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The World Health Organization's Drive for Universal Health Coverage in Egypt and Morocco

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Abstract

While the World Health Organization's (WHO) role in global health is well-documented, there is a notable gap in research regarding its influence on domestic health policy in Lower-Middle Income Countries (LMICs). This paper, therefore, explores the WHO's impact on advancing the Universal Health Coverage (UHC) agenda within the Middle East and North Africa (MENA) region given its heterogeneity in regard to income levels and social policies' development. Specifically, it examines the degree of alignment between the WHO's recommendations and the health reforms implemented in Egypt and Morocco from 2010 to 2022, a timeframe shaped by major regional and global shifts, including the Arab Spring and the WHO's expanding UHC agenda. The findings uncover a medium degree of alignment with WHO recommendations in both countries, despite their distinct socio-economic and political profiles. However, the study shows variations in how these countries tackled key UHC dimensions—social coverage, service expansion, financial protection, in addition to health system strengthening. Understanding this variability is crucial for assessing the effectiveness of WHO's influence on national health policies besides highlighting the diverse paths LMICs take in striving for UHC.

Zusammenfassung

Während die Rolle der Weltgesundheitsorganisation (WHO) im Bereich der globalen Gesundheit gut dokumentiert ist, gibt es eine bemerkenswerte Lücke in der Forschung hinsichtlich ihres Einflusses auf die nationale Gesundheitspolitik in Ländern mit niedrigem bis mittlerem Einkommen (LMICs). In diesem Beitrag wird daher der Einfluss der WHO auf die Förderung der Agenda zur universellen Gesundheitsversorgung (UHC) in der Region Naher Osten und Nordafrika (MENA) untersucht, die sich durch eine Heterogenität hinsichtlich des Einkommensniveaus und der Entwicklung der Sozialpolitik auszeichnet. Konkret wird untersucht, inwieweit die Empfehlungen der WHO mit den Gesundheitsreformen übereinstimmen, die zwischen 2010 und 2022 in Ägypten und Marokko umgesetzt wurden – einem Zeitraum, der von großen regionalen und globalen Veränderungen geprägt war, darunter der Arabische Frühling und die Ausweitung der UHC-Agenda der WHO. Die Ergebnisse zeigen, dass trotz der unterschiedlichen sozioökonomischen und politischen Profile beider Länder eine mittlere Übereinstimmung mit den Empfehlungen der WHO besteht. Die Studie zeigt jedoch Unterschiede darin, wie diese Länder wichtige Dimensionen der UHC angegangen sind – soziale Absicherung, Ausbau der Dienstleistungen, finanzielle Absicherung sowie Stärkung des Gesundheitssystems. Das Verständnis dieser Unterschiede ist entscheidend für die Bewertung der Wirksamkeit des Einflusses der WHO auf die nationale Gesundheitspolitik und verdeutlicht die unterschiedlichen Wege, die Länder mit niedrigem und mittlerem Einkommen bei ihren Bemühungen um eine UHC einschlagen.

Contents

1. Introduction

The Arab Spring significantly shifted priorities in the Middle East and North Africa (MENA), bringing Universal Health Coverage (UHC) to the forefront of national agendas. New constitutions and national policies explicitly included UHC as a core goal, and civil society organizations and media outlets amplified its importance (Saleh et al., 2014). International organizations (IOs), especially the World Health Organization (WHO), supported this push, advocating for "health for all" since the Millennium Development Goals (MDGs). In 2010, the WHO formally introduced UHC as a strategy to ensure equitable healthcare access for vulnerable populations, providing comprehensive care without financial hardship (WHO, 2010e).

While many studies have addressed the influence of the World Bank on domestic health policy-making in specific countries (De Carvalho, 2022; Malinar & De Carvalho, 2024) and the role of the WHO is discussed widely in global health research (Clift, 2013; Ruger & Jach, 2009; Liden, 2014), few studies have examined the role of WHO recommendations in domestic health policy-making in Lower-Middle Income Countries (LMICs) (Gostin et al., 2015; Taylor, 1992). The role of the WHO in MENA countries has been insufficiently analyzed. Instead, research on developments in health policy in the region tends to focus on challenges that health systems face (Akala & El Saharty, 2006; Pande et al., 2017) or the structure of health systems (Mate et al., 2017; Jurjus, 2015). Therefore, insights into how the WHO shapes policy at the domestic level in the context of LMICs are needed to better understand the IOs' potential to advance the UHC agenda.

In an effort to address this research gap, the present study explores the extent to which two MENA countries – Egypt and Morocco – aligned their national health policy reforms with recommendations made by the WHO in accordance with the UHC framework. The study focuses on the period 2010–2022, a timeframe shaped by major regional and global shifts, including the Arab Spring and the WHO's expanding UHC agenda. To examine WHO's role in LMICs, the analysis compares Egypt and Morocco. The two countries offer useful variation—Egypt as a republic and Morocco as a monarchy, each with distinct social policy trajectories—while sharing comparable health challenges and long-standing cooperation with the WHO. This combination of differences and similarities makes them well-suited for assessing how WHO engagement plays out across contrasting political and policy contexts within the same region. A two-country focus allows for a detailed and analytically coherent examination of alignment processes, which would be difficult to capture with comparable rigor across the entire MENA region. .

The main research question is, *to what extent did the health insurance reforms of Egypt and Morocco align with WHO recommendations?* By comparing these two cases, the study aims to examine the degree of national to international policy alignment in the context of a common source of external normative influence – the WHO – and similar internal health-specific challenges in otherwise highly diverse policy environments. In doing so, the study may shed light on the extent to which a leading IO in global health can shape LMICs' policy responses in this area.

To address the research question, a document analysis was conducted on WHO recommendations and key health insurance reforms in Egypt and Morocco. The analysis had two objectives: first, to outline WHO's recommendations categorized into three UHC dimensions—social group coverage, service expansion, financial protection—and health systems strengthening; and second, to assess the alignment between these recommendations and domestic health reforms. This alignment was evaluated by analyzing relevant sections of the legislation to determine whether WHO's UHC language or related measures were included or prioritized. Alignments were rated on a scale from no alignment to high alignment, with scores assigned to each recommendation and overall alignment within each dimension.

In what follows, the paper first provides background on the WHO's domestic role and its push for UHC and health system strengthening; and Egypt and Morocco's political socio-economic and health profiles. The methods are then present-

ed, focusing on the identification of data sources, data extraction and data analysis. Following that, the results section entails two parts. Firstly, it describes WHO recommendations to Egypt and Morocco on UHC and health systems strengthening. Secondly, it showcases alignments between WHO recommendations and the selected health insurance reforms and the degree of these alignments. The paper concludes with a summary and discussion of the findings, including an overview of the study's limitations and future research avenues.

2. Background

2.1 The WHO's Role in Domestic Healthcare Policy

IOs use various tools, such as aid/loans attached to conditionalities, prescriptions, normative standards, regulations, capacity building, and policy exchange (Kaasch, 2013; Joachim et al., 2008). Research-based IOs engage in policy exchange and mutual learning with national governments (Maxwell & Stone, 2004). Their recommendations aim to address global challenges, improve lives, and strengthen health systems. They provide policy prescriptions, information, and recommendations in the form of models and suggestions for reforming healthcare systems, targeting diverse audiences like healthcare professionals, the public, health managers, and policymakers (Oxman et al., 2007). These recommendations are based on analyzing policy issues, identifying evidence-based solutions, and designing actionable reforms for governments (Nakamoto et al., 2021).

