منتـــدى السياســـات الصحيـــة في الشـــرق الأوســـط وشمـــال افريقيـــا
MIDDLE EAST AND NORTH AFRICA HEALTH POLICY FORUM

UNFPA

MOROCCO

Readiness to Meet

SEXUAL AND REPRODUCTIVE HEALTH-RELATED

Sustainable Development Goals

Policy Brief

In Morocco, the coverage of health services and affordability of care have been the subjects of high-level debate and important political decisions in recent years. Coverage of essential services has improved in urban areas and among the middle and upper economic classes, but it remains low among the poor and in remote rural areas. The country's main challenge is to provide a minimum benefits package, including sexual and reproductive health (SRH) care, for these disadvantaged populations.

This brief highlights the results of an assessment of the readiness of the healthcare system to support SRH services in Morocco, and to adopt the integrated vision of SRH called for in the global Sustainable Development Goals (SDGs) for 2030.

The Assessment

In 2016, research teams in four countries gathered data using a standardized data-collection tool developed by the Middle East and North Africa Health Policy Forum. (The other three countries were Egypt, Jordan, and Kingdom of Saudi Arabia.) For each country, the team assessed the current state of sexual and reproductive health and related services; the accessibility and coverage of the health system; the adequacy of the health workforce; equity in health service access and outcomes among population subgroups; and information gaps.

The assessment relied on various sources of information, including the national census, the population survey, the 2011 National Survey on Population and Family Health, information systems and reports of the Ministry of Health and the Higher Planning Commission, the Health Sector Strategy (2012-2016), and reproductive health program strategies.

The State of Sexual and Reproductive Health in Morocco

In Morocco, the average age of marriage has increased, and higher percentages of men and women are unmarried than in past decades. Nevertheless, in some communities, early marriage and teenage childbearing persist. The adolescent fertility rate is high, at 32 births per 1,000 women aged 15–19.

Maternal mortality declined by 35% between 2011 and 2017 [1] as the health ministry has made significant efforts to improve maternal health care. Yet, maternal and neonatal mortality remain unacceptably high, with large disparities between urban and rural areas, and between the richest and poorest populations. Morocco therefore faces critical challenges to achieving the 2030 SDGs, including:

- Reducing maternal mortality from 73 deaths per 100,000 live births in 2017 to less than 50 per 100,000.
- Reducing the neonatal mortality from 21 per 1,000 live births to less than 15 per 1,000.
- Reducing the unmet need for family planning from 10% of women of reproductive age to less than 5%.
- Reducing the adolescent fertility rate from 32 births per 1,000 women aged 15-19 to less than 10 per 1,000.

Although contraceptive use is widespread—67% of married women use a method—more than 20% of pregnancies are unwanted, and more than 20% of contraceptive users experience a method failure. Ten percent of married women of reproductive age have an unmet need for family planning—that is, they want to avoid pregnancy for at least two years but are not using contraception.

The prevalence of HIV infection in the general population is low (0.12%), but it is higher in urban areas and in certain regions, and it is between 2% and 4% among populations at risk, which include sex workers, men who have sex with men and injecting drug users. A major challenge for the HIV/AIDS program is to reach at-risk populations with prevention and treatment services.

Government Policies and Plans

The Health Sector Strategy for 2012–2016 places high priority on reducing maternal and neonatal mortality and implementing the National AIDS Plan. In recent years, new strategies for the detection and management of cervical and breast cancers have been developed at the national level. There is no policy or national plan in place, however, to reduce early marriage and teen childbearing. Morocco also lacks a strategy for providing information and access to contraception to unmarried women, even though today, the average age of marriage is now 27 in rural areas and 29 in urban areas.

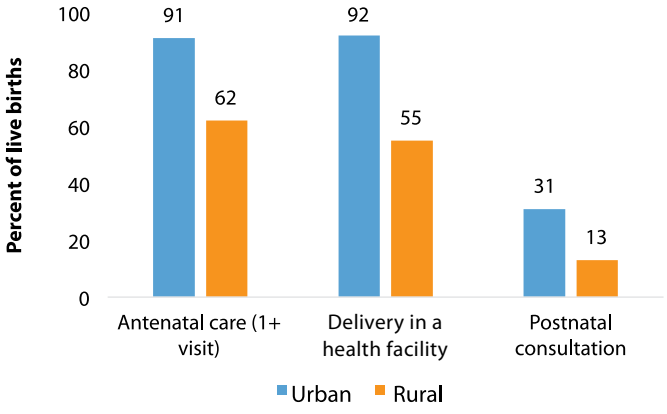
To reduce financial barriers to accessing health care, a social security scheme works through two mechanisms: medical insurance coverage funded by employer and employee contributions; and medical coverage for the poor, funded by state and local authorities. The scheme currently covers more than 60% of the population, but financial constraints limit coverage of the poor. To increase access to maternal and newborn health care among populations in need, the health ministry has begun providing free deliveries and caesarean sections nationally.

