

**COOPERATION STRATEGY  
WHO - MOROCCO  
2004-2007**

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## I. INTRODUCTION

Within the framework of the **Country Focus Initiative (CFI)** and cooperation strengthening between WHO and the Kingdom of Morocco and its action programming improvement, WHO is launching a definition step for cooperation called **Country Cooperation Strategy (CCS)**. Morocco has already been associated to similar steps with the United Nations system for UNDAF elaboration, with UNDP for the Country Cooperation Framework (CAF) elaboration or with the World Bank for the Country Assistance Strategy (CAS) definition.

The **CCS** aims to strengthen the WHO-Morocco partnership for an adequate support to the country needs accordingly to new orientations of the WHO strategy (Tenth General Work Program, *WHO Corporate Strategy*).

The **CCS** step was well met by all WHO local partners and comes at the right moment to meet their expectations related to actions concentration and stability of activity programming developed within the framework of the WHO-Morocco cooperation. The period retained for the first **CCS** (2004-2007) includes two biennium and coincides with the period covered by the Government current program.

The development of the present **CSS** occurs in a context of transition and competition of challenges. The analysis of the country common assessment (2000) shows that Morocco is, more than ever, facing the development issue and means to reach development. Morocco remains indeed strongly challenged by social development requirements which are the access to basic education and quality primary health care, elimination of illiteracy, reduction of poverty and social inequalities, training and employment (UNDAF, 2002-2006).

Further to the recommendations of the WHO Macroeconomics and Health Commission, a recent World Bank<sup>1</sup> report on social protection in Morocco recommends an increase of public health care expenditure with an emphasis on rural programs, improvement of financing and hospital reform, as well as promotion of health sensitising initiatives and creation of intersectoral partnerships.

Public administration decentralisation and modernisation are the major areas of the reform policy adopted by the Kingdom of Morocco. In his statement on the Government general policy, the Prime Minister specified the Government choice on "*Health for all*" as a motto and objective of the policy promoted by His Majesty King Mohammed VI.

To support the Government policy and more particularly the Ministry of Health (MOH) in the process already engaged on reform and sectoral strategies formulation, namely for the development of primary health care and prevention of emerging risks, the WHO cooperation over the 2004-2007 period will focus on the three following components:

1. Developing necessary instruments to health policy planning and orientation;
2. Supporting the decentralised management of the health system aiming at effectiveness and equity;
3. Strengthening technical partnership to consolidate assets, ensure action targeting priority programs and meet emerging needs.

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<sup>1</sup> World Bank, Kingdom of Morocco: note on social protection, report nr 22486-MOR, December 2002

The identification of these three components is the result of a deepened and broadened consultation with all WHO partners in Morocco.

The programmatic framework allowing the execution of this strategic Agenda will be the agenda of the biennium programs developed during the joint programs review meetings (JPRM).

## **II. HEALTH AND DEVELOPMENT CHALLENGES IN MOROCCO**

Morocco has to meet major development challenges at the beginning of this third millennium. It has on one side to complete its political, economic, socio-demographic and epidemiological transitions, and on the other side to accompany and anticipate any evolution related to international policies (globalisation, oil price instability, decrease of tourism...).

This situation has motivated the interlock of a series of reforms aiming to modernize the public administration and rationalise public expenditure (regionalisation, education reform, financing reform, public expenditure reform, etc). These reforms reflect a strong political goodwill towards development, favoured by the democratisation process strengthening. However, this goodwill has to face constraints related to irregular economic growth, natural resources degradation (dryness and deforestation) and progression of monetary poverty.

### **1. HEALTH DETERMINING FACTORS**

(see country profile in Appendix 1)

#### **□ Demographic data**

The demographic analysis shows that Morocco is undergoing a demographic transition. Its population increase rate and its synthetic fertility index have moved respectively from 2.5% and 7 children in 1960 to 1.6% and 3.1 children in 1997. This transition enables to foresee an inversion of trends for the groups at-risk: decrease of the number of births and children less than 5 years and increase of the number of married women and old people, the adolescent population still remaining high.

The demographic analysis shows another major factor related to the ongoing strong urbanization. Towards 2012, the urbanization rate, 55% currently, will reach 64%. This shift in population involves the development of a new suburban population, particularly vulnerable on the epidemiological level because of its strong density and promiscuity.<sup>2</sup>

#### **□ Education level**

Schooling has known a renewed interest since these last years. The rate of total schooling exceeded the 90% threshold, but is estimated to 76% in rural areas. Combined schooling (primary to high education) is about 52%, which sets the problem of school dropping. Literacy remains close to 50% despite a large literacy program for adults.

#### **□ Socio-economic level**

The socio-economic situation in Morocco is characterized by irregular economic growth (currently decreasing). The GDP per capita is estimated at \$ 3546 and the debt servicing at 10% of the GDP. The unemployment rate increase (13.6%), particularly in the cities (20%), and progression of monetary poverty (19%) reinforce the constraints to development. The

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<sup>2</sup> Santé en chiffres 2001

level of national income remains limited since the GDP/per capita does not exceed \$ 1,200. In 2001, Morocco ranks 112th for the human development indicator (HDI) and 56th among 94 developing countries for the human poverty indicator (HPI)<sup>3</sup>.

#### □ **Involvement in health**

Morocco dedicates 1.1% of its GDP to public health expenditure versus 2 to 2,5% in countries with similar capita income. This proportion appears insufficient to ensure the population access to an acceptable level of care. In addition to their insufficiency, public health expenditure largely favour urban areas (78% of incurrent expenditure are assigned to urban hospitals and clinics)<sup>4</sup>.

In addition, 18% of the population do not have access to drinking water, 31% of rural populations are located at more than 10 km of the nearest health facility and 35% of Moroccans do not have access to essential drugs.

With an equivalent or lower GDP/per capita, some countries like Jordan, Egypt, Equator, Sri Lanka and Georgia have better health indicators.

## **2. HEALTH STATUS**

In Morocco, life expectancy in good health is estimated at 55.4 years in 2002 vs 69 years of life expectancy at birth. The Moroccan health system ranks 151<sup>th</sup> for reactivity and 125<sup>th</sup> for financial contribution equity. These indicators show the necessary efforts to be made in health and health system performance.

The other characteristic of the health situation in Morocco refers to its epidemiological transition showing a structural inversion of morbidity burden. According to the study on the burden of overall morbidity in Morocco (*Etude sur la charge de morbidité globale au Maroc*), the communicable and peri-natal diseases (Group I of CIM 10) represent 33% of life corrected years of incapacity (AVCI), vs 56% for non communicable diseases (gr. II of CIM 10) and 11% for trauma (Group III of CIM 10).