Established literature on the role and impact of the WHO mainly focuses on its global reach (e.g., Clift, 2013; Ruger & Jach, 2009; Liden, 2014). This involves advocacy for global health, surveillance and fighting certain diseases, and the use of human rights instruments as part of the WHO's normative dialogue (Ruger & Yach, 2009). The WHO has evolved significantly over the decades, shifting its focus from managing communicable diseases like malaria and smallpox in the 1960s and 1970s to addressing broader issues related to healthcare systems and health inequalities, as reflected in the MDGs (Merson et al., 2012).

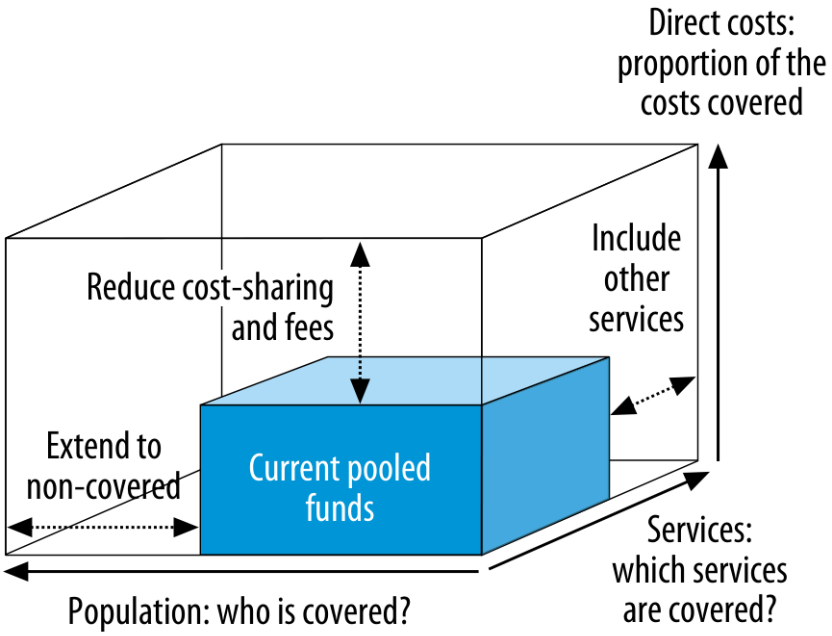
Few studies have explored the WHO's domestic role (e.g., Gostin et al., 2015; Taylor, 1992). However, it is important to recognize that the WHO's domestic influence is closely tied to its global mandate. Gostin et al. (2015) emphasized the WHO's domestic impact through both its soft and hard powers. The WHO is considered a normative leader with unparalleled constitutional authority. In contrast to International Financial Institutions, which leverage aid and conditionalities to shape health policy, the WHO exerts influence through soft power, primarily by setting normative standards. While these standards are non-binding, they hold significant weight in national contexts, underpinned by science, ethics, and human rights. Specifically, Taylor (1992) argued that the WHO plays a pivotal role in advancing the goal of health for all by assisting nations in enacting legislation that upholds these principles.

The WHO's domestic influence is shaped by its core functions, which include normative functions, research and technical cooperation, and coordination efforts. Its normative role involves issuing international conventions, agreements, and recommendations to member states, as outlined in Article 23 of the WHO Constitution (Ruger & Jach, 2009). While these recommendations carry soft power, they are not enforceable, as Article 62 of WHO's constitution lacks enforcement mechanisms (Gostin et al., 2015). The WHO also plays a critical role in disease eradication, pandemic response, and coordinating global health efforts, often working alongside other UN agencies and experts (Ruger & Yach, 2009; WHO, 1946). To understand the WHO's global influence, it is crucial to examine its impact on national health policies.

2.1.1 Advancing the UHC agenda.

The WHO has made UHC and health systems strengthening a central priority in its efforts to influence domestic health policies. The concept of UHC did not emerge suddenly; rather, it evolved through a series of initiatives led by the WHO and other IOs. The 1978 Alma Ata conference marked a pivotal moment, shifting the focus from disease

Figure 1. UHC Coverage Cube



Source: WHO, 2013, p. 7

eradication to strengthening healthcare systems to achieve ''health for all''. It emphasized the enhancement of primary healthcare services and set a target for universal health by 2000, aiming to provide comprehensive health services, including promotive, preventive, curative, palliative, and rehabilitative care (Merson et al., 2012). Later, the 2005 World Health Assembly resolution reinforced the call for universal coverage as a key strategy for achieving broader development goals (WHO, 2013a).

UHC was explicitly highlighted in the World Health Report (2010), which recommended that member states reform their health financing systems to align with UHC principles. Conceptually, UHC encompasses three key dimensions: the health services required (which services are covered?), the populations in need of these services (who is covered?), and the financial burden of these services on users and third-party funders (direct costs and financial protection), as illustrated in Figure 1. To achieve UHC, countries are encouraged to extend coverage to excluded groups, expand services, and reduce cost-sharing fees. The goal is to ensure that vulnerable populations, particularly the poor, have access to preventive, promotive, rehabilitative, and palliative care without facing financial hardship (WHO, 2010e).

Other international bodies also strongly advocated for UHC. For example, the United Nations General Assembly's 2012 resolution emphasized the importance of ensuring access to healthcare services and financial protection, linking UHC to the achievement of the MDGs by addressing poverty and healthcare inequalities. UHC was further emphasized in the Sustainable Development Goals (SDGs) set forth by the UN in its 2030 SDGs' agenda, which aimed to address the unfinished business of the MDGs. The SDGs include 17 development goals, covering economic, social, and environmental dimensions (WHO, 2015a).

Goal 3 of the SDGs aims to ''ensure healthy lives and promote well-being for all at all ages.'' Target 3.8 specifically focuses on UHC, which includes financial risk protection, access to quality healthcare services, and affordable essential medicines and vaccines for everyone. This goal highlights the need for equitable healthcare access, especially for marginalized populations. Additionally, the SDGs prioritize reproductive and sexual health services, mental healthcare, and the prevention and treatment of non-communicable diseases (NCDs) (WHO, 2015a; 2019a).

Health systems strengthening is a fundamental pillar for achieving UHC. A health system comprises key functions like service delivery, health personnel, financing, governance, and oversight, all of which require resources and strong political will. According to the WHO's World Health Report (2000), strengthening health systems involves improving six core building blocks: service delivery, medical products, health workforce, financing, governance, and health information. The overarching goals are to improve health outcomes, equity, financial fairness, responsiveness, and efficiency. Access and coverage are pivotal in achieving optimal health outcomes as illustrated in Figure 2 (WHO, 2007). In the context of UHC, strengthening health systems is critical for enabling LMICs to provide quality services to marginalized populations facing barriers to healthcare access (Merson et al., 2012).

Against this backdrop, the present study examines one of the WHO's normative functions: providing recommendations to LMICs. This paper examines how recommendations related to UHC and health systems strengthening are articulated in WHO documents. It further explores how similar recommendations were directed at Egypt and Morocco, despite their divergence across a number of socio-political factors, suggesting that these recommendations are more closely linked to the shared challenges faced by both health systems, which may be attributed to the countries' similar economic classification (Lower-Middle-Income (LMI) as per the World Bank, 2024). While both countries' reforms appear to align with most of the WHO's UHC and health systems recommendations, the extent of this alignment varies.

