated and a

number of improvements were made in the areas of student supervision and learning. The renovations were technically overseen by the Délégation de l'éducation nationale and were covered financially by the commune. Two other initiatives were undertaken by other partners. The first, carried out by the commune and the Haute Délégation de la Résistance, was a cultural and historical enhancement project at the Essouaken site in the form of a statue symbolizing the Battle of the Three Kings that took place there (approximate budget: 60,000 Dh). This enhancement proved to be of great interest to the commune and the community and was seen as a means of increasing tourism and improving the economy. Sensitized to the harmful effects of discharging liquid waste, thanks to BDN activities, the Essouaken commune undertook a clean-up project in conjunction with the association and the affected population (500 Dh and 13,000 Dh, respectively), with the assistance of a local philanthropist, who contributed 17,000 Dh. The total cost of the project was 385,000 Dh. As can be seen, the only supports for intersectoral action in these examples were the action plan, which spelled out the responsibilities and contributions of the various parties, and the successful mobilization efforts of the BDN associations, the federative component of the partnership movement. The community leadership provided by these associations, allied with medical leadership (the chief medical officer in this instance) sustained intersectoral action in the context of the BDN, without the use of explicit operational mechanisms, such as monitoring/evaluation tools. It is the monitoring activities of association members, and those of the health delegation, whether formal or informal, that have sustained the BDN activities initiated. In the case of the Essouaken commune, this dynamic association leadership is also attributable to another factor, namely the presence of the Essouaken health centre.

### ***B.3. The team approach to problem-solving in the district: A catalyst for partner-community synergy***

One of the characteristics of the BDNP since its inception in Morocco back in 1995, has been its three interim evaluations.<sup>17</sup> These evaluations have generated a variety of outcomes, as well as recommendations for corrective action. Three such recommendations have recurred on a number of occasions: the need to restructure intersectoral and partnership action by incorporating coordination, communication and systematization mechanisms into the internal BDN monitoring/evaluation tool; the need to establish a legal basis for the operations of the CDLs by opting instead for BDN associations (under a 1958 law that regulates associations in Morocco); and the need to reinforce and improve health services in BDN sites. This last point received particular attention at the Larache BDNP. The WHO recommended a district team problem-solving approach as a means of supporting and improving health services in the two rural communes selected as BDN sites (hence in Larache).

Use of this approach to acquire new health service management tools (analysis tools, health problem prioritization tools, tools to facilitate joint problem-solving and planning) proved helpful in terms of organizing joint CDL-BDN association activities. The practical training provided in this approach (September 21 to October 5, 2002) produced convincing results in this regard. The approach was systematized and is still in use in the Essouaken health district; it has, in fact, contributed to a greater

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<sup>17</sup> Chikhaoui Naima (2002). Interim evaluation of the Chefchaouen and Sahrij Gnaoua Fez BDNP. 2002, Ministère de la santé/WHO, Harzenni A. (2004) Interim evaluation of BDN projects in Zbirat Oulad Sabah, Ain Cheggag, Bni Lent and Ain Maatouf. January 2004, Ministère de la santé/WHO.

understanding of the links between the environment, population health and the social determinants of health. The qualitative partnership between association stakeholders and the personnel of the medical centre, particularly the nursing officer, has continued, fostering the dissemination of health information in the community and a joint approach to identifying solutions and making improvements in the area of health. As part of this process, the local health representative, health leaders within the health delegation, and the BDN association work as a team. Aware of the advantage of developing solutions that capitalize on local resources, the partners have emphasized rational, realistic planning. These data were confirmed at the evaluation workshop (November 17-19, 2004), which revealed that the action plans were achieved. In addition to the reorganization of activities in the centres, and the improvement in the quality of services, the involvement of community resources was observed in some districts; the Essouaken district exemplifies this comment made in 2014. A broad-based dialogue was established between the health centre and the members of the BDN association and use of monitoring data by the latter in the context of community awareness and information activities bolstered the confidence of partners and community members. Although certain deficiencies have persisted (medical personnel instability, failure to designate a nurse practitioner or to provide a vehicle for the mobile team, failure to respect the calendar of meetings),<sup>18</sup> this approach has played a large role in the establishment of a successful partnership between the health sector (at the local and provincial levels) and community representatives via the BDN association. The ultimate impact of this partnership was the organization of a series of socio-cultural activities centred around issues of health by the Essouaken BDN association. Compared with the direct partnership between the community and the private sector, the intersectoral partnership remains timid at best, and that with the Social Development Agency (SDA), the third crucial BDNP partner, remains undeveloped.

