Adolescent and Youth Reproductive Health in

Morocco

Status, Issues, Policies, and Programs

POLICY

POLICY is funded by the U.S. Agency for International Development under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. The project is implemented by Futures Group International in collaboration with Research Triangle Institute and the Centre for Development and Population Activities (CEDPA).

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ADOLESCENT REPRODUCTIVE HEALTH IN MOROCCO

Status, Policies, Programs, and Issues

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January 2003

POLICY Project

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ACKNOWLEDGMENTS

This report was prepared by the POLICY Project as part of a 13-country study of adolescent reproductive health issues, policies, and programs on behalf of the Asia/Near East Bureau of USAID. Dr. Karen Hardee, Director of Research for the POLICY Project oversaw the study.

This report is based on the unpublished report, Beamish J. 2001. Young Adult Reproductive Health in the Near East: Programs, Policies. Washington, DC: Focus on Young Adults.

The authors acknowledge the many persons who made the writing of this report possible. They contributed their time generously, gave deep thought to the issues that this paper seeks to illuminate, provided a wealth of information and materials, pointed the writer in the direction of other key informants, and helped set up interviews. During Ms. Beamish's visit to Morocco, they also showed extraordinary hospitality and made her visit not only productive but thoroughly enjoyable.

The authors are most grateful to Susan Wright and Taoufik Bakkali at the USAID Mission; Moustafa Tyane, Abdelylah Lakssir, and El-Arbi Housni at the Directorate of Population in the Ministry of Public Health; Zahara Dukali and Mohamed Graigaa of the Association Marocaine de Planification Familiale; Vincent Fauveau at UNFPA; Kamal Alami at the Directorate of Epidemiology at the Ministry of Health; Alami Mounabih at the Directorate of Youth and Childhood at the Ministry of Youth and Sports; Volkan Cakir, Malika Laasri, and Adil Saibari at the PROGRESS Project; the three Mohameds—Kattiri, Jebbor, and Oubnichou—at the Commercial Marketing Strategies Project; Zineb Benjelloun at UNIFEM; Nadia Bezad of the Organization Panafricaine de Lutte Contre le Sida and of the Directorate of Educational Support at the Ministry of Education; Issam Moussaoui of the Projet PASA at the Association Marocaine de Solidarité et de Développement; Badr Tazi of the public hospital in Témara; and Yosr Tazi of the SNPE – Conseil et Développement.

The authors would also like to thank the following people for their support of this study: Lily Kak, Gary Cook, and Elizabeth Schoenecker at USAID; and Ed Abel, Karen Hardee, Pam Pine, Lauren Taggart Wasson, Katie Abel, Nancy McGirr, and Koki Agarwal of the Futures Group. The views expressed in this report do not necessarily reflect those of USAID.

POLICY is funded by the U.S. Agency for International Development under Contract No. HRN-C-00-00-0006-00, beginning July 7, 2000. The project is implemented by the Futures Group International in collaboration with Research Triangle Institute (RTI) and the Center for Development and Population Activities (CEDPA).

ABBREVIATIONS

ACLS	Association de Lutte Contre le SIDA
AIDS	Acquired immune deficiency syndrome
AMPF	Association Marocaine de Planification Familiale (Moroccan Family Planning Association)
AMSED	Association Marocaine de Solidarité et le Développement
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
CEDPA	Centre for Development and Population Activities
DHS	Demographic and Health Survey
FP	Family planning
HIV	Human immuno-deficiency virus
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
ILO	International Labor Organization
INSAF	Institution Nationale de Solidarité avec les Femmes en Détresse
ISIAPFW	International Society for Islamic Activities on Population and Family Welfare
IUD	Intrauterine device
LDDFs	Ligue Démocratique pour les Driots de la Femme
LEA	Ligue d'Etats Arabes
MPEP	Ministère de la Provision Economique et du Plan
NGO	Nongovernmental organization
NPC	National Population Council
OPALS	Organisation Panafricaine de Lutte Contre le Sida (Pan African AIDS Control Organization)
RTI	Research Triangle Institute
STI	Sexually transmitted infection
TFR	Total fertility rate
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

1 INTRODUCTION

This assessment of adolescent reproductive health (ARH) in Morocco is part of a series of assessments in 13 countries in Asia and the Near East.[1] The purpose of the assessments is to highlight the reproductive health status of adolescents in each country, within the context of the lives of adolescent boys and girls. The report begins with the social context and gender socialization that set girls and boys on separate lifetime paths in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. The report also outlines laws and policies that pertain to ARH and discusses information and service delivery programs that provide reproductive health information and services to adolescents. The report identifies operational barriers to ARH and ends with recommendations for action to improve ARH in Morocco.

Adolescents comprise about 20 percent of Morocco's population, or 6.2 million (ages 15–24). Estimates indicate that the 15–24 age group will continue to grow until 2010 peaking at around 6.8 million, and will then decline to about 6.4 million by 2020 (Figure 1). Overall girls' educational attainment is increasing. Between 1992 and 1995, the percent of girls with no education decreased from 50 to 46 percent. Girls' secondary and higher educational attainment increased between 1992 and 1995, from 29 percent to 33 percent, respectively (Figure 2). Twice as many boys (ages 15–24) participate in the labor force compared with girls. About 1.7 million boys are employed, compared to about 800,000 girls. Yet almost three times as many boys are unemployed compared with girls; 315,000 compared with 129,000 (Figure 3). Total pregnancies and births continue to increase for girls (ages 15–24), but will peak in 2010. By 2020, an estimated 330,000 pregnancies among adolescents will lead to about 250,000 births (Figure 4). Data indicate that unmet need for family planning is declining for girls between the ages of 15 and 24. In 1995, unmet need was calculated at 11.8 percent for 15–19 year olds and 12.2 percent for 20–24 year olds (Figure 5).