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

On the level of specific morbidity, Morocco carried out important assets regarding the struggle against communicable diseases: three target diseases are being eradicated (diphtheria, poliomyelitis and neo-natal tetanus) and the eradication of three other diseases is scheduled towards 2010 (malaria, bilharziosis and trachoma). A pressing demand for chronic diseases care has already been expressed and prioritise the problematic access to health care.

## **3. THE HEALTH SYSTEM DEVELOPMENT CHALLENGES**

WHO distinguishes four determining universal functions in the performance of health system. The challenges faced by the Moroccan health system will be examined according to these 4 basic functions.

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<sup>3</sup> World report on human development – UNDP -2002.

<sup>4</sup> World Bank, Kingdom of Morocco: note on social protection, report n° 22486-MOR, December 2002.

## □ Health service delivery

The offer of primary health care has known a great extension. Morocco counts currently more than 2 347 primary care facilities vs 394 in 1960. The ratio of the number of facilities per 10 000 inhabitants is estimated at 0.8 (1/12 400 inhabitants). Despite these efforts, more than 31% of the rural population are still located at more than 10 km from a health facility. Primary health services usage knows a progressive evolution but remains strongly marked by the disparity between the urban and rural areas.<sup>5</sup>

Along with this gap in access to care, the health care system suffers from under usage of services. The usage ratio of medical consultations is estimated at 0.4 contact per capita and per annum, i.e. an average of 18 medical consultations/doctor/working day. The usage of preventive care services shows an overall coverage of 59% for contraceptive prevalence (variation of 15 points among areas), 56% for peri-natal care (variation of 47 points among areas), 46% for childbirth in attended centres (variation of 50 points among areas), 87% for immunization (variation of 13 points among areas).

The public hospital network follows a slower evolution. It currently counts about 120 facilities with a total bed capacity of 24 360 beds (i.e. less than 1 bed/1000 inhabitants). This hospital capacity has known an increase of more than 8 000 beds between 1960 and 1997<sup>6</sup>, but still remains slower than the overall population growth. In addition, the allocation of beds shows a great iniquity among areas and social classes.

Nearly 6 000 000 people annually attend public hospitals (i.e. 0.2 contact/capita/year). More than half of these contacts are emergencies. Despite their insufficiency, hospital beds are under used with an average 56% occupation rate.<sup>7</sup>

The hospital network is being strengthened within the context of the hospital reform that aims to modernize hospitals and develop their autonomy. This action is supported by an important project financed by an IRDB loan: *Projet de financement et de gestion du secteur de la santé* (health sector financing and management project).

The private sector coverage sets the problem of its distribution often limited to urban areas and large cities. It covers 2/3 of the primary health care offer and 20% of the national bed capacity. The private sector development appears less well catalysed and little controlled by the medical authorities.

On the level of health services organization, it is scheduled to strengthen the deconcentration process within the framework of the region. Indeed, since the promulgation in 1996 of the law ruling regions that led to the creation of a local authority at the regional level (*Conseil régional*), the health sector initiated a certain number of activities and projects aiming at the implementation of the regionalisation. It is the case of PROGRESS, financed by USAID and aiming to support health programs in two regions: Souss-Massa Draa and Tangier-Tetouan. It is also the case of PAGSS in the eastern region financed by the European Commission and aiming to develop a regional organization pattern for health care.

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<sup>5</sup> Sectorial strategy 2000-2004 -

<sup>6</sup> 15 500 beds in 1960 vs 23 600 in 1997.

<sup>7</sup> Direction des Hôpitaux et des Soins Ambulatoires – Ministry of Health - 2000

The regions have also known a reinforcement of their administrative and technical organization, particularly through the nomination of a delegate (*délégué*) in each region main city and regional coordinators and the creation of regional epidemiological observatories.

#### □ **Financing**

The overall health expenditures in Morocco are about DH 15 billion (i.e. 4.5% of GDP), of which 54% are financed by households and 41% through collective financing (taxes, insurance and local municipalities). These two data show that the Moroccan health system suffers from an insufficient and not well united financing). This results in a medical consumption weakness worsened by expensive care and drugs and limited purchasing power (*comptes nationaux de la santé*).

Compared to other countries with similar income, Morocco dedicates less funds to health despite the weakness of its health indicators.

Public hospitals (SEGMA and CHU) generate insufficient receipts due to the delay to implement the medical coverage Code, inadequacy of tariffing, and lack of management capacities. These public hospitals own receipts represent less than 30% of their operating budget (DH 206 000 000 for 2001).

The national health system dedicates more than 37% for drugs and medical supplies, 31% for hospital care and 20% for ambulatory care. With the epidemiological transition and Code of basic medical coverage, this structure is likely to be strongly modified.

The MOH budget is insufficient. It represents hardly DH 175 per capita (5% of the overall State budget). 47% of this budget goes to hospitals and 38% to basic health care network.

The financial flow analysis of medical insurance, which contributes for 16.4% in total health expenditures, shows that only 6% of these expenditures go to public hospitals, whereas they offer 80% of the national bed capacity.

To mitigate the under-financing of the health sector, it is scheduled, within the framework of the code of basic medical coverage already voted at Parliament, to implement two new financing mechanisms: the obligatory medical insurance (AMO) and medical care pattern (RAMED). Medium-term projections envisage to double the population covered by medical insurance to 32%. RAMED financing share is not yet given.

#### □ **Generation of resources**

The centres of health professional staff training are represented by the Faculties of Medicine, (currently four), the national Institute of Medical Administration (*Institut national d'administration sanitaire*), the training Institutes for Health Careers (*Instituts de formation aux carrières de santé*) and the training Institutes for health techniques (*Instituts de formation aux techniques de santé*). The advent of law 01/00 related to the reform of higher education comes at the right moment to reorganise these facilities which are less and less able to meet the needs of a transitional health system open on important reforms.

More than 200 facilities of the health care network are currently closed due to a lack of human resources. Although the proportion of specialists remains in the Maghreb average, the

demand for gynecologists-obstetricians, anaesthetists and nephrologists is pressing. In addition to the absence of tools to regulate the offer (medical chart or regional care offer diagram), there is a quasi-absence of planning for health staff. The training centres active role supposes to adapt training to the health system needs and develop a national policy of human resources management.

To mitigate these non covered needs, the trend appears to be directed towards the search for alternatives to relieve the State from the continuous increase of the budget labour burden.