#### ***B.4. The BDN/SDA partnership agreement in Larache - insufficiently operationalized***

On June 9, 2003, the BDNP in Morocco established a framework agreement with the SDA, in addition to the agreement it has already established with the MI and MPH. Since the primary mandate of this national agency (the SDA) is to combat poverty and social marginalization, it was felt that a partnership with the BDNP would be useful, given that both organizations work with the same target population and both aspire to promote human development at the local level, as well as sustainable improvements in population health. The major contribution of the SDA would be to mobilize additional funding to sustain the creation of infrastructures and IGAs, in addition to carrying out outreach and training activities as part of the projects undertaken. One of the great merits of the partnership established through the BDNP-SDA framework agreement is the more direct involvement of the SDA in community health matters. A consultant recruited by the WHO to coordinate these development/community health issues is now a member of SDA, following the termination of her contract with WHO. Informed by the concept of “quality health care for all” as a broad objective of all development, the tripartite partnership centred on the BDNP would go on to extend the terms of its cooperation by establishing other duties for the consultant, namely:

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<sup>18</sup> Ministère de la santé (2006), BDN approach and district team problem-solving approach, case of the rural commune of Essouaken. Paper presented on May 3, 2006, in Fez. Forum: “BED au service de l’INDH.” Data confirmed while preparing this case study.

- “put in place a health sector action plan that reflects the Agency’s strategy;
- provide technical support for projects initiated under the BDNP;
- provide assistance to the SDA in developing health projects in which the Agency will take part;
- monitor the execution of earlier projects developed by other partners and submitted for funding to the Agency;
- validate the appropriateness, timeliness and technical and financial feasibility of projects through on-site visits;
- assist regional coordinators in establishing the priority of health projects;
- monitor and provide technical/financial advice on studies and projects submitted to the SDA by its partners;
- ensure that obligations under the partnership agreement are met;
- produce regular reports on the evolution of health sector activities.”<sup>19</sup>

BDNP-SDA cooperation is facilitated by a common MI-SDA platform and the fact that both organizations are aligned with the national policy of decentralization. To this end, the SDA has developed a new strategy for the 2005-2010 period, one that provides for the adoption of a territorialization approach. With this approach, territories are targeted based on the major criteria of poverty and vulnerability. This is a feature it shares with the BDN approach, which stipulates that sites should be selected with a view to aiding “the poorest of the poor.” A second common feature is the diagnostic process that is applied (community diagnosis in the case of the BDN program), culminating in the development of a local action plan that lists the activities to be carried out (IGAs, institution building, training, etc.) through intersectoral efforts and the mobilization of local, national and international financial resources (BDNP and SDA). This SDA/BDNP partnership, with its potential for shared objectives, values, processes and work tools, would soon (2005) encounter a further opportunity for consolidation, this time through a commitment toward greater intersectoral action through the INDH.

The INDH, presented and promoted as a long-term societal project, invites all partners to review and adapt their strategies. The SDA has aligned itself with the INDH by seeking to “further integrate [its strategy] with national efforts to promote development, eradicate poverty and strengthen social cohesion.”<sup>20</sup> In keeping with this new spirit, “the primary objective of the new strategy for 2006-2010 is to place the Agency’s expertise and means at the service of local human development initiatives (ILDH).”<sup>21</sup> On March 27-28, 2006, the BDNP signalled its support for the national objectives of the INDH by holding a forum in Fez, the theme of which was “BDNP at the service of the INDH” (WHO-MPH).

The INDH constitutes not only a catalyst of intersectoral action and partnership, but a large-scale initiative to transform the manner in which partnerships are funded and organized, in order to achieve a more sustained form of partnership synergy, with operational mechanisms that are optimized, rational, effective and efficient. The case of the SDA/BDNP partnership is particularly instructive in this regard, as it did not immediately integrate the new INDH dynamic and, in fact, had barely begun to adopt the objectives and consolidate the joint endeavours (local action plans established

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<sup>19</sup> Consultant’s terms of reference. Consultant’s annual report: Health sector intervention of the SDA. December 31, 2005. Dr. Saïda Choujaa Jroundi.

<sup>20</sup> Annual report of consultant Dr. Saïda Choujaa Jroundi: Intervention de l’ADS dans le domaine de la santé, December 31, 2005.

