HEALTH-RELATED SDGS IN ARAB COUNTRIES

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EXECUTIVE SUMMARY

This report was commissioned by the Social Research Center (SRC) of the American University in Cairo under the SDG learning platform project. The main objective of this report is to i) monitor the progress of some EMR countries towards health related SDGs and examine the impact of conflict on this progress, ii) use the Morocco case study to illustrate the need for better information system that allows more in depth analysis to better embrace the SDGs health related indicators and help with policy making advice.

The report is composed of two parts. The first part aims to analyse the progress towards achieving health related SDGs in selected 14 Arab countries grouped in four sub-regions, namely oil rich countries, Maghreb countries, countries in conflict which was subdivided into two groups in conflict countries and least developed in conflicts countries (those are countries that have been or currently in conflict). The analysis was based on the SDG health indicators annexed to WHO health statistics reports in the process of monitoring health for the SDGs (2016 and 2020 reports). The levels of the SDG health indicators for the four sub-regions were compared to their levels for the Eastern Mediterranean Region (EMR) levels and to their global levels.

The second part of the report focuses on Morocco as a case study. This part highlights the progress made by Morocco in achieving the health SDGs targets. This part was mainly based on national data sources. In case when national level data were unavailable, WHO estimates were implemented. The results were compared to the national health targets, and the EMR and global levels.

Part I:

The analysis showed the four sub-regions under study have made some progress towards achieving health SDGs. However, the rate of this progress varies widely among the four sub-regions as follows

- Despite the vast differences in financial resources for health between the oil rich countries and the Maghreb countries, these two groups showed similar levels for almost all the health related SDGs indicators. This similarity in the levels was particular observed for life expectancy and health life expectancy, adolescent birth rate, births by skilled personnel, child nutrition, communicable diseases, non-communicable disease and death due to environmental causes.
- For the other health indicators, the analysis showed that the Maghreb countries are on the right track to achieve the SDG targets.
- By contrast, in conflict countries and the least developed in conflicts countries are still facing important challenges to honor the 2030 agenda commitments.
- Despite the observed progress, health equity and SDG #10 “leaving no one behind” in the area of health are by far under-investigated in these subgroups. A recent study carried out by the Social Research Center of the American University in Cairo (SRC/AUC) in collaboration with the UNFPA/ASRO in 2019 on sexual and reproductive health (SRH) equity in some selected Arab countries demonstrated significant inequalities across geographic and social stratifiers (wealth and gendered context).

- The SRC and UNFPA/ASRO report highlighted the different structures of SRH priorities and SRH equity priorities. The report calls for the adoption of the social determinants of health equity framework that traces the inequities to their root structural causes. It concluded with specific recommendations that cut across both the general policy domain and the health sector policy domain.
Results of the current analysis emphasize the importance of more in-depth analysis of health SDGs targets with a particular focus on their inequities among the different social groups to better inform policy development and strategic interventions which can pave the way for the Arab countries to fulfill the 2030 Agenda health commitments.

In addition, the Covid-19 pandemic is threatening the fragile health system and its achievement in all countries. Moreover, the Covid-19 pandemic is disrupting the development trajectory undertaken by the Arab countries since the 2000s due to its negative impact on the economic and social life of the population, hindering therefore the translation of policies and strategies into health SDGs gains. To overcome this negative impact of Covid-19 pandemic and accelerate the cadence to achieve the health SDGs in the Arab countries, economic revival is necessary but not sufficient.

Based on the current analysis, it is strongly recommended that

- The adoption of social determinant of health equity framework to not only address health inequity but their root structural causes.
- Building on the gained experience in the health sector in confronting the pandemic and its adapting strategies with digital health care services to reach the wider population groups. current experience
- The HIS Strengthening is of paramount importance to monitor the progress and evaluate the implemented policies and strategies.

Part II:

Since early 2000s, the Kingdom of Morocco has engaged in several socio-economic and strategic action plans in fulfilling its commitment to achieve the MDGs targets. The adoption of 2030 agenda in 2015 was a real opportunity for Morocco to consolidate the achievements, accelerate the reforms and implement new strategies to achieve the SDGs by 2030.

In this regard, the National Sustainable Development Strategy approved by the Government on June 2018 and the third phase of the National Human Development Initiative launched by the King in 2018 are two examples of the most ambitious strategies which contribute beside other plans and sectoral strategies to accelerate SDGs achievement by 2030.