2.2 Egypt and Morocco: Different Profiles Similar Challenges

From the 1950s to the 1970s, several MENA countries adopted an authoritarian corporatist approach to social policies, with a centralized state responsible for health, education, public subsidies, and pensions for state employees (Karshenas et al., 2014). However, key differences exist in the social policy regimes of these countries. Left-oriented republican regimes, like Egypt, extended services to broader segments of the population, including the middle class, while conservative monarchical regimes, like Morocco, confined services primarily to white-collar groups, including the military and bureaucracy (Eibl, 2017). Egypt follows the former model, while Morocco follows the latter.

Egypt and Morocco represent distinct cases within the MENA region. Egypt, as a republican regime, exemplifies other republics in the region,

Figure 2. The WHO health system framework

Source: WHO, 2007, p.3

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while Morocco represents monarchical systems. Both countries maintain medium-term agreements with the WHO, indicating significant cooperation. Despite sharing a similar economic classification, and facing comparable healthcare challenges, they differ in the development of their social policies. These differing development models have a significant impact as they influence the nature of their healthcare systems.

Egypt, with its left-oriented republican regime, historically emphasized a central state role, adopting socialist policies such as free public healthcare services, a model common in post-independence MENA countries. In contrast, Morocco, a conservative monarchy, developed a substantial private healthcare sector during the 1960s and 1970s (Anderson, 1990). This divergence explains why Egypt preceded Morocco in its attempts to cover the general public which started by the creation of the Health Insurance Organization (HIO) in 1964. In contrast, Morocco introduced its compulsory health insurance much later, in 2002 (Cottin, 2019).

In the present study, health system reforms emerging in the aftermath of the Arab Spring are studied, as the constitution of these countries began to prioritize health coverage for the general public during this period (Saleh et al., 2014; Makhon, 2023). Notably, the countries' political systems differed then and now: Egypt is republican state and Morocco is monarchy. Following the Arab Spring, Egypt underwent significant changes, including overthrowing Hosni Mubarak's regime, and the leadership of two presidents: Mohamed Morsi (2012-2013) from a civilian background, and Abdel Fattah el-Sisi, a former military leader (2014-present). In contrast, Morocco's monarchy remained intact, with King Mohammed VI ruling since 1999. Despite these differences, Egypt's social contract remained largely unchanged post-Arab Spring, becoming even more repressive, while Morocco took steps toward greater political inclusivity to avoid conflict (El Haddad, 2020).

2.2.1 Egypt

Egypt's healthcare system is composed of public and private sectors, each regulated according to distinct economic categories: government, parastatal, and private. The government-run sector is managed by various ministries, with funding primarily from the Ministry of Finance. The parastatal sector includes quasi-governmental organizations, where the government influences decision-making through entities such as the HIO and the Teaching Hospitals and Institutes Organization (Pande et al., 2017). The private sector includes both for-profit and non-profit entities, such as private practitioners, pharmacies, hospitals, and charitable or religiously-affiliated clinics registered with the Ministry of Social Affairs (Jurjus, 2015). Despite the involvement of multiple actors, Egypt's healthcare system remains largely state-regulated and financed by societal organizations (GH2set, 2021)[1].

Egypt has seen notable health improvements over the past three decades, with life expectancy rising from 63.5 years in 1990 to 71 years in 2020 (Statista, 2024). The country achieved the MDG goal for child mortality, largely due to expanded basic health services. However, significant health disparities remain, particularly between urban and rural areas. Poorer, less-educated populations are more affected by communicable diseases such as hepatitis C, while NCDs are prevalent among wealthier, older groups. Until 2016, the government lacked an NCD strategy and data on NCD risk factors (Pande et al., 2017).

Egypt's healthcare system faces several challenges, including low government spending on health (5% of total government expenditure) and high out-of-pocket costs, which account for 61% of healthcare expenses (WHO, 2013b; Pande et al., 2017). Although the HIO covers 58% of the population, its reach is limited, particularly for the poor and informal workers, and public services are of low quality. The private sector is significant but poorly regulated in terms of service quality and costs. The system is highly centralized, with fragmented service delivery and uneven resource distribution across different care levels (WHO, 2013b), hindering the provision of comprehensive healthcare for all.

2.2.2 Morocco

Morocco's healthcare system, like Egypt's, is structured around both public and private sectors. The public sector is managed by the Ministry of Health (MOH), in collaboration with the Ministry of Defense and local governments, primarily serving low-income and rural populations. The private sector includes for-profit entities such as hospital clinics, dental surgeries, and pharmacies, as well as non-profit organizations like the National Fund for Social Security and the Moroccan Red Crescent (Frichi et al., 2019). For-profit organizations are more common in urban areas, catering to wealthier individuals, while health insurance beneficiaries typically rely on non-profit services (Boutayeb, 2006). Unlike Egypt's healthcare system, Morocco's system is both societally regulated and financed (GH2set, 2021).

The health profile reflects notable progress over recent decades. Life expectancy rose from 47 years in 1967 to 74.8 years in 2013. Both infant and maternal mortality rates also saw significant declines: infant mortality dropped from 113.6 per thousand live births in 1967 to 28.8 in 2013, while maternal mortality fell from 359 per hundred thousand live births in 1981 to 112 in 2013 (Mahdaoui & Kissani, 2023).

Nonetheless, Morocco's healthcare system faces several challenges, including low healthcare funding, with only 5.8% of the state budget allocated to health (Boukhalfa, 2023). NCDs account for over 80% of deaths (Mahdaoui & Kissani, 2023), and high out-of-pocket expenses represented 54% of total health expenditure in 2010. The health insurance system is fragmented, restricting access to services, particularly in rural areas. Additionally, the system's top-down governance approach lacks integrity and effective evaluation mechanisms (WHO, 2013f).

In summary, the Egyptian and Moroccan health systems share some challenges. These include low government spending on healthcare, centralized governance, fragmented services and insurance schemes, and high out-of-pocket costs. As a result, many people struggle to access coverage.

Accordingly, this case selection reflects the principles of Mills methods of agreement[2] (Mill, 2017). While not entirely opposing cases, both countries diverge along key variables embedded within the national constellation of factors held to be relevant for social policy change (Nullmeier et al., 2022). Still, they share similar engagement with the WHO in their national health policy making processes and potentially similar policy results. Thus, by selecting these two 'different' cases and comparing policy developments in response to a shared factor – WHO recommendations – the case selection of the present study offers insights into a comparative analysis of the impact of a leading IO in national policy making.

3. Methods

The data collection was conducted using two different data sources—WHO documents that feature recommendations for Egypt and Morocco and national health system legislations. This paper uses document analysis, specifically the READ approach (Dalglish et al., 2020). This methodology involves several key steps: preparing and gathering the relevant documents, extracting the necessary data; analyzing the data and distilling the findings. These steps are described in greater detail in what follows, with additional information on the identification of data sources and the selection of the period of observation.

3.1 Identification of Data Sources

3.1.1 WHO recommendations

WHO documents for Egypt and Morocco were extracted mainly from the WHO repository of the East Mediterranean Regional Office (EMRO). Initially, thousands of documents were extracted and then filtered by the country. To ensure feasibility, the number of documents was narrowed down using the following criteria:

i. Documents addressing UHC, particularly those focused on expanding coverage or prioritizing specific health benefits.

ii. Documents with relevant titles, such as cooperation strategies or situation analyses.
iii. Documents categorized under ''health systems.''
iv. Documents published between 2010 and 2021.