#### □ **General administration**

The administration of the public health care system is characterized by a strong centralisation that contrasts with a low capacity of the offer regulation and coordination of the health system stakeholders' action (partnership and inter-sectoral collaboration). The legal framework of the health system remains very insufficient regarding the institutionalization and sustainability.

The general administration also suffers from a difficulty of absorption of the development aid in a context of major changes dominated by the country involvement in a great reform process: the Ministry of Economy and Finance recently launched a reform of public expenditures which includes: (i) the globalisation of loans (II) the development of contracting between the central administration and public decentralised services (III) the development of health partnership.

The implementation of these mechanisms will enable the central administration to have a legal framework to control its relations with the decentralised services on the first hand and civilian society and private sector on the second hand.

Concerning care offer regulation, the trend goes towards the development of regional care offer Diagrams to give a regional impulse. This tool is currently being implemented in the eastern region in order to be tested.

Within the deconcentration process reinforcement, the MOH is currently reviewing its administrative organization to create the health region and re-centralise the central administration on missions of the health system control and regulation. A technical and organisational audit study is currently being committed in this direction and will propose at the end of the current year the creation of the medical region and reorganisation of central administration.

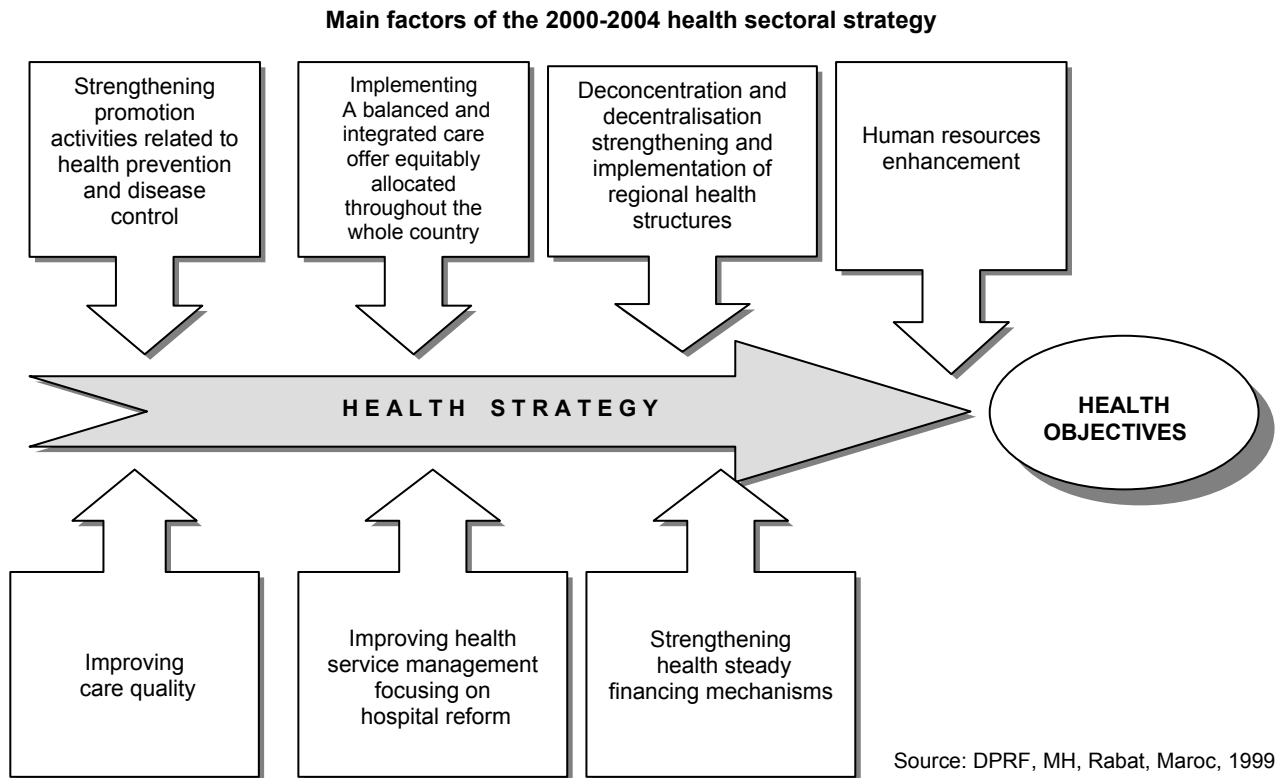
The MOH General Inspection also knows a new reorganisation dynamics within the framework of a cooperation project with the French government (Support project to hospital managers and general inspection staff). It is intended to create a branch of medical inspectors and revise the general inspection organisation in order to enhance its mandate and possibly deconcentrate its activities.

Beyond these sectoral dimensions, the governance improvement became a priority for the Government policy as well as for development assistance programs (UNS, IRDB, EC, etc.).

#### 4. HEALTH PRIORITIES IN MOROCCO

##### □ Health in the economic and social development plan

Within the 2000-2004 economic and social development plan, the MOH developed a sectoral strategy based on seven priority areas (see figure below).



This sectoral strategy constitutes the political and budgetary framework of the health system reform. The health system reform is supported by two sectoral projects: the PFGSS that is funded by an IRDB loan and PAGSS<sup>8</sup> funded by the European Commission. It is based on four essential components:

- The financing reform: aiming to improve financing through the implementation of two new financing mechanisms, the obligatory medical insurance (AMO) and medical assistance regime (RAMED);
- The hospital reform: that is a prelude to the financing reform aiming to modernise public hospitals (non CHU) and strengthen their management autonomy.
- The institutional strengthening: aiming to ensure the success of the two prior reforms through MOH capacity-building for policies formulation and new legal framework for the health system.

<sup>8</sup> PFGSS: Health sector financing and management project (*projet de financement et de gestion du secteur de la santé*) ; PAGSS: Support project for health sector management (*projet d'appui à la gestion du secteur de la santé*).

- The organisation of offer and balance of the health care network: This area, mainly implemented by PAGSS, aims to improve the offer regulation through the implementation and development of resource allocation criteria and planning tools for the health care offer.

□ **Health as a national health charter**

Along with the health reform implementation, the MOH initiated, with WHO support, a process preceding a social debate that could lead to the adoption of a National Health Charter setting the basic choices for health policy in Morocco.

The first stage of this process consisted in analysing the health status trends and sectoral orientations. This stage was based on seven thematic issues: the right to health, health status and its trends, health care offer, drugs and medical supplies, health system governance, health financing and research & development.

□ **Health in the Government statement**

More recently, new health needs were underlined in the Government statement. These new needs are particularly related to diabetics and chronic renal insufficiency. The response to these new needs could generate an update of the 2000-2004 sectoral strategy.