As with other countries in North Africa and the Middle East, one of the most striking features affecting policies and programs as well as popular attitudes and practices in Morocco is the powerful influence of Islam. It is ubiquitous and closely linked to policy, and in Morocco the constitution states that the country is an Islamic state. One detects a widespread disinclination among policymakers and the various political parties to even raise ARH issues as a topic of policy or public debate for fear of incurring opposition from Islamic leaders and parties.[2] Departing from this norm and breaking the silence on this issue, however, and perhaps hinting at things to come, one of the king's aunts spoke out last year on AIDS in Morocco.[3] In fact, it is being argued that perhaps Muslim leaders' positions on family planning are not always interpreted correctly; these leaders may, in fact, be no more opposed to reproductive health programs than are other members of society.[4]

Muslim culture directly affects programs and policies involving ARH, and it shapes ARH issues and challenges to a great extent. Islamic law, for instance, condemns prostitution, homosexuality, and sex outside of marriage. Consequently, their occurrence is not readily acknowledged and there is reticence all the way from inside the family to program managers and policymakers to address them.[5] Interestingly, the *interpretation* of the Koran presents both challenges and opportunities for ARH programs, policies, and public opinion in the region. For instance, while some religious scholars in Morocco oppose

[1] The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.
[2] National STD and AIDS Control Program, 2001; Kattiri, Jebbor, and Oubnichou, 2001; Maasri, 2001.
[3] Pelham, 2001.
[4] Various interviews; Underwood, 2000.
[5] Various interviews.

sexuality education and condom promotion for unmarried youth as a transgression of the Koran,[6] others stress that the *hadith*[7] includes clear guidelines for sexuality education.[8] The *hadith* also mandates good health, economic stability, and social standing as prerequisites for marriage, ostensibly discouraging precipitous decisions leading to early marriage for which the man, at least, is not prepared.[9]

While there are significant cultural differences among the countries of North Africa and the Middle East, which translate into different reproductive health policies,[10] it may be useful to look at other countries in the region to gain some insight into the situation and opportunities in Morocco. Some countries have *fatwas*[11] that require taking care of marginalized groups,[12] which seemingly could include subpopulations of adolescents. In Iran, where in the late 1980s religious leaders running the country introduced an extensive family planning program, *fatwas* declare that family planning methods in general, and oral contraceptives, intrauterine devices (IUDs), and tubal ligation specifically are allowed.[13] In Egypt, which since the 1960s has had a population policy aimed at reducing demographic growth, all major family planning/reproductive health projects engage religious leaders as allies.[14] Yet, while the family planning field in that country has found strong allies in religious authorities and many Muslim "scholars have supported family planning in Egypt since the 1930s, other leaders with popular bases of support have condemned the practice as 'un-Islamic,'" and conflicting messages about the "religious legitimacy of family planning" may be undermining the efforts of the government's population program.[15] In any case, social development cannot be separated from religion,[16] and experience in Islamic countries shows that the success of reproductive health programs depends in large part on whether they can establish a reliable alliance with religious leaders.

What may be most interesting in terms of ARH policy and programs in Morocco is what appears to be underway. The new and modern king, H.M. Mohamed VI, and his administration have indicated that improving the status of women and youth are priorities, although the government is moving slowly and with trepidation in the face of strong, opposing forces of Islamic parties. Government institutions are equally cautious, so while they sometimes push ahead onto new ground, they also censor themselves. However, a new and powerful movement, which runs counter to custom and Islamic parties and is gaining important popular support, represents an innovative agenda to improve women's status and promote reproductive health.

In terms of programs, there are a number of public sector activities targeting youth, but these approaches are not institutionalized. One finds a big gap in which there might be programs implemented to provide ARH information and services. Interestingly, and not unlike Tunisia, Moroccan ministries tend to encourage nongovernmental organizations (NGOs) to target populations and problems that they, themselves, dare not address. NGOs, which are not under the same scrutiny of Islamic parties and other traditionalist forces as is the government, are the leaders in the ARH arena in Morocco in terms of paving the road to tackle forbidden topics if not in their reach and capacity. The challenge for NGOs may be that they do not have enough depth in terms of skilled staff, or enough resources for extensive programs.

[6] Dialmy, 2000b; National STD and AIDS Control Program, 2001.
[7] Traditional account of what the Prophet Mohamed and his companions said and did.
[8] National STD and AIDS Control Program, 2001; various Agadir workshop participants.
[9] Graigaa, 2001.
[10] For a brief summary and examples of these differences, see Fathalla, 2002.
[11] Theological decisions made and declared by a Muslim legal advisor (mufti) who is consulted for the application of religious law.
[12] National STD and AIDS Control Program, 2001.
[13] Dungus, 2000.
[14] Croll and Kamal 2001; National Population Council and Options II Project, 1994.
[15] Ibrahim and Ibrahim, 1998, p. 41.
[16] Yaish, 2001; ISIAPFW, 1990.

Figure 1. Total Adolescent Population
(Ages 15-24)

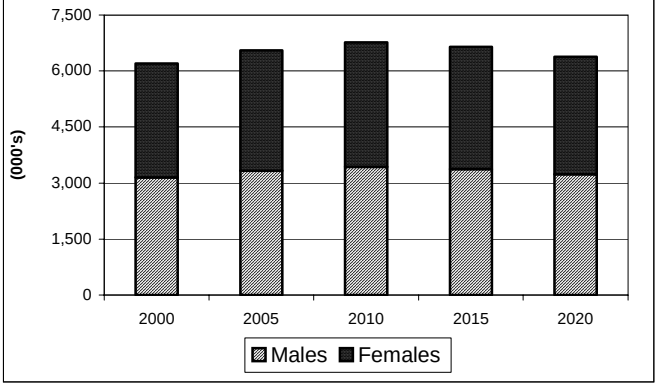


Figure 2. Years of Education Completed
(Ages 15-24)

