Precariousness and health management in Morocco

Meriyem ADDAD, doctoral student at the University USMBA de Fès.
Mkik Marouane, doctoral student at the university Mohammed V Rabat
El Menzhi Kaoutar, professor at the University Mohammed V Rabat

ABSTRACT:

Society is a multi-faceted treatment system, involving dynamic social interactions between individuals, providers and the health care system. It is, of course, a comprehensive social phenomenon. Therefore, the social context of wellness must be taken into account.

We will focus on social precarity and well-being in this paper because we believe, based on several studies, that it has varied effects on the community. We will begin by identifying the fundamental principles and the links between them, then look at the social dimension of health in Morocco, then show examples of urban/rural inequalities, and finally discuss the initiatives of the Ministry of Public Health to promote health.

Keywords: ***social precariousness; health; society, health, stability***

INTRODUCTION

People who live in unstable circumstances, or situations that contribute to precariousness, people who are "not yet precarious but likely to become so", are of particular concern to us today. This is why we have decided to go a little deeper into the definition of precariousness.

But, since we are interested in precarious populations from a wellness perspective, we must recognize where health and precariousness converge. After that, we will outline and describe some concrete examples, and then we will describe the 2020 vision of the Ministry of Health in this context.

I- 1. Definitions:

A-poverty/health/social deprivation:

Precariousness:

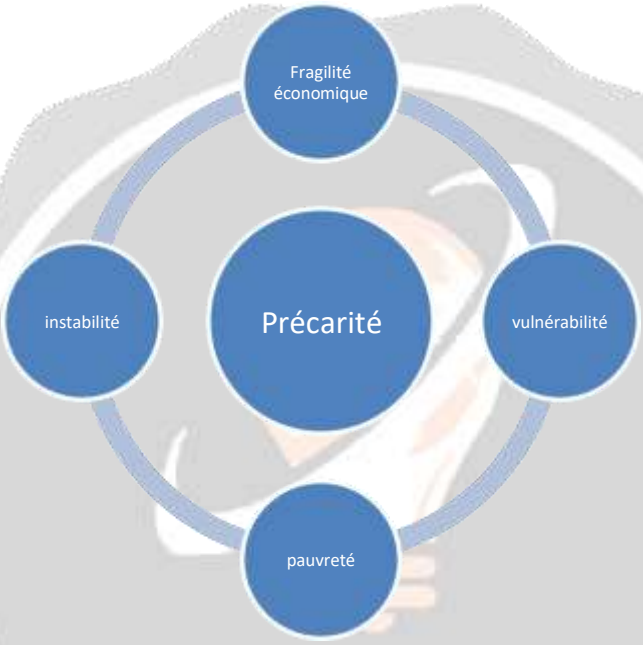
Insecurity can be defined as "*the absence of one or more types of protection, including job security, that enable individuals and families to fulfill their professional, family and social obligations while exercising their fundamental rights. The resulting insecurity can be severe or minor, with varying degrees of severity and permanence. It contributes to extreme insecurity when it affects several aspects of life, when it persists, and when it jeopardizes the hopes of resuming one's duties and recovering one's privileges on one's own."*

Etymology

The term precarious, derived from the Latin precarius, has several meanings: it has been used as an adjective, as a verb, in ordinary vocabulary and in law; in the latter case, it has also been used in the feminine form:

Precariousness in the modern sense applies to something of which we know neither the future, nor the duration, nor the solidity, to what is insecure and uncertain, to what is brief, transient or fleeting, and also to what is delicate and fragile.