<sup>21</sup> Ibid.

within the framework of local BDN/SDA agreements) set out under the SDA-MPH-WHO tripartite framework agreement signed in June 2003. Problems of implementation remained unresolved, chief among which were two major organizational constraints. The first of these was tied to the work approach, which was meant to be a common approach but was not perceived as such by the various partners on the ground. Each party was convinced of the efficacy of its own approach and its incompatibility with the approaches of other parties, choosing to ignore section 2 of the framework agreement, which explicitly stated that the SDA would be responsible for establishing the action plans emanating from the results of the field survey relating to the situational diagnosis and the prioritization of the needs of the BDN project site “based on its specializations, the rules set out in its implementation guide and the principles of its approach...”. Two approaches that were not that dissimilar created an obstacle that immobilized the partnership and made it close to ineffectual. This technical constraint was exacerbated by a leadership conflict at the technical coordination, monitoring and evaluation level, between the national coordinator of the BDNP and the person charged with representing the interests of the co-organizers of the WHO-SDA framework agreement. The role of the technical consultant in providing guidance and setting the stage for the kinds of technical decisions that facilitate the achievement of joint actions set out in the action plans, was thwarted by a leadership conflict at the level of the BDNP national committee, which remained unspoken but was nonetheless felt. As a result, intersectoral action via the SDA/BDNP partnership was greatly reduced and projects to be carried out with SDA funding (such as the milk cooperative in Essouaken) were delayed.

These limitations were recognized early and helped motivate the partners to find timely, preventive solutions. Accordingly, the SDA, in partnership with the WHO and the Ministry of Public Health, held a national seminar (“Health and local development in Morocco”) in Rabat on March 25-26, 2005. Chief among the partners who took part in this seminar were the central and site representatives of the BDNP, and the coordinators and regional stakeholders of the SDA. The three partners shared information and discussed their respective visions and strategies. The SDA and BDNP officials also undertook to revise their methodological tools together. The “territorial diagnosis” tool was put forward as suitable for all SDA interventions, in that it allied the territorial approach advocated by the SDA and the community diagnosis approach favoured by the BDNP: “the methodology favoured by the BDNP was used as a reference, since it has been tested in several sites. It has been improved through the identification and incorporation of local potentialities, including the expertise of the populace and local players, their interrelationships, and their capacity to mobilize resources and to commit themselves to improving the quality of life of their community.”<sup>22</sup> The elements introduced, which were theoretically intended to concretize the overall philosophy of the BDNP, were placed front and centre as the elements that would guide actions on the ground, since the interim BDNP evaluations conducted to that point had shown that these elements had been inadequately applied in BDNP project sites. This revised approach is currently being put into effect as part of the implementation of the territorial social development plan (INDH and BDNP) in 12 rural communes in El Hajeb province. This relatively recent experiment appears to have encountered a number of start-up problems. Similar difficulties can be observed at other sites, including the Larache BDNP site, and are due, in the opinion of the consultant entrusted with the “health and local development file,” to inadequate contact between

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<sup>22</sup> 2005 report, Dr. Saïda Choujaa Jroundi, WHO consultant. Internal document.

the Ministry of Public Health and the SDA. This lack of contact was explained as follows: “aside from a few efforts made by regional coordinators and the national office of the BDNP to meet delegates of the MPH and provincial BDNP centres, the SDA has had little involvement in institution-building, local training, or the funding of projects in targeted communities.”<sup>23</sup>

The absence of organized communication channels and systematic coordination mechanisms is therefore explainable, although a seminar was held and did not appear to have arrived at the same conclusion. The conclusions of the SDA<sup>24</sup> also refer to the inadequacy of existing BDNP action plans<sup>25</sup> in terms of financial estimation and accountability for partner contributions, which are not adopted by the various sectors concerned. This shortcoming, which is observable in other sites as well, has been addressed at the Larache BDN project site, the focus of the present case study, but the commitment of the SDA materialized slowly. This delay can be explained by another observation made by SDA, relating to the constraints inherent in the technical aspects of project development as carried out by the associations and the BDN community development centres: the “principal difficulty is currently the inability of local committees and local associations to mount and submit projects for funding to the various partners, including the SDA.”