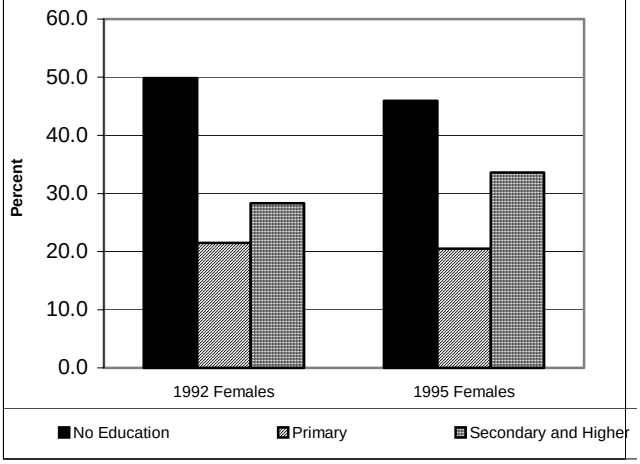


Figure 3. Employment by Sex
(Ages 15-24)

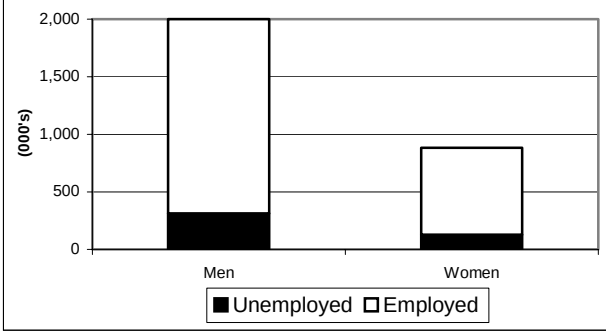


Figure 4. Annual Pregnancies and Outcomes
(Ages 15-24)

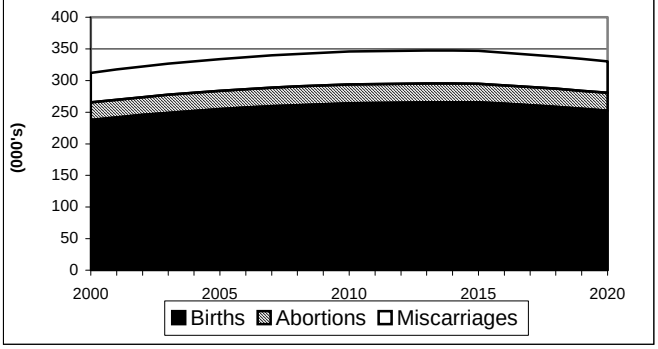
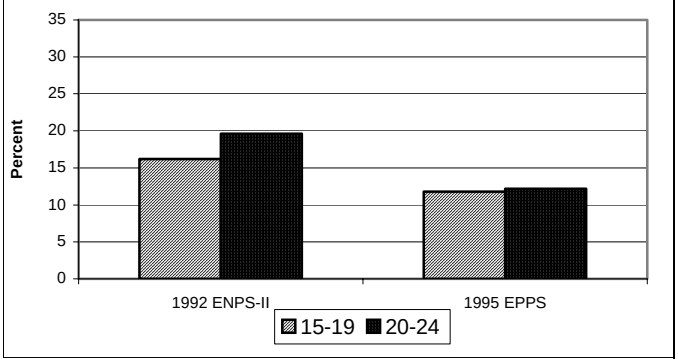


Figure 5. Total Unmet Need for FP
(Ages 15-24)



Note: See Appendix 1 for the data for Figures 1 through 5

2 SOCIAL CONTEXT OF ARH

Gender socialization

Morocco is by tradition a patriarchal society, although the society is in a state of noticeable transition. Nevertheless, girls and women are under the guardianship of males from birth until death.[17] Early on, girls discover that they are second to their brothers. From a young age, girls have to assume adult responsibilities, starting with domestic chores, whereas boys can enjoy a more leisurely childhood. Imposing these responsibilities on girls is part of the process of raising them to become good wives. Girls grow up aspiring to marriage and motherhood. They are instilled with the belief that their bodies are the source of somewhat mysterious problems, and they are ordered to remain "pure" (virgins) until they marry. Girls' movements are much more restricted than those of boys, who enjoy considerable freedoms at home and in the street. In rural areas, girls follow closely in the footsteps of the mothers and aunts who raise them, although young women's attitudes are now diverging from tradition as they are exposed to new ideas on television. In urban areas, where families are becoming less patriarchal and more nuclear so that the influence of grandmothers is waning, young women are moving away from the customs of their mothers' and grandmothers' generations. This is especially true among girls and young women with higher levels of education.[18]

In many cases, young women do not choose their husbands; a marriage is arranged by the couple's families. Not uncommon, either, is a type of "shotgun" marriage between a woman and the man who has deflowered her and/or made her pregnant. Once the couple marries, there is social pressure on them to bear children right away and hence prove the woman's fertility, which is considered an important virtue. The possibility that a man may be infertile does not readily enter the equation. A wife's duties are to be faithful and obedient to her husband and in-laws while the husband has the power to repudiate her and take up to three more wives. In addition, *chari'a* law makes wives the property of their husbands. A woman is forbidden from having sexual relations with anyone other than her husband; premarital and extramarital sex is strongly condemned and the consequences for a woman who does engage in this behavior are severe.[19]

Homosexuality:[20] In Morocco, sex between men is strongly condemned, illegal, and tagged as an "unnatural act" that is punishable by up to six months in prison. It is considered immoral and perverse; the Arabic word for homosexuality is *choudoud*, which literally means perversion. As part of its health education curriculum, the Ministry of Youth and Sports emphasizes teaching young adults about the danger and depravity of what they call "unnatural sex acts" (homosexual acts). Unlike in the West, men who have sex with men do not identify themselves as homosexual. The act is separate from their identity. What may shape the sexual identity of a man who has sex with men is whether he is the "active" or "passive" partner. In the latter case, he may, indeed, be considered homosexual but in a strictly deprecatory way. The passiveness in this context is considered the antithesis of manliness and any homosexual act is censured by public opinion and Islam.[21]

[17] LDDF, 2000.
[18] Guessous, 2000.
[19] Ech-Channa, 2000; Dialmy, 2000b; Belouali and Guédira, 1998; LDDF, 2000.
[20] Studies of lesbian identity and sexuality in Morocco appear to be absent from public health discourse.
[21] Dialmy, 2000a; Dialmy, 2000b; Boushaba and Himmich, 2000; Mounabih, 2001.

