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Mila Sicorsky
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The Social Dimensions of Reproductive Health:

Analyzing Disparities in Morocco through Health Indicators and Social Determinants

Mila Sicorsky

Academic Director: Belghazi, Taieb

Advisor: Hassar, Mohammed

Vanderbilt University

Medicine, Health, and Society Department

Africa, Morocco, Rabat

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Abstract

This paper explores the social dimensions of reproductive health in Morocco through a look at its health indicators and social determinants. Existing literature discusses reproductive health differences that run on economic, social, and cultural lines. In this paper, I shed light on how best to measure and understand these disparities. The research shows that reproductive health in Morocco is most accurately indicated by maternal mortality rates (MMR), access to prenatal and postnatal visits, and access to adequate family planning. It also finds that location of residence, economic status, and women's status are key social determinants of reproductive health in Morocco. Overall, this project uses a holistic framework for measuring and understanding reproductive health and its disparities in Morocco.

Keywords: Social dimensions, reproductive health, health disparities

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Introduction

Background

Morocco is a low-middle income country located in North Africa. Despite its young population and relative abundance of resources, Morocco ranks as 125th in the Human Development Index (HDI) (Bouyateb 2006). In the last few decades, experts have asserted that health inequality, a key factor of human development, contributes to this ranking. As a result, throughout the years the Moroccan government has launched programs to promote health access and equity. For example, the National Initiative for Human Development (NIHD) set out to create more health services for socially and economically excluded Moroccans. The Moroccan government also launched more specific programs, like the maternal mortality surveillance system (MMSS), which sought to reduce maternal mortality rates around the country. Still, deep problems and systemic health disparity remain between rural and urban, rich and poor, as well as repressed and free. In order to understand these disparities, it is helpful to look at health issues through their social dimensions.

Definitions

In this paper, I will use health indicators and social determinants to analyze the social dimensions of reproductive health. Health indicators are measures of different health situations in a given population. This paper will focus specifically on health indicators of reproductive health in Morocco. I will define reproductive health in a holistic way: as the “state of complete physical, mental, and social well-being and not merely the absence of diseases or disorders” (Wang 2001). It is important to note that indicators do not provide the full picture of the health status of a given population because there are a multitude of events that affect health; still, they

provide a clear and measurable understanding than solely analyzing crude quantitative and qualitative data. Indeed, health indicators are composed of a sum of data that help describe different health situations. Next, social determinants help explain the relationship between complex social forces and health outcomes. Social determinants show that health issues have structural and systemic roots from which they cannot be divorced. With that said, social determinants shed light on the unequal distribution of status, wealth, and access that breed health disparities. Without these determinants, the world is left with an incomplete view on health outcomes and events for specific populations. Taken together, health indicators and social determinants allow for a more holistic view on health focused on its social dimensions.

Literature Review

Existing literature on reproductive health in Morocco follows an abundance of research on global health more broadly. Still, scholars agree that differences exist geographically and demographically; men's health in more developed regions cannot be compared on the same field as women's health in developing countries. With that said, the last few decades have witnessed a diversification and specification of various subgroups within the broader umbrella of global health. Moreover, much work has been done on analyzing not just health systems and outcomes in isolation, but also on the underlying reasons behind the health of a population and disparities that exist within it.

Women's Reproductive Health and its Key Issues

Although women have for a long time been included in health systems, the field of women's health and all the care that goes into it has been misunderstood. Indeed, many existing definitions of the health field are quite narrow. For example, a 1986 National Conference on Women's Health labeled women's health as "any matter that affects the health of women exclusively, that impacts predominately on women's health (at any age), or that affects women's health differently from that of men" (Collins 1995). Yet this simple exclusionary definition of women's health being anything that does not directly affect men is narrow-minded; indeed, it fails to take into account the multifaceted nature of women's health as a "physical, social, and emotional" field (Collins 1995).

This insular understanding of women's health is not confined to that conference; rather, it dates back to an anti-scientific framework of women's health. Scholars and non-experts alike attributed women's health issues, including indigestion, sore throat, and headaches, to their

reproductive organs “acting up” (Collins 1995). With the rise of the modern feminist movement, and with incentives for hospitals who noticed their primary revenue came from women, women’s health grew into a movement and a valid field of health and medicine (Collins 1995).

The concept of women’s health, and specifically women’s reproductive health, which this paper centers on, contains key issues that experts and advocates treat worldwide. Researchers have identified three key global women’s health issues found in most countries. First, reproductive tract infections (RTIs) affect women disproportionately. Although the ancient discourse often views women as carriers of viruses or caretakers for men affected by RTIs, the reality of the situation is quite different: male-female transmission is far more likely than female-male (Ravindran 1995). Additionally, women are less likely to be in a position to stop sexual advances and assert safer sex (Ravindran 1995). Politically, policymakers often latch onto primitive and traditional ideals of women as sexually chaste and less likely to castigate men in sexual encounters; all of these misconceptions lead to vast gender-divides and disadvantages for women affected by RTIs.