This deficiency was corroborated by both the interim evaluations, which referred to the need to provide support for the technical and financial feasibility studies relating to projects submitted by the community via the CDLs, and by communicators from the Larache BDN project site. The two BDN associations in Essouaken, which approached the SDA for funding for a dairy cooperative, were granted an agreement in principle, on condition that such a technical and financial feasibility study be carried out. The Doukkala BDN association submitted a similar request for funding under the INDH and was asked to enlist the services of a provincial associative network to meet the same requirement. The process must be initiated by the associations themselves and, since the latter are not well-prepared, they must dedicate a considerable amount of time and travel, with all the difficulties inherent in travelling between these rural areas and the cities of Larache and Ksar El Kebir. The SDA, which raised the issue, recognized that local associations had neither the capacity nor the means to conduct these studies and suggested that the technical departments of local communities and other provincial departments perform them, at the express request of the CDLs and associations. Since the CDLs and associations had not been informed of this possibility, owing to the inadequate functionality of intersectoral mechanisms around the BDNP, they were unable to take advantage of it. The coordination mechanisms of the BDNP, both centrally (Rabat) and provincially (prefecture of the Ministry of the Interior) proved inadequate in terms of providing informational support to the CDLs, BDN associations and sectoral partners. The proposal of the SDA for dealing with this issue of unrealized projects, was to adopt the solution recommended by UNFPA (WHO/MPH partner at the community mutual level), which consisted of recruiting a technical advisor, who would initially be based in Marrakech and operate in the region of Marrakech Tensift-El Haouz and Tadla Azilal. The BDNP sites in other regions, such as Larache, would have to wait and rely on the considerable dynamism of the BDN associations. The latter submitted their INDH project proposals to the provincial INDH committee (social

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<sup>23</sup> Jroundi Choujaa S. (2005). (WHO, internal document).

<sup>24</sup> Ibid.

<sup>25</sup> Observation confirmed via interim evaluation of the Chefchaouen and Sabrij Gnaoua Fez BDNP project. WHO consultant, Dr. Chikhaoui Naima. 2002.

development division). These proposals are being evaluated and the associations will have to accept that the result they seek to achieve may not be realized, given the unresolved issue of prior technical and financial studies.

The BDNP focal point, domiciled within this same administration, which is dependent upon the MI (Larache prefecture) has been unable to assiduously monitor the projects emanating from BDN associations, given the imponderables associated with changes of governor (three changes) and the numerous non-BDN files to be managed. An effort to restart the process is underway and a search for a coordinator—occasioned in part by the field of the case study—with the leadership of the MI at the level of the health delegation should be noted [*preceding sentence ungrammatical and indecipherable – translator*]. These same leaders are supporting the initiative of the Doukkala BDN association (submitted to the Délégation de l'Éducation) to establish a literacy program at the insistence of the community. These health sector leaders continue to provide technical advice through fruitful exchanges taking place in connection with the creation of a dairy and green tourism cooperative by the Doukkala BDN association. The privileged interlocutor in this instance was to have been the Ministry of Agriculture for the cooperative and the Ministry of Tourism for the green tourism aspect (for technical advice at this stage). However, in the absence of an organized intersectoral partnership at these levels, it was not possible to provide this support. It is obvious that if adjustments had been made to existing mechanisms—particularly through systematic coordination meetings and the provision of necessary logistical resources—functionality could have been assured and an organized, institutionalized and sustainable initiative might have emerged. The fragility of existing mechanisms—which lacked financial means, independent management capabilities and powers of decision—can be seen in the rapid succession of senior officials, one example being three successive changes of governor. The only informal structure (a legacy of the Progress project) that continued to sustain intersectoral action, be it pre-BDNP (health education) or partner-initiated intersectoral action through the BDNP, had been whittled down to its leader (the chief medical officer) and a few partners (such as the officer in charge of health education with the national health delegation). The departure of key members of this informal structure, due to their rich career briefs and suitability to replace departing or retiring administrators, made it almost impossible for the structure to continue to function. These career briefs were characterized by skills and know-how in the area of communications, mobilization skills and credibility acquired through an extensive unionist background, and, in one instance, skills as a maternal health facilitator, along with experience working with NGOs and women's groups. The BDNP was meant to capitalize on the skills acquired and the team spirit developed in the context of the Progress project, which had soon come to an end due to lack of funding. Losses were contained by the active presence of the leadership. The latter felt rather isolated in its efforts since the central BDNP mechanism, namely the Governor-MPH framework agreement, was not sufficient; clearly other mechanisms of intersectoral action were needed. The sums initially allocated by the BDNP (WHO...), which were scaled down from the amounts initially announced, were probably detrimental to the emergence of effective intersectoral action around the BDNP. The leadership's effectiveness from the standpoint of regulation, stimulation and motivation, has been limited owing to systems of communication that remain unilateral, occasional and intermittent. The predominance of oral communication and the paucity of written information materials and follow-up communication mechanisms make intersectoral

and intrasectoral communication difficult. This has sometimes been exacerbated by a rather nonchalant work culture and a tendency among some leaders toward administrative overcontrol, due to a subjective attitude of ownership and a subjective perception of the issues: attitudes that are antithetical to effective intersectoral governance, complementarity, systematic exchanges, etc. This situation was further exacerbated by the absence of periodic reports or newsletters on the intersectoral activities being carried out in the context of the BDNP, even within the two departments concerned (MPH and MI).

