

Universal health coverage for sexual and reproductive health in Morocco



Evidence brief

Evidence and policy implications



Key messages

- ▶ In Morocco, recognition of the importance of access to comprehensive sexual and reproductive health (SRH) services as part of universal health coverage (UHC) is growing, and some progress has been made.
- ▶ Maternal health care (including antenatal, intrapartum and postnatal care) is a key component of SRH services. It is considered a national priority, with services being included in the national health insurance schemes and delivered free of charge at public health facilities.
- ▶ Despite progress in addressing issues related to gender-based violence (GBV), health sector interventions remain limited. More work is needed to better integrate these issues into SRH services in primary care facilities.
- ▶ Progress has been made in preventing unintended pregnancies through the development of communication tools to promote family planning. A training guide on post-abortion care has strengthened the skills of health workers at the primary health care level. Antenatal care services have adopted information, education and communication messages for the prevention of future unintended pregnancies.
- ▶ A range of specific policy measures to address programme implementation and service delivery challenges have been proposed to advance progress in: maternal health care services; the prevention of unintended pregnancies; post-abortion care; and services for the prevention of GBV (as well as care for those affected by it). The measures include the participation of women, and vulnerable and marginalized groups in public decision-making and political processes related to priority-setting, design, implementation, monitoring and accountability of SRH and UHC policies and programmes.

Introduction

In UHC, “all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course” (1). Universal access to a comprehensive range of SRH services is fundamental to achieving UHC (1).

Since the adoption of the “Programme of Action” of the 1994 International Conference on Population and Development in Cairo, Egypt, Morocco has made significant progress in improving access to SRH services. Several policy reforms and health strategies (see Box 1) aim to facilitate the integration of SRH services into UHC. These were consolidated by the adoption of the 2011 National Constitution, which reinforces the fundamental rights of citizens and emphasizes

the mobilization of all available resources to facilitate equitable access for the entire population, particularly women, to health services (2).

To advance progress towards UHC, Morocco implemented a national health insurance system, comprising three main schemes. The first was the Mandatory Health Insurance Plan (*Assurance Maladie Obligatoire* [AMO]), which is based on contributions by employers and employees. The second was the Medical Assistance Scheme for the Economically Disadvantaged (*Régime d'Assistance Médicale* [RAMED]), which is based on state subsidies and a contribution from the communes. The third was the Self-employed Health Insurance scheme. These schemes provided coverage for approximately 62% of the population.

The health benefits packages (HBPs) of AMO and RAMED are similar. SRH services in the HBPs include family planning, antenatal care, intrapartum care, postpartum care, sexually transmitted infection and HIV screening and management, breast and cervical cancer screening. The schemes differ in that RAMED allows access to services in public health facilities only.

In April 2021, a social protection framework agreement (Law No. 09-21), including the provision of public health insurance for all Moroccans by the end of 2022, was adopted. This is in accordance with the new development model targeting economic and social transformations, which mentions social protection as a fundamental right of citizens. Most SRH services are provided free of charge through primary health care facilities.

About this evidence brief

This evidence brief builds on a case study conducted in Morocco on the process and status of the integration of SRH services within UHC policies, programmes and strategies. The study focused on three tracer conditions: maternal health, gender-based violence, and the prevention of unintended pregnancies and post-abortion care. The case study was based on a desk review and interviews with key stakeholders, including policy-makers, programme managers, national experts, service providers, nongovernmental organizations (NGOs) and United Nations agency representatives.

Box 1. Key milestones

In Morocco, a reform process to establish UHC through non-subsidized and subsidized social health insurance was launched in 2002. The reform process included the following:

- Law No. 65-00 on the code of basic medical coverage, promulgated by Dahir 1-02-296 of 3 October 2002 – compulsory health insurance component (AMO) for employees implemented in 2005;
- The Free Delivery and Caesarean Policy in Public Health Services (ministerial circular No. 108 of 11 December 2008);
- Medical Assistance Scheme for the Economically Disadvantaged (*Régime d'Assistance Médicale* [RAMED]) – piloted in 2008 and scaled up to national level in 2012;
- Convention on the Elimination of All Forms of Discrimination against Women ratified;
- National Health Action Plan 2008–2012;
- 2011 National Constitution;
- National Reproductive Health Strategy 2011–2020;
- Self-employed Health Insurance (Law No. 98-15 for the medical coverage of workers who are not employees) – adopted in 2017;
- National Healthcare Plan 2025;
- The project of Law No. 10-16 on abortion;
- Law No. 103-13 on combating violence against women;
- New Social Protection Law No. 09-21;
- National Strategy to Combat Violence Against Women, 2020–2030.