The selection of documents was based on identifying WHO recommendations for Egypt and Morocco between 2010 and 2021. This period was chosen for two main reasons: it marks key developments pertaining to WHO's UHC and SDG goals, and it coincides with significant reforms in both countries. For Egypt, since the reform was enacted in 2018, WHO documents from 2010 to 2018 were included. For Morocco, where the reform was introduced in 2022, documents from 2010 to 2021 were selected. This allows for the observation of alignment of national policy in the context of a crucial shift in the WHO's normative agenda. According to these developments, nineteen documents were extracted for the two cases —ten for Egypt and nine for Morocco.

WHO recommendations were found across various document types, including technical reports, situation analyses, annual reports, and cooperation strategies. The purpose of these documents varied depending on their type. Some assess the overall health situation or specific health indicators in the country, while others describe the health context or outline WHO's strategic priorities. These documents also highlight WHO's collaboration with the country to achieve these goals. The recommendations themselves were presented in different formats and styles. In some cases, they were implicit, suggesting the importance of addressing specific issues. In other instances, the recommendations were explicit, offering clear roadmaps and strategic priorities for both the WHO and the country.

The Country Cooperation Strategy is a key document provided to Egypt and Morocco, outlining WHO's medium-term vision for technical cooperation and establishing a framework for collaboration. It takes a comprehensive approach to assess the country's health conditions, set priorities, and present a five-year action plan to strengthen health development. Annual reports track the activities and achievements of both the WHO and the country, focusing on strategic areas. Health system profile documents offer data on health indicators and identify the system's strengths, weaknesses, opportunities, and priorities. Situation analyses review challenges and report on actions taken. The Regional Director's messages are brief documents summarizing the director's speeches on specific themes. These documents aim to assess the country's challenges, outline WHO's support, and recommend actions to improve the health system and advance UHC.

3.1.2 Legislations

A corpus of text was collected for Egypt and Morocco based on two key aspects: identification and downloading of health-related legislation. First, the titles of relevant laws were gathered from secondary literature stored in a Zotero library. The literature was systematically selected using keywords related to healthcare system functions, such as health system regulation, financing, and provision. Second, the identified laws were downloaded into the Zotero library. Health insurance reforms targeting broad population coverage were chosen. This selection aimed to examine the extent of coverage for different social groups, in line with the WHO's recommendation for a comprehensive health insurance model to achieve UHC.

For Egypt, *the Comprehensive Health Insurance Law No. 2* (2018), was selected as a key document. This law represents a transformative reform in health system financing, with a primary focus on enhancing health equity through the reorganization of the health system. Among its numerous priorities, the law emphasizes financial protection, the efficient provision of services, the delivery of quality healthcare, improved governance, and the mobilization of resources to ensure financial sustainability. As such, it is viewed as a critical tool for alleviating poverty and achieving health equity (Cortez, 2017).

This legislation was chosen due to its ambitious goal of achieving UHC for all Egyptians within the next decade (Khalifa et al., 2022). Unlike previous laws that targeted specific groups —such as students in Law No. 99 of 2012, children in Decree

No. 86 of 2012, or female breadwinners in Law No. 23 of 2012—this law aims for comprehensive coverage for the entire population (Saber & Gomaa, 2024). These laws were also repealed under Law No. 2/2018. The law was adopted in the aftermath of the WHO's Country Cooperation Strategy with Egypt (2010-2014), offering an opportunity to examine whether WHO recommendations influenced its adoption.

For Morocco, two key pieces of legislation were selected: *Dahir 1-02-296* (2002), which introduced Law 65-00 on Basic Medical Coverage, and *Decree No. 22-2-797* (2022). Law 65-00 was a milestone in establishing Morocco's health insurance system, laying the foundation for UHC by introducing both subsidized and non-subsidized health insurance schemes. *The Assurance Maladie Obligatoire scheme* (AMO) launched in 2008, protected workers in both public and private sectors, while *Regime d'Assistance Médicale* (RAMED), introduced in 2012, targeted vulnerable and low-income groups (Chen, 2018). In 2022, these systems were merged, expanding AMO coverage to include all citizens, regardless of socio-economic status, under Decree No. 2-22-797. This reform is part of Morocco's broader social protection law, No. 9/21, adopted in 2021, which aims to safeguard citizens from economic and social risks (Mansour & Benmouro, 2023). Understanding the 2022 reform requires reference to Law 65-00, as it provided the framework for integrating RAMED beneficiaries into the AMO system.

The selected legislations were chosen because they align with the timeframe of WHO recommendations. Specifically, Decree No. 2-22-797 corresponds with the WHO Country Cooperation Strategy for Morocco (2017-2021). Since the paper focuses on the period from 2010 to 2021, these laws are the only relevant health insurance legislations for both Egypt and Morocco within this period.

3.2 Data Extraction

The data was collected using various methods, each requiring a distinct approach to data extraction. A Word document template was utilized to extract relevant information from WHO documents (see Appendix A). The template contained a set of indicators related to healthcare system recommendations, focusing on areas such as financing, regulation, and provision. It also included indicators related to UHC recommendations, specifically on expanding coverage to the population, extending benefits, and enhancing financial protection. In some cases, additional fields were included based on the document's content (e.g., challenges faced by the country). Data extraction involved quoting sentences containing relevant information for each indicator, along with page numbers for future reference. A separate codebook was unnecessary, as the indicators themselves served as codes and primary themes for categorizing the recommendations.

To extract information from the legislations, three laws were annotated using a generosity codebook by Schmid et al. (forthcoming), which mirrors UHC cube dimensions. The codebook focuses on three areas: inclusiveness (population expansion), benefits categories (benefit expansion), and level of benefits (financial protection). Inclusiveness categorizes around thirty social groups, such as residents, workers, and citizens. Benefits categories include in-kind services (e.g., secondary and inpatient care) and cash benefits (e.g., sickness benefits). The level of in-kind services includes free care and co-payment requirements. The annotation was done using Inception software, linking social groups' entitlements to services, providing a clear understanding of *who* is entitled to *what* under each legislation.

3.3 Data Analysis

The WHO-specific UHC recommendations were compared with annotated sections of the legislations to assess alignment between health reforms and WHO recommendations. The grouping of information from both the WHO documents and legislations was done thematically. The extracted recommendations were grouped based on UHC-related themes: social groups expansion, benefits expansion, financial protection and

health system strengthening. The information from legislations were categorized in relation to their codes on the social groups covered, benefits granted and financial protection (including information on cost sharing). Subsequently, using the themes from both documents, recommendations and their potential reference in the legislations were cross-checked against each other to check for alignment. It is important to note that the aim of this paper is not to establish causality regarding the WHO's influence on the countries, but rather to identify alignment as a potential indicator of the WHO's impact on national policy-making.

The alignment scale used in this study draws on common practices in qualitative policy analysis, where graded coding schemes are employed to capture varying degrees of policy alignment or compliance. This approach allows for a systematic and nuanced evaluation of alignment rather than a binary classification. WHO recommendations typically comprise multiple operational components, including required structures, procedural mechanisms, and specific implementation actions. As, these recommendations extend beyond general principles, it was necessary to identify their core aspects. These were derived through a close reading of each recommendation, focusing on the action-oriented elements that are essential for implementation. In doing so, each recommendation was operationalized into analytically meaningful components that could be compared consistently across national reforms. Therefore, the scale includes four degrees: *no alignment, low alignment, medium alignment and high alignment* which are defined as the following:

''No alignment'' indicates that the recommendation is not mentioned in the reform. ''Low alignment'' means that part of the recommendation is addressed but in a broad sense. ''Medium alignment'' refers to partial inclusion of the core aspects of the recommendation. ''High alignment'' indicates that the recommendation is fully considered in the legislation, with similar terms to those used in the WHO documents.