Five years after the adoption of the 2030 agenda, significant progress has been made in the three dimensions of the sustainable development including health and well-being. In fact, in this case study we report a reduction of maternal, neonatal and under five mortality, an improvement of reproductive, maternal and child health services as well as strengthening prevention and control of NCDs and CDs. Moreover, medical coverage has been extended to more than two thirds of the population as a pathway towards UHC.

Nevertheless, despite these important achievements at national level, available data show that the progress has not benefited equally to territories and populations.

In fact, important disparities are noted between urban and rural areas and regions (ex: MMR in rural areas is 2.5 times its level in urban area) and significant differences are observed according to various socio-economic determinants.

Furthermore, Morocco's health system is facing tremendous challenges requiring important investment in financial and human resources.

Based on the Moroccan case study and taking into consideration the anticipated consequences of the Covid-19 pandemic, we are recommending the following to help Morocco honor its international commitments in terms of health SDGs goal:

- Implement specific strategies to overcome quickly the negative impact of the pandemic on the path to achieving the 2030 agenda;
- Consolidate intersectoral public policies to reduce territorial and social inequalities and support the implementation of health-promoting policies and practices;
- Allocate significant financial resources to the health sector and improve its governance;
- Strengthen the HIS to provide reliable data for monitoring progress and supporting research and evidence-based decision making.

As a final note, the new development model initiative launched in 2020 under the High Royal Directives represents a concrete promise towards SDGs achievement. In fact, this initiative targets a paradigm shift of the socioeconomic development of Morocco in order to benefit to the most vulnerable people and reduce inequities, by implementing new reforms and proving significant impetus to initiated or planned strategies and plans in favor of SDGs achievement.
HEALTH SDGs ACHIEVEMENTS IN SELECTED ARAB COUNTRIES

The Agenda 2030 established in 2015 by the United Nations, integrates all three dimensions of sustainable development (economic, social and environmental) recognizing that eradicating poverty and inequality, creating inclusive economic growth and preserving the planet are inextricably linked. Health is centrally positioned within the 2030 Agenda, with one comprehensive goal (SDG 3) and its 13 targets covering all major health priorities, and links to targets in many of the other goals.

WHO has been monitoring health and health related SDGs and associated targets since 2016 to reflect achievements at global, regional and country level.

The current report was commissioned by the Social Research Center (SRC) of the American University in Cairo under the SDG learning platform project. The main objective of this report is to i) monitor the progress of some Arab countries towards health related SDGs and examine the impact of conflict on this progress, ii) use the Morocco case study to illustrate the need for better information system that allows more in depth analysis to better embrace the SDGs health related indicators and help with policy making advice.

Methodology

Due to the large diversity of the Arab countries with regard to their economic development and political stability and given the limitation of the data, the current analysis is limited to 14 Arab countries classified into four groups according to their economic level and the stability of the country (in conflict or not). The four sub-regions are the Maghreb sub-region, the oil rich countries, and in-conflict countries which in turn were classified into two subgroups, namely in-conflict countries and least developed in conflict countries (these include countries that have been or currently in conflict) (table 1).

<table>
<thead>
<tr>
<th>Sub-regions</th>
<th>Countries</th>
</tr>
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<tbody>
<tr>
<td>Maghreb countries</td>
<td>Morocco, Tunisia, Algeria</td>
</tr>
<tr>
<td>OIL RICH COUNTRIES countries</td>
<td>Kuwait, Saudi Arabia, Qatar, United Arab Emirates, Bahrain, Oman</td>
</tr>
<tr>
<td>Least developed countries in conflict</td>
<td>Sudan Yemen, Somalia</td>
</tr>
<tr>
<td>In conflict countries</td>
<td>Syria, Libya</td>
</tr>
</tbody>
</table>

- The analysis is based on WHO data presented in the annexes to World health statistics reports related to monitoring health for the SDGs for 2016 and 2020. For missing data, ESCWA database has been used
- Sub-region aggregated indicators were calculated as the arithmetic average for each indicator weighted by the size of the countries’ population size.
- Aggregate indicators have been computed without considering countries with missing data. However, when the data is not available for many countries, the indicator was excluded from the analysis.
- When the reference period of data is wide, the middle of the interval has been considered for assessing the progress and interpreting results.
- In the absence of a regional set of health and health related targets, comparisons were made between the levels for the four sub-regions and the levels for the WHO Eastern Mediterranean Region(EMR) and the global level.
Progress assessment in health and health related SDGs in 14 selected Arab countries