Education

Increasing literacy and access to education have become priorities for the Moroccan government, which recognizes education as a universal right.[22] Over one-fourth (26 %) of the national budget is allocated to the Ministry of Education. Social indicators show fairly rapid improvements in literacy and education thanks to the efforts of government and nongovernmental institutions. Illiteracy among adolescents declined about six percentage points in the second half of the 1990s. Still, illiteracy remains too common—over one-third (35.7 %) of 15–24 year-olds were in illiterate in 1999 (down from 41.6 % in 1994).[23] There is also a large gender gap in this area, with literacy rates in Morocco at 62 percent for men and 36 percent for women ages 15 and older.[24] (Between 1982 and 1994, there was no improvement in the gender gap in literacy rates among adolescents; the proportion of illiteracy among girls was almost twice that of boys.[25])

While access to education also improved in the late 1990s,[26] there is, as with literacy, a gender gap in school attendance. The secondary school enrollment ratio is 44 percent for males and 34 percent for females, and the primary school level attendance is 94 percent for males and 76 percent for females.[27] The gender gap appears to be closing more quickly in cities. In Casablanca from 1994 to 1999, for example, the difference between the proportion of 13–19 year-old males and females with some education dropped from nearly six percentage points to less than two.[28]

Employment

The lower levels of education, especially among girls, raise the question of what youth do if they don't attend school. Girls may be required to stay at home to help around the house. In the rural areas, starting at age five to six, girls are also regularly sent to cities to work as live-in domestic help for families that are more well-to-do.[29] The experience is often fraught with its own set of problems for the young girls, including physical and sexual abuse and the forfeiture of opportunities to improve their socioeconomic situation.[30] In cities, young women are increasingly finding work in factories, which do not require a high level of education but instead conduct on-the-job training.[31] Two popular choices for young men are the cottage industry and manual labor.[32]

Unemployment is considered one of the most significant socioeconomic problems facing young adults in Morocco today, and its effects extend into the sexual and reproductive lives of Moroccans.[33] Around the Middle East and North Africa, unemployment is highest among young people and women; women in this region face the highest rate of unemployment in the world.[34] Among Morocco's youth, 24.1 percent of

[22] Belouali and Guédira, 1998.
[23] MPEP, 1999.
[24] UNICEF, 2002.
[25] CERED, 2000.
[26] MPEP, 1999.
[27] UNICEF, 2002. These are gross enrollment ratios, which are the number of children enrolled in a level (primary or secondary) regardless of their age, divided by the population of the age group that officially corresponds to the same level. In contrast, the net primary school enrollment ratio is the number of children enrolled in primary school who belong to the age group that officially corresponds to primary schooling, divided by the total population of the same age group. In Morocco, the net primary school enrollment ratios are 64 for girls and 77 for boys.
[28] CERED, 2000.
[29] Guessous, 2000.
[30] Ech-Channa, 2000; Dialmy, 2000b.
[31] Guessous, 2000.
[32] CERED, 2000.
[33] Tazi Benabderrazik, 2002.
[34] ILO 2000, cited in Roudy, 2001.

20–24 year-olds and 16.3 percent of 15–19 year-olds are unemployed. Unemployment rates are highest among youth with secondary- or higher-level education at 40.5 percent. These young adults are unemployed, on average, for over three years (nearly 39 months).[35]

Sexuality and marriage

Types of marriage: Traditional Moroccan marriages, which are the norm, reflect families' desires to preserve their economic and symbolic patrimony through the union of couples from the same social, professional, cultural, religious, or tribal group. Therefore, while it is not as common as in other Arab countries, endogamy (marriage—typically arranged by the families—between blood relations) is still fairly widely practiced in Morocco. In 1995, 29 percent of marriages were consanguineous (down from 33 percent in 1987).[36] Marriage of a couple with similar social, cultural, or professional backgrounds is very common, particularly in rural areas. But the more educated an individual, the more likely she or he is to marry someone outside her or his village or immediate social, cultural or professional circles.[37]

Polygamy is sanctioned by Islam and practiced in Morocco, although to a limited extent, and the custom appears to be on the decline. Polygamy aggravates women's already subordinate status. It is charged with leading to women's flight from marriage, their clandestine emigration from Morocco, "white marriages" (marriages that are official but do not involve intimate relations between legal spouses and are often used as a mechanism to get women into prostitution rings), and the proliferation of *al moutaa* marriages ("marriages of pleasure" or *mariages de jouissance*).[38]

Al moutaa marriages are clandestine marriages also practiced in Iran and are the Moroccan cousin of the phenomenon called *orfi* in Egypt. Young men who do not have the financial means for a wedding or a household use *al moutaa* as a way to have sexual relations that are legitimate under Islam. For marriage, *chari'a* law requires only that the wife have an adult male guardian there to witness the union, and there be some kind of dowry. However, these marriages are not legitimate under state law ("personal status law") and they are usually clandestine, excluding the couple's families and networks of support. In these unions, the couple does not even live together. Typically, *al moutaa* is the choice of young Islamic men who dare not engage in premarital sexual relations.[39]