Key findings

Differences in prioritization and implementation of SRH programmes

Across the three tracer conditions there are varying levels of prioritization and implementation.

Maternal health

Prioritization

Maternal health has received strong political commitment from the Ministry of Health (MoH), along with development partners and national government agencies. As a result, several health strategies and development plans have been established as a national priority. This has strengthened the country's commitment to, and engagement with, the global health strategy on maternal and child health care to achieve the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs).

The prioritization of maternal health was reinforced by its inclusion as a key component in the first National Health Action Plan developed by the MoH, which ran from 2008 to 2012. All relevant departments and key stakeholders (i.e. development partners, other ministerial departments and NGOs) were involved. The plan included the integration of safe delivery, whether vaginal or by caesarean section, to be provided free of charge in public health facilities at all levels. Maternal health was also mainstreamed in the 2012–2016 “National plan of action to accelerate the reduction of maternal and neonatal mortality” to achieve MDGs 4 and 5. The free care package was extended to include childbirth (vaginal or caesarean section), standard medical check-ups, management of obstetric complications (during pregnancy, childbirth and the postpartum period), and newborn health care. The policy allows pregnant women access to free obstetric care, regardless of their socioeconomic status. Maternal health is also included in the National Healthcare Plan 2025 as a national priority, to fight preventable maternal and neonatal mortality. Related activities are implemented by the MoH through a multisectoral approach, with strong involvement from other ministerial departments, civil society and the community.

Programming and implementation

Morocco's commitment to improving maternal health is visible through the implementation of several health interventions. These include: the reinforcement of the “Safe Motherhood” programme in 2000, the “Reproductive and maternal health package” in 2008, the

“National plan of action to accelerate the reduction of maternal and neonatal mortality” in 2008, the “National plan to fight against preventable maternal and neonatal mortality” in 2012, and the National Healthcare Plan 2025, which emphasizes the importance of integrating maternal health within the SRH continuum of care, and UHC policies and strategies.

These commitments have resulted in significant improvement in maternal health outcomes. Between 2011 and 2018, antenatal care coverage increased nationally (from 77.1% to 88.4%), the number of births attended by a skilled provider improved (from 73.6% to 86.6%) and maternal mortality declined (from 112 to 72.6 per 100 000 live births) (4).

Despite this progress, challenges persist. These include disparities in access according to geographic area (i.e. urban versus rural), socioeconomic status and a range of vulnerable situations, such as social exclusion or marginalization. For example, the difference in maternal mortality between urban and rural areas (44.6 versus 111.1 per 100 000 live births) remains large (3). The proportion of deliveries attended by a skilled provider is higher among educated women (99%) than among those lacking access to education (91%) (3). There is also a huge gap between the wealthy and the poor in terms of access to delivery assistance from skilled health personnel (98% and 68%, respectively).

The quality of maternal health care also remains a major challenge in Morocco. For example, the 2015 “Confidential enquiry into maternal death” revealed that haemorrhage (58%), hypertensive disease (26%) and infection (8%) are the main causes of maternal deaths. The study also showed that the majority of these deaths (80.9%) were preventable and linked to challenges in quality of care. Issues included inappropriate treatment (42%), insufficient monitoring systems (39%) and delays in care (32%) (3).

Gender-based violence

Prioritization

To address GBV, Morocco adopted several policies and legal frameworks; for example, by engaging in the international convention recommending “to end impunity for violence against women” (United Nations Resolution 63/155 of 2008). The 2011 National Constitution included a ban on, and a pledge to combat all forms of GBV and discrimination. It also reformed the law criminalizing violence against women that was adopted in 2018. A “National strategy to combat violence against women (2020–2030)” was also launched.

Programming and implementation

Health sector interventions to address GBV include early identification through clinical inquiry, first-line support and response, and treatment and care for survivors of intimate partner violence and sexual assault. Support units for survivors and reception officers in hospitals, police districts and courts were also established, to ensure effective support for victims is provided. In addition to these measures, national, regional and local commissions, as well as hospital units for the care of women victims of violence have been set up. Furthermore, a “National observatory of violence against women” was put in place in 2014. Annual awareness campaigns are also organized, to address issues related to GBV.

In 2008, a multisectoral programme (TAMKINE) was launched to fight GBV. It focuses on the empowerment of women and girls, as well as the eradication of violence against women, by promoting the application of gender-sensitive policies and establishing multisectoral referral systems for women and girls who are victims of violence.