**On the whole**, this evolution shows that a quasi-consensus has been established on the goals and priority interest fields. The translation of this consensus in terms of suitable resources development and implementation of effective strategies has still to be done. It requires a dialogue with all medical development sector partners in Morocco, and more specifically the civilian society, private sector and development organizations and agencies.

### III. DEVELOPMENT ASSISTANCE

#### 1. THE IMPORTANCE OF DEVELOPMENT ASSISTANCE IN MOROCCO

The resources structure analysis of the health system shows that international cooperation funding remains still weak (1% of health total expenditures). International assistance to the sector of health is estimated at approximately US\$ 15 million/year of which 62% are invested in maternal and infantile health<sup>9</sup>.

The international economic situation and improvement of health indicators rank Morocco among the less eligible countries to external assistance. For UNFPA, Morocco is ranked among class B countries who can benefit only from 35% of external assistance. These considerations penalize the Moroccan rural sector that suffers from a systematic iniquity as regards health compared to the urban sector. The USAID, which primarily supported reproductive health and more specifically family planning (US\$ 120 million in 30 years) decided to phase out from the health sector in Morocco and re-orientate its funding to support "economic growth". In the same way, other organizations support pattern is more and more oriented towards rural development projects and partnership with the civilian society according to multi-sectoral approaches.

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<sup>9</sup> Source: Comptes Nationaux de la Santé, 97/98

In addition, it is important to note that development assistance within bilateral cooperation becomes increasingly active. These last years, Morocco signed major conventions with France, Belgium, Germany, Japan, etc.

**Table 1: International assistance allocation in the field of health according to financing source (in US\$ million)**

International organization or agency	Amount	Period	Annual average contribution	%
UNICEF	1.7	2002- 06	0.34	2%
UNFPA	9	2002 – 06	1.80	9%
UNDP	0.7	2002 – 06	0.14	1%
USAID	15	99 – 2003	3.00	16%
France	1	2002	1.00	5%
GTZ	3.7	2001- 05	0.74	4%
Luxembourg	1.45	2000	1.45	8%
European Union	30.435	1996-2003	3.80	20%
Belgium	4.1	99 – 2002	1.025	5%
Spain	0.8	99 – 2001	0.266	1%
Italy	1.45	99 – 2001	0.48	3%
Japan	11	2002-2004	3.66	19%
China	0.35	1998	0.35	2%
WHO	2.0	2002-03	1.00	5%
Total	-	-	19.051	100%

This table shows that the average annual contribution within cooperation is about US\$ 19 million. This amount represents 3.8% of the MOH budget estimated at US\$ 500 million. Compared to the 1998 health national accounts data, international aid has increased from US\$ 15.4 million in 1998 to US\$ 19 million in 2001.

In terms of proportion, this aid appears to have been reduced compared to that reported by the national health accounts which is 5% (12% out of salaries). This is explained by the fact that the State budget has significantly increased during this period.

The table also shows that the main international donors are USAID, European Union and Japan with more half of international assistance (56%). The contribution of United Nations organizations represents more than 17%. The WHO support accounts for 5% of the international assistance for health.

With the USAID withdrawal from the health sector, the financial structure of international assistance will know a great change, more especially because the cooperation with Japan is not traditional and could know fluctuations.

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

## **2. MAIN ASSISTANCE DEVELOPMENT PROGRAMS IN THE FIELD OF HEALTH**

These are international aid funding areas by international agencies and organisations.

#### ▪ UNFPA

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

#### ▪ USAID

In Morocco, USAID supports the four following programs:

- Support the Moroccan Government decentralisation efforts in two regions (PROGRESS). These activities are related to MCH and reproductive health programs, information system, on-going training, quality assurance, partnership with the civilian society.
- Support the national nutriment strategy (micro-nutriments).
- Support the “Commercial Market Strategies” (CMS); this project concerns the commercial contraceptive products promotion by the private sector.
- Support the capacity-building of general physicians: through training in IUD insertion in partnership with the Moroccan Association of General Physicians and through the introduction of a family medicine cursus in on-going training sessions for general physicians (private & public sectors) in partnership with the Faculty of Medicine of Marrakesh.

#### ▪ UNICEF

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

- Access to care and essential drugs
- Children diseases integrated care (PCIME)
- National nutrition strategy: deficiency in iodine and vitamin A
- Vaccine Independence Initiative

#### ▪ UNDP

UNDP main health support areas are:

- Hospital equipment strengthening and maintenance
- Fight against STI/AIDS.

#### ▪ EUROPEAN UNION

Three projects have been implemented:

- Fight against IST/AIDS in 15 provinces
- Maternal and neo-natal health
- Combating drugs addiction

Two projects are currently being implemented:

- Support project for health sector management (PAGSS)
- Support the Medical Coverage Code implementation

▪ ▪ (*JICA*)

Japan funds a major investment project in the field of safe maternity.

▪ GERMAN COOPERATION

- Health services decentralisation support in a Northern region.
- Technical training in dental prosthetics.
- Strengthening of a decentralised project on maternal health and family planning in a pilot-province in Southern Morocco.

▪ FRENCH COOPERATION

The cooperation with France focuses on the following fields:

- On-going training for specialists (orthopaedics, psychosomatics, emergencies, child-psychiatry...)
- Care techniques development: organ transplanting (kidney, cornea, spinal chord), traumatology, neo-natal resuscitation, open heart surgery, ionising radiation, transfusion, haemodialysis and support to laboratories.
- Support the creation of a branch of hospital and inspection management specialists, maintenance policy, mobile emergency service (SAMU) development in Morocco, medical fluids normalisation, drugs policy.
- Epidemiological monitoring.
- Support the role of the National Hygiene Institute (INH) laboratory in controlling other laboratories quality.

▪ BELGIAN COOPERATION

The Belgian cooperation is funding two projects:

- Health care funding in 2 Southern provinces.
- Fight against STI/AIDS (in the Grand Casablanca area).

▪ OTHER PARTNERS

Spain, Italy and Luxembourg contribute to the health sector and support equipment funding and punctual technical assistance on demand; however this aid remains very fluctuant.

China's assistance is particularly concretised through a bilateral convention in the field of medical human resources and equipment.

### 3. TRENDS AND CONVERGENCES

Among the programs that seem to benefit much interest from international cooperation are the "safe maternity" and the "STI-AIDS" programs. In the first program, international assistance reaches US\$ 10 million per annum, i.e. more than half of international aid in the field of health. The MOH mobilizes the same amount within its general budget. For STI-AIDS, international funding is estimated at more than US\$ 600 000 USD per annum, i.e. 31% of the total amount mobilized for the SCD-AIDS program. This support will know a consistent increase with the advent of the World Fund against AIDS, tuberculosis and malaria.