Another key issue within women’s reproductive health is maternal mortality, which is the primary cause of death for women in most developing countries (Ravindran 1995). Although the true number of maternal mortality rates is unreliable due to a severe official undercount, 99 percent of maternal deaths are in developing countries and most are completely avoidable (Ravindran 1995). Even if mothers do not die from giving birth, the dangerous practice of giving birth in many areas of the world lead to chronic ill health from many survivors.

Moreover, the lack of family planning services and access continues to plague many communities. Family planning, which centers on providing contraceptives to women, has both medical and sociocultural importance. First, women need family planning in order to have a

healthy life for themselves and their dependent children. Also, family planning empowers women and their communities; policymakers must respect women's reproductive right to choose how and when to have children. Although oftentimes family planning centers on the quantity of contraceptives, this factor is not enough to protect and empower women. Instead, the emphasis should be on each woman's individual choice (Ravindran 1995).

Slowly, and through extensive world-wide research and advocacy efforts, women's health, including reproductive health, continues to transform into a complex field of its own. Experts have shown that women's health is intertwined with the social, economic, and cultural conditions in which women live. Indeed, women's reproductive health is difficult to fully understand without a close look at its social dimensions, including its health indicators and social determinants.

Importance of Health Indicators and Social Determinants in Global Health

While it is tempting to analyze health issues for what they appear to be on the surface, a closer look reveals that deeper forces are at play under the surface. Indeed, health experts agree health issues are dictated by complex social, cultural, and economic mechanisms behind the issue itself. Health indicators and social determinants are key ways to better understand the complexity and holistic nature of health issues across the world and how closely related they are to other issues simultaneously occurring. In the past two decades, health researchers have made strides in understanding these concepts.

Health Indicators

When analyzing health issues, it is important to have a system to accurately measure them. Over the years, international and domestic governing bodies and public health experts

have incorporated the use of indicators into understanding the health of populations. As the Pan-American Health Organization explains, on a broad scale an indicator is a “measurement that reflects a given situation” (PAHO). When applying the definition to health, one can see that health is not a numerical value; rather, it is through the use of indicators that it can be properly understood and addressed. As such, health indicators are effective ways to measure health systems because they can “reveal a situation that is not obvious when considered by itself” (PAHO). Due to their dependence on the factors at hand in a given system, health indicators are dynamic and constantly changing with changing circumstances in given populations.

Health indicators can be divided into positive and negative indicators. A positive health indicator has a direct relationship with a given health outcome; the higher the value of an indicator, the *better* the health of a population is. For example, life expectancy at birth is an indicator for long-term survival; thus, it is a positive health indicator (PAHOS). Conversely, a negative health indicator has an inverse relationship with a given health outcome; the higher the value of an indicator, the *worse* that the health of a population is. An example of a negative health indicator is the rate of incidence of heart disease because it negatively affects health.

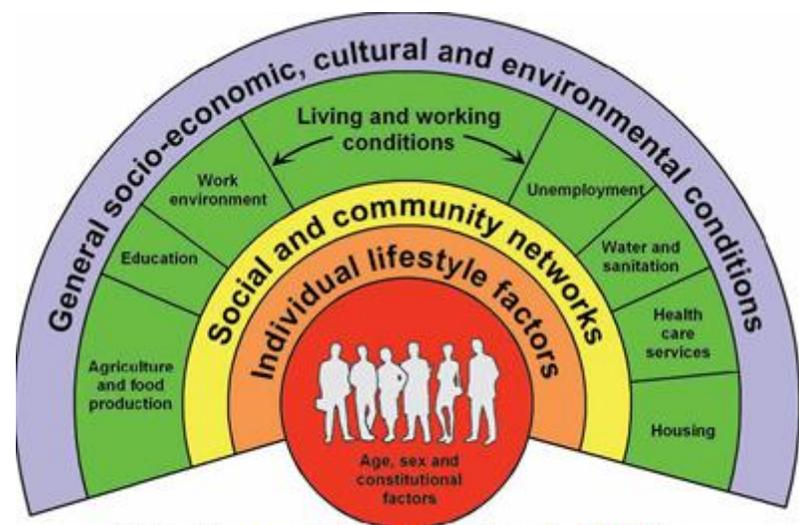
Beyond their use in health lexicon, health indicators are important tools for public and global health policymaking. By understanding the links between indicators and the health of a population, policymakers can work on or prevent certain indicators. For example, experts can more accurately describe the state of a health system by describing its health indicators. Politicians can forecast and predict certain health outcomes by looking at the state of its health indicators. Scientists can explain health phenomenon by taking a closer look at health indicators. Advocacy efforts can find palpable statistics for public health efforts by looking at trends in

health indicators. Others, like the author of this study, can analyze them to better understand health disparities within a population.

Social Determinants

A social determinant is another useful term that shows how illness and disease actually pan out in a population; specifically, it helps explain the relationship between society and health outcomes. One leading expert defined social determinants as a “myriad of complex social forces that may be said to affect or cause the commonly understood ‘medical’ causes of health and illness” (Oakes 2013). In other words, social determinants shed light on the ways our social, cultural, and economic lives clash with our medical ones. Indeed, they show that all these lives are indeed closely intertwined.