The Violence Against Women strategy is part of a multi-sectoral strategy with inputs from several departments (Health, Social Affairs, Justice), the police, and non-governmental organizations. A network of support units, referrals, and guidance has been established to support women survivors of sexual and domestic violence. These structures are insufficient and inefficient, however, and are virtually non-existent in remote and rural areas.

Coverage and Accessibility of the Health System

The public sector provides 70% of health benefits, including antenatal care, deliveries, caesarean sections and other maternal and neonatal health services. The availability of the minimum package of mother and neonatal health care varies widely between regions and between urban and rural areas (see Figure 1). No plan or policy requirements exist for implementing the minimum package on a large scale.

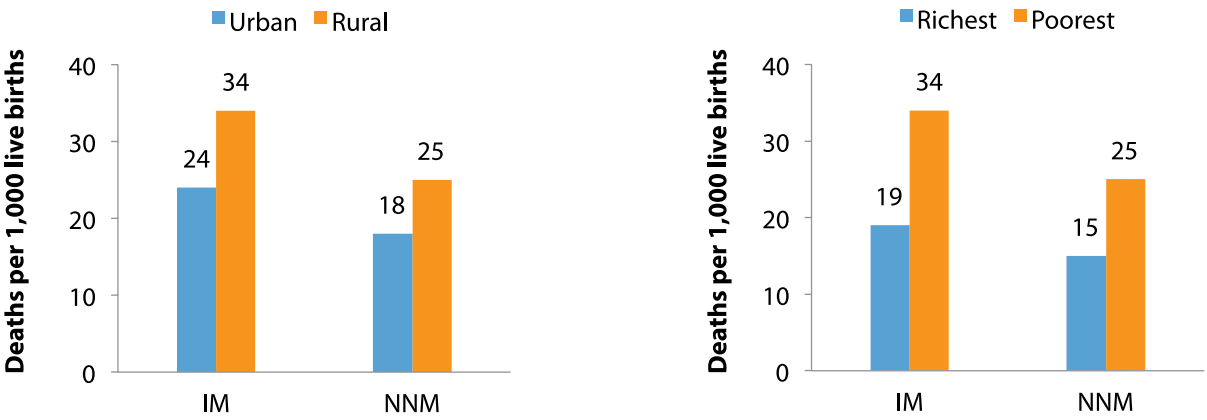
Figure 1: Pregnant women in urban areas are much more likely to receive essential care than those in rural areas.



Source: *Pan Arab Project for Family Health, Enquête Nationale sur la Population et la Santé Familiale, 2011*

Health coverage is based on a network of 150 hospitals, and 2,800 primary health care centres, 2,000 of which are in rural areas. Analysis shows that additional health centres are needed, estimated at 50 in urban areas and 150 in rural areas, as well as 200 delivery units in rural areas. Only 30% of delivery units in Morocco offer the whole range of basic emergency obstetric and neonatal care.

Figure 2: Infant mortality and neonatal mortality are higher in rural areas than urban areas, and higher among the poorest 40% compared with the richest 40% of the population.



Note: IM=infant mortality (under age 1); NNM=neonatal mortality (under 28 days).

Source: *Pan Arab Project for Family Health, Enquête Nationale sur la Population et la Santé Familiale, 2011.*

Health Workforce

Morocco faces a chronic shortage of human resources. Staff turnover is high, and the recruitment of new staff has not kept pace with departures. In addition, absenteeism is common, often due to practitioners taking on illegal work in the private sector.

Moreover, training and recruitment of medical specialists are limited by the state budget. The training curricula for doctors and nurses are often limited to modules with defined objectives and a defined number of hours per module. There is neither a clear definition of objectives in terms of competencies (except one developed recently for midwives), nor training modules developed and disseminated to teachers and students. Quality control depends mainly on the availability, commitment, and quality of the teacher.