Age of marriage: Islam encourages early marriage. At the same time, the *hadith* calls on young men to be prepared for marriage before they embark on it: "Oh youth, he among you who is capable of *ba'a* [being sexually and reproductively healthy and competent and able to take care of and support a wife], be married."[40] In fact, the mean age at marriage in Morocco has risen dramatically to 26.4 years in 1997 (27.8 in cities and 24.7 in rural areas).[41] The principal factor delaying marriage is the high rate of unemployment among young adults, although there are other reasons that are not all necessarily understood.[42] Early marriage, traditionally the norm in Morocco, is a manifestation of patriarchal culture in which there is an almost immediate, direct transition from childhood to adulthood without passing through a stage marked by formal education and remunerative work. Increasingly, however, people consider adolescence as a period of immaturity before preparing to take on the responsibilities of marriage and as a time of growth during which they gain and learn from sexual, romantic, and other

[35] MPEP, 1999.
[36] MSP, 1987; MSP, 1995.
[37] Tazi Benabderrazik, 2002.
[38] LDDF, 2000.
[39] Dialmy, 2000b; LDDF, 2000.
[40] Dialmy, 2000b, p. 200.
[41] Tazi Benabderrazik, 2002.
[42] Dialmy, 2000b; AMPF/Experdata, 1995; Cakir, 2001.

experiences.[43] A survey of adolescents in Casablanca found that their ideal age at marriage was between 22 and 28 years of age. Men and women considered 26 and 27.5, respectively, the ideal age at marriage for men while they considered 22 and 23, respectively, the ideal age at marriage for women.[44]

The rising age at marriage in Morocco indicates that marriage during adolescence is becoming less common. In 1960, nine of every 10 young women ages 20–24 years and four of every 10 ages 15–19 were married; almost 40 years later, only four of every 10 young women (39 %) ages 20–24 and just over one of every 10 young women (13%) ages 15–19 were married. A study of urban adolescents in 1999 found even more striking figures: less than 6 percent of women and less than 1 percent of men married before the age of 20, down from less than 18 percent and 3 percent, respectively, in 1994.[45] A national survey of maternal and child health in 1997 found that while nearly half (45%) of women ages 45–49 had married by the time they were 18 years old, only 16 percent of those ages 20–24 had married by their eighteenth birthday.[46] Coupled with a lack of services and information for unmarried youth, this delayed age at marriage signifies that there is typically a long period of time when young persons may be sexually active but not covered by targeted, youth-friendly services.[47]

Sexual activity: A qualitative study of Moroccan youth living in Morocco (some of whom had returned from abroad) and France suggested that young women are particularly inclined to reject early marriage because they want a chance to "date" men before being trapped in a marriage that may be unsatisfying. Although according to Islam a man's sexual dissatisfaction is grounds for obtaining a divorce, this is not a socially accepted reason for separation, but it is not uncommon for married men to have extramarital relationships. For women, however, extramarital sex is severely scorned and the consequences are severe—rejection by her husband and family, loss of custody of her children, and social condemnation, eventually leading some to prostitution.[48]

The young women's thoughts about delaying marriage seem to reflect rapidly changing sexual behaviors and attitudes among young people. Sexual activity can now be characterized by behaviors that were inconceivable in Morocco 40 years ago such as premarital sex, male prostitution, and having multiple partners. Part of this change is speculated to be a reaction, manifested as the pursuit of freedom through the private world of sexuality, to political and social oppression. In addition, in the absence of sexuality education at school or at home, adolescents are taking it upon themselves to learn about sex through their own explorations and experimentation. The precariousness of the lives of young people, the decline in income, and high unemployment are other factors considered to be fostering sexual risk-taking.[49]

Awareness and social acceptance of the sexual activity of young adults in Morocco lag far behind the process of change in their sexual attitudes and behaviors. Government institutions shy away from

[43] Dialmy, 2000b.
[44] CERED, 2000.
[45] CERED 2000.
[46] MSP and LEA, 1990.
[47] Cakir, 2001; Mounabih, 2001.
[48] Dialmy, 2000b.
[49] Dialmy, 2000b.

discussion or study of adolescent sexuality and any efforts undertaken in this area – and they are rare – must be discreet, unofficial, and executed by private individuals and organizations.

3 ARH ISSUES

Premarital sexual activity: The rising age at marriage and young people's rapidly changing attitudes about sexuality mean that more young adults are sexually active and are sexually active—presumably for longer periods of time—before marriage.[50] However, popular attitudes still condemn unmarried women's sexual activity, judging women who are sexually active to be prostitutes, regardless of whether or not material gain is involved and even if their only sexual encounter was forced on them.[51] Great value is placed on a woman's virginity until she marries, and in the current marriage certificate the bride's father declares to the groom, "I give you as a bride my daughter who is still a virgin."[52] Consequently, there is strong resistance to protecting young women from unwanted pregnancy and sexually transmitted infections (STIs), as these are seen as the price a young woman has to pay for being deviant and as a deterrent to premarital sexual activity. Interestingly, however, in what may reflect changing social attitudes about young women's sexuality and reproductive health, a study of junior civil servants from several government ministries in cities around Morocco found that in Rabat, the majority was in favor of allowing young, unmarried women access to contraception and STI prevention.[53] In the other cities, however, the majority of participants did not believe in providing young, unmarried women access to reproductive health services.