Fiigure1: synonyms and similarities of the word precariousness:



Source : author

Social precariousness:

From a prognostic point of view, societal precarity is a state of risk of social disintegration at every moment; an aggregation of social and medical threats -Health:

Health:

The WHO defines this concept as follows: "Health is more than the absence of disease or infirmity; it is a condition of full physical, emotional and social well-being. [2]"

[2] This **definition** is enshrined in the 1946 preamble to the World **Health** Organization (WHO) Constitution. This WHO **definition has not been** modified since 1946.

oeconomics, New York : W.W.Norton

B- link between health and precariousness :

Today, it is widely accepted that the degree of socio-economic growth of a country and the health of its population are inextricably linked. Individuals are both actors and beneficiaries, as health is an important component of growth. This interactive relationship can be explained as follows:

On the one hand, any economic and social change would have a beneficial effect on the well- being of the population in the long run.

On the other hand, any human energy provided by better health would inevitably lead to economic and social growth.

II- social dimension of health in Morocco: a- basic data :

• Health actions in favor of the abolition of precariousness :

The Ministry of Health takes measures to eliminate precariousness, provide for the needs of people in medical or social situations, etc.

- Community-based health promotion and disease prevention strategies and actions to address socioeconomic determinants of health and health inequities.

- Moroccan culture is known for its widespread suffering and strong marginalization of women.

- The Department of Public Health conducts numerous surveys, including the WFS, DHS, PAPCHILD, and PAPFAM surveys, which are conducted in cooperation with one or more foreign agencies (Department of Health, 1984, 1993, 1997, 2005).

- It reflects on topics with social or socio-economic connotations, such as poverty, living conditions, housing, consumption, employment and the status of women, many of which have been targeted by the Statistics Directorate's field operations.

b-Social inequalities/health inequalities: b.1-social inequalities:
Two conditions must be met to be able to speak of socio-economic inequalities:

The first is that the element must be recognized as valuable in society: successful care/ineffective care for non-scientific or technical reasons; life/death, health/illness, injury, physical and psychological suffering; effective care/ineffective care for non-scientific or technical reasons.

The second is that this socially valued object is about the dominant/dominated hierarchical social classes. The other systemic social disparities that distinguish a nation at any given time in its existence and economic growth are simply the consequence, the end product of social inequalities in health.

Health inequalities are due to causes outside the health sector, such as the work environment and individual behaviors. Therefore, they are primarily the result of social decisions about employment and housing, as well as education and taxes.

b.2-Health inequalities:

These are the inequitable and preventable etiologies of health problems with which people are not on an equal footing within or between nations. These health inequalities represent the differences that occur within a country and between communities in general. The socioeconomic circumstances of individuals determine their chances of getting sick and the steps they must take to avoid or cure disease if it occurs. In Morocco, socioeconomic disparities in well-being manifest themselves in the following ways:

- Life expectancy varies by gender and location.
- In both metropolitan and rural areas, there is a lack of sanitation facilities and connections to basic amenities.
- Meeting the health needs of rural women is the most deficient. Both in terms of birth attendants and delivery

beds (1 bed for 2,770 women of childbearing age),

- The maternal mortality rate is 121 deaths per 100,000 live births (WHO report, UNICEF).

- In reality, an unsatisfactory water source and storage conditions are linked to 80% of diseases: WHO IS RESPONSIBLE?
- illiteracy is still widespread, especially in rural areas, and more than a quarter of the population lives in poverty (rural areas)
- the lowest rate of prescriptions and social benefits (8.5%), and the lowest rate of medical and health consultations (56.7%).

C-Impact of inequalities on early age subjects: table 1(HCP 2015) :

Socio-economic characteristics	Neonatal mortality	Post-neonatal mortality	Infant mortality	Juvenile mortality	Infant and child mortality
Gender of the child					
Male	33	18	51	9	59
Female	23	14	37	11	48
Place of residence					
Urban	24	9	33	5	38
Rural	33	22	55	15	69
Mother's level of education					
Illiterate	33	19	52	11	63
Primary	21	11	33	10	42
High school and up	17	6	23	4	27

Well-being quintile					
The poorest	38	24	62	16	78
Medium	25	12	37	10	47
The richest	19	5	24	2	26

Here are some of the conclusions we can draw from this table:

- Male children have a much higher mortality rate;
- The woman's (mother's) level of education has a favorable effect: the higher the woman's level of education, the lower the mortality rate;
- A woman's quality of life has a significant impact: the more affluent she is, the lower the risk of death for all levels.