Although the term “social determinants” probably would not have appeared in a scholarly journal before the 21st century, they have always existed in health systems. Social determinants can be as clear as economic forces and



G. Dahlgren and M. Whitehead (1991)

access to health care, but they can also be as intangible as social roles and gender norms. As obvious as these may seem to some people, others may seem more inclined to focus on the microscopic medical data that describes illness and disease. Yet scholars assert that looking at the underlying forces behind these health outcomes is just as important. Indeed, “...the pervasive issues that drive much of the microscopic phenomena remain relatively under-appreciated, under-researched, and under-funded” (Oakes 2013).

Social determinants often shed light on health disparities. Scientists, including those in the relatively new field of social epidemiology, attempt to show how, historically and presently, “society’s innumerable social arrangements” yield disparate health outcomes (Oakes 2013). Rather than being solely differences among individuals, these relationships are present throughout society. Thus, oftentimes health outcomes are closely tied and can be partially traced back to a society’s social, economic, and cultural forces.

Incorporating Social Dimensions of Health into Reproductive Health

Reproductive health is extremely impacted by its social dimensions. Across the world, especially in developing regions, women are extremely vulnerable to gendered social forces, norms, and actions. Although no person is immune to change by their environment, women especially fall prey to discriminatory forces, oftentimes in the form of policy. It is no wonder, then, that many of the health indicators associated with reproductive health, such as maternal morbidity and women’s status, deal exclusively with women. Although there are other health indicators that are not as gendered, women are more affected by those that are. Moreover, social forces disproportionately affect women’s reproductive health and, as such, many social determinants impact women disproportionately more than men.

As such, it is not enough to focus on the biological models of understanding women’s health. Instead, it is important to highlight the gendered forces that follow women throughout their life and impact their health. In order to do this, one must identify health indicators to accurately measure the health of women in a population. Then, with a closer look at these indicators, one can locate and analyze the underlying social determinants that affect the health of these women.

Theoretical Framework

The last few days of my study abroad stay in Morocco found me in Beni Kula, a remote village in the north of Morocco. Mere hours into our stay with a welcoming host family and a tranquil landscape surrounding us, my team got news of the worsening COVID-19 pandemic. My peers and I found it difficult to engage with the villagers, but I was even more heartbroken knowing that the crisis severely threatened Beni Kula, where many families do not have their basic health and sanitation needs met. I was especially moved by the women of my host family and the village, who welcomed us with open arms through meals, hugs, and smiles. My previous experiences and lectures in Morocco taught me that Moroccan women were disproportionately affected by many of the nation's worst health issues, and I saw that rural areas fared far worse than urban ones.

Three days later, I was back in the United States, and I could not stop thinking about the women I met in Beni Kula. Since I knew I could not return and help in-person, I decided I could try to *understand* instead. For that reason, I resolved to research the ways that health systems and dynamic affect Moroccan women. In this paper, I dig deeper into more recent public health research to shed light on the social dimensions of women's reproductive health.

Both the political emphasis on reproductive health and research into the social dimensions of health are relatively recent. In this paper, I seek to show how closely intertwined the two are. As I emphasized earlier, it is not enough to look at reproductive health data or observations alone because this does not provide the full picture. Until recently, however, looking at crude medical data and observations was the norm and "the pervasive issues that drive much of the microscopic phenomena remain relatively under-appreciated, under-researched, and under-funded" (Oakes 2013). Thus, I hope to show how gendered social dynamics help explain

reproductive health issues. In doing so, I dig deeper into the social, cultural, and economic forces underlying reproductive health issues.

Methods

Assumptions

Before beginning this project, I had a much more simplistic view on the reproductive health of Moroccan women. I believed that results would be more uniform throughout the country, with a few outliers in regions with less access. Indeed, I thought the only areas with substantial differences in their reproductive health status would be the remote and mountainous regions of the Atlas Mountains. While it is true that these areas are disproportionately plagued with reproductive health issues, they are not the only ones that face disparities. I was surprised to learn how far-reaching reproductive health disparities were in Morocco. Indeed, I found significant differences along economic, class, and gender lines throughout the whole country. I was also shocked to see how closely these issues were tied to broader systemic issues outside the control of the affected populations. An analysis of both quantitative and qualitative health data shows how clear the social divides lie with their subsequent reproductive health disparities.

Limitations

Originally, I expected to conduct field research while visiting the regions and populations I was studying. Unfortunately, the COVID-19 pandemic hit and forced me to evacuate from Morocco before I could conduct this field work. Thus, I conducted all the research from a distance. One clear limitation of my study was the lack of immersive field work I was able to do. Conducting interviews in-person and observing my work firsthand would have given me a

clearer picture that is difficult to replace with solely remote work. Still, I was able to conduct remote interviews with local experts on the field as I would have done in person. Moreover, the six weeks I spent learning and living with my host family in Morocco gave me a more realistic understanding of the health system and the population when I was doing research. As I stated earlier in the paper, staying with a host family in a rural village with basic sanitation needs unmet at the onset of the pandemic gave me insight into how many Moroccans deal with health issues and crises in rural, underdeveloped regions. Additionally, my advisor and professor provided me with reliable sources and a comprehensive understanding for how best to conduct public health research from afar. Throughout the research process, I have also been keeping up with my female Moroccan teachers, host family, and friends and using their experiences to better understand the complexities of navigating the health system as a woman. Although conducting research in-person would have given me a much more complete framework, my discussions with these experts, families, and women gave me insight into the realities of reproductive health in Morocco.