Premarital sexual activity among young Moroccans is characterized by sex with multiple partners (either in succession or simultaneously); the relative stability of monogamy appears to be uncommon. This would appear to build the kind of sexual networks that can fuel the spread of STIs and an HIV epidemic in Morocco.[54]

Contraception: Data on contraceptive use by sexually active, unmarried adolescents are unavailable. Awareness of contraception among urban youth is high; a qualitative study of adolescents in Casablanca found that nearly 85 percent of adolescents ages 13–19 knew of at least one method). Awareness is highest among youth with the most advanced levels of education. Conversely, awareness is low among illiterate youth, with more than a third of these adolescents ages 13–19 not knowing any method of family planning.[55] However, adequate *knowledge* of contraception is severely lacking, and youth are starved for more information about sexual and reproductive health.[56]

Unplanned pregnancy: The rising age at marriage and the longer periods of premarital sexual activity, combined with young persons' inadequate reproductive health knowledge and difficulty in accessing services and family planning methods, leads to what are believed to be high rates of unplanned pregnancy. Subsequently, because of the disgrace that unwed pregnancy represents, and the social, economic and legal difficulties that unwed mothers have to face, illegal abortion is quite common. Rough estimates indicate that 130,000 to 150,000 illegal abortions are performed each year, most of them for young women.[57] Some consider access to abortion much easier for, and relatively more common among, women with higher socioeconomic standing in Morocco.[58]

[50] From various interviews; Dialmy, 2000b.
[51] Dialmy, 2000a.
[52] Ech-Channa, 2000, p. 145.
[53] Dialmy, 2000a.
[54] Dialmy, 2000b.
[55] CERED, 2000.
[56] AMPF/Experdata, 1995.
[57] Fauveau, 2001.
[58] Various interviews; Tazi Benabderrazik, 2002.

Unmarried, pregnant girls and women are shunned, rejected by their families and communities, and sometimes abused for bearing an "illegitimate" child. Giving birth only exacerbates the problem. The children of unwed mothers suffer legal and concomitant social and economic consequences because, without a confirmed father, they do not have a legal identity. Without this, they are "non-persons" who are denied basic rights such as access to health care and education. Obtaining legal papers that establish a baby's identify is difficult, and the barriers to a single mother obtaining the papers, combined with social disapproval of her motherhood, can be a strong deterrent to obtaining the legal papers.[59]

In the event that a child doesn't have a care-giving mother, *chari'a* law provides for the maternal grandmother to become the baby's primary caretaker. However, the shame attached to a birth out of wedlock often scares away the mother's family from caring for the child. Single mothers often choose to abandon their infants. Until recently, they typically did this at hospitals, but recent legislative changes now require unwed mothers to obtain court permission to give up her baby. These young women, fearful of the law and intimidated by the legal system, are therefore more likely to give birth out of sight from state institutions—outside the health care system—resulting in more high-risk deliveries. This is compounded by stigmatization of unwed mothers so severe that social service institutions sometimes deny help to these mothers and even report them to the police.[60]

Consanguineous marriage: The still-common practice of consanguineous marriage has two effects. Such arranged marriages reinforce the control the husband's family has over the young married couple, which can be especially difficult for the wife and even contribute to separation and divorce. This type of marriage also has health repercussions because it increases the risk of genetic defects in the couple's children.[61]

Prostitution: Perhaps more than the other countries in the region, sexual behavior patterns in Morocco, including informal and formal prostitution, contribute to a high risk of STIs and HIV among young people and make the country vulnerable to a full-blown HIV/AIDS epidemic.[62] Morocco is becoming an important location for those seeking sex workers. Prostitution is both heterosexual and homosexual and sex workers are young. One study of male prostitution found the average age of sex workers at first paid sexual contact to be 15 years.

Unemployment, poverty, migration, urbanization, the tourism industry, students' need for financial support, and the common practice among boys and young men of seeking the services of a sex worker, particularly to initiate their sexual lives, lead to high levels of formal and informal prostitution.[63] Historically it has been common for young men to initiate their sexual activity through the services of a sex worker, although this practice may be declining as young women become sexually more active prior to marriage. Nevertheless, it is by no means unusual for young men – both those residing in Europe and returning to Morocco on vacations and those who have stayed in Morocco – to seek the services of sex workers. In addition, informal prostitution has been on the increase since the country embarked on a program of structural adjustment starting in 1983. Informal prostitution can include the growing practice of young women using sex to gain material benefits, however modest, or young men and women using sex to emigrate with foreigners or Moroccans living abroad.[64]

A study by the Association de Lutte Contre le Sida (ACLS, the AIDS Prevention Association, an NGO) in Casablanca and Marrakech confirmed the existence of male prostitution in Morocco. Traditionally,

[59] Tazi, 2001; Ech-Channa, 2000; Joutei, 2001.
[60] Ech-Channa, 2000; Joutei, 2001.
[61] MSP, 1995.
[62] National STD and AIDS Control Program, 2001, various participants form the Agadir workshop.
[63] Boushaba and Himmich, 2000.
[64] Dialmy, 2000b; AMPF/Experdata, 1995.

there has been an informal type of homosexual prostitution for Moroccan men seeking young males. What is new is a more professional, formal form of homosexual prostitution in which the workers acknowledge their profession. The business typically involves young men seeking a living from adult clients, who are most often foreigners.[65] In Morocco, as it is elsewhere in the Arab Muslim world, male prostitution is "far from being acknowledged, the behavior often vehemently condemned" and punishable by law. As a result, male prostitution is not only diffuse but it is also clandestine, making it hard to reach the affected population through public health interventions.[66]

HIV/AIDS and STIs: The unstable, "mercenary," polygamous, secretive, and guilt-ridden nature of Moroccan adolescents' sexual activity leads to high-risk sex that makes youth vulnerable to HIV/AIDS and STIs.[67] Furthermore, popular notions about HIV/AIDS and STIs reflect social attitudes about women's culpability in matters of sexuality, pointing to women as the root cause of STIs and detracting from preventive behaviors. *Berd* is a well-known term used to refer to all STIs, except syphilis. Literally, *berd* is the word for cold. Women are considered the cold gender, and so, the notion goes, they harbor all the cold, and in this case venereal, diseases. By default, women are considered high-risk sexual partners. STIs are believed to be transmitted in the direction of woman to man. This attitude appears to exempt men of the responsibility to prevent STIs.[68] Similarly, there is a popular misconception that it is primarily women who are infected with HIV. This belief stems from the *berd* notion, which contends that HIV/AIDS is a germ that is created in the woman's vagina, such as when sperm mix and stagnate in the woman's body, as a result of women's debauchery.[69]