In the final section of this paper, two tables are presented, comparing WHO recommendations related to UHC and health system strengthening for Egypt and Morocco with the relevant articles in their domestic legislations. The degree of alignment is indicated for each recommendation and its corresponding article. Additionally, overall alignment is assessed for each dimension—social groups covered, benefits granted, financial protection, and health system strengthening—based on the individual alignment scores between the WHO recommendations and the legislative articles.

4. Results

4.1 The WHO Recommendations

4.1.1 Egypt

The priorities and strategic areas for WHO's collaboration with Egypt were clearly outlined in two key documents (WHO, 2010a; 2018a). The Country Cooperation Strategy identified major focus areas, including communicable disease control, health promotion, and health systems development, with three broad priorities: strengthening institutional capacity within the MOH, and addressing both NCDs and communicable diseases (WHO, 2010a). The annual report highlighted key achievements in areas such as strengthening health systems toward UHC, promoting health across the life course, tackling NCDs and communicable diseases, and improving emergency preparedness, surveillance, and response (WHO, 2018a).

The WHO documents included several recommendations on UHC (summarized in figure 3 below), focusing on expanding coverage to marginalized social groups. A key recommendation, found in most documents, was ensuring full coverage for the poor and vulnerable populations (WHO, 2010a). The WHO also emphasized integrating migrants and refugees into health systems, noted in three documents (WHO, 2012a; 2013c; 2013d). One document specifically recommended a new strategy to renew the MOH's commitment to supporting displaced Iraqis and ensuring equitable service provision. Situation reports highlighted the challenges faced by Syrian refugees and documented WHO's efforts to address their health needs, including providing emergency and

primary care in collaboration with UN organizations (WHO, 2013c; 2013d). Additionally, the WHO recommended integrating mental health services into primary care facilities in Egypt to better serve Syrian refugees (WHO, 2018a).

The integration of women into service provision was emphasized in an address by the regional director on women's health (WHO, 2010c), highlighting the importance of their inclusion in achieving health for all. The document also addressed specific challenges faced by Egyptian women, such as female genital mutilation, and emphasized the role of the National Observatory for Women's Health in tackling these issues (WHO, 2010c). Additionally, the study on NCDs recommended targeting school children and their parents as part of efforts to combat NCDs (WHO, 2012b).

WHO documents highlighted several recommendations for expanding health services in Egypt. The 2013 Egypt Profile suggested extending the family practice model to all primary care facilities and improving emergency care through the establishment of emergency spots, emergency vehicles, and a nationwide wireless communication network (WHO, 2013b). The WHO emphasized integrating mental health services into the basic benefits package via the family physician model, and prioritizing preventive, diagnostic, rehabilitative care, and health promotion (WHO, 2010a). The 2016 Egypt Health Profile also stressed the importance of political commitment to improving access to medicines and the production of vaccines and biologicals (WHO, 2016a).

In terms of financial protection, Assessing the Regulation of the Private Health Sector in the Eastern Mediterranean Region 2014 recommended reducing out-of-pocket payments by advocating for self-funding mechanisms rather than obligating providers to offer free services at the point of care (WHO, 2014).

The WHO issued several recommendations on strengthening health systems. These included advocating for greater involvement of civil society and the private sector (WHO, 2016), as well as regulating public-private partnerships, reducing subsidies, and promoting self-funding to enhance public sector service quality (WHO, 2014). The WHO also emphasized a holistic, multisectoral approach to managing NCDs, involving relevant ministries, organizations, and international collaborations to address NCD risks (WHO, 2012b). Additionally, the WHO recommended expanding risk pooling and promoting health equity (WHO, 2014).

Notably, some documents highlight the WHO's direct involvement in the development of Law 2/2018. The WHO played a crucial role as a partner to the HIO in advancing social health insurance in Egypt, within the broader context of health system strengthening toward UHC. Specifically, the WHO provided technical support and worked closely with the social insurance committees, particularly the sub-committees on governance, implementation, and costing and pricing (WHO, 2018a). Additionally, the WHO assisted Egypt in drafting the law, which was based on a family physician model (WHO, 2010a).

4.1.2 Morocco

The WHO's strategic priorities for Morocco were outlined in two country cooperation strategies (WHO, 2010b; 2018b). The first strategy focused on four key areas: public health and health security, protection of vulnerable populations, advocacy and intersectoral action for health, and strengthening the health system's capacity and performance (WHO, 2010b). The second strategy prioritized enhancing equitable access to affordable, high-quality health services to advance UHC and contribute to SDGs, particularly by reducing health inequalities and disease burden. It also aimed to reinforce public health functions, improve health security, and support regionalization and governance strengthening in the health sector (WHO, 2018b).

Similar to Egypt, the WHO provided Morocco with recommendations related to UHC, including the goal of achieving UHC by 2020 (WHO, 2019). The documents emphasized expanding coverage to vulnerable populations such as pregnant women, newborns, the disabled, migrants, the elderly, children, and adolescents (WHO, 2010b; 2018b). The WHO analyzed maternal, newborn, and child health in Morocco, assessing progress towards achieving MDGs 4 and 5,

and recommended solutions to accelerate progress, particularly for populations with the greatest geographical and socioeconomic needs (WHO, 2013e). Additionally, the regional director's message in Rabat highlighted the importance of providing quality, accessible healthcare to low-income groups (WHO, 2015b).

Similar to Egypt, the WHO recommended expanding benefits in Morocco by adopting the family medicine primary care model (WHO, 2010b; 2013f; 2015b; 2018b; 2018c). They advocated for collaboration between the WHO and the MOH to expand immunization programs and address communicable diseases. The WHO also emphasized strengthening health programs targeting maternal, neonatal, child, and infant health. Additionally, it supported the implementation of a national multisectoral strategy to curb NCDs, focusing on preventive, palliative, and mental health services. Recommendations included developing a strategy to ensure the quality and safety of care (WHO, 2010b; 2018b) and improving access to medicines as part of broader UHC goals (WHO, 2013f; 2016b; 2018c).

The WHO (2013e) provided specific recommendations to improve maternal and child health as part of efforts to achieve UHC. These included enhancing the quality and availability of medicines, expanding vaccination coverage for individuals aged 9 months to 35 years, and increasing access to primary healthcare facilities. The recommendations also emphasized integrating maternal and child health services at the community level, with a focus on neonatal and post-neonatal health. A tailored package of services was suggested, including family planning, antenatal and post-partum care, maternal and neonatal death audits, regulating obstetrical emergencies in rural areas, providing free transportation, and implementing a perinatal care program.

The WHO Regional Director's address (2010d) highlighted challenges in cancer prevention and control, advocating for a regional strategy to address these issues. It recommended comprehensive measures to improve public health, including widespread hepatitis B immunization and the HPV vaccination to prevent cervical cancer. The address also emphasized the importance of preventive actions, such as promoting awareness of healthy lifestyles and implementing early screening programs.

In terms of financial protection, the WHO (2010b) recommended gathering more data on equity and catastrophic healthcare expenses. Additionally, the WHO emphasized the importance of addressing social determinants of health to highlight health inequities (WHO, 2018b). To reduce these inequities, the health profiles recommended lowering out-of-pocket payments and achieving sustainable financing levels (WHO, 2013f; 2016b;2018c).