Health Equity and Universal Health Coverage

Progress in reducing maternal and neonatal mortality in Morocco is slow, at 4% per year. To achieve the mortality reduction targets of the SDGs, the pace should exceed 5% per year. The slow progress is mainly due to inaccessibility of good medical care—or any care at all—for the rural poor. For example, in 2011, the maternal mortality ratio in rural areas was double that of urban areas. Neonatal mortality was 25 per 1,000 among the poorest 40% of the population, compared with 15 per 1,000 among the richest 40% (see Figure 2).

Universal access to comprehensive reproductive health care and HIV prevention is hampered by the inaccessibility of services to the most disadvantaged populations, and by the exclusion of young people, unmarried people, and high-risk populations.

In this context, women and adolescent girls pay the heaviest price because of early marriage, illiteracy, lack of information and empowerment. Other factors that are not addressed in sexual and reproductive health programs include unwanted pregnancy, abortion, violence against women, and HIV infections among young women. These gaps are compounded by little or no health coverage and lack of affordability of care, always affecting the same sectors of the population.

Morocco's sexual and reproductive health strategies, even if well prepared and well-funded, would not meet the targets set for 2030 without a specific policy component for these populations. Indicators for monitoring progress should be disaggregated by region and socio-economic class, and should pay specific attention to adolescent girls.

Health Financing

Morocco spends 6% of its gross domestic product on health, but more than half of this comes from out-of-pocket spending. Total health expenditures are as follows: 54% from households, 25% from fiscal resources, and 19% from medical insurance coverage. The poorer classes continue to spend a disproportionate share of their incomes on health, creating a vicious cycle of poverty.

The two major health insurance plans for public and private employees covered 8.5 million people in 2015, and the Health Insurance Scheme for the Economically Deprived

(RAMED) covered almost 9 million people. However, the latter scheme allows access only to public health facilities and does not guarantee the availability of all health services; therefore, patients may have to pay for medicines or other health benefits.

Government spending on maternal and newborn health have increased significantly because of the introduction of free delivery and caesarean-section deliveries in public hospitals, the purchase of equipped ambulances, the establishment of childbirth kits and caesarean kits at all maternity hospitals and birthing centres, the mobilization of operational resources, the implementation of obstetric rural ambulances to regulate obstetric and neonatal emergencies in rural areas, the establishment of mobile health units, and the upgrading of delivery structures. Despite these efforts, the poor continue to suffer financial inaccessibility, as health strategies are not based on an economic assessment of vulnerable populations.

Information Gaps

Most of the information needed to assess sexual and reproductive health comes from demographic surveys and Pan Arab Project for Family Health (PAPFAM) surveys, conducted every 5 years. These important surveys exclude unmarried women - who represent half of women over age 15- resulting in a huge data gap. Demographic and health information should be updated annually based on vital registration systems; however, civil registration does not currently cover the entire population and is not of high quality.

The health information system should provide regular information on the use of services and health coverage, but it is handicapped by a lack of reliability and production delays. The health account survey, one of the main sources of information on financial and medical coverage for health, was last published in 2017 using data from 2013. In this context, the following issues must be addressed:

- Integration of unmarried people in PAPFAM surveys;
- Strengthening of the national health information system to ensure quality and consistency, integrating private-sector healthcare providers for at least some key indicators;
- Improving vital registration to provide regular information on marriages, births and deaths; and
- Producing more regular health account reports, e.g., every 5 years.

The PAPFAM surveys planned between 2017 and 2021 will be essential for monitoring and evaluating these objectives. They must be reinforced, however, by further analysis to better understand the situation of the most marginalised populations in need of sexual and reproductive health services.

Conclusions and Recommendations

The main challenges for achieving the sexual and reproductive health SDGs in Morocco are:

- Reducing maternal and neonatal mortality in all areas of the country;
- Providing better access to family planning information and services, including for unmarried women;
- Providing better access to information and to sexual and reproductive health services for young people and especially young girls;
- Reducing the incidence of early marriage and adolescent fertility;
- Developing new HIV prevention strategies for high-risk populations in urban areas; and
- Enhancing health coverage in rural areas and isolated populations.

Morocco's strategy for health sector should consider these challenges by adopting clear objectives and mobilising adequate resources, to be equitably distributed across the population. To achieve the sexual and reproductive health-related SDGs, the Moroccan government must focus on specific issues related to human resources, equity and financing.

- Develop a new human resources strategy, maintaining a balance between departures and hires and between urban and rural areas, to ensure availability, competence, and motivation of health providers.
- Ensure that sexual and reproductive health services are accessible and of good quality for rural people as part of universal health coverage.
- Create more balance in health funding through a system of risk-sharing that involves all partners in one system, with a new form of governance.

Acknowledgments

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www.menahpf.org

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