Adolescents, particularly girls and young women, lack adequate knowledge of HIV/AIDS and STI prevention. A 1995 survey of 418 urban and rural youth in four provinces in Morocco found that 39 percent of adolescent girls and women did not know of any STI prevention method. Among males, 14 percent did not know of any prevention method. Correspondingly, it is rare for female adolescents to use a method of HIV/AIDS or STI prevention, whereas about half of male adolescents appear to use some prevention method. In this study, 95.4 percent of the women and 38 percent of the men reported never using any method to prevent HIV/AIDS and STIs. These proportions included sexually active and not active youth.[70]

Gender-based violence: It is widely believed that violence against girls and women is prevalent in Morocco, but there are no programs to address it, and data on this problem are lacking.[71] A qualitative study found that some young women's first sexual encounter is against their will, but it remains difficult to tell how common this is. The same study found that gang rape of girls and women is not unusual.[72] Although physical abuse is severely punishable by law,[73] the Moroccan Democratic League for Women's Rights states that abuse of women is widespread; custom authorizes husbands to beat their wives if they refuse sex and common law allows husbands to beat their wives for any reason.[74] There aren't available data on the occurrence of sexual abuse against boys and young men, although a qualitative study of young Moroccans suggested that it may not be an uncommon practice.[75] Another qualitative study of male

[65] Dialmy, 2000b.
[66] Boushaba and Himmich, 2000.
[67] Dialmy, 2000b.
[68] MSP and AIDSCAP, 1997.
[69] Various sources, including Dialmy, 2000b; AMPF/Experdata, 1995.
[70] AMPF/Experdata. 1995.
[71] Graigaa, 2001; Boushaba and Himmich, 2000; Ech-Channa, 2000.
[72] Dialmy, 2000b.
[73] Belouali and Guédira, 1998.
[74] LDDF, 2000.
[75] Dialmy, 2000b. For instance, one study participant casually offered that he had raped boys because he couldn't afford to have a wife.

prostitutes found that there is a high rate of violence occurring between male sex workers and their clients.[76]

[76] Boushaba and Himmich, 2000.

4 LEGAL AND POLICY ISSUES RELATED TO ARH

Legal barriers

Sexual activity and childbearing: Marriage is the only setting in which sexual activity is allowed under Islam and in which pregnancy and childbearing are legally legitimate.[77] This presents what could be the single greatest obstacle to addressing ARH in Morocco. It impedes investigating the issues in-depth to gain a real understanding of the situation. It constrains educating youth to enable them to develop healthy attitudes about sexuality and reproduction and to avoid high-risk sexual behaviors. It precludes designing and funding reproductive health and related programs to target the large and ever-growing population of adolescents and unmarried young adults in Morocco. It rules out providing services in a manner that is friendly and acceptable to youth. In general, the condemnation, prohibition, and denial of unmarried adolescents' sexuality is a major impediment to improving the sexual and reproductive health and even the opportunities and lives of this large and growing segment of the population.

Age at marriage: The legal age at marriage in Morocco is 15 years for women and 18 years for men. At 15 years of age a female is still a child who is neither psychologically nor physiologically ready for marriage, sexual intercourse, or childbearing. However, from the Moroccan perspective, it follows that early marriage is the perceived solution to the reproductive and sexual health risks and challenges that adolescents face.[78] The age difference between spouses can perpetuate male dominance in a marriage, leading to unequal, precarious relationships for which the woman suffers the graver consequences.[79]

Moudawana: The *Moudawana* is a set of *chari'a*-inspired laws that govern familial relationships. While the Moroccan constitution grants the same responsibilities and rights to men and women, the *Moudawana*, enacted in 1958, deprives women of many rights and commits them to secondary status. Under these laws, men are entitled to polygamy and to repudiation ("destruction of the marriage vow"), whereas the wife's duties include being faithful, obedient, managing the household (which the husband nevertheless directs), and showing deference to her husband's parents and other close relations.[80] As aforementioned, unmarried adolescents have limited access to reproductive health education and services. Once they are married, this does not change because the laws and customs that dictate roles and relationships within a marriage compromise women's freedom to plan the timing and number of pregnancies, seek reproductive health care, and protect themselves from STIs and HIV/AIDS.

Prostitution: Prostitution is illegal and condemned by Islam. How this affects reproductive health can be illustrated by the fact that police are allowed to use an individual's possession of condoms as proof of prostitution. This frustrates outreach efforts targeting high-risk populations, such as men and women engaged in sex work and young men who have sex with other men, who need to be better informed and equipped to protect themselves from STIs and unwanted pregnancy.[81]

Abortion: Under the penal code, abortion is illegal unless it is deemed necessary to save the life of the mother or otherwise protect her health. But even in these cases, the law requires the husband's consent, which is a particularly problematic condition considering that most adolescents are unmarried. In the absence of a husband or in the case he might not agree to the abortion, written permission must be sought

[77] Dialmy, 2000b; Ech-Channa, 2000; Joutei, 2001.
[78] Dialmy, 2000b, AMPF/Experdata, 1995.
[79] LDDF, 2000.
[80] From Arabic text of *Moudawana*, described in Tazi Benabderrazik, 2002; Belouali and Guédira, 1998.
[81] Boushaba and Himmich, 2000.