**On the whole**, this shows the need for reinforcing the MOH leadership as regards international cooperation in order to ensure a better coordination in international assistance.

In addition, and in the framework of UNDAF operationalisation, the WHO office has to get involved, through the inter-agencies working group, to support the actions to fight against poverty and food safety through a common strategy between the agencies and organizations of the United Nations System focussed on fostering local governance and participatory approach, namely through implementing local development projects (being able to adopt the Basic Development Needs approach).

#### **IV. CURRENT WHO PROGRAM**

The basic agreement between WHO and the Kingdom of Morocco related to technical advisory assistance, currently into force, was signed on September 15, 1961. This agreement replaced the previous one adopted on April 30, 1953.

The opening of the Representative office of WHO in Morocco goes back to 1986.

The credits granted under the regular budget since the opening of the WHO Office arise, by biennium, as follows:

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

On the whole and since 1986, more than US\$ 19 million have been mobilized by WHO for Morocco, excluding the extra-budgetary resources or the regional activities resources.

##### **1. AREAS OF WORK AND PARTNERS**

a) Within the framework of the joint cooperation program, the budget granted to the Kingdom of Morocco by WHO for 2002-2003 amounts to **US\$ 1.975.000, excluding technical assistance through regional advisers (*Conseillers régionaux*) technical missions or Moroccan professionals participation in inter-country activities.**

The current WHO program in Morocco includes nineteen action programs. Compared to the previous two years, this number has been reduced to **30%**, i.e. from 28 programs for the 2000-2001 to 19 currently (see list of programs in Appendix). This confirms the trend started already since last biennium aiming to opt for consistent integrated programs among different structures (rather than several small programs).

At the end of the first year, the achievement rate of the joint cooperation program between WHO/Kingdom of Morocco is about **50%**, showing a significant improvement compared to the previous biennium.

b) Concerning the work areas, the nineteen action programs are allocated as follows:

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

Among the nineteen programs, six programs mobilize **60%** of the credits allocated for the biennium:

- **Basic Development Needs** program.
- **Health policy formulation** program.
- **Integrated care of children diseases** development program.
- **Adult respiratory health** program.
- **Epidemiological monitoring** development program.
- **Human resources management and planning** program.

c) By components, the execution assessment for the first working year of the 2002-2003 biennium shows that **training** occupies the first area of expenditures with approximately 50% of the loans used (grants and seminars), followed by **printing** expenses (guides, didactic and educational material) with 13%, **equipment** (including more than 50% for computer equipment) with 7,5%, local contracts to perform specific work with 7%, and **local costs** (studies and surveys) with 5,5%.

Concerning expertise and technical assistance, 12 international consultants visited Morocco in 2002. These visits concerned:

<i>Consultation field</i>	<i>Number</i>
Health policy and management	2
Health system and service development	4
Health promotion and protection	3
Integrated fight against diseases	3

d) In addition, the WHO headquarters as well as the Regional Office contributed significantly, particularly in joint review meetings on several important national programs leading to action plans some of which are currently being implemented:

- combating tuberculosis
- epidemiological monitoring
- safe maternity
- pharmaceutical sector
- injection safety
- launching a national program on chronic diseases monitoring

## **e) Partners**

Since 3 years, the joint collaboration program individualises partners other than the MOH and the management of the budgets allocated to them; these partners currently represent 10% of the regular budget. The situation is the same for NGOs (1.5 to 2%)

Therefore, the Ministry of National Education, the Ministry of High Education (Faculties of Medicine), the Ministry in charge of Women Condition, Family Protection, Childhood and Integration of Handicapped, the Department of Environment, some NGOs will remain, with the MOH, WHO partners for the 2002-2003 biennium.

In addition, and like all the United Nations agencies and organizations, the WHO Office contributes to the different System studies and activities such as the Country Common Assessment, UNDAF as well as to community steps development and local development projects through the permanent Working Group.

The WHO Representative heads, since 4 years, the UNAIDS/Morocco thematic group that contributed to the development process of the National Strategic Plan against AIDS and Country Coordination Mechanism (CCM) that led to a funding from the World Fund against Tuberculosis, malaria and AIDS (Morocco is the first country of the region to benefit from this Fund).

## **2. TECHNICAL STAFF AND WORK CONDITIONS**

In addition to the Representative, the WHO Office in Morocco technical staff includes:

- 1 administrative assistant (2 years in the WHO office)
- 1 project coordinator (SSA) (5 years in the WHO office).

Since the WHO Office moved to new premises, the work conditions have significantly improved.

## **V. GLOBAL AND REGIONAL WHO DIRECTIONS**

### **1. WORKING GENERAL PROGRAM GUIDELINES 2002-2005**

The WHO general working program has adopted four areas of strategic action for the 2002-2005 period:

- reducing mortality, morbidity and disability, especially in poor and disadvantaged populations
- promoting healthy life styles and reducing risk factors to health related to environment, economical and social context and behaviour
- developing health systems that equitably improve health outcomes, and respond to the people's legitimate expectations, and are financially fair
- designing a basic policy and an institutional framework in the health sector and promoting awareness on health issues to social and economic partners, as well as in the field of environment and development.

## 2. THE REGIONAL WHO PRIORITIES (EMRO)

Within the EMRO region, the ten following areas of work are considered as a priority:

- human resources development
- essential needs approach to reduce poverty and health development
- communicable diseases and safe transfusion control;
- healthy life behaviour promotion, Tobacco Fight Initiative, aged people health promotion and nutrition promotion
- non communicable diseases prevention
- maternal and child health
- access to and rational usage of essential drugs
- health systems and services development
- promotion of technological transfer, health information material and capacity-building in health research
- environmental health, water sanitation and safety

## 3. THE WHO FUNCTIONS AT THE COUNTRY LEVEL

To define its action at the countries level, WHO identified the five following functions:

- ❑ **F1:** supporting sustainable implementation of routine activities.
- ❑ **F2:** facilitating and catalysing the adoption and adaptation of strategies, tools and technologies.
- ❑ **F3:** supporting research and development in the field of health, as well as activity monitoring of health system performance.
- ❑ **F4:** sharing and disseminating knowledge and information on health, providing options on general policies, norms & standards, advocacy.
- ❑ **F5:** providing advices on specific policies; serving as a broker, supporting health policies, actions and financing.