Beside the life expectancy that reflect the global performance of the health system, the health and health related SDGs indicators have been aggregated into sub themes as follows:

1. Life expectancy at birth (LEB) and healthy life expectancy at birth (HLEB)
2. Reproductive and maternal health
3. Infant and child health
4. Communicable diseases
5. Non communicable diseases and mental health and environment risk factors
6. Injuries and violence
7. Universal health coverage and Health systems

1. Life expectancy and healthy life expectancy at birth

The life expectancy at birth (LEB) is considered as one of the important indicators which reflects population health status. Based on the 2016 data, both the Maghreb and oil rich countries sub-regions showed almost similar life expectancy at birth (LEB) estimates (77 years for Maghreb sub-region and 76 years for oil rich countries) (Figure 1) with men showing lower LEB than women (75 years for men and 77 years for women) (Figure 2).

Figure 1: Life Expectancy and Healthy life Expectancy at birth-2016

Estimates for the healthy life expectancy at birth (HLEB) also showed losses of 11 and 10 years for ill health for in Maghreb and oil rich countries sub-regions, respectively, producing similar estimate of HLEB for the two sub-regions. The estimates for both LEB and HLEB were higher in these two sub-regions compared to the estimates for EMR and the global level (figure 1).

By contrast, LEB dropped to 66 years and 63 years in countries in conflicts and in least developed-in conflicts countries, respectively (figure 1). These two sub-regions also showed a loss of 8 and 9 years to ill health producing HLEB of 58 and 54 years in in-conflict countries and least develop in conflict counties sub-regions, respectively. These lower LEB and HLEB confirm the well documented impact of conflicts not only on LEB but also on HLEB, especially for men who are directly involved in the armed battles. (figure 1 and 2).

Figure 2: Life expectancy by sexe-2016

2. Reproductive and maternal health

Data in 2017 showed that the Maghreb, the oil rich countries and the in-conflicts countries sub-regions have succeeded in maintaining their low
Maternal Mortality ratio (MMR)\(^1\) (indicator 3.1.1) or improving it to reach the expected target at global level (< 70 per 100,000 live births). By contrast, the MMR in the least developed in conflicts countries exceed by far the target (>200 per 100,000 live births). With these MMR levels, the three sub-regions of oil rich countries, Maghreb and in conflict countries are performing better than the level in EMR and the global level. The only exception is the least developed in conflicts countries sub-region (figure 3 and table 2) that exceed these two levels, despite the fact that there was significant improvements in their births attended by skilled health personnel between 2010 and 2015.

Figure 3: Maternal Mortality ratio

Table 2 shows improved levels of proportion of births attended by skilled birth personnel in the three sub-regions of oil rich countries, Maghreb and in conflict countries that exceed the proportions in EMR and the global level. But, the least developed in conflict countries lagged behind with only 55% of their births were attended by skilled health personnel.

Universal access for family planning assessed in terms of the proportion of women of reproductive age who have their need for family planning satisfied with modern methods (indicator 3.7.1) is still not achieved since the partial available data shows a significant threatening decline in the Maghreb countries sub-region.

Table 2: Proportion of births attended by skilled health personnel (%)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Maghreb countries</td>
<td>93</td>
<td>85</td>
</tr>
<tr>
<td>Oil rich countries</td>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>Least developed</td>
<td>55</td>
<td>26</td>
</tr>
<tr>
<td>countries in conflict</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In conflict countries</td>
<td></td>
<td>97</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td>69</td>
</tr>
<tr>
<td>EMR</td>
<td>79</td>
<td>67</td>
</tr>
<tr>
<td>Global</td>
<td>81</td>
<td>73</td>
</tr>
</tbody>
</table>

For the adolescent birth rate (per 1000 women aged 15-19 years) (indicator 3.7.2), the Maghreb and oil rich countries sub-regions have made significant progress in reducing fertility among very young adolescents (12.7 and 13.6 per 1000 respectively) with their levels are far below the EMR and global levels. This progress needs to be sustained and consolidated. The least developed in conflicts and in conflicts countries are struggling to lower their levels (76.2 and 41.8 per 1000 respectively) (Figure 4).

