Morocco

General Information

Morocco is a country with an approximate area of 447 thousand sq. km. (UNO, 2001). Its population is 31.064 million, and the sex ratio (men per hundred women) is 100 (UNO, 2004). The proportion of population under the age of 15 years is 31% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 63.3% for men and 38.3% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.1%. The per capita total expenditure on health is 199 international $, and the per capita government expenditure on health is 78 international $ (WHO, 2004).

The main language(s) used in the country is (are) Arabic. The largest ethnic group(s) is (are) Arab, and the other ethnic group(s) are (is) Berber. The largest religious group(s) is (are) Muslim.

The life expectancy at birth is 68.8 years for males and 72.8 years for females (WHO, 2004). The healthy life expectancy at birth is 60 years for males and 61 years for females (WHO, 2004).

Epidemiology

A WHO assisted study on prevalence of mental disorders has been conducted on representative samples (n=6000) from many regions of the country using the Mini International Neuropsychiatry Interview (MINI), and the results are being compiled. Data is regularly collected from public psychiatric institutions. In 2002, among outpatients (n=1 504 508), 34% had schizophrenia, 25.1% had mood disorders, 16.7% had neuroses and 1.8% had alcohol and drug use disorders. Among inpatients (n=15 398) 65.2% had schizophrenia, 11.9% had mood disorders, 2.5% had neuroses and 5.1% had alcohol and drug use disorders (Ministry of Health, 2004). Kadri et al (2002) used DSM-IV criteria to assess sexual dysfunction in a representative sample of the population of women aged 20 and older in one city (n=728). The 6-month prevalence was 26.6% with dysfunctions of sexual arousal as the commonest disorder. Age, financial dependency, number of children and sexual harassment were positively associated with presence of sexual disorder. Ghazal et al (2001) evaluated a randomly selected and representative sample of students attending six secondary schools (n=1887) and a second group composed of students of the French secondary school (n=157). Subjects completed a sociodemographic questionnaire and the Bulimic Investigatory Test of Edinburgh (BITE). In the first group, 15.3% of subjects took at least one substance, 12.7% were dependent on tobacco and 5.7% consumed alcohol occasionally. Almost a sixth of students reported a familial history of disturbed eating behaviour. The overall prevalence of bulimia in this group was 0.8% (1.2% in female and 0.1% in male subjects). The mean age of bulimic subjects was 18.6 years. In the group from the French school, the prevalence of bulimia was 1.9% in the whole sample (3.4% among girls and no case among boys). Bulimic subjects did not differ from the non bulimic subjects with regard to sociodemographic characteristics. Kadri et al (2000) assessed 100 adult males for two consecutive years over a 6-week period during Ramadan with clinical interviews, visual analog scales and the Hamilton Anxiety Scale. Smokers were significantly more irritable than non-smokers before the beginning of Ramadan. An increase in irritability was noted in both groups during Ramadan, but irritability increased more in smokers than in non-smokers. Taoudi Benchekroun et al

(1999) reported that during Ramadan the sleep chronotype as evaluated by the Horne and Ostberg scale changed significantly with an increase of the evening type and a decrease in the morning type. Daytime sleepiness as evaluated by the Epworth Sleepiness Scale was significantly increased.

Mental Health Resources

Mental Health Policy

A mental health policy is present. The policy was initially formulated in 1972.

The components of the policy are promotion, prevention, treatment and rehabilitation. Decentralization is also a component of the policy. Since 1972, the mental health policy has been reviewed several times with the help of the ' Moroccan Society of Psychiatry'. The legislation on mental health, which was formulated in 1959 by 'Dahir', is the highest legislation form in the country.

Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1972.

National Mental Health Programme

A national mental health programme is present. The programme was formulated in 1973.

The mental health programme has been revised in 1992 and 1995. The programme was formulated according to the 'Dahir'. The programme has been reviewed several times.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1972.