According to these functions, and taking into account the health system overall functions, the WHO Morocco action programs are allocated (in percentage) as follows:

**Table 2: Allocation (in %) of the current program activities according to the WHO functions at the national (country) level**

Health system functions (according to WHO)	F1	F2	F3	F4	F5	Total
General administration		1	4		11	16
Service delivery	10	50	7	3	3	73
Resource generation	3	3	3	3	1	13
Financing	-	-	-	-	-	-
Total	13	54	14	6	15	100

The above table is the result of the allocation (in percentage) of the different action programs activities (in terms of allocated resources) according to WHO functions at the country level.

This analysis shows that with 54% of the activities volume, the function related to catalysing and adopting strategies, tools and technologies remains predominant in the WHO current program and thus favouring the health system delivery function. Moreover, these results are confirmed through the achieved activities assessment during the first year that shows that training ranks first for expenditures with 50% of spent credits.

## **VI. STRATEGIC AGENDA FOR MOROCCO**

### **1. NATIONAL PARTNERS' EXPECTATIONS**

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

1. formulating and implementing health policies, more specifically planning and decision-making tools development
2. epidemiological monitoring and care of prevalent morbidity
3. strengthening health safety and monitoring
4. developing management skills and capacities in human resources
5. health system general administration
6. developing the Health Information System
7. developing targeted and concerted research

### **2. CHALLENGES TO BE MET**

Given the demographic and epidemiological transition and the changes in its economic and social environment, the Moroccan health system has to face challenges in the four following health system functions:

- ❑ Care and service delivery: the challenge relates to the health authorities capacity to overcome four major obstacles:
  - the disparity in the access to care
  - the transition of care demand
  - the resources under-usage
  - the low integration among the different delivery levels and the different health sectors (public and private)

To meet this challenge, it is necessary to strengthen the policy of subsidy and management decentralisation.

- ❑ Along with care organisation and offer equity issues, under-financing remains the main obstacle to Moroccan health system development. The health reform cannot be implemented without improving financing and an equitable financial allocation.

- ❑ The function related to creating resources knows a great deficit. Except the pharmaceutical industry sector that produces more than 80% of the country drugs solvent demand, the biomedical technology market remains very limited and far from meeting the hospital technical renewal or development needs scheduled within the hospital reform.

On the level of human resources production, and despite the initial training autonomy for the different health staff categories, the system stills suffers from an inadequacy between supply and demand.

- ❑ Concerning the sector governance, the challenge relates to the health system strong centralisation that contrasts with a weak regulation capacity and a weak care cost control.

Moreover, the health system transitional positioning needs the efforts made in generating information in the health status area and system performance to be maintained and strengthened to guide political choices through evident data and better pilot the current reforms.

The cooperation strategy WHO-Morocco has been developed to contribute to the efforts made by the health authorities to face these challenges.

## **2. COOPERATION STRATEGY WITH MOROCCO**

The Moroccan health system is living a critical evolution phase. Given the national priorities and new WHO guidelines, the WHO-Morocco cooperation will aim to reinforce its contribution to improve the Moroccan population health and health system performance. It lies within the scope of the promotion of sustainable human development and concern of achieving the millennium goals.

The WHO support takes into account the main policy and strategy choices made in the health sector and upon which a consensus seems to have been established.

The priority proposed by WHO in the middle term is to accompany the reforms launched by the Government while ensuring the continuity of WHO technical support targeting priority health programs.

Thus, the 2004-2007 CCS will include three main components (see Appendix 3):

### **Component 1: Developing necessary instruments to health policy planning and guidelines**

Component 1 meets the common concern to generate information useful to strategic decision-making and facilitate the adoption and adaptation of necessary tools to design or assess health policies. The choice of the instruments to be developed is dictated by the concern to influence the actions scheduled in the reforms that have been launched. Priority will be thus given to the actions that allow:

- ❑ Health status measuring: study on the morbidity burden, surveys on the health status or on risk factors, etc.; these studies and surveys will enable assessing health priorities

- ❑ Health system performance measuring: national health accounts, system reactivity measuring, sectoral governance analysis, joint national programs reviews, development of performance indicators, etc.
- ❑ Offer regulation: priority will be given to human resources planning and basic training adequate to health needs, health mapping development, access improvement to primary health care and essential drugs.

## **Component 2: Supporting the care system decentralised management**

Deconcentration reinforcement is a general policy choice in Morocco. Toward the end of the 90's, deconcentration has known a renewed interest since the promulgation of the law on regionalisation. To consolidate this national direction, it is proposed that WHO action is pragmatically set within the health care system decentralised management strategy. Integrated programs such as access to health care, service organisation, child diseases integrated care will be primarily dealt with within the decentralisation framework. Accordingly, three work areas will be strengthened:

- ❑ Skills development through basic and on-going training strengthening in the areas of health service management, action-research and operational research development, etc.
- ❑ Management tools development to facilitate responsibility delegation and service management transparency. In this area, WHO will support initiatives to implement control mechanisms such as contracting, quality control, accreditation and internal audit. ?
- ❑ Programs integration and intersectoral collaboration: decentralisation and deconcentration consolidate the intersectoral collaboration possibilities and participation opportunities at the community level to manage health problems. From this point of view, community-based initiatives and, particularly the program "Basic Development Needs", will go on, particularly in the form of technical collaboration either with the Agency of Social Development for funding or with any other agency with a similar mission (contribution through experience and methods). Deconcentration is also an opportunity to take in order to ensure more integration in the health care offer and in programs management, i.e. supporting the children diseases integrated care program (PCIME), health sector organization (orientation-recours system), DTSP step (problem-solving by the district staff) and promotion of public-private sectors partnership.

## **Component 3: Technical expertise development**

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

- ❑ consolidating the WHO-Morocco cooperation by updating the traditional technical programs such as immunization, tuberculosis or malaria; supporting structuring actions such as the National Information Health System and training at the National Institute of National Administration (*Institut national d'administration sanitaire*), or strengthening information dissemination and sharing supports.
- ❑ reinforcing, in a targeted way, some MOH key-programs such as epidemiological monitoring, maternal health, safe maternity and STI-AIDS;
- ❑ preparing and developing a national response to emerging problems which will need structured priority programs in the future, i.e. activities aiming the reduction of health risks (see the 2002 Report on Health in the World, namely fight against tobacco, healthy lifestyles promotion...), chronic diseases management and care, health safety and adolescent health promotion.

**NB:** In order to answer to the partners' expectations and implement the programs developed under this strategic agenda, it is necessary to reinforce the WHO role in Morocco, more especially as USAID will withdraw from the health sector during the period covered by the present CCS. The importance of USAID support (around 50% of international assistance), the concentration of its actions in maternal health which constitutes a national and regional priority, and the risks for the rural world coverage due to this withdrawal must encourage WHO to play an advocacy and additional resources mobilization role for health within bilateral and multilateral cooperation. The CCS will be a major support to guide this advocacy and reinforce collaboration with development agencies and civilian society.