## **C. Impact of intersectoral action - the case of the Larache BDN project**

### ***C.1. The Larache BDN project - an ongoing process***

The Larache BDN project has been implemented over three time-frames: one in the recent past that is ongoing, with a focus on decentralization-deconcentration, which was also attempted at the level of the health delegation, through the Progress initiative; a present period of broad scale reforms led by the Ministry of Public Health; and, in a parallel fashion, a program of major social reforms/national priorities that look to the future: the INDH. The major point of commonality is the desire to alleviate poverty and social disparities through investments in human capital and citizen participation, and through the promotion of human rights, particularly the right of all citizens to health services that are based on principles of quality, equity and dignity.

The favourable partnership culture which is the legacy of the Progress initiative has made it possible to initiate intersectoral activities to promote better health care for all. The period was characterized by instability, the recruitment of different partners and efforts to encourage MPH personnel to welcome other sectoral partners, including private sector and civil society partners. The Progress experience introduced a new culture and team work approach. The meetings, training sessions and workshops that took place contributed to the initiation of these work-related changes and the introduction of new approaches to the management of health issues in their various social and human dimensions. The direct benefits of this period that have endured are the emergence of a partnership with the associations around health projects and the arrival on the scene of associations that are working to address the social and human dimensions of health. In Larache, this includes the emergence of MPH-SIDA (MPH-AIDS), and groups that are tackling diabetes and epilepsy. The members of the Progress team and the core that later remained have played a major role in consolidating these associations and still play an active role in the latter's activities. Some members of these associations went on to become involved (MPH-SIDA) in health-centred activities organized by the BDN associations (Essouaken...). The second major contribution of the Progress initiative has been the opportunity to establish a local leadership structure in the form of the chief medical officer and the Larache health delegation, headed by a delegate who is a proponent of the BDN philosophy, having tested it previously in Chefchaouen.

An appreciation of intersectoral partnership and the need to promote equity in matters of health, particularly through outreach activities and community participation, constitute the legacy of the BDNP experience in Chefchaouen: "It is important to join the community on the ground, to listen to its concerns and to restore its confidence" the

Larache health delegate has said on more than one occasion. The chief medical officer adds that the “challenge is to make the community a full-fledged partner rather than simply provide it with assistance. This fosters empowerment and enables community members to identify new needs and to develop solutions to address those needs. It teaches them to take the initiative, to ask questions and to open the necessary sectoral doors without fear.”

## ***C.2. BDNP - emergence of the key partner of intersectoral action: The community***

Beyond the immediate impact of improving the living conditions of communities through the BDNP, by increasing the incomes of poor families and individuals through micro-credits, another highly laudable aspect of the program is the ability of the BDN associations to mobilize the communities. Micro-credits create interest in the BDN concept and sensitize the population to other needs, such as schooling and literacy. The application of micro-credits to livestock production helped to underscore the value of this central activity and generated interest in another project that promises to have an even greater impact in terms of creating jobs and increasing incomes, that of establishing a dairy cooperative in two communes. The demand was favourable to such an endeavour and the economic environment was propitious. The effect in terms of alleviating poverty has been far from negligible: widows and the unemployed cling to this modest social safety net... Whereas contributing to monitoring these local health care delivery parameters is a requirement of the Essouaken medical centre. The association monitors health indicators with the nursing officer, oversees drug distribution, and serves as a conduit for community concerns. The BDN associations are aware of their new community role and are getting involved in human/sustainable development efforts in their respective localities. BDN association leaders are recognized within the community. New confidence in the potential of local partnership and in the key partner (in this case the MPH representatives) is undeniable. The members of the two BDN associations (Doukkala and Essouaken) strongly believe in the value of working with their health sector partner, stating that the added value of the BDNP, aside from micro-credits, is a direct, open and improved relationship with the health sector partner: “We never thought we would be able to comfortably walk into the office of the chief medical officer or the nursing officer.” BDN associations feel “supported by the delegation, listened to and taken seriously.” Association members, as well as CDL/BDN and community representatives, state that they have been able to move past the psychological obstacle of the “repressive and indifferent makhzen (government elite).” The quest for partners, including sectoral partners, around community projects, is permeating practices and influencing attitudes regarding the administrator-administratee relationship: “it was difficult, before the BDNP, to imagine that we might walk into the prefecture, much less speak to officials about our problems or about community projects.” A process of demystification is taking place and there is more interest in sectoral-community action through outreach work that is more congenial and less subject to preconceived ideas. The BDN association has become a true bridge and a mechanism of communication between the sectors and the community.