Findings

Reproductive Health Indicators

While there are many indicators relating to reproductive health, some are more pertinent to the case of Morocco. Although there are a great number of measurements that describe the reproductive healthiness of Moroccan women, I chose those that were highlighted in various studies across time. While these are present in other areas of the world, many are disproportionately present among women in countries with developing health systems, like Morocco. Additionally, there are both governmental and non-governmental efforts to combat all

these indicators, but many need a great deal of work in order to improve the reproductive health of Moroccan women. Many reproductive health indicators reveal socioeconomic gaps that point to disparities within the Moroccan reproductive health system. In the following subsections, I will describe these health indicators.

1. Maternal Mortality Rate (MMR)

In piece after piece of scholarly research, the rate of maternal mortality comes up as the leading health indicator for the lack of reproductive health in Morocco. As one scholar pointed out, “if there is one tragedy that illustrates both the social insecurity and vulnerable health status of a large portion of the female Moroccan population, it is surely the continuing high incidence of maternal mortality” (Yaakoubd 2008). As such, policymakers have considered maternal mortality to be the most desperate aspect of a failing reproductive health system. Indeed, the Ministry of Health has labeled it as among their top priorities in the latest years (Maternal Mortality Estimation Inter-Agency Group).

Despite this consideration, Morocco lags far behind its neighbors in correcting maternal mortality rates. Data from 2017 shows that there are 70 maternal deaths for every 100,000 live births (Maternal Mortality Estimation Inter-Agency Group). Although this number is an improvement from less than a decade earlier, where the rate was 227 deaths per 100,00 births, it is still very high (Yaakoubd 2008). Additionally, this fact is particularly disappointing when taking into account the comparisons between Morocco and countries like Tunisia, which contains a similar social fabric and demographic to its neighbor but has a figure of 43 maternal deaths per 100,000 live births (Maternal Mortality Estimation Inter-Agency Group). There is also a disparity in maternal mortality rates between Morocco and Jordan, which share a similar GNP per capita; Jordan counts 46 maternal deaths per 100,000 live births (Maternal Mortality

Estimation Inter-Agency Group). In other words, the data shows that the Moroccan mortality rate is significantly greater than some otherwise similar countries.

Another health indicator that is closely tied to maternal mortality rates is the rate of infant mortality. Moreover, infant mortality rates are health indicators that show just how much gender is ingrained into health systems. Scholars show that the first years of a child's life are those where the child's health is most affected by gendered treatment, especially that of the infant's mother (Yaakoubd 2008). The better a medical treatment is that is guaranteed to a mother, thus ensuring her safety, the higher her infant's survival chances are.

2. Access to Adequate Prenatal and Postnatal Care

Although prenatal and postnatal care are usually classified under the umbrella of children's health, the link between this indicator and women's reproductive health is too strong to be ignored. Indeed, women are the ones that must go and receive this care, which aids themselves and their reproductive system as well as the health of their child¹. Unfortunately, the rates of access to prenatal and postnatal care are very low and almost non-existent for many Moroccan women (Yaakoubd 2008).

Statistics for women who have access to prenatal and postnatal care are low across the nation, although there are visible gaps depending on other factors². While 15.1 percent of women in urban households did not receive prenatal care, 52.1 percent of rural women did not receive any sort of care (Yaakoubd 2008). The numbers are particularly concerning for postnatal visits; 83.7 percent of urban women and 96.4 percent of rural women did not receive a postnatal care

¹ For the purposes of this paper, I have included medically supervised birth as another form of prenatal and postnatal care.

² I will discuss the social determinants of reproductive health in the next section, which will help explain these gaps.

(Yaakoubd 2008). Additionally, while only 16.4 percent of women gave birth at home, 61.1 percent of rural women did, with only 33.8 percent of them assisted by a traditional midwife (Yaakoubd 2008). These numbers are evidence of a vast disparity within households of access to natal care, which I will explore through their social determinants.

Another adverse effect of lack of access to prenatal and postnatal care is an increase in maternal mortality. In most cases, maternal mortality is entirely avoidable. Indeed, studies show that it is not simply a matter of “reaching the hospital”; instead, it is often the lack of adequate prenatal and postnatal care that proves fatal (Bouyateb et al. 2016). The numbers for Morocco show that nearly 80 percent of the maternal deaths in 2009 were avoidable (Bouyateb et al. 2016). Additionally, over half of these deaths were attributed to inadequate care from providers. Another study found that women with no history of prenatal care were eight times more likely to die an avoidable death as mothers, even if they delivered their baby at a hospital. This disheartening statistic highlights the close link between prenatal and postnatal care and maternal mortality. For this reason, it is important to emphasize that what Moroccan health systems should be striving for is not just prenatal and postnatal care, but *adequate* prenatal and postnatal care.