The list is revised each year. The last review was in 2000. New as well as old drugs (neuroleptics, anti-depressants, mood-regulators) are on the list.

Mental Health Legislation

The Dahir 1-58-295 relating to the prevention of mental illnesses and protection of the patients is the latest mental health legislation. Though it is old, its articles are well formulated and were examined by WHO experts in 1998. Reviews may be done in the future. The main aim is to guarantee the medical characteristics of mental institutions by entrusting them with the prime mission of treating the sick while protecting their rights and their property during their period of illness. The Law created the Central Service for Mental Health and Degenerative Diseases and the Mental Health Committee, organized mental institutions and other psychiatric set-ups and specified different manners of patient admission and discharge among its many other laws, as well as the modalities of protection of the sick and of its material owns.

The latest legislation was enacted in 1959.

Mental Health Financing

There are budget allocations for mental health.

Details about expenditure on mental health are not available.

The primary sources of mental health financing in descending order are tax based, social insurance, out of pocket expenditure by the patient or family and private insurances.

Each state has its own budget line specified for equipment and investment work in hospitals at regional levels.

The country has disability benefits for persons with mental disorders. Those who become handicapped or lose their autonomy benefit from the system in the form of paid sick leave plus disability card if the disability is definite. Common diseases are supported like other illnesses.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Outpatient clinics are integrated to some extent into the primary health care system. Two hundred health centres spread over the country offer mental health services within primary health care.

Regular training of primary care professionals is carried out in the field of mental health. Training on primary mental health care is integrated in basic academic courses of general physicians, in faculties of medicine and in the institutes of health works (Instituts de Formation en Carrières de Santé: IFCS).

There are community care facilities for patients with mental disorders. The community programme includes the family which plays an important role in the therapeutic programme.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.783
Psychiatric beds in mental hospitals per 10 000 population	0.52
Psychiatric beds in general hospitals per 10 000 population	0.17
Psychiatric beds in other settings per 10 000 population	0.1
Number of psychiatrists per 100 000 population	0.4
Number of neurosurgeons per 100 000 population	0.12
Number of psychiatric nurses per 100 000 population	2.2
Number of neurologists per 100 000 population	0.3
Number of psychologists per 100 000 population	0.03
Number of social workers per 100 000 population	0.007

The condition is unsatisfactory, especially in public sector; e.g. occupational therapy is provided by psychiatrists, nurses and social workers.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation.

Information Gathering System

There is mental health reporting system in the country.

The country has data collection system or epidemiological study on mental health. Several specific studies were conducted by the main psychiatric university centers like Ibn Rochd (Casablanca) and Ar-Razi (Rabat-Salé). An exhaustive list of studies and results is available from the Ministry of Health.

Programmes for Special Population

The country has specific programmes for mental health for children.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, levodopa.

Other drugs are available in the primary health centres.

Other Information

There has been a psychiatric tradition in Morocco since the Middle ages - 'The Moristanes' (health care places for the mentally ill) were psychiatric hospital precursors of public sector. Then, two Psychiatric University Centres came up in Salé in the 1960s and in Casblanca in the 1970s. Recently, two university centers were created in Marrakesh and in Fès. According to mental health policy of the Ministry of Health, several mental health services are being created each year in the general hospitals. The goal is to have sectorized coverage of mental needs of the population in the entire country.

Additional Sources of Information

•Des organismes charges de la prevention et du traitment des maladies mentales et de la protection des malades mentaux (Government document).

•Ghazal, N., Agoub, M., Moussaoui, D., et al (2001) Prevalence of bulimia nervosa among secondary school students in Casablanca. Encephale, 27, 338-342.

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•Moussaoui, D. (2002) Creating a department of psychiatry in a developing country. World Psychiatry, 1, 57-58.

•Taoudi Benchekroun, M., Roky, R., Toufiq, J., et al (1999) Epidemiological study: chronotype and daytime sleepiness before and during Ramadan. Therapie, 54, 567-572.