Figure 4: Adolescent birth rate (per 1000 women aged 15-19 years)-2010-2018

3. Infants and child health

The 2018 data shows that the oil rich countries sub-region has achieved the under-five mortality rate (U5MR) and neonatal mortality rate (NNMR) targets (8 and 4 per 1000 live birth, respectively), and the Maghreb sub-region is on the right track to do so (22 per 1000 L.B, and 14 per 1000 live birth respectively). However, the

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\(^1\) The slight increase of the MMR in 3 countries out of the six oil rich countries needs to be confirmed with national data.
conflict is dangerously jeopardizing the achievement of these targets in Libya and Syria (for Syria: U5MR +32% and NNMR +29% between 2015 and 2018). Furthermore, the least developed in conflicts countries are still far from these targets (Figures 5 and 6).

Figure 5: Under five mortality (per 1000 live birth)

Figure 6: Neonatal mortality (per 1000 live birth)

For children malnutrition, both the oil rich countries and the Maghreb sub-region have succeeded in achieving the child malnutrition targets (2.2) with slight improvement for the two indicators (2.2.1 and 2.2.2) between 2010 and 2015. For the other two sub-regions, child malnutrition targets are jeopardized by conflicts with a clear rise or a stagnation in the in conflicts countries and the least developed in conflicts countries that calls for additional and intense efforts to achieve the targeted levels for these indicators (figures 7, 8 and 9).

4. Communicable diseases

Between 2014 and 2018, the four sub-regions have achieved some progress with regard to HIV incidence (indicator 3.3.1: between 0.03 and 0.08 per 1000 uninfected population), tuberculosis (TB) incidence (indicator 3.3.2: between 10 and 97 per 100000 population) and hepatitis B prevalence (indicator 3.3.4: 0.3-4.1% among children <5 years) calling for sustained efforts to achieve the target especially for least developed in conflicts countries (HIV, TB, and
hepatitis) and Maghreb sub-region (TB). While three of the four sub-regions reported a lower HIV incidence compared to the EMR and the Global level, the least developed in conflict countries reported higher tuberculosis and hepatitis B prevalence compared to the EMR and the Global level (figures 10, 11 and 12).

**5. Non communicable diseases, mental health and environment risk factors**

Although the Maghreb sub-region has achieved a significant progress in reducing the premature mortality due to NCDs (3.4.1) by 36.86% between 2012 and 2016, it is not the case for the other three sub-regions, including the oil rich countries that experienced a stagnation or a significant rise in this indicator threatening the target achievement by 2030 (figure 13).

During the same period, while the significant rise of the suicide mortality rate (indicator 3.4.2) in in-conflicts countries is understandable, such a rise from 1.3 to 3.4 per 100000 in the oil rich countries worth exploring (figure 14).

Moreover, the alcohol consumption per capita (indicator 3.5.2) in the four sub-regions remains the lowest in the world with almost no changes
between 2012 and 2016. The average consumption in the 14 countries is very low with less than 1 litter per capita among population over 15 years (figure 15).

Figure 15: Total alcohol per capita (≥ 15 years of age) consumption (liters of pure alcohol)

With regards to environmental risk factors, air pollution is a real challenge in the four sub-regions since a significant rise was observed between 2012 and 2016 in the mortality rate attributed to household and ambient air pollution (indicator 3.9.1). In 2018, the lowest rate is observed in the Maghreb sub-region with 50 deaths per 100 000, while the highest level is recorded in least developed in conflicts countries with 193 deaths per 100 000. It is also noted that the average of mortality rate attributed to air pollution in the 14 countries remains lower than the EMR and the global levels (figure 16).

Figure 16: age-standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)

Despite the significant decline in mortality due to unsafe water, unsafe sanitation and lack of hygiene (WASH) (indicator 3.6.2) and unintended poisoning (indicator 3.9.3) in least developed in conflicts countries between 2012 and 2016, the challenge remains significantly large compared to the EMR and the global level to achieve the SDGs targets (figures 17 and 18).

Figure 17: Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)

Figure 18: Mortality rate from unintentional poisoning (per 100 000 population)

6. Injuries and violence

With regards to violence and injuries, the available data in the four sub-regions show a decline between 2013 and 2016 in road traffic deaths (indicator 3.6.1) in the Maghreb sub-region and in the in conflicts countries. For the in conflict sub-region, this decline is probably due to the important reduction of the traffic in these countries. The rise of the road traffic deaths in the oil rich countries and the least developed in conflicts countries is noticeable during the same period highlighting the remaining challenge to achieve the target related to halve, by 2020, the number of global deaths and injuries from road traffic accidents. The average in the 14 countries has not changed between 2013 and 2016 (24 deaths per 100 000 population).
population) and remains higher compared to EMR (18 per 100 000) and global (18 per 100 000) levels (figure 19).