Results from surveys on the prevalence of violence against women, carried out by the High Commission for Planning in 2009 and 2019, show a general downward trend in the prevalence rate of GBV in all forms (physical, sexual, psychological and economical) and contexts (at home, at work, in the streets, etc.), which decreased among women aged 18–64 from 63% in 2009 to 57% in 2019 (4).

While these findings may suggest that GBV has decreased over a sustained period because of political and social action, it is important to note that acts of violence against women are rarely reported. Indeed, only 10.4% of survivors of GBV surveyed stated that they had reported the incident to the police or other competent authority (4). In addition, the integration of health sector interventions to address GBV (i.e. early identification through clinical inquiry, first-line support and response, treatment and care for intimate partner violence and sexual assault) in primary health care facilities remains limited and clinical and psychological care services are available only in hospitals in urban areas.

Prevention of unintended pregnancies and post-abortion care

Prioritization

Abortion is the fourth leading cause of maternal death in Morocco. Results generated from the “Confidential enquiry into maternal death” conducted in 2015 showed that 1.3% of direct obstetric causes of maternal mortality

are related to complications of abortion (2). Induced abortion is illegal in Morocco, as stipulated in Article 449 of the criminal code. However, prevention of unintended pregnancies and post-abortion care services are considered national priorities by the MoH.

Advocacy efforts by civil society have brought the prevention of unintended pregnancies and post-abortion care into public and political debate. In 2015, a national conference on abortion was organized, and a bill (Law No. 10-16) (5) amending the penal code (Article 453) to relax laws on abortion in cases of rape, incest and birth defects was submitted to Parliament.

Programming and implementation

Significant progress has been made in preventing unintended pregnancies and improving post-abortion care services in Morocco. Several activities have been adopted, at country level, to prevent unintended pregnancies, including development of tools to communicate messages about unintended pregnancies and to promote the use of effective modern family planning methods. These tools (including capsules, videos, flyers and posters) are intended for women of childbearing age and their partners. A key message on the flyers is: “To prevent unintended pregnancy and to become pregnant at a convenient and appropriate time for you, a choice of family planning methods is in your hands.” A sexual and reproductive health education guide for health workers was also developed to provide reliable information on SRH, including the prevention of unintended pregnancies. The national family planning programme has also incorporated the emergency contraceptive pill into its range of contraceptives. The emergency contraceptive pill is now available in primary health care facilities and hospital units for the care of women victims of violence.

The government is in the process of developing training guides on post-abortion care, to ensure capacity-building of health workers at primary care facilities. The training guides highlight the quality of care that should be provided to women who are facing spontaneous abortion or complications from induced abortion.

Progress in monitoring and accountability mechanisms for SRH

Monitoring

There has been progress in monitoring the results of health programmes, as well as the allocation of resources. Since 1980, national population-based demographic and health surveys have enabled the MoH to monitor the development of a number of indicators related to fertility, mortality, maternal and child health, and family planning.

Routine data from the national health information system are also important to assess the performance of SRH programmes, through several process and outcome indicators. The MoH has initiated a review of the national health information system to integrate SRH.

The monitoring and evaluation of national health programmes, including maternal health and GBV services, allows for tracking of the progress towards related indicators and targets. In addition, the impact of GBV and progress towards its elimination is also monitored through surveys conducted by the High Commission for Planning.

Accountability

In general, the accountability mechanisms used for health are mainly political (i.e. implemented through Parliament or the media), or financial (through audits and administrative procedures using periodic programme reports and surveys). Morocco is still working on strengthening accountability tools and mechanisms to reach SRH-related SDG targets by 2030. As part of this initiative, and to assess health system performance, in 2018 the MoH established a core set of SRH indicators, including: the proportion of births attended by skilled personnel, utilization of modern contraceptive methods, the number of women victims of violence admitted in hospitals, as well as cancer and HIV-related indicators. This is part of the annual finance framework, and progress is reported and reviewed on an annual basis.

In 2009, Morocco established the Maternal Death Surveillance System, based on the confidential investigation of maternal deaths. The system enabled a better understanding of the causes and circumstances of maternal deaths and provided a basis for action. Commission on Information and Accountability for Women's and Children's Health roadmaps were developed, with WHO support. They agreed on the accountability mechanisms that came as a response to the maternal and child health acceleration plan developed in line with the Dubai Declaration in 2013. To enhance implementation of the national strategy to eliminate maternal and neonatal mortality, consultative committees (task forces) at the district level were established by Ministerial Decision No. 13867 in 2017. This provided an opportunity for various stakeholders to discuss and assess the issues related to maternal and child health programmes.