Shared health concerns and the work being done by local BDN associations to alleviate inequalities of health can provide creative opportunities to increase community awareness. To this end, BDN associations are capitalizing on local know-how in this area and no longer hesitate to call on local human and financial resources. Shared

interests and collective participation are once again community values (culturally rooted, of course) after having become weakened during a period of socio-economic and political flux. There are concrete examples of this in Essouaken, which underwent a sustained process of awareness, information, education and communication that included highly original activities. The association also organized a tobacco awareness campaign in six villages. They chose the Month of Fasting, with its religious connotations, sociocultural conviviality and religious/philosophical emphasis on care of the body as the vessel of the soul. The campaign established a ritual that would be observed throughout the month: breaking the fast with a village family, accompanying the men to the mosque for prayers, and promoting the anti-tobacco message with the aid of didactic tools (photographs, large posters...). The slogan of the campaign was “le tabac nuit à ta santé et Ramadan est ton opportunité...” (Tobacco is harmful to your body; Ramadan is your opportunity...). The ritual was completed on the last feast of Ramadan with a ceremony in which symbolic gifts were distributed to all those who had managed to stop smoking for the entire month.

The outcome of this activity was very positive: three persons stopped smoking in Essouaken, 5 youth (aged 15 and over) stopped in Dabla and 12 people in Bourkab gave up the habit. It was decided that the initiative would be repeated, this time in the cafés that are highly popular during Ramadan, particularly with young people. Word of the campaign reached Larache. “How did this small association achieve such a feat?” A similar dynamic around issues of health yielded two campaigns around STDs and AIDS. These were carried out in May and June, the harvest period, a time when workers earn extra income and may be tempted to visit prostitutes, etc. The message proved timely, as community members are psychologically more disposed at these times to consider issues of sexuality. The Essouaken BDN association was successful in mobilizing doctors, health delegation representatives, and members of the local health centre around these activities.

A more large-scale partnership was mobilized to conduct a major medical campaign at the local level in 47 villages (26,631 inhabitants). The campaign, which focused on respiratory diseases, diabetes and high blood pressure, was held October 30-31, 2004. The BDN association was the mainspring of this activity and the leadership displayed by a doctor from the area, installed in Rabat, helped to mobilize 24 physicians, as well as pharmacists and nurses. Various partners supported this activity (United Emirates Embassy, the Ksar El Kébir development association, the Mohamed V foundation for solidarity and Moulay Youssef hospital), and the necessary medical equipment (ultrasound machine, etc.) was transported to the area. Clinical examinations of 4,000 individuals were carried out over a two-day period, complete with awareness activities, information and the distribution of medications. The impact of this activity on the community was enormous and is still discussed today.

The Essouaken BDN association and a number of its partners then proceeded to take on another thorny issue, namely the seemingly intractable intra and inter-village conflicts that had been raging for 10 years and the harmful effect these conflicts were having on the health of the community. The water table of the village of Imir Tlek had become contaminated by animal waste which had infiltrated local wells. A total of 4,000 villagers were affected by this problem, many of whom were suffering from water-borne diseases and contending with unpleasant-tasting water. The Essouaken BDN association, assisted by the nursing officer, took on the issue, displaying considerable ingenuity to convince the community that something needed to be done. The first step consisted of obtaining doctors’ certificates confirming that the water table had indeed

become contaminated by animal waste, which served to enhance the association's credibility. An awareness campaign urging the community to get involved in the development of sealed waste collection sites was successful. The rural commune joined in: contaminated sites were cleaned up with a grader and roads and laneways were also developed. Fully 95% of the problem has been resolved, with the remainder to be addressed through work planned for June 2007.