Several WHO documents emphasized health systems strengthening, particularly through improved financing to expand coverage for more social groups (WHO, 2010b; 2018b). The Regional Director's message recommended covering the poor through prepayment schemes (WHO, 2015b) and advised strengthening the integration and regulation of the private sector to ensure quality service provision (WHO, 2013b; 2015b; 2018c). The WHO also stressed enhancing the capacity of the MOH through an intersectoral approach to achieve UHC and meet SDGs' targets. This could be accomplished by fostering partnerships, promoting health policies across sectors, and increasing resource allocation to the health sector (WHO, 2019b). Additionally, an intersectoral approach to maternal and child health was also recommended (WHO, 2013e).

In short, the WHO provided similar recommendations to both Egypt and Morocco, likely due to the shared challenges they face, as mentioned earlier. These recommendations can be summarized as follows: expanding primary care based on the family medicine model, extending coverage to vulnerable populations, strengthening the MOH's capacity through a multisectoral approach, and promoting the use of pre-payment schemes. Furthermore, it is evident that the goals of UHC and the SDGs were translated from the global agenda to the regional level, and subsequently to the national context through WHO's recommendations.

Figure 3. List of overall Recommendations for Egypt and Morocco

Inclusion of vulnerable groups as the poor, migrants and refugees the poor and women
Focus on primary care through the expansion of family practice model
Integrating mental health services in the basic benefits packages and giving attention to preventive, diagnostic and rehabilitative care
Increasing access to medicines and vaccines
Emphasis on health promotion and protection, disease prevention,
Upgrading emergency care
Expansion of prepayment schemes to reduce high share of out-of-pocket spending
Following a multisectoral approach involving the concerned ministries, organizations and collaborations with IOs to deal with the risk of NCDs.
Increasing the involvement of civil society and private sector
Expanding risk pooling and promoting health equity
Providing quality services
Advancing regionalization and strengthening governance in the health sector
Ensuring health security

4.2 Alignments between Recommendations and Legislations

4.2.1 Egypt

A comprehensive review of the annotated sections of Law No. 2 (2018) reveals the social groups covered and the scope of the benefits package available to them. According to Article 1, health insurance is extended to all citizens within the country, and optionally to citizens working or residing abroad, along with their families. Article 3 outlines the guaranteed service package, which includes diagnostic, rehabilitative, and therapeutic care. The extensive range of services covered under this law encompasses medical examinations, surgical procedures, hospitalization, outpatient care, medical treatments, pharmaceuticals, emergency care, and the provision of medical devices. These services are organized within a primary care model, where general practitioners serve as the first point of contact, alongside specialist services. Notably, Article 20 stipulates that preventive care is provided at no cost to citizens.

The WHO has emphasized extending UHC to migrants, refugees, the poor, vulnerable groups, and women. Law No. 2 (2018) represents progress toward this goal by extending coverage to all citizens, surpassing previous laws that targeted specific groups. However, the law leaves migrants' coverage unclear. Article 59 allows foreigners to access health insurance under separate arrangements, implying that some residents and visitors may theoretically be eligible for the service package. However, this provision remains vague, as it does not specifically define whether 'foreign residents' includes migrants or refugees. Vulnerable groups' coverage is also ambiguous, with Article 38 exempting individuals unable to contribute from paying premiums, without specifying which groups qualify. Article 41 targets low-income groups, such as craftsmen and agricultural workers, but does not define other vulnerable categories. Although Article 40 includes women under insured citizens and families, it does not treat them as a distinct category. In short, the law has low alignment with this UHC dimension due to the vagueness surrounding coverage of vulnerable groups.

In extending health benefits, the WHO recommended expanding primary care facilities through

a family practice model, which is partially reflected in Article 20 of the law by emphasizing primary care through basic and family units, along with general practitioners' services. The WHO also stressed the importance of health promotion and early detection, but the law only vaguely acknowledges preventive care without providing detailed descriptions. While the WHO called for upgrading emergency care, the law includes first aid and emergency care but lacks a focus on enhancing these services. The law does adequately address preventive, diagnostic, and rehabilitative care as part of the benefits package in Article 3, with no reference to mental health services. Overall, the law shows medium alignment with this UHC dimension.

In terms of financial protection, Article 4 outlines prepayment schemes, specifying that contributions are the primary source of financing for the insured, who also pay on behalf of their dependents. However, the financing of services targeting the poor remains unclear. The law aligns with the WHO recommendation on cost-sharing, as insured individuals are responsible for service costs, although the poor are exempt from paying fees at the point of service. Overall, the law demonstrates medium to high alignment with this UHC dimension.

For health systems strengthening, the WHO recommended integrating the private sector into service provision, a recommendation that is reflected in Article 9 of the law. This article stipulates that the General Authority for Comprehensive Health Insurance (GACH) includes private sector representatives, although their participation is capped at a quarter of the board. Article 20 also stipulates that both public and private health units are responsible for delivering basic services. The law partially aligns with the WHO's call for a multisectoral approach, as Article 5 includes representatives from various ministries, including the MOH, the Ministry of Finance, the Ministry of Manpower, and the Ministry of Social Insurance, but lacks further detail on this collaboration. In terms of quality assurance, Article 28 establishes the Quality and Accreditation Authority to oversee the quality of medical services through supervision, control, and inspections of medical facilities. However, critical aspects like risk pooling, health equity, and strengthening the MOH's institutional capacity are not addressed. In short, the law exhibits medium alignment with this UHC dimension.

In conclusion, Egypt's Law No. 2 (2018) exhibits a medium alignment with most of the WHO's recommendations, as summarized in Table 1 (p. 14). This indicates that the WHO played a pivotal role in shaping and influencing the country's health insurance policy.

4.2.2 Morocco

According to Articles 2 and 3 of Law 65-00 (2002), the social groups eligible for basic medical coverage are classified into two distinct categories, each encompassed within separate programs. The first program, the AMO, provides coverage for employees in both the private and public sectors, pensioners from these sectors, military personnel—specifically former resistance fighters and members of the liberation army—and students enrolled in public and private higher education institutions. The second program, RAMED, is designed to provide medical coverage for economically disadvantaged individuals who are not covered under AMO. Article 118 outlines the specific groups eligible for RAMED, including homeless individuals, disabled children, abandoned minors or adults without families, and prisoners. Additionally, Article 5 addresses the dependents of the insured, specifying coverage for spouses and children in general and unmarried and disabled children in particular.

Article 7 delineates the comprehensive range of services available to beneficiaries of the first program. This package includes preventive and curative care, inpatient services (hospitalization), surgical procedures, pharmaceuticals, rehabilitative care, medical examinations, maternity care, dental services, general physician consultations, and medical appliances. Similarly, Article 121 outlines the benefits package for individuals covered under RAMED, which are identical to the services provided to AMO beneficiaries.

