WEBINAR 1 · HEALTH WORKS FOR ALL, DECISIONS WITH ALL · 2 NOVEMBER 2026

# From the right to coverage to effective access

UHC and Morocco’s National Health Compact through a civil society lens: what they must deliver for HIV, TB and malaria

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# Morocco is not starting from scratch

The Compact builds on reforms already funded. The remaining gap is who has a seat at the table.

### 2010

**WHO certifies Morocco malaria-free**

No local transmission

### 2021

**Framework Law 09-21 on social protection**

Universal AMO becomes a legal obligation

### 2022

**Framework Law 06-22 on the health system**

GST, HAS. Primary care as the entry point

### Dec. 2025

**National Health Compact launched in Tokyo**

Among 15 countries in the first wave

### 2026

**Health budget: MAD 42.3bn**

8.7% of the state budget. Investment up 61%

**88%**

of the population covered by AMO (2024). Target: 100% by 2030

**82bn**

MAD in total health spending: 6.1% of GDP, growing 7.6% a year

**69%**

UHC service coverage index (SDG 3.8.1, WHO, 2021)

Sources: WHO (certification). Framework Laws 09-21 and 06-22. World Bank, Morocco National Health Compact, Tokyo, 6 Dec. 2025. Draft Finance Law 2026

# What the Compact actually commits to

A government-led five-year agreement: clear on money and coverage, silent on disease programmes.

PILLAR I

## Financial protection

22M more people. AMO coverage from 88% to 100%. Out-of-pocket share from 38% to 25% by 2030

PILLAR II

## Infrastructure

100% of primary care facilities meet standards (63% today). 1,600 facilities and 91 hospitals in 2026

PILLAR III

## Health workforce

8,000 posts in 2026. 7.9 doctors per 10,000 people (WHO threshold: 44.5)

PILLAR IV

## Private sector

PPPs and contracting frameworks. Private providers integrated into the digital system

**Key wording:** civil society appears **only once**, in a list of “partners” invited to support Morocco, alongside donors, foundations and the private sector. It is not listed among implementing partners.

Source: World Bank, Morocco National Health Compact (2025), pillars, targets and partner annex

# Coverage does not guarantee protection

**31.85M**

enrolled in health insurance: 86.5% of the population

**8.54M**

still without effective access: 23.2% of the population

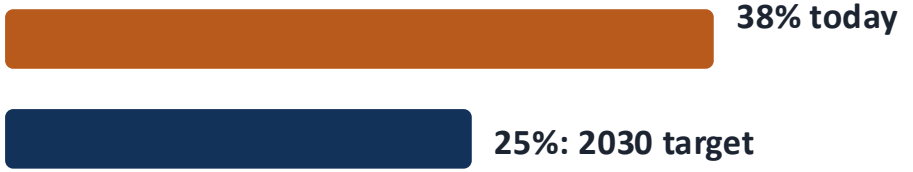
**3.57M**

enrolled but with inactive entitlements, mainly self-employed workers

**60%** of uninsured people and **36%** of insured people report foregoing care for financial reasons.

CESE opinion on extending AMO, 31 October 2024

## Out-of-pocket share of health spending




Medicines account for 33% of AMO spending. Prices are 3–4 times those in France or Belgium (sample of 321 medicines)

Sources: CESE, Opinion on Extending AMO (Oct. 2024). MSPS, National Health Accounts 2022 (via P4H). National Health Compact (2025)

WHO WAS CONSULTED?

# We were not in the room

And we are asking for a seat.

## What the Compact records

- Governance: interministerial steering committee (Health, Finance, Interior) and technical committee (CNSS, HAS)
- Named partners: World Bank, JICA, AFD, EU, AfDB, IsDB, WHO, UNICEF, UNFPA. **No CSO named**
- No consultation mechanism, list, timetable or feedback loop. We document an absence, without accusation

## What institutions say

- CESE (Oct. 2024) finds a lack of dialogue and limited or absent information and consultation on AMO
- It recommends an AMO High Council, more representative boards and regular national forums
- The Center for Global Development describes the first wave of Compacts as largely “one-sided”

Sources: Morocco National Health Compact (2025). CESE, AMO Opinion (2024), recommendations 24, 27, 28. CGD, “One-Sided Compacts” (Dec. 2025)

# HIV, TB and malaria: three areas of risk

| | MOROCCO'S CURRENT POSITION | WHAT THE COMPACT SAYS | CIVIL SOCIETY NEEDS |
|---|---|---|---|
| **HIV** | ≈21,500 people living with HIV, ~800 infections/year. 95% on ART and virally suppressed. Testing still lags | **Never mentioned.** Implicitly covered by the insurance pillar | Community testing and peer navigation, funded through the benefits package |
| **TB** | Incidence: 98/100,000 (2024). ~29,300 notified cases: a detection gap | **Never mentioned.** | Testing, adherence support and action on stigma: a plan and a budget line |
| **Malaria** | Eliminated in 2010. Risks: imported cases and climate-sensitive vectors | Mentioned once as a climate-related threat, alongside dengue | Cross-border surveillance: a public good monitored by communities |

A **disease-blind Compact** is defensible if these programmes are deliberately integrated into primary care, rather than disappearing as external funding ends.

Sources: MSPS, National AIDS Report 2023. MSPS/UNAIDS (cascade). WHO, Global TB Report 2025 and malaria certification. Compact (2025)

# The transition has a date

**31 Dec. 2026**

end of the current Global Fund grant implemented by MSPS

**US$14.07M**

Global Fund allocation for 2026–2028, HIV and TB in transition (GC8)

**US$2bn**

in aligned financing (World Bank, Gavi, Global Fund), using Compacts as the vehicle

## What must be sustained

- Community testing, outreach and peer navigation for key populations
- Social contracting: the state purchases services from associations instead of annual grants
- Community-led monitoring, with a requirement for a documented response

## Where the levers are

- **MSPS:** leads the Compact, defines the benefits package and contracting rules
- **Economy and Finance:** finances the transition and co-leads the steering committee
- **World Bank and UHC Knowledge Hub:** where the rules for the next wave are being shaped

Sources: Global Fund, Data Explorer (MAR-C-MOH grant, 2024–2026) and Transition Timelines (April 2026). World Bank, 6 Dec. 2025

# Five asks for the next wave

Specific, low-cost and achievable before the Tokyo UHC High-Level Forum on 12 December 2026.

1 **Publish the participation record**
Who was consulted, on which version, at what stage, and what changed as a result

2 **A civil society seat in Compact governance**
A named representative, transparently selected and funded, with published feedback (WHA77.2)

3 **Publish a map of resources**
Domestic and external, including off-budget and Global Fund resources, with gaps identified

4 **Include social contracting in the reform**
A legal and budgetary route for public purchasing of community HIV, TB and malaria services

5 **Institutionalise responses to community-led monitoring**
A named recipient, a deadline and published corrective action for every finding

# UHC means effective access for those most excluded, beyond insurance enrolment rates.

Health works for all, decisions with all: nothing about us without us.

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Thank you