Through the mobilization efforts of the BDN association and a financial contribution from the community (100 Dh per household, for a total of 34 households), the Essouaken commune was able to complete a sanitation project. Other community-based projects with an economic, sociocultural or health focus were submitted for possible intersectoral and partner-led initiatives via the BDN associations, particularly within the framework of the INDH. The announcement made to the associations two months ago regarding the conversion of the BDN bank, which had formerly resided with the Governor, provided further reassurance and increased the emerging sense of trust. The self-management provided by the dual BDN mechanisms (the CDL for funding and micro-credit recipient identification; the association for the legal and banking-related management aspects) will facilitate the management of both the community fund established as part of the BDNP and the fund converted over to the CDLs and BDN associations.

### ***C.3. The team problem-solving approach: A district lever to promote health and community participation***

The implementation of the BDNP was seized upon as an opportunity to introduce measures to address the determinants affecting the health of mothers and their babies, beginning with the prioritization of local health-related problems and the identification of solutions by the team, assisted by members of the community. Securing the participation of the community and concerned partners constituted an integral part of systematizing this approach. This new managerial know-how was applied and paved the way for changes, not only in terms of the quality of health services, but in behavioural and relational terms, in dealings with care recipients and the community as a whole. The effectiveness of the new approach in mobilizing local resources and using these resources to promptly resolve problems soon gave impetus to new partnership initiatives. The rural commune provided an ambulance and driver to the medical centre; this, in addition to the road work performed under the BDNP, has facilitated the transportation of emergency cases to Larache. The BDNP framework has also provided for the training of traditional midwives (four in all). The health delegation has provided means of transportation for the mobile nurse and has overseen the organization of educational sessions for the public (96 IEC sessions for 1,404 participants).<sup>26</sup> Cooperation with the BDN association was so effective that the latter has become a focal point for health awareness activities. It now oversees well sanitation activities, providing chlorine tablets that members can add to their wells on a regular basis. The result has been a marked decrease in water-borne diseases. Ongoing communication concerning vector-borne communicable diseases has also been effective in terms of altering behaviours and attitudes with regard to environmental protection. This approach proved to be conducive to better work organization at the centre; follow up

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<sup>26</sup> Ministère de la santé (2006). 2004 follow up evaluation of "district team problem-solving." Paper presented at the forum "Le BED au service de l'INDH," on May 3, 2006, in Fez by the Larache BDN team, health delegation.

will be provided by the nursing officer. Indicators were updated regularly by the latter and began to show improvements in maternal and infant health. Maternal and infant mortality rates began to decline significantly (five deaths in 2002 and none in 2004; obstetric complications receiving appropriate care: 3% in 2002 and 14% in 2004...). The supervision of pregnant women began to increase, particularly after the arrival of two female doctors, as did the rate of supervised deliveries (26 in 2002 to 90 in 2004 (or 24%)). Use of the ambulance to transport emergency cases was 11% in 2004, as opposed to 0% in 2002 when the commune did not have an emergency vehicle (the ambulance was acquired on September 17, 2003). It was determined that health service delivery would improve even more if the significant patient load and large population to cover were reduced (47 villages). Two projects were proposed to address these pressures: the opening of a new medical centre in Hrach (proposed by the nursing officer) and the establishment of a health club in rural schools (proposed by the president of the BDN association). As its contribution to the medical centre, the community offered up the land and workers, while the health delegation was in charge of the facilities, personnel and medications. The school-based health club provides emergency care (student accidents) and conducts health awareness activities.

Clearly, the funding for the initiatives being carried out comes from microcredit working capital, as well as other diversified sources, such as the rural commune budget, private donors, certain funders that deal directly with the local association and its players, who themselves make the necessary contacts and establish provisions to direct funds toward local and community development.

The focus of most applications and re-applications for funding is the INDH endowment reserved for Larache and its communities. The local BDN associations proceed to develop projects (dairy cooperative, cultural and rural tourism amenities...) which they then submit for funding to the Division de l'Action Sociale, which is responsible for the local execution and monitoring of the INDH. The funding mechanisms are there and two orders come into play for the sites in our case study: an initial WHO fund dedicated to the BNDP and a "pending grant," which is managed by the Ministère de l'Intérieur via the Division de l'Action Sociale, which is located within the Larache Prefecture. The first fund is managed by the BDN associations in an autonomous fashion. For many years, however, it was at the mercy of the Governor, which resulted in a slow and cumbersome process and, for association players, numerous trips between enclaved rural communities and the city of Larache. Autonomous financial management rests on a rotating microcredit mechanism that benefits community members and on modest credit in the form of a community chest (BDN). The latter is the primary means of providing assistance and ensuring internal solidarity in villages by covering such things as funeral costs, the medical costs of sick persons in need, as well as the cost of small community-based projects, such as clearing roads.