Decree No. 2-22-797 (2022) represents a significant extension and advancement toward achieving UHC. As outlined in Article 1, individ-

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Table 1. Alignment between Egypt's Law No. 2 and WHO recommendations

WHO recommendation	Reference to alignment in the law	Degree of alignment for each recommendation	Overall alignment
On social groups covered			
Integrating migrants and refugees in health provision	Article 59: probability of covering foreigners and visitors (as opposed to citizens who have the advantage of mandatory insurance)	Low alignment	LOW ALIGNMENT
Full coverage for the poor and vulnerable among the society	Article 49: those who are unable to pay and those who have chronic diseases are exempted from paying services Article 41: coverage of craftsmen and agriculture workers	Medium alignment	
Women's inclusion in the goal to achieve health for all	Article 40: the women here are mentioned as part of the insured family and not as a distinctive category	Low alignment	
On health services granted			
Expanding family practice model to cover all primary care facilities	Article 3: General practitioners services included Article 20: provision of primary care services through basic and family units	High alignment	MEDIUM ALIGNMENT
Integrating mental health services in the basic benefits packages and giving attention to preventive, diagnostic and rehabilitative care	Article 3: The legislation grants these benefits: diagnostic, rehabilitative, preventative and therapeutic care under the family model. However, there is no mention of mental care	Medium alignment	
Increasing access to medicines as well as the production of vaccines and biologicals.	Article 3: medication is included Article 23: medication and medical supplies are to be provided, vaccines are not mentioned	Medium alignment	
An emphasis on health promotion and protection, disease prevention, early detection, management and control	Article 1: preventative care is part of implementing the first level of care (see the glossary)	Low alignment	
Upgrading emergency care through emergency spots in hospitals, emergency vehicles and nationwide wireless communication network	Article 20: medical aid emergency to be provided free of charge as per article 2	Low alignment	

WHO recommendation	Reference to alignment in the law	Degree of alignment for each recommendation	Overall alignment
On financial protection			
Expansion of prepayment schemes to reduce high share of out-of-pocket spending	Article 40: Contributions paid by the insured are a funding source for the GACH	High alignment	MEDIUM TO HIGH ALIGNEMENT
Cost-sharing	Article 40 and 45: the insured bears medical costs, but the poor is exempt from paying fees at the point of service.	Medium alignment	
On health system strengthening			
Building institutional capacity in the MOH for enhancing the functions of the health system	No specific article on this since the insurance law is implemented based on decentralization.	No alignment	MEDIUM ALIGNMENT
Multisectoral approach involving the concerned ministries, organizations and collaborations with IOs to deal with the risk of NCDs.	Article 5: the representation of different ministries in the GAHI board	Low alignment	
Increasing the involvement of civil society and private sector	Article 9 and article 20: services are provided partly through private facilities	High alignment	
Expanding risk pooling and promoting health equity	Nothing specific on this	No alignment	
Providing quality services	Article 28: the GAHI is responsible for ensuring standards and quality of services	High alignment	

Source: author's own compilation

WHO recommendation: the WHO recommendation categorized based on UHC dimensions
Reference to alignment: this refers to the article in the law that mentions terms or themes similar to those found in WHO recommendations
Degree of alignment: alignment scores are given based on comparing the latter indicators. Each of these degrees are defined in the methods section.
Overall alignment: The overall score is given for each UHC dimension in accordance to the individual scores for each recommendation.

uals who were previously covered by RAMED are now eligible to join AMO, provided they are not already beneficiaries of another insurance scheme. While the law does not explicitly specify the list of services provided, it is reasonable to infer that vulnerable groups may have access to the AMO benefits package, as described above. Consequently, any recommendations for expanding benefits should be assessed in relation to the AMO benefits package outlined in Law 65-00.

The WHO emphasized the integration of vulnerable groups—such as women, infants, and adolescents—into health insurance coverage. This recommendation is reflected in both legislations: Law 65-00 includes vulnerable populations in a dedicated scheme, and Decree No. 2-22-797 extends their coverage under the AMO program. Law 65-00 also covers students. However, the law does not clearly address the inclusion of migrants, as its primary target is citizens. Additionally, the WHO recommended including mothers and children in health coverage. Articles 5, 7, and 121 stipulate the provision of maternity services for mothers under both the AMO and RAMED schemes, as well as the inclusion of disabled and abandoned children. *In summary, the law has medium to high alignment with this UHC dimension, covering key vulnerable groups, though migrant inclusion remains unclear.*

The recommendations for expanding benefits were inadequately addressed in the law. Similar to Egypt, the WHO recommended a family medicine-based primary care model, but while Articles 7 and 118 acknowledge care through general practitioners, there is no further detail. The WHO also advocated for including preventive, palliative, and mental health services to combat NCDs, yet only preventive care is explicitly mentioned in Law 65-00. The law provides insufficient attention to cancer patients, referring only to preventive care without clarifying which services are included. The WHO's call to improve access to medicines and vaccines, especially for mothers and children, was largely overlooked- While pharmaceuticals are covered, vaccination services are not mentioned, nor are specific services for women and children. Additionally, recommendations to enhance fairness and service quality, as well as to address family planning, were not incorporated. *Overall, the law shows low alignment with this UHC dimension.*

The recommendation concerning financial protection and the reduction of out-of-pocket payments was largely implemented. This is reflected in the financing structure of the programs at the point of care. As outlined in Article 109 of law 65-00, employees and those who can afford care are required to make contributions, while the state primarily funds the vulnerable population, as specified in Article 125 of law 65-00. AMO beneficiaries, on one hand, have access to both public and private healthcare facilities, with cost-sharing applicable mainly in private settings. In contrast, former RAMED beneficiaries are limited to public hospitals, public health establishments, and state-run services, where they receive care free of charge. *In short, the law demonstrates medium alignment with this dimension of UHC.*

Regarding health systems strengthening, the recommendation to integrate private care providers is addressed in Article 19 of Law 65-00. The multisectoral approach is reflected in both legislations, with Article 61 of Law 65-00 outlining stakeholders managing the National Insurance Agency, including representatives from various sectors and health insurance experts. Article 21 of Decree No. 2-22-797 emphasizes collaboration between the National Security Fund and the Ministry of the Interior to identify and verify eligible individuals. The implementation of the law is a shared responsibility, involving multiple ministries: the Ministry of the Interior, the Ministry of Economy and Finance, and the Ministry of Health and Social Protection. However, the law does not address regionalization or reinforce health security. *Overall, the law shows medium alignment with this UHC dimension.*

In conclusion, the reforms in both countries appear to align with WHO recommendations, with key recommendations integrated into their respective legislations. However, the nature and extent of this alignment vary across individual recommendations and the broader dimensions of UHC and health systems strengthening. Similar to Egypt, the WHO has played a positive role in advancing UHC in Morocco as displayed in table 2 (p. 17). Yet, the degree of alignment is more

Table 2. Alignments and between WHO recommendations and Law 65-00 (A) and Decree no. 2-22-797 (B)

WHO recommendation	Reference to alignment in the law	Degree of alignment for each recommendation	Overall alignment
On social groups covered			
Focusing on providing services for migrant populations	Not mentioned	No alignment	MEDIUM to HIGH ALIGNMENT
Targeting vulnerable segments of the population	Article 5 of A: disabled children under the dependents are insured Article 118 of A: covering of homeless, residents of charitable organizations, abandoned children or adults Article 1 of B: economic threshold to benefit from AMO	High alignment	
Integrating mother and child health in achieving development goals	Article 7 and 121 of A mentions maternity services given to mothers for both AMO and RAMED Articles 5 and 121 of A: disabled and abandoned children are included	Medium alignment	
On health services granted			
Achieving adequate family model in the provision of primary care	Article 7 and 118 of A: General practitioners service is provided but no description of the family model	Low alignment	LOW ALIGNMENT
Focusing on curbing NCDs through preventive, palliative and mental care services.	Article 7 and 118 of A: provides curative, rehabilitative and preventative Mental and palliative care not provided	Low alignment	
Improving access to medicines and vaccines especially for mothers and children	Article 7 and 118 of A: medicines are granted for AMO and RAMED beneficiaries	Low alignment	
For cancer prevention, the effective coverage of the population with hepatitis B immunization and HPV vaccination for cervical cancer.	Article 7 of A: refers to preventative care but no further description on this	Low alignment	
Increasing fair access to affordable, high-quality health services, with a view to moving towards UHC	Not mentioned	No alignment	
Responding to the unmet needs in family planning	Not mentioned	No alignment	