3. *Access to Adequate Family Planning*

Family planning services allow women to make reproductive choices regarding the timing and state of their pregnancies. At a global level, access to family planning services is a key indicator for successful reproductive health systems. The focus on family planning as a key health concern was as a population control effort (Wang 2001). Not until recently, however, did politicians view family planning within the domain of women’s health. Indeed, it was at the 1994 Conference on Population and Development that leaders began to see family planning as a reproductive health issue and understand the positive effects it has on reproductive health.

Lack of contraceptives alone is not the only impediment in lack of family planning services. Rather, faulty contraceptives and unmet need for contraceptives also contribute to insufficient family planning services (Bernstein and Edouard). Studies show that inadequate contraceptives and adverse gender dynamics are the leading causes for low reproductive health status in the developing world. At a household level, a lack of choice for women leads to unwanted and unaffordable pregnancies. These undesired high fertility rates can then contribute to high maternal mortality rates and unsafe child delivery (Wang 2001). Additionally, a lack of reproductive decision-making has negative mental and physical effects on women, who repeatedly have their reproductive human rights violated (Wang 2001). For this reason, access to adequate family planning is a key indicator for a healthy reproductive health system.

Reproductive Health Social Determinants

Social determinants shed light on the social forces behind key health issues; in this section, I will show the various dynamics that help explain reproductive health issues. For each determinant, I will show how it affects the reproductive health indicators I had previously discussed. As such, one can see how closely intertwined society is with reproductive health outcomes. While external forces shape reproductive health systems around the world, I will focus on Morocco and how its unique social determinants impact the reproductive health of Moroccan women.

1. Location of Residence: Rural vs. Urban

Data for all health indicators addressed above shows worsened reproductive health for women living in rural areas versus urban areas. This disparity is attributed to the “marginalization of the rural world, and its corollary in terms of rural exodus, unemployment,

poverty and insecurity (Abdesslam 2011). Indeed, Moroccans residing in rural areas fare significantly worse on literacy rates, economic status, and access to medical care (Abdesslam 2011). In other words, the daily, under-resourced life of women living in rural areas affects other areas of their life, including their health.

The numbers for the access to care and overall healthiness of rural areas is disproportionate in urban areas. In all, over 44 percent of the rural Moroccan population was unable to pay for necessary medical care, which excludes elective procedures (Abdesslam 2011). Additionally, although the average doctor-to-inhabitant ratio is 1:2100, the ratio increases to 1:4600 in the most underserved rural areas. Explanations for these discrepancies lie in the distance to health facilities in many rural areas; almost 30 percent of Moroccans living in rural areas lived 10 km from any health center (Abdesslam 2011). In fact, a 2010 study showed that only 1 percent of rural women live within 1 km of a health care facility, compared to 59 percent of their urban counterparts (Semlali 2010). The chasm between rural and urban grows even greater for the most isolated areas; for example, the ratio of hospital bed to inhabitants is about 1:600 in the Rabat-Sale, but it is 1:2000 in one region of the Moroccan Sahara (Semlali 2010). These statistics adversely affect the healthiness of the overall rural population; despite spaced-out government efforts, there is an average of 5.6 years of difference between life expectancies for rural and urban dwellers. Still, the rural group that feels the greatest blow continues to be women.

Location of residence greatly affects maternal mortality in Morocco, and living in a rural area makes a mother more likely to die from reproductive causes. Studies show a problem of infrastructure for women to receive adequate care, and many health facilities are too far for women to reach timely and safely (Yaakoubd 2008). Thus, most women resort to giving birth at home. Indeed, while 16.4 percent of mothers from urban areas gave birth at home, 61.1 percent

of rural women did the same (Yaakoubd 2008). Although some rural women may have chosen to do an at-home birth, oftentimes there are few other possibilities afforded to them. These at-home rural births are mostly done without a traditional mid-wife and performed in areas with little to no sanitation or medical attention. All of these factors contribute to a staggering discrepancy in maternal deaths for rural women when compared to urban women: rural women are 1.5 times more likely to die during birth than their urban counterparts (Bouyateb et al 2016). Clearly, infrastructure and distance are huge issues that hinder rural women from accessing quality reproductive care. Consequently, these problems create a widespread chasm between the maternal mortality rates of rural and urban women, most of which are entirely avoidable.

Women living in rural areas also had less access to adequate prenatal and postnatal care. Again, the statistics become even more disheartening in the most remote regions; one study of the Moroccan High Atlas region showed that only 35.8 percent of women consulted a medical professional during their pregnancy, compared to the national average of 77.1 percent (Sebbani 2020). This difference corresponds to the oftentimes fatal complications many rural women face during their pregnancy and birth since prenatal check-ups prevent complications during and after pregnancy (Sebbani 2020). Other researchers found an equally disturbing rural-urban difference for postnatal care; while the post-neonatal mortality rate is 9 percent for urban women, it climbs to 22 percent for rural women (Yaakoubd 2009). Like the maternal mortality statistics, many attribute this great chasm between rural and urban access to pre- and post-natal care to infrastructure challenges. When compared to socioeconomically similar neighbors, like Tunisia, Morocco has more remote regions with less access to health care facilities. Indeed, Tunisia has a more easily accessible road network and a less rugged landscape, which can isolate many people from health care facilities (Obermeyer 1993) This distance helps explain why women in

Morocco have lower rates of pre- and post-natal care than their Tunisian counterparts, as well as the higher rate of infant mortality in Morocco (Obermeyer 1993).