#### ***C.4. INDH: An opportunity for joint action and consolidation of intersectoral governance***

National mobilization around the INDH, a societal project to alleviate poverty and social disparities and to eradicate vulnerability, offers a strategic opportunity to establish effective, efficient and sustainable modes of intersectoral governance. For programs and projects initiated to pursue these objectives, the INDH provides a favourable setting for synergies of effort and the pursuit of intersectoral activities to address the national and integrated social policies that constitute the philosophical

underpinnings of this initiative. In terms of promoting health equity and addressing the determinants of health, the INDH/health sector partnership is already bearing fruit, as the health sector projects that have been funded and programmed attest. Moreover, Morocco's commitment to achieve the Millennium Development Goals (MDG), a commitment which dovetails with the social reforms underway, constitutes a determining factor that speaks to the need for the kind of intersectoral action that the INDH can foster. The national government's decision to focus on social, gender and regional disparities necessarily spills over into the health sector. These social disparities are corroborated by the data on health inequalities and the alarming indicators relating to reproductive health and the so-called diseases of poverty. While Morocco has achieved close to 65% of the Millennium Goals, more needs to be done, with fewer than 10 years remaining until the MDG deadline (2015). Despite certain successes, such as reducing the mortality rate for children under age 5 by two-thirds (from 76 deaths per 1,000 live births in 1990 to 47 deaths per 1,000 births in 2004), the maternal mortality rate declined by only 34% in cities and 26% in rural areas. This is far from the goal for 2015 (only 42.2% of the goal).

The Larache BDNP did not remain on the sidelines as the INDH dynamic unfolded, particularly as the direct partners of this program (WHO and SDA), soon proceeded to examine the possibility of harmonizing the BDNP implementation process with INDH/SDA modes of intervention. The key sector charged with executing, monitoring and evaluating the INDH is the Ministry of the Interior, also a key partner of the BDNP, and they have been collaborating since 1998 (via a collective agreement), a factor that facilitates any sustained effort to organize effective intersectoral activities to address health needs and promote health equity. The Larache BDN associations have also capitalized on the INDH/BDNP partnership, by submitting community-based, integrated local development projects for evaluation by the competent provincial authorities of the INDH.

Through the INDH opportunity, the SDA, the second and equally important partner of the BDNP, may find solutions to the very real start-up problems associated with this partnership. In fact, the SDA has stated its intention to tailor its current strategy to the INDH agenda and to play a major role in implementing social initiatives in this field. The SDA/BDNP capital is in place; community health has been explicitly established as the field of intervention; and a person in charge of engineering the process is in place at SDA. These aspects need to be reinforced as the SDA pursues its total commitment to the INDH [*an interpretation – translator*]. The INDH represents not only an opportunity to extend the BDNP, but also a platform for the institutionalization of intersectoral effort in which technical, financial and decision-making resources are brought to bear to achieve the goals of health equity and health-service quality under the banner of "health for all."

In addressing the urgent challenge of implementing intersectoral initiatives to foster health equity, we must not overlook the lessons learned from the embryonic intersectoral governance experiment already initiated. These lessons can be summarized as follows:

- Effective intersectoral action is interdependent with the harmonization of visions and work approaches, along with a shared understanding among stakeholders and partners (work charter, practical provisions for formative or participatory cooperation...)

- Effective, systematized information circulation and improved information-sharing arrangements between partners are essential in order to optimize resources and avoid duplication of effort.
- Representatives from every sector engaged in intersectoral initiatives should be officially designated and granted the latitude to make technical and financial decisions.
- Tools to monitor the execution of action plans and the technical and/or financial responsibilities of the various partners, should be a requirement.
- A vital component is the provision of independent, sustainable budget lines dedicated to intersectoral action, complete with action plans, programs and audits.
- Officially institutionalized structures are needed for the work team responsible for monitoring/evaluating intersectoral activities, along with appropriate logistical supports as required.
- Regulatory and conflict-resolution mechanisms and arrangements are needed, particularly to address a number of isolated cases in which key program responsibilities linked to intersectoral initiatives have been voluntarily or involuntarily taken over.
- Intersectoral action requires organized, permanent and functional means and channels of communication.
- Leadership needs to be strengthened through professional development and a sustained commitment.

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