WHO recommendation	Reference to alignment in the law	Degree of alignment for each recommendation	Overall alignment
On financial protection			
Reducing out-of-pocket payments and reaching a sustainable level of financing	Article 109 of A: contributions are deduced and cost-sharing is one of methods financing AMO Article 125 of A: RAMED is financed by state resources besides donations	Medium alignment	MEDIUM ALIGNMENT
On health system strengthening			
Supporting the drive towards advanced regionalization and strengthening governance in the health sector	Not mentioned	No alignment	MEDIUM ALIGNMENT
Establishing partnerships that include the MOH with different stakeholders.	Article 61 of A: the different actors who administer the National Insurance Agency Article 21 of B: different stakeholders take part in implementing the system	Medium alignment	
Strengthening the integration of private sector in the services provision	Article 19 of A: mentions the private sector as one of healthcare providers	High alignment	
Reinforcing essential public health functions and health security	Not mentioned	No alignment	

Source: author's own compilation

clearly defined in the case of Egypt, where some recommendations were fully incorporated, whereas, in Morocco, certain recommendations did not align as effectively with the reforms.

5. Discussion and Conclusion

The findings of the present study suggest that the WHO was an important contributor in shaping national health reforms in Egypt and Morocco. This speaks to the relevance of IOs in influencing domestic social policy, as substantiated elsewhere (see Joachim et al., 2008; Maxwell & Stone, 2004). Although causality could not be established here, evidence of alignment suggests that WHO recommendations were adopted in the language of national reforms in Egypt and Morocco.

Fueled by health inequities as well as UHC calls, both the WHO and domestic actors have put these reforms on the agenda. As shown, both countries had medium term agreements with the WHO, suggesting that cooperation between the WHO and both countries was already in place. Accordingly, both countries introduced health insurance reforms that addresses UHC dimensions.

Taken together, the present findings establish that despite having divergence across variables related to the development of social policy, political systems and health systems, both countries received similar recommendations and exhibited comparable levels of alignment. This suggests that the WHO recommendations are largely directed at the specific challenges within each country's health system, which may stem from the similar economic contexts shared by both countries.

Although both Egypt and Morocco mostly aligned with the WHO recommendations, their degree of alignment is far from identical. For instance, the dimension on social groups' coverage showed low alignment in Egypt and medium to high alignment in Morocco. While, the dimension on benefits' extension showed medium alignment in the case of Egypt and low alignment in the case of Morocco. The financial protection dimension showed medium to high alignment in the case of Egypt and medium alignment in the case of Morocco. Additionally, the single recommendations given to Morocco showed more instances of no alignment with the reforms compared to Egypt.

Even though the combined overall alignment for all the four dimensions seems to be medium level of alignment for both countries, Egypt showed more defined alignments to each of the WHO recommendations especially in the dimension of services' extension and financial protection. This could be traced back to the WHO's direct involvement in drafting Law 2/2018 as per WHO reports (2010a, 2018a), indicating WHO's significant influence domestically.

Medium alignment, however, should not be interpreted as inherently negative. Countries may diverge from certain WHO recommendations not because of weak commitment or resistance, but because they are simultaneously pursuing other health system priorities that fall outside the scope of this study's dataset. Governments often need to sequence reforms due to fiscal, administrative, or political constraints, meaning that some WHO recommendations may not be taken up within the same reform window. It is therefore possible that Egypt and Morocco prioritized alternative policies that also contribute to UHC, even if these areas were not examined in this paper. This suggests that medium or partial alignment does not necessarily indicate policy failure, but may instead reflect deliberate choices, capacity limitations (represented in the aforementioned challenges facing these countries), or different pathways toward achieving UHC

The lack of alignment, or the varying degrees of alignment, can also be attributed to other factors. First, the WHO's recommendations are non-binding, meaning countries are not obligated to fully adhere to them. Second, the WHO's frameworks offer a broad, comprehensive set of guidelines, making it unlikely that every specific recommendation be incorporated into a single reform initiative. Third, certain legislative provisions are framed in broad terms, without specifying the precise elements within those categories, leading to ambiguity in the legislation on certain aspects. Finally, the variance in alignment can be attributed to differences in development models and health-

care systems. Egypt established health insurance shortly after gaining independence, giving it more experience in drafting and implementing such laws. In contrast, Morocco did not introduce a health insurance system until 2002 and is still in the process of adapting and refining its health insurance policies. This difference in experience likely accounts for Egypt's closer alignment with WHO recommendations compared to Morocco.

In sum, this study makes an important contribution to filling the research gap on the WHO's influence on national health policy in LMICs. This study, however, is not without limitations. Firstly, the time frame followed in this paper is quite short; 2010-2022. This means that the WHO's influence was highlighted in a certain decade which might ignore other important recommendations and reforms and their developments. Secondly, the paper compares many recommendations against few reforms. Therefore, there is an expectation that these few reforms would not be able to encompass all the WHO's recommendations. Finally, even though, the paper made some references to the de facto situation of health in both countries, it did not consider whether Egypt and Morocco actually implemented WHO recommendations.

A disconnect between law and reality can result in the oversight of critical issues. For example, the insurance systems discussed in this study rely on contributions from formal sector workers. Therefore, the recommendations overlooked and excluded the vast majority of informal workers in both countries. Both domestic policymakers and the WHO must remain vigilant to the dynamics of national labor markets and ensure that marginalized social groups are considered when formulating recommendations.

Consequently, future research should examine whether countries are actually implementing WHO recommendations to understand the real impact of IOs in affecting policy change. Hence, this study raises further questions, ''Are LMICs implementing WHO recommendations?'' ''Do national actors influence alignments between recommendations and reforms?'' Other research methods such as in-depth interviews with local actors such as MOH officials, will be essential to confirm these findings.

Notes

1 This is spart of A04 data collection as part of the Collaborative Research Centre at the University of Bremen

2 This method suggests the explanation of certain effect for two or more cases is due to a list of different factors except in one factor which is common between the cases. This one factor explains why the cases share the same result (Mill, 2017)

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Appendix A. Data extraction template

Document Code	
IO (WHO or World Bank)	
Document Name	
Document Reference (APA)	
Year of Publication	
Retrieved database(s)	
Reviewer's initials Review date (DD.MM.YYYY)	
Document Type - *Geographic scope*: Global vs. Regional vs. Country targeted document; - *Nature of content*: e.g. Normative guidance, technical assistance, strategic development, financial agreements, assessment document, procurement plan, country cooperation strategies, annual reports etc.) *Note: to name document type, keep with the language of the IO*	
Aim(s) of the document - To put forth recommendations/guidance, including strategic development and the setting of targets - To elaborate an agreement between the organization (plus partners) and country or countries – if agreement includes project information, indicate - To provide technical assistance -	
Period of observation specific to document, if applicable (i.e., years covered by a plan or strategy etc.)	
Specific countries addressed, if applicable:	
Recommendations specific to health system strengthening	
Functions of health system:	
Recommendations on financing	
Recommendations on service provision	
Recommendations on regulation	
Recommendations specific to UHC	
Any info related to expansion of population	
Any info related to expansion of benefits	
Any info related to the degree of financial protection	
Misc. notes by reviewer	