Access to family planning services is also limited for many Moroccan women. Additionally, this limitation is exacerbated for rural women, especially for access to contraceptives. First, contraception is not widely available in Morocco; only 41 percent of women use contraceptives. Although there is insufficient data to show the disparities in contraceptive use between rural and urban areas, there is evidence that rural women do not have sufficient access to contraceptives. Their remoteness and distance from health facilities discourage them from making the far-away journey to access these drugs, and a stigma exists in making the trek (Semlali 2010). If rural women do have access to contraceptives, it is through an arduous journey undertaken by a mobile medical team, where professionals use motorbikes or donkeys to distribute contraceptives (Semlali 2010).

2. Financial Resources

It is a universal truth that health outcomes are closely linked to economic status, and Morocco is no exception to this rule. Although Morocco as a whole is a low to middle-income country, it has vast disparities in wealth. Additionally, many of these disparities run on gendered lines. While the rate of economic activity for men is 74.4 percent, it is 25.9 percent for women—a disparity that has not seen improvement in the last few decades (Semlali 2010). Since women are so disproportionately affected by this economic chasm, their reproductive health is likewise adversely affected.

Lower economic status has a direct correlation with maternal mortality rates. A national public health survey found that financial barriers were the key obstacle to getting emergency obstetric care—a type of medical attention which often precedes maternal death (Bouyateb

2016). Similarly, while 96 percent of women in the richest quintile are medically assisted during delivery, only 37.7 percent of the poorest quintile are afforded this luxury (Bouyateb 2016).

Moreover, financial barriers also decrease access to prenatal and postnatal care. Although 71.7 percent of women in the richest quintile attend prenatal visits, only 13.8 percent of those in the poorest quintile do the same (Bouyateb 2016). This disparity largely corresponds to the data on neonatal mortality between rich and poor Moroccan women, where the richest and poorest quintiles experience a 15.1 and 24.9 percent rate of neonatal mortality, respectively (Bouyateb 2016).

Studies show that access to family planning is inversely correlated with economic resources; in other words, poor Moroccan women are less likely to have access to adequate family planning services. Indeed, having work and livable wages “provides women with the necessary material resources and greater independence,” which often translates to greater reproductive rights (Wang, Pillai 2001). When women do not have a financial say in their reproductive rights, their reproductive health suffers. This relationship creates a vicious cycle, where women with unintended pregnancies do not have the means to provide for their children or able to control fertility rates. Still, more research is needed on the links between economic status and access to family planning services.

3. Women's Status

Women's status can take many different forms in Morocco, including legal attitudes, systemic gender divisions, and attitudes from women themselves. All three variations of women's health status greatly affect women's reproductive health, and it impossible to divorce the two. Oftentimes, these social forces have been ingrained for decades and are hard to break, which makes it harder to break upsetting patterns in Moroccan women's reproductive health.

Additionally, government public health policies have the highest likelihood of making a positive impact on reproductive health; thus, it is important for the Moroccan government to have women's health in mind.

In Morocco, the primary driver to correct concerning maternal mortality rates is the government. For years, the Moroccan government neglected concerning maternal mortality rates. It was only in 2008 that the Ministry of Health launched the Maternal Mortality Strategy to reduce the national maternal mortality rate (Bouyateb 2016). Although the government's initial goal was to reduce the MMR to 50 by 2015, it quickly realized that it would not be possible (Bouyateb 2016). Experts blame this failure to the lack of accountability and understanding of women's health issues. This disheartening example shows how ill-equipped Moroccan government policy aimed at women is in alleviating reproductive health issues. Additionally, many women's own attitudes towards their health dissuades them from seeking proper medical treatment to prevent maternal mortality (Bouyateb 2016). Oftentimes, the "absence of compelling reasons" to seek care as well as questions of "convenience, cost, and courtesy" yield to higher rates of reproductive health issues, such as maternal mortality (Obermeyer). In fact, one study found that women view traveling far distances to access maternal care treatments as a "situation of shame and disgrace and incapacity of the future mother" (Sebbani 2011). Thus, it is no wonder that many women are discouraged by the stigma associated with maternal care practices, even if it may prevent maternal mortality.

Similarly, women's status impacts access to prenatal and postnatal care. For instance, many Moroccan women's attitudes toward their own health prevent them from seeking pre- and post-natal visits. Household surveys show that many women do not find it necessary and others are unaware of the potential harms in pre- and post-natal complications. One such study found that

only 36 percent of participants were aware of the potential complications during pregnancy (Sebbani 2011). The same study found that 42.5 percent of these women claimed that there was “no risk of complications” for women after childbirth (Sebbani 2011). Additionally, there are feelings of shame associated with prenatal and postnatal visits for Moroccan women. In households where women lived with their in-laws, they were less likely to attend visits because of stigma and lack of independence. Other women view prenatal and postnatal visits as a “threat for the women’s intimacy,” especially when carried out by a male doctor. In fact, oftentimes it is the role of the mother-in-law to conduct prenatal and postnatal “check-ups”, even if they are not medical in nature (Sebbani 2011). When women in one study did seek postnatal care, it was mostly done for the vaccination of their child, and the women were not checked by a doctor (Sebbani 2011). Clearly, attitudes and perceptions about Moroccan women hinder many life-saving prenatal and postnatal visits.