The second national survey on the prevalence of violence against women indicated that only 28.2% of women who experienced abuse reported it. The majority of the

women who reported GBV live in urban areas. In addition, only 6.6% of victims reported having filed a case (4).

Morocco has made significant efforts in preventing unintended pregnancies and providing post-abortion care services. Further work is needed to secure essential drugs and equipment for post-abortion care at primary and secondary health care facilities. Further promotion of preventive and management measures are needed for people in vulnerable situations who are more inclined to perform induced abortion. Capacity-building of health workers in post-abortion care is also needed to improve quality of services. Finally, political commitment is needed to maintain sufficient budget to ensure that resources – including equipment, infrastructure and relevant commodities – continue to be available.

Referring to the use of information and communication technologies to enhance the monitoring and evaluation of health programmes and improve transparency, pilot projects aiming to establish integrated SRH platforms are still under construction by the MoH and have not yet been taken to scale.

Policy and programme implications

A key strategy is that the government, civil society, private sector and all development partners must join forces through a multisectoral approach to ensure the effective integration of SRH within UHC. Specifically, efforts should be focused on the following.

- Encourage – through NGOs and civil society organizations – the active participation of marginalized and vulnerable groups in decision-making and priority-setting processes, to provide opportunities for them to influence decisions related to SRH and to hold state authorities accountable for the commitments they made.
- Enhance advocacy efforts in favour of SRH, targeting legislators as key stakeholders with roles in legislation, budget allocation and oversight, to hold the government accountable for SRH commitments.
- Undertake analysis of SRH policies to identify issues that decision-makers need to consider when designing and implementing programmes to improve SRH services and to bridge the gap between policies and programme implementation.
- Enact additional UHC legislation to ensure that the right to SRH, including maternal health and post-abortion services and prevention of GBV and unintended pregnancies are guaranteed in law and

in practice, and that related services are included in the HBPs.

- Establish adequate accountability mechanisms to monitor progress towards UHC, including integration of SRH into voluntary national SDG reviews and implementation of rapid assessment tools to identify context-specific GBV, as well as prevention of unintended pregnancies and post-abortion care, and to assess their magnitude and implement appropriate responses to improve them.
- Increase public awareness of the role of SRH, including services related to the prevention of unintended pregnancies and post-abortion care, in improving women's and their partners' health and well-being, for better engagement and social mobilization, to tackle deficiencies in programme design and implementation and to effectively represent the voices of marginalized groups.

References

1. Universal health coverage (UHC). Fact sheet. Geneva: World Health Organization; 2021 ([https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))), accessed 3 January 2022).
2. Bezaïd R, Bouchra A, El Alami El Fellousse A, Ababou M; Analysis of the design and implementation of sexual and reproductive health services within universal health coverage. (Unpublished). Rabat: World Health Organization; 2020.
3. Enquête Nationale sur la Population et la Santé Familiale (ENPSF-2018). Rabat: Ministère de la Santé; 2018.
4. Note sur les violences faites aux femmes et aux filles: L'enquête nationale sur la violence à l'encontre des femmes et des hommes 2019. Rabat: Haut Commissariat au Plan du Maroc; 2019 (<https://mujeres.andaluciasolidaria.org/fr/rapport-violences-faites-femmes-filles/>), accessed 2 January 2022).
5. Kingdom of Morocco House of Representatives. Bill on the organization of medical pregnancy interruption. Rabat: House of Representatives; 2018 (<http://www.chambrederesrepresentants.ma/sites/default/files/loi/085.pdf>), accessed 20 December 2021).

Acknowledgements

The Sexual and Reproductive Health Integration into Health Systems (SHS/WHO) Unit is grateful to the individuals and organizations that have contributed to the development of this evidence brief: Karima Gholbzouri (WHO/EMRO), Hafid Hachri (WHO, Morocco), Abdelylah Lakssir (Partners in Population and Development Africa Regional Office) and the Ministry of Health in Morocco. The development process was coordinated by Georges Danhondo (WHO/SRH) and Veloshnee Govender (WHO/SRH).



World Health Organization



Contact us:

Department of Sexual and Reproductive Health and Research
World Health Organization
Avenue Appia 20, 1211 Geneva 27, Switzerland

Email: reproductivehealth@who.int

www.who.int/reproductivehealth

Universal health coverage for sexual and reproductive health in Morocco: evidence and policy implications. Evidence brief

ISBN 978-92-4-004462-3 (electronic version)

ISBN 978-92-4-004463-0 (print version)

© **World Health Organization 2022**. Some rights reserved.
This work is available under the CC BY-NC-SA 3.0 IGO licence.