## VII. IMPLICATIONS FOR THE WHO OFFICE

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

On the programming level, the CCS implementation supposes on one side a reinforcement of the functions of general administration and resource generation and a reconsideration of the actions supporting care service and service for a better integration. On the other side, a resource re-deployment is necessary to ensure a reinforcement of the WHO country-level F2 function (facilitate and catalyse the adoption and adaptation of strategies, tools and technologies) and F5 function (provide advices on specific policies) (see Appendix 2). This deployment takes into account the intervention of other partners and the comparative advantage of WHO in terms of expertise. It is detailed Table 3 below:

**Table 3: Relative importance of WHO actions in Morocco (in 2004-2007)**

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

To ensure a better monitoring in the cooperation programs and their integration in the overall health sector current dynamics, it would be suitable to institutionalise a yearly WHO-Morocco joint program review. The joint program review is an annual meeting between the WHO Representation and its national partners aiming to a midterm assessment of the biennium action Program. The results of this meeting will mainly help to reprogram activities for the second year of the biennium.

The financial programming should be adapted to catalyse adequately the CCS actions. WHO will mobilise consequent extra-budgetary resources within the context of international cooperation in order to support the CCS goals.

**Table 4: WHO-Morocco cooperation strategic Agenda (synopsis)**

COMPONENT 1 Developing the necessary instruments to plan and guide the health policy	COMPONENT 2 Supporting the care system decentralised management	COMPONENT 3 Technical expertise
<b>1.1. Health status measuring</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Morbidity burden</li> <li><input type="checkbox"/> Surveys on risk factors</li> <li><input type="checkbox"/> Surveys on health status</li> </ul>	<b>2.1. Skills development</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Training</li> <li><input type="checkbox"/> Action-research</li> <li><input type="checkbox"/> Operational research</li> <li><input type="checkbox"/> Experience sharing</li> </ul>	<b>3.1. Assets consolidation</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Updating traditional programs (immunisation, tuberculosis, malaria, trachoma, water-borne diseases,...)</li> <li><input type="checkbox"/> SNIS</li> <li><input type="checkbox"/> National Institute of Health Administration (INAS)</li> <li><input type="checkbox"/> Information dissemination and sharing supports (CDS, WHO office web site)</li> </ul>
<b>1.2. System performance measuring</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> System responsiveness</li> <li><input type="checkbox"/> National health accounts</li> <li><input type="checkbox"/> Governance</li> <li><input type="checkbox"/> Joint national programs reviews</li> <li><input type="checkbox"/> Performance indicators</li> </ul>	<b>2.2. Management tools development</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Contracting</li> <li><input type="checkbox"/> Internal audit</li> <li><input type="checkbox"/> Accreditation</li> <li><input type="checkbox"/> Quality control</li> </ul>	<b>3.2. Targeted interventions in priority programs</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Epidemiological monitoring</li> <li><input type="checkbox"/> Safe maternity</li> <li><input type="checkbox"/> STI/AIDS</li> <li><input type="checkbox"/> Water and environment</li> </ul>
<b>1.3. Offer regulation</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Human resources planning</li> <li><input type="checkbox"/> Adaptation of basic training to health needs (re-definition of profiles and curricula, trainers' training)</li> </ul>	<b>2.3. Integrating programs and intersectoral collaboration</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> DTSP</li> <li><input type="checkbox"/> Children diseases integrated care program (PCIME)</li> </ul>	<b>3.3. Response to emerging needs</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Health safety</li> <li><input type="checkbox"/> Health risks reduction (tobacco, lifestyles...)</li> <li><input type="checkbox"/> Chronic diseases management</li> </ul>

<ul style="list-style-type: none"> <li><input type="checkbox"/> Health mapping</li> <li><input type="checkbox"/> Access to drugs</li> <li><input type="checkbox"/> Primary health coverage</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> BED and other community-based initiatives</li> <li><input type="checkbox"/> Care network organisation (hospital-primary health care relation)</li> <li><input type="checkbox"/> Public-private sectors partnership</li> </ul>	<p>and care</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mental health</li> <li><input type="checkbox"/> Vulnerable groups, namely adolescents...</li> </ul>
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**Table 5: CCS actions according to WHO functions at the country level and health system functions**

Health system functions	WHO functions at the national (country) level				
	F1	F2	F3	F4	F5
<b>General administration</b>	<ul style="list-style-type: none"> <li>▪ Health Information National System (SNIS)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Human resources planning</li> <li>▪ Health mapping</li> <li>▪ Contracting</li> </ul>	<ul style="list-style-type: none"> <li>▪ Burden of morbidity</li> <li>▪ Risk factors surveys</li> <li>▪ Health status surveys</li> <li>▪ System responsiveness</li> <li>▪ National health accounts</li> <li>▪ Governance</li> </ul>	<ul style="list-style-type: none"> <li>▪ Accreditation and quality assurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ Basic health coverage</li> <li>▪ National programs joint reviews</li> <li>▪ Performance indicators</li> </ul>
<b>Service delivery</b>	<ul style="list-style-type: none"> <li>▪ Updating traditional programs (vaccination, tuberculosis, malaria, trachoma, water-borne diseases...)</li> <li>▪ Epidemiological monitoring</li> <li>▪ Training</li> </ul>	<ul style="list-style-type: none"> <li>▪ Contracting</li> <li>▪ Internal audit</li> <li>▪ Accreditation</li> <li>▪ Health quality</li> <li>▪ DTPS</li> <li>▪ Children diseases integrated care program (PCIME)</li> <li>▪ Health network organisation (hospital-primary health care relation)</li> <li>▪ Public-private sectors partnership</li> </ul>	<ul style="list-style-type: none"> <li>▪ Supporting referral laboratories</li> <li>▪ Action-research</li> <li>▪ Operational research</li> </ul>	<ul style="list-style-type: none"> <li>▪ Information dissemination and sharing supports (CDS, WHO office web site...)</li> <li>▪ Experience sharing</li> </ul>	<ul style="list-style-type: none"> <li>▪ Access to drugs</li> <li>▪ BED and other community-based initiatives</li> <li>▪ Safe maternity</li> <li>▪ CSD/AIDS</li> <li>▪ Water and environment</li> <li>▪ Health safety</li> <li>▪ Health risks reduction (tobacco, lifestyles, etc.)</li> <li>▪ Chronic diseases management and care</li> <li>▪ Mental health</li> <li>▪ Vulnerable groups, namely adolescents</li> <li>▪ ...</li> </ul>
<b>Resource generation</b>	<ul style="list-style-type: none"> <li>▪ National Institute of Health Administration (INAS)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Adapting basic training to health needs (profiles &amp; curricula re-definition, trainers' training)</li> <li>▪ National Institute of Health Administration (INAS)</li> </ul>			
<b>Financing</b>	-	-	<ul style="list-style-type: none"> <li>▪ Rationalising resource allocation (criteria development for resource allocation, development of gain of productivity tools)</li> </ul>	-	-