Last, access to family planning and women’s status are inextricably linked, especially in relation to governmental policy. Many international organizations noted uncontrollable fertility rates as reasons for high levels of poverty in the developing world; soon, they proposed controlling these rates through family planning. However, it was only until the last three decades that governing bodies began to see family planning as in the domain of women themselves (Wang 2001). When governments do not recognize family planning as a women’s choice and as a fundamental reproductive right, women are far less likely to practice it (Wang 2001). Oftentimes, patriarchal systems place family planning decisions in the domain of the male partner or male-dominated governing body. Studies show that this denial of reproductive rights and “disapproval by male partners” as the main reasons for “low reproductive health status” (Wang 2001). Other studies found a lack of knowledge regarding contraceptives; one survey

found that 88.6 percent of women only knew contraceptive pills as the only method of family planning (Sebbani). The same study found a gap between knowledge and practice when it came to family planning; only 24.2 percent of the married women surveyed used the oral contraceptive (Sebbani). Moreover, access to contraceptives and abortion are often left in the hands of the government for many Moroccan women; when the government does not make these services easily accessible, many women, especially poor women who rely on public health services, have nowhere else to turn or rely on charlatans.

Local Perspectives from Experts

An effective analysis of the social dimensions of reproductive health issues in Morocco would be incomplete without voices from the ground. Indeed, conversations with local Moroccan experts helped me understand the issue from a more human perspective. First, I spoke to Stephanie Willman Bordat, a human rights lawyer and NGO activist based in Morocco and specializing in women's human and legal rights. Willman is a Founding Partner at MRA Mobilizing for Rights Associates, where she advocates for grassroots and legal reform for women across the Maghreb, which is comprised of Morocco, Algeria, Tunisia, and Libya (MRA Women).

Willman highlighted the ways that reproductive health is closely linked to women's socioeconomic status. She explained that a woman's position on the economic spectrum will determine their access to reproductive health. For example, if a woman has enough money to pay for adequate private health insurance, she can go to a private doctor or clinic and "get top notch care" (S. Willman, personal communication, May 1, 2020). Willman also acknowledged that women living in rural areas are more likely to be disadvantaged when accessing reproductive

health care. She cited a lack of infrastructure and human resources in developing areas that prevent women from getting adequate reproductive health care. Despite these areas of concern, she expressed hope at improvements and actionable steps from the Ministry of Health in expanding access; she applauded the Ministry for their efforts to expand family planning and setting up hospitals in vulnerable areas.

As an expert in human and legal rights for Moroccan women, Willman expressed most concern for the ways that women's social and legal status is linked to reproductive health. She explained how power and gender dynamics within Moroccan families as an impediment to adequate reproductive health access. She explained that oftentimes women in abusive marriages and family situations are devalued, perhaps not making women's health a priority. For example, she cited cases where husbands controlled their wife's access to family planning services, or even threw out their contraceptive pills. These actions can completely erode women's autonomy in deciding their reproductive health or planning.

Moreover, she illustrated how women's legal status adversely affects their reproductive health. First, Willman explained that premarital sex is both illegal and heavily socially stigmatized. Unmarried women facing sexual and reproductive health issues have an additional barrier to get consultation since access to care would be admitting to committing a crime. Socially, women living in tightly-knit neighborhoods are unlikely to buy contraceptives when their neighbors can see them. Thus, many unmarried women refrain from getting preventive services and care. Additionally, Willman shows how the illegality of premarital sex does not necessarily prevent the act from happening, but it does diminish space for negotiating and establishing safe sex. She shows that a consequence of this lack of cooperation means less time to use contraception and emergency contraception, also known as morning after-pills, which are

marketed for married couples (Chtatou 2019). As a result, unmarried Moroccan women oftentimes forgo these necessary conversations and are discouraged from using emergency contraception. These women are also more likely than married women to undergo unsafe “back-alley” abortions. Loose underage marriage laws are another way that women’s status adversely affects their reproductive health. Willman explains that the younger women get married, the less autonomy and ability they have to be an equal partner in their sexual health. Consequently, these women oftentimes do not have a say in their access to contraceptives and the number of children they want to have. Willman’s observations are in line with her observations that underage women suffer from more sexual and reproductive health problems.

Willman recommends the government to incorporate actionable steps and solutions to address the underlying social issues behind reproductive health disparities in Morocco. First, she wants the Moroccan government to address the systemic discrimination and practices against women. Specifically, she advocates for reforming the criminal code, which criminalizes sex outside of marriage; she explains that doing so would yield better reproductive health outcomes for women discouraged from accessing care. Moreover, Willman calls for tightening up the laws on underage marriage in order to address their costs on reproductive health.