D-Women of reproductive age:

Table 2: Reasons for not consulting among women in rural areas (HCP2015) :

Reasons for not consulting	urban	rural	set
Consultation of a f'qih	-	1.9	0.9
Use of traditional medicine	21.8	26.7	24.0
self-medication	41.1	22.2	32.5
Illness deemed not serious	8.0	16.8	12.0
Lack of money	24.5	24.9	24.7
Refusal of the husband	0.5	1.4	0.9
Other reasons	4.1	6.1	5.0
set	100	100	100

The various explanations for the woman's refusal to consult (including her offspring) can be categorized as follows:

- Ignorance: a major factor that leads women to avoid consulting a doctor and prefer to consult a fqih, use medicinal plants, visit religious sites in the hope of receiving a blessing, etc.

- Underestimation of the disease: the woman or her family members believe that the disease is not serious, or they self-medicate when someone else has taken the same medication and it worked

- Poverty: When a woman is poor, she cannot see a doctor because of the high cost of transportation, medication, biological and radiological tests, which may deter her.

- Subordination: Women are subordinate to their husbands in rural areas, and often in urban areas as well. It is he who makes the decision whether or not to allow his wife to obtain a consultation. He holds both the authorization and the funds.

III. Elements of comparison between urban and rural areas:

Table 3: Rural-urban disparities in Morocco.

Elements of disparity comparisons	Urban	rural
Total population 2014 in millions	33.3	
of urban population	60	74
Total fertility rate 2004/2014	2.1	3.0
% of women of reproductive age 2004/2013	4	10
Population living below the poverty line2004/2013	5	15
% completion of lower secondary education2004/2012	45	9
Prenatal Care 2004/2014	66	40

Presence of qualified personnel during delivery 2004/2014	92	55
Infant mortality rate 2004/2014	33	55
Underweight children under 5 years of age 2004/2014	2	4

Here are some of the disparities we can see in the table above:

- Demographics: rural areas have high demographics;
- Poverty is also widespread in rural areas;
- Insufficient qualifications (no more than college);
- Health: Health care supply and access is inadequate in rural areas, which has a negative impact on high child mortality and morbidity rates.

IV. Public Sector Efforts for Health Promotion in Morocco :

Axis 1: Reinforcement of prevention actions, consolidation of programs to fight communicable diseases and development of actions to fight non-communicable diseases

- encourage people to lead healthier lives
- to be more proactive in addressing risk factors
- Enable and promote citizen interest in public health initiatives.
- The development of a global plan for NCDs would improve the coordination and coherence of the various activities to be undertaken.

Axis 2: Improve access to services by promoting equity in the allocation of capital and reducing disparities.

- The reorganization of the health sector under the current devolution regime, which allows the country to play a recognized role in cooperation, collaboration, strategy and control of the implementation of health policies;
- The development of instruments for coordinating and controlling the supply of health care, such as the health map and the regional health care supply plan (SROS). The creation of means of planning and regulating the supply of care, in particular the health map and the regional scheme for the supply of care (SROS);
- The creation of incentive structures for health spending, especially in rural areas, as well as incentives, motivation and strengthening of human resources.

Axis 3: Addressing the shortage of health care workers, meeting the growing demand and strengthening the position of human capital in the health care sector:

The programming will be done in two stages:

1- Optimal use and strengthening of the training capacities of health professionals by increasing the number of

clausus of the current medical schools and the formation of new medical schools and CHU, as well as the advancement of paramedical training in public and private institutions;

2- The establishment of a new human resources plan capable of covering all the demands, distributing skills appropriately and valorizing them in the public and private sectors. One of the answers to this problem was the government's plan to train 3,300 doctors by the year 2020.