from the doctor-in-charge in the prefecture or province. Any provider who violates the law can be punished with five to 10 years in prison and up to 20 years for performing multiple abortions. Anyone accused of seeking an abortion or being an accomplice to an abortion can be fined and imprisoned for one to five years.[82]

Existing ARH policies

There are no policies in evidence directly addressing ARH. In fact, during international ("Prepcom") meetings in 1999 to review the Program of Action adopted at the 1994 International Conference on Population and Development (ICPD), Morocco was among a handful of countries that opposed some of the core principles of reproductive health and rights in the Program of Action. The proposals these nations challenged were aimed at reducing unsafe abortion, providing sexual health education and services for adolescents, and including emergency contraception in the provision of safe and effective contraceptive and family planning methods.[83]

Although there are no national health policies directly aimed at adolescents, several policies related to population and family planning, health, and marriage do have an impact on ARH.[84]

National population policy: Contraception was legalized in the 1960s, one year after the national family planning program was launched to slow population growth. Reviews of today's family planning policy and program indicate that family planning, safe motherhood, and STI and HIV/AIDS services are available through vertical programs, but that a comprehensive and integrated reproductive health program is still lacking. Efforts have focused on urban areas and left rural areas behind. There is no policy to address the reproductive health needs of youth, though the Ministry of Public Health states that services for youth are part of their overall services. In fact, the official position that services are available to all, including youth may be considered more of an impediment than an opportunity for ARH services and information, as it exonerates the institutions from specifically addressing the needs of adolescents by saying this population is already covered in the broader programs.

STIs and HIV/AIDS: Although the National AIDS Control Program was first established in 1988, fighting STIs actually became a part of the country's health policy in the mid-1990s with the launch of the Interim Plan for HIV/AIDS and STIs. However, this plan, and the subsequent National Strategic Plan for 1996–2000, omitted adolescents as a specific target group, even though they called for interventions specifically designed for "high-risk populations."[85] In February of last year, the king's aunt, Princess Lalla Fatima Zohra, broke new ground by speaking publicly about AIDS in Morocco and calling for condom promotion to prevent its spread.[86] True to all questions surrounding sexuality, especially among the unmarried, HIV/AIDS and the patterns of behavior that are fueling its spread in Morocco have been cloaked in silence. The princess' public declarations may have heralded a new openness and political willingness to deal with HIV/AIDS, which could also help pave the way for more frank treatment of other sexual health issues.

Premarital testing: A 1992 law made premarital health tests obligatory, although these examinations were not well defined and even the Ministry of Public Health lacked certainty about what they entailed. Taking advantage of the intervention point this law offers, the Ministry of Public Health launched an

[82] CERED, 1998.
[83] Sadasivam, 1999.
[84] Education policy also affects ARH; relevant points about it were summarized earlier in the section on education.
[85] CERED, 1998.
[86] Pelham, 2001.

effort in 1999 to introduce counseling and information on family planning, maternal and child health, and STIs and HIV/AIDS during young couples' premarital testing visits.[87]

Motherhood: Legislation has been crafted to protect the lives of mothers and children and the national population policy aims to protect maternal health through access to contraception. In addition, the National Health Plans of 1981–1985 and 1988–1992 provided for improvements in prenatal care. The Moroccan Civil Code provides for maternity leave for working women and married women are generally prohibited from working in jobs that are dangerous, such as mining, or that may otherwise have negative effects on their families, such as work during the night shift.[88]

Policy initiatives

Reforms to the Moudawana and the Plan for Integration of Women in Development: There is a strong movement underway, which the king is supporting, albeit with great tact and only incrementally, to eliminate the *Moudawana* and replace it with a revised civil code. A commission has been created to oversee and review the *Moudawana*. The proposed new civil code would introduce changes in laws affecting women's status and relationships between men and women, including inheritance laws, marriage laws, polygamy, and children's legal status. There was an earlier era of *Moudawana* reform in 1993, but those amendments—requiring the wife's signature to make a marriage certificate valid, calling for (with exceptions) the wife and husband to appear before a judge in order for a repudiation by the husband to become valid, and demanding that a husband inform his wives in the event that he marries more than one—are considered to have been ineffective in improving women's status.[89]

A proposal for the "integration of women in development," funded by the World Bank is based on a national needs assessment and involves the public sector and NGOs. It identifies urgent actions in the areas of women's poverty, empowerment, education, legal status, age at marriage, and reproductive health. While it does not specifically target adolescents, its implementation would affect adolescents directly. The plan, which essentially defines a new civil code proposed to replace the *Moudawana*, calls for the following reforms:

- Raise the legal age at marriage of women to 18 years.
- Allow women to divorce without having to obtain the assistance and authorization of a *wali*, or a "marriage guardian."
- Eliminate men's unilateral right of repudiation and replace it with legal divorce that can be initiated by either the wife and husband. In the case of divorce, give women the right to equal inheritance, and to a duplicate of their proof of civil status to prevent blackmail by the husbands.
- Prohibit polygamy, providing for exceptions only with the full consent of the man's first wife (or wives).
- In terms of child custody and guardianship, there are a number of reforms proposed, including making the age until which parents have custody over children the same for both sexes (15 years) and allowing women who have custody of their children to remarry or move away from the father's location without losing custody.
- Provide an alternative option to the legal identification and registration of children of single mothers as "fatherless."[90]

[87] Tyane, 2001.
[88] Belouali and Guédira, 1998.
[89] Belouali and Guédira, 1998; LDDF, 1998.
[90] LDDF, 1998, citing *La vie économique* of 26 November 1999.

There is an ongoing tug of war over the *Moudawana* reform and the proposals for a new civil code, and progress on this may have halted this year. The struggle has been between those advocating for the new civil code on the one hand, and Islamists on the other.[91] Two years ago the conflict came to a head with protest marches that drew about 