In addition, I spoke to Dr. Nada Douraidi, a medical doctor in Morocco, about her view on reproductive health in Morocco and its social dimensions; specifically, she highlighted the lack of health care for many poor Moroccan women. She pointed out that the Moroccan government is not allocating enough money to its health sector; she wrote that Morocco spends only 5 percent of its GDP on health, while the WHO recommends 12 percent spending. Dr. Douraidi also highlighted the lack of human and material resources in the Moroccan health sector. Oftentimes, the lack of both doctors and facilities plagues rural areas, where there are

only a total of 1270 rural health centers. Due to the lack of infrastructure coupled with low pay for doctors employed in the public health sector, many doctors flock to the private sector. Thus, the public health sector, which treats many rural areas, is even more neglected. This deterioration of the public sector is, again, especially worrisome for poor Moroccans, who cannot afford to pay the high rates of private health care. When many are forced to pay for services that they cannot afford, they are further plunged into debt they oftentimes cannot get out from.

Moreover, Dr. Douraidi emphasized the importance of actionable steps to improve reproductive health access and care in Morocco. Overall, she recommends building up the public health sector in order to improve conditions for many poor and rural Moroccans, especially Moroccan women. Specifically, she suggests a fairer distribution of resources in all regions of Morocco, a shift to universal health care, and more financial regulation of the private health sector in Morocco. She also advocates for better sex education in Moroccan schools, where many institutions barely focus on basic reproductive anatomy, sexually transmitted diseases, and safe sex. The absence of sex education creates “a generation completely ignorant of their physiologies and reproductive systems” (N. Douraidi, personal communication, May 3, 2020). Additionally, like Dr. Willman, Dr. Douraidi also condemns the stigma surrounding family planning and safe sex. She cited married women seeking medical help after being beaten by their husband for using contraceptives. Additionally, she echoes Dr. Willman’s points on the increased stigma and criminalization of unmarried women facing reproductive health issues. Dr. Douraidi asserts that these women need more legal and medical protections to ensure reproductive justice.

Conclusions

Importance of Social Dimension Analysis of Health

Throughout this paper, I have shown that it is impossible to divorce reproductive health from society; reproductive well-being is inextricably linked to its social dimensions. First, a look at health indicators shows readers see that illness is difficult to measure as a whole. Instead, it is helpful to quantify and qualify disease through the use of indicators. In the case of reproductive health in Morocco, I utilized maternal mortality rates (MMR), access to prenatal and postnatal visits, and access to adequate family planning services as health indicators for reproductive health in Morocco. Without defining and looking these health indicators, it is difficult to measure and analyze the reproductive health of a population. Moreover, the use of social determinants helps readers understand the underlying social, cultural, and economic forces of reproductive health in Morocco. Social determinants allow for a holistic and comprehensive view on health and illness as one closely tied to broader societal dynamics. Additionally, social determinants shed light on health disparities that are utterly dependent on disparate social settings, such as location, gender, and economic status.

Need for Greater Relief Efforts

Although governments and NGOs have worked on many of the disheartening reproductive health statistics highlighted in this paper, significant work remains to be done. Indeed, without more intervention, the suffering will continue to exist and, perhaps, get worse. Mostly, experts have called on the Moroccan government, which presides over the bulk of health and economic reforms in the country, to expand its public health efforts. They have highlighted several paths the government can take to aid reproductive health in Morocco. First, advocates continue to push for policy to decrease the drastic inequality in health status, income, and access.

There are various, multilateral ways to alleviate this deep chasm. For example, the World Bank demands that the government repair infrastructure and transportation networks, which are currently “a trademark of less advanced regions as well as impoverished peripheral neighborhoods of urban agglomerations in Morocco” (WB). As mentioned earlier in this paper, rural areas feel the worst of reproductive health outcomes due to their remoteness and lack of development. The World Bank also asserts that this systemic inequality disproportionately affects women, especially young women—a fact that is especially concerning for the reproductive well-being of Moroccan women. Moreover, health efforts should concentrate on areas of concern, including poor, underdeveloped areas; these areas continue to lack the health services and medical professionals necessary to promoting reproductive health. Although the government has aided the reproductive health of many Moroccan women, they should develop more programs that specifically cater to disadvantaged populations. Since poor and socially repressed women are more likely to face worse reproductive health outcomes than other women, promoting access to financial and social services would benefit reproductive health outcomes.

Rights-based Approach to Health

There must be a greater understanding, both within Morocco and around the world, that health is a human right. Thus, this paper advocates for a human rights-based approach to health that demands equity for Moroccan women’s reproductive health. As one researcher points out, “reproductive rights are inseparable from reproductive health” (Wang 2001). Although it is the government’s job to promote health access and equality, the reproductive health of Moroccan women should fall into their own hands and decision-making. Additionally, policymakers should look beyond the biological and medical models of reproductive health. Indeed, they should make

their approach more holistic by focusing on the broader sociocultural and economic context.

Politicians should promote programs that empower women in their communities and nationally.

The Moroccan government should understand that “reproductive health, bodily integrity, and security...are unattainable without women’s equality and empowerment” (Wang 2001).

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