**Figure 19: Road traffic mortality rate (per 100 000 population)**

Between 2012 and 2017, the mortality rate due to homicide has declined significantly in the three of the four sub-regions. The exception to this trend was observed in the least developed in conflicts countries. While the average in the 4 sub-regions (3.6 per 100000 populations) is lower than the EMR and the global level (5.1 and 6.3 respectively) (figure 20), only the oil rich countries sub-region has managed to achieve the target.

**Figure 20: Mortality rate due to homicide (per 100 000 population)**

On the other hand, important efforts are still needed to improve immunization coverage and achieve the target 3.b particularly in least developed in conflicts countries and in conflicts countries. In fact, compared to the average of the 14 countries and the EMR and global levels, the gap in DTCP (3) coverage in these two sub-regions remains large. It reflects the real challenges these sub-regions are facing to achieve universal coverage (Figure 24).

7. **Universal health coverage (UHC) and Health systems**

Although the Maghreb sub-region and the oil rich countries show the same level of progress in their UHC index (indicator 3.8.1) (UHC index 74 in 2017) and International Health Regulation (IHR) core capacity score (indicator 3.d) target achievements (77 and 81 respectively in 2019) (figures 21 and 22), the four sub-regions are facing real challenges to achieve required skilled health professional density (44,5 per 10 000) (indicator 3.c.5) needed to achieve the health targets of the Sustainable Development Goals (figure 23).
8. Health equity challenges in the selected Arab countries

Despite the significant progress towards health SDGs targets reported above for the Maghreb and oil-rich countries sub-regions, and the fragile improvements in least developed in conflict countries and in conflicts countries sub-regions, there is a serious concern when it comes to the equal distribution of these health gains according to the geographic place of residence and socioeconomic status of the population.

Based on a recent report “Reproductive health equity in the Arab world: fairness and social success, 2019”, carried out by the SRC in collaboration with the UNFPA/ASRO, a in depth analysis of the sexual and reproductive health inequities distribution in selected countries is provided to illustrate the health equity challenges which needs to be addressed urgently to help achieve the health SDGs targets.

Using the two traditional stratifiers of geographic region and wealth and the newly developed gendered context stratifier, the findings show that for some countries (Egypt Morocco), geographic area inequality is more severe than wealth and gender inequality. In other countries, the wealth stratifier is the one portraying higher inequality (Jordan).

The report calls for the adoption of the social determinants of health equity framework that traces the inequities to their root structural causes. It concluded with specific recommendations that cut across both the general policy domain and the health sector policy domain.

9. Concluding remarks and recommendations

The Covid-19 pandemic is threatening the fragile health system and its achievement in all countries. Similar to countries around the world, the Covid-19 pandemic is disrupting the development trajectory undertaken by the Arab countries since the 2000s due to its negative impact on the economic and social life of the population, hindering therefore the translation of policies and strategies into health SDGs gains.

To overcome this negative impact of Covid-19 pandemic and accelerate the cadence to achieve the health SDGs in the Arab countries, economic revival is necessary but not sufficient.

The current report joins forces with the SRC and UNFPA/ASRO equity study and suggests the following recommendations:

- The Arab countries are encouraged to consolidate and maintain their current efforts and progress towards achieving health related SDGs.
- Particular attention should be directed to countries in conflict and in particular those classified as least developing countries as they struggle in achieving
their targets and require substantial support whether within these countries or from the international development partners.

- More attention should be directed on health inequality, particularly, given the high level of inequality across social groups and the fact that the priority health inequality challenges are different from priority health challenges.
- Monitoring the trend of inequalities is a key requirement in order to assess the effect of the interventions and policies on tackling these inequalities.
- The different countries in the Arab world need to identify the appropriate and relevant social stratification to its context.
- The commitment to addressing SRH inequality needs to be demonstrated through an information system capable of systematically and periodically measuring, monitoring and tracing and relating inequality to their structural root causes and to the fairness of these causes. Such monitoring can also support the assessment of progress in the adopted efforts.
- Assessing and monitoring SRH inequalities calls for well qualified institutions and individuals who are capable to analyze data and information and can draw evidence-based policy recommendations. This calls for institutions and individual capacity building in the area of SRH inequalities, in particular, the concepts of inequality and inequity, their conceptualization and frameworks, the their measurement approaches and the translation of the findings in proper policy implications.
- The health sector needs to adopt a fairness lens in its provision of services and in its evaluation of performance. The health system should be able to respond to differentiated needs within the society.
- To tackle the root causes of health inequities, the health sector needs to assume the stewardship role in relationship to other actors to be able to tackle health inequities. This role is directed to other social actors. WHO speaks to three dimensions of this role, namely advocacy, partnership, and leadership.
  - The advocacy dimension assigns the health sector the responsibility to provide and disseminate evidence to support integrating an equity lens in social policies known to impact health.
  - The partnership dimension requires the health sector to engage with the other social partners and other actors in society in supporting the needed equitable integrated and intersectoral policies and actions for health.
  - The leadership dimension is demonstrated in the role of health sector in supporting good governance and a whole government approach to SRH equity.
MOROCCO CASE STUDY