## APPENDIX I

### COUNTRY PROFILE

#### 1. GENERAL

Country Name:	Morocco		
Capital Name:	Rabat		
Total land area:	710 850 km <sup>2</sup>		
Official Language:	Arabe		
Currency:	Dirham `	Exchange rate/in US\$	9.75

#### 2. DEMOGRAPHIC INDICATORS

##### POPULATION YEAR: 2002

<b>Total</b>	<b>2.9636.000</b>
Urban: Rural ratio	55,9
Male: Female ratio	50,2
Under 1 year (%)	2,1
1 – 4 years (%)	10,08
5 – 14 years (%)	20,81
15 - 49 years (%)	21,72
Over 65 years (%)	2,2

- Population growth rate 1,5
- Crude birth rate 22,4 (%0)
- Dependency ratio 61.55
- Total fertility rate 2,9
- Population density 40 (hab/km<sup>2</sup>)

#### SOCIO ECONOMIC INDICATORS

Indicators	Year	Total	Male	Female
Adult literacy rate (15+ years)	01-02	51.7	65.2	38.1
School enrolment ratio (first level)	00-01	85	88	81
School enrolment ratio (second level)	00-01	28	30	26
Percentage of regular smokers	00	17.7	34.5	1.6

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

#### 3. BUDGETARY RESOURCES INDICATORS IN 2000

- National health expenditure as % of GNP 4.5
- Allocated resources to MOH from total government budget 5.3% (2003)
- MOH expenditures as % of GNP 1.3% (2001)
- National health expenditures devoted to local health care
- Annual budget of MOH (per capita) 17,5 US\$ (2002)
- National expenditures on health (per capita) 50 US\$

#### 4. HUMAN AND MATERIAL RESOURCES INDICATORS

	Rate per 10 000 population
1- Physicians	4,2
2- Dentists	0,8
3- Pharmacists	1,56
4- Nursing and midwifery	10,03
5- Hospital beds	10,08
6- PHC units or centers	2,73

## 5. INDICATORS OF COVERAGE WITH PRIMARY HEALTH CARE IN (2001) YEAR

### PERCENTAGE OF POPULATION WITH ACCESS TO LOCAL HEALTH SERVICES:

- Total 85
- Urban 100
- Rural 65

### THE SAME INDICATORS BY REGION/ PROVINCE/GOVERNORATE

### PERCENTAGE OF INFANTS FULLY IMMUNIZED IN THE YEAR (2001) WITH:

- BCG 92
- DPT 60
- OPV 92
- Measles vaccine 68
- Hepatitis B Vaccine 78

### PERCENTAGE OF PREGNANT WOMEN GIVEN 2 DOSES OF TETANUS TOXOID

42

### PERCENTAGE OF TOTAL POPULATION WITH ACCESS TO:

- Safe drinking water 77
- Adequate excreta disposal facilities 72

PREGNANT WOMEN ATTENDED BY TRAINED PERSONNEL	56
DELIVERIES ATTENDED BY TRAINED PERSONNEL	45,6
INFANTS ATTENDED BY TRAINED PERSONNEL	62
MARRIED WOMEN (15-49) USING ANY FORM OF CONTRACEPTIVES	59

## 6. HEALTH STATUS INDICATORS

YEAR VALUE

• Newborn with birth weight at least 2.5 Kg.	1999	97%
• Children with acceptable weight for age	1997	91,1
• Infant mortality rate	1997	36,6
• Probability of dying before reaching 5 <sup>th</sup> birthday	1997	45,8
• Maternal mortality rate	1997	22,8
• Life expectance at birth		
▪ Total	1999	69,5
▪ Male	1999	67,5
▪ Female	1999	71,52

## 7. SELECTED MORBIDITY INDICATORS

Disease	Annual number of reported cases in 2002
Cholera	0
Malaria	106
Poliomyelitis	0
Measles	6000
Pulmonary Tuberculosis	27804
Diphtheria	0
Tetanus	18
Neonatal Tetanus	05
AIDS	140
Meningococcal Meningitis	505

## APPENDIX II

### EXPENDITURES ALLOCATION OF BIENNIUM 2000-2001 ACCORDING TO WHO DIFFERENT ACTION PROGRAMS

Program title	Allocated budget (in US\$)	%
4.3 Sustainable human development – Essential development needs approach	430 000	21,72
1.1 Health policy formulation	260 000	13,13
7.2 Child and adolescent health – Service for children victims of violence.	181 500	9,17
10.1 Adult respiratory health	176 000	8,89
11.1 Epidemiological monitoring	120 000	6,06
2.1 Human resources policy management, planning and formulation	107 500	5,43
1.4 Preparation to emergency situations and risk management	100 000	5,05
6.1 Promotion of healthy lifestyles, health at school and health education targeting youth.	90 000	4,55
5.1 National drugs policy based on essential drugs – Pharmacy monitoring and monitoring medical treatments used in health programs.	75 000	3,79
5.3 Implementation of assurance quality program in the laboratories supporting health programs	66 500	3,36
4.1 Care quality approach development	65 500	3,31
10.3 National Program against STI and AIDS	55 900	2,82
2.2 Supporting medical teaching	50 000	2,53
4.2 Strengthening the re-adaptation community-based program targeting the handicapped	45 000	2,27
7.1 Supporting the safe maternity strategy, genesis health and family planning	44 600	2,25
1.3 Supporting research on health systems	38 000	1,92
8.4 Assessing health risks related to environment	35 000	1,77
1.2 Reinforcing health legislation	20 000	1,01
6.5 Food hygiene	19 500	0,98
<b>Sub-Total</b>	<b>1,980,000</b>	<b>100</b>
<b>Extra-budgetary funds</b>	<b>72,000</b>	
<b>TOTAL</b>	<b>2,052,000</b>	

**NB:** Excluding inter-country financing, such as participation to inter-country meetings and headquarters and EMRO technical support represented by visits to regional advisors (*conseillers régionaux*) and by planning visits (JPRM).

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