-Axis4: Build on the successes of the WCD and expand health care financing through the creation of collaborative and supportive risk-sharing strategies.

Consolidate and expand the position of the National Health Insurance Agency (ANAM) in oversight, enforcement, standardization and coordination;

The development of national institutions capable of providing technological oversight, guidance and implementation of WCD reform.

Creation and Administration of Supplementary Health Insurance;

-developing opportunities for consumers and health care providers to participate effectively in strengthening the BMC.

Axis 5: Improve the governance of the health system

- Establish the Superior Advisory Council on Health, which will advise on national health policies and objectives.

Accelerate the adoption of the regionalization policy and give the necessary autonomy and means of action to the health regions, particularly through contractualization;

Develop appropriate legislative structure and coordination frameworks to stabilize the public- private relationship and enable it to play a more active role in expanding access to care;

Strengthen accountability, ensure clinical ethics, and provide protocols for responding to patient grievances and complaints;

Adopt new modes of collaboration, especially with local governments and non-governmental organizations, to strengthen bilateral and multilateral cooperation actions.

Axis 6: Expand the scope of hospital reform and sustain its successes, particularly in terms of quality improvement tools:

Institutionalization of quality improvement tools, such as hospital accreditation, health due diligence and promotion of effective nursing practice guidelines.

This long-term sustainability would include the mobilization of experienced management teams capable of meeting the challenges of success and quality assurance.

Axis 7: Ensure that medicines and health supplies are accessible, available and safe.

A reorganization of the pharmaceutical industry to enable it to meet the current challenges of globalization;

Developing generic manufacturing and encouraging their use;

Strengthening the pharmaceutical industry's monitoring and enforcement processes;

Reviewing prescription taxes, regulating the medical products industry and controlling the costs of these devices;

The creation of a clear regulatory framework for pharmaceutical research.

Axis 8: Development of health sciences:

The development of the National Health Research Observatory, whose main responsibilities are:

Identify health research needs and objectives, particularly in the areas of health systems research and clinical studies;

Ensure that appropriate funds are mobilized to support health research programs through a call for proposals;

Ensure that the results of clinical science are widely disseminated and used;

To this end, provide an appropriate legislative system that encourages clinical research while respecting human rights.

This vision for the health sector is in line with one of the main priorities of His Majesty King Mohammed VI, namely to place health at the center of the government's concerns and develop a health system that is :

- Consistent with universally recognized human rights, including those relating to integrity, dignity and freedom.

Focused on intangible ideas such as:

i. The personal and social responsibility of the population for the safety, maintenance and restoration of health is expanded;

ii. The establishment of an egalitarian, autonomous and hierarchical health care system.

iii. Continuous search for new ways to improve the quality of services;

iv. Establishment of a reasonable, appropriate and long-term funding model;

v. The public's need for an improved health care system.

Bibliography:

Health & precariousness, in The Observatory, n° 65, 2010.

Fassin, D. Inégalités et santé. in : Problèmes politiques et sociaux, N° 960, 2009, 435 p.

Leclerc A, Kaminski M, Lang T. Inequalities in health. Du constat à l'action. Paris: La Découverte, 2008, 297 p.

Roussel I, Charles L. Environmental and social health inequalities and their determinants. in : Environnement Risques et Santé, Vol 10, N°3, 2011, pp. 200-206.

Boissonnat Pelsy H, Sibue de Caigny C, Zimmer MF, Adobati M, Social inequalities in health and early childhood. Analyse et ressenti de personnes en situation de grande précarité. Paris: ATD Fourth World Movement, 2014-02, 18 p.

Delattre E., Sabatier M. Inequalities in health and employment: The impact of social factors. CNRS : UMR8184. University of Cergy Pontoise / Institute of Research in Management and Economics (IREGE). University of Savoie, 2012, 22 p

http://www.sante.gov.ma/Pages/Accueil.aspx: Ministry of Public Health website. http://www.who.int/fr/ : official website of the WHO.