Since early 2000s, the Kingdom of Morocco has engaged in several socio-economic and strategic action plans in fulfilling its commitment to achieve the MDGs targets. The adoption of 2030 agenda in 2015 was a real opportunity for Morocco to consolidate the achievements, accelerate the reforms and implement new strategies to achieve the SDGs by 2030.

In this regard, the National Sustainable Development Strategy approved by the Government on June 2018 and the third phase of the National Human Development Initiative launched by the King in 2018 are two examples of the most ambitious strategies which contribute beside other plans and sectoral strategies to accelerate SDGs achievement by 2030.

Five years after the adoption of the 2030 agenda, significant progress has been made in the three dimensions of the sustainable development including health and well-being.

Morocco case study aims to monitor the progress made by the Kingdom of Morocco in achieving the SDGs related to health. The analysis is carried out using the indicators of the global SDG monitoring framework. In this regard, comparisons will be made with national targets when they exist, and with EMR and global level, using WHO data. For this purpose, the most recent national data sources are used, particularly national surveys conducted by the Ministry of Health (MoH) of Morocco during the period 2004-2018. However, when data is missing, WHO estimates are used.

1. Life expectancy and Healthy life expectancy at birth

A significant progress was made in improving population health in Morocco. In the 1960s, LEB was around 47 years, while today it is around 76 years; 77 years for women and 75 for men. In comparison with the EMR and the global level, Morocco seems to be performing well.

\[\text{Figure 25: Life Expectancy at Birth, 2016}\]

\[\text{Figure 26: Healthy Life Expectancy at Birth (HLEB), 2016}\]

Despite the increase in LEB, Moroccans live many years with disability. Women have a longer life expectancy than men, but they live also longer with disability. In fact, women expect to live 65.5 healthy years and 11.5 years with disability, while men, expect to live 9.8 unhealthy years.

2. Reproductive, maternal and child health

Reproductive and maternal health

In the last 15 years, Morocco has made significant progress in reducing maternal mortality due mainly to the implementation of successive action plans to improve maternal health. Indeed, the maternal mortality ratio (Indicator 3.1.1) has decreased from 227 in 2004

https://www.sante.gov.ma/Publications/Etudes_enquete/Pages/default.aspx
to 72.6 deaths per 100 000 LB in 2018. In its strategic plan for 2025, MoH has set as a target to achieve MMR of 48 per 100000 live birth in 2025 and of 36 per 100000 live birth in 2030.

Figure 27: Maternal Mortality Ratio, 2004-2018

It is worth noting that this decline in maternal mortality is closely associated to the implementation in 2011 of the free of charge usage of maternal health services, including delivery in public hospitals. Indeed, the proportion of births attended by skilled health personnel (indicator 3.1.2) has increased significantly from 73.6% in 2011 to 86.6% in 2018.

However, this important progress was not equal to all population groups and territories. In fact, MMR in rural area is almost 2.5 times its level in urban area and the proportion of births attended by skilled health professional varies from 68.4% for the first wealth quintile to 97.8% for the fifth wealth quintile. Such disparities call for the implementation of more equitable and efficient intersectoral public policies that tackle these inequities and close the gaps among the different social groups.

Figure 28: Proportion of births attended by skilled health personnel (%) Besides, the birth rate among adolescent girls (15 to 19 years) (Indicator3.7.2) has also decreased significantly from 32 births per 1,000 adolescent girls in 2011 to 19.4 in 2018. This progress could be attributed to the new family code implementation stating the marriage age over 16 years.

Figure 29: Adolescent birth rate (per 1000 women aged 15–19 years)

Child health

Child health has always been one of the highest priorities for the Moroccan Government. During the last ten years, an important progress has been made to improve the survival of children under five years. The under five mortality (U5M) (Indicator 3.2.1) has declined significantly from 47 in 2004 to 22.2 per 1000 live birth in 2018 foreseeing the 2030 national target achievement (12 per 1000 live birth).

Figure 30: Under five mortality

As for neonatal mortality (Indicator 3.2.2), it has fallen over the same period from 21.7 to 13.6 deaths per 1,000 live birth. Disparities are noted between urban and rural area (11.2 and 16.3 per 1000 per live birth respectively). This difference
highlights significant challenges that call for the appropriate strategies and intervention.

Figure 31: Neonatal mortality

On the other hand, Morocco has made international commitment in order to combat malnutrition in all its forms. This commitment has resulted in the development and implementation of several programs, strategies and interventions in the field of nutrition over the past decades. These programs have contributed to improving the nutritional and health status of the population. These include the national strategy of nutrition (2011-2019).

Although the nutritional situation of children under five has been improved in recent years, Morocco is still facing significant challenges to achieve the national targets by 2030. The main challenges call for the reduction of stunting prevalence among children (indicator 2.2.1) from 15.1% in 2018 to 9% in 2030 and maintaining the current levels of wasting and overweight (indicator 2.2.2) (<5% and <11% respectively).

Figure 32: Prevalence of malnutrition in children under five

3. Communicable diseases

In order to address communicable disease burden, Morocco has implemented several strategies in particular for HIV-AIDS and tuberculosis.

In terms of HIV, the latest estimates show that in 2019, the number of new HIV infections remains low in the general population, at the rate of 0.03 per 1,000 uninfected populations (indicator 3.3.1). This level is lower compared to the global (0.24) and EMR levels (0.07).

For tuberculosis, the annual incidence (Indicator 3.3.2) has also decreased from 106 in 2014 to 99 per 100,000 populations in 2018. The Tuberculosis national strategic plan (2018-2021) has been implemented to reduce the related deaths by 40% by 2021.

Figure 34: Tuberculosis incidence (per 100,000 population)

According to WHO estimates, the prevalence of Hepatitis B among children under 5 years (indicator 3.3.4) in 2015 is around 0.45%, while
it is 0.8% and 0.69% at the global level and in EMR, respectively.

**Figure 35: Hepatitis B surface antigen prevalence among children under 5 years (%) - 2015**

![Graph showing hepatitis B surface antigen prevalence among children under 5 years in Morocco, EMR, and Global in 2015.]

4. Non communicable diseases, mental health and environment risk factors

Non-communicable diseases (NCDs) are the main cause of death in almost all countries worldwide. Morocco is currently experiencing an epidemiological transition characterized by the increase of the burden of NCDs, particularly, cancers, diabetes, cardiovascular diseases and chronic respiratory diseases. The probability of dying from these four NCDs between age of 30 and 70 (indicator 3.4.1) reached in 2016, 12.4% which remains relatively low in comparison with the EMR level and global level.

**Figure 36: Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70 (%)**

![Graph showing probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and 70 in Morocco, EMR, and Global in 2015 and 2018.]

In order to control NCDs, it is necessary to control risk factors. In this regard, Morocco signed in 2004 the “Framework Convention on Tobacco Control” adopted by WHO in 2003.

According to the results of the national survey on population and family health-2018, 11.3% of population aged 15 years and over is smoking tobacco (indicator 3.a.1), with higher prevalence among men (21.9%). Moroccan authorities expect a reduction in tobacco consumption among this population by 20% by 2029.

**Figure 37: Prevalence of tobacco use among persons 15 years and older-2018 (%)**

![Graph showing prevalence of tobacco use among persons 15 years and older in Morocco, EMR, and Global in 2018.]

For alcohol consumption, the recent estimates of WHO show that each Moroccan aged over 15 years old consumes annually 0.7 litter of pure alcohol (indicator 3.5.2), far lower than alcohol consumption at global level (9 times higher). The target by 2030 is to reduce consumption to achieve 0.4 litter per person.

**Figure 38: Total alcohol per capita (≥ 15 years of age) consumption (liters of pure alcohol)**

![Graph showing total alcohol per capita consumption in Morocco, EMR, and Global in 2015 and 2018.]

Regarding the mortality by suicide, the estimates of WHO indicate that suicide mortality rate (indicator 3.4.2) in Morocco has decreased from 5 to 2.9 per 100 000 populations between 2012 and 2016 which means a decrease of 42% during the same period.
Regarding the mortality attributed to air pollution, the recent data shows an increase between 2012 and 2016 of the mortality rate attributed to household and ambient air pollution (indicator 3.9.1). The rate has increased from 28.8 to 49.1 per 100,000 populations calling for urgent focus and efforts to reduce the air pollution in Morocco.

Concerning mortality attributed to unsafe water, unsafe sanitation and lack of hygiene (WASH), significant progress is noted through the reduction in its mortality rate (indicator 3.9.2). It declined between 2012 and 2016 from 3.4 to 1.9 per 100,000 populations. A significant low level compared to the mortality rate on the EMR level (10.6) or the global level (11.7).

Also, the mortality rate attributed to unintentional poisoning has dropped between 2012 and 2016 to reach 0.6 per 100,000 populations (indicator 3.9.3).

This section focuses on road traffic injuries (indicator 3.6.1) and violence including homicide (16.1.1). Prevention of road traffic accidents is a real challenge in Morocco and significant efforts have been made to this end. Thus, the mortality rate from accidents on public roads populations went from 11 deaths in 2016 to 9.37 deaths per 100,000 in 2019. However, additional efforts are required to meet the target by 2030 (5.5 deaths per 100,000).
Besides, the mortality rate due to homicide has also decreased between 2012 and 2017 to reach 2.1 per 100,000 populations. This rate remains the significantly lower than EMR level or the global level.

6. Universal health coverage and Health system

Achieving UHC is highly dependent on strengthening the health system and improving its capacities.

This section focuses on the progress made on the targets relating to UHC (3.8) and health system (3.b, 3.c and 3.d).

Since the adoption in 2002 of the law on Basic Medical Coverage and the implementation in 2005 of the compulsory health insurance for employees in public and private sectors and the medical assistance scheme for poor people since 2012, in 2019, the medical coverage rate has reached 68.8% of the Moroccan population. The coverage was extended to students (private and public schools and institutes) through the establishment of compulsory health insurance.

Besides, service coverage index (indicator 3.8.1) has increased between 2015 and 2017 to reach 70%, while it is only 57% in EMR and 66% at global level.

On the other hand, progressing towards UHC means ensuring more financial protection to the population. This indicator is measured by the proportion of population with large household expenditures on health as a share of total household expenditure or income. In 2014, 13.4% of Moroccans have spent at least 10% of their household budget paying out of their own pocket for health services. Compared to the estimates of WHO, this proportion seems to be higher than EMR level and global level. Considering 25% as a threshold, this proportion drops to 2% compared to 2.9% at the global level.

Thus, extending health insurance to self-employed people (30% of population) should improve access to quality essential health services and ensure financial protection as an important step towards achieving UHC.

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3The recent available data for Morocco is for 2014 through the National Survey on household consumption and expenditures, HCP, 2014.
Regarding access to vaccines, Morocco is one of the pioneer countries which are committed to ensuring maximum protection for all children against the risks of morbidity and handicap related to infectious diseases.

Through the National Immunization Program, Morocco has been able to maintain very high vaccination coverage rates. Thus, the DTP3 immunization coverage among children of 1-year-old has stabilized at 99% between 2015 and 2018.

Moreover, achieving health related SDGs and UHC can only be done through investment in health professionals by increasing their density and strengthening their skills.

In Morocco, health sector suffers from acute shortage in human resources. In fact, the density of health professionals (physicians, nurses and midwives) remained stable during the last 7 years. It is around 16 health professionals per 10 000 populations while the required density to reach health SDGs is about 44.5. To achieve this target, Morocco needs more than 100 000 health professionals distributed fairly between regions. This calls for expanding health workers and implementing urgent interventions to strengthen training capacities.

Under the International Health Regulations (IHR) (2005), all States are required to have or to develop minimum core public health capacities for surveillance, response and reporting of an event that may constitute a public health emergency of international concern. In this regard, Morocco is making great efforts to enhance IHR core capacities. According to the recent assessment, the average of 13 IHR core capacity score is 75 while it doesn’t exceed 63 at the global level.
In addition to the previous recommendation for the Arab countries in the first section, we recommend the following: Implement specific strategies to overcome quickly the negative impact of the pandemic on the path to achieving the 2030 agenda;

- Consolidate intersectoral public policies to reduce territorial and social inequalities and support the implementation of health-promoting policies and practices;
- Allocate significant financial resources to the health sector and improve its governance;
- Strengthen the HIS to provide reliable data for monitoring progress and supporting research and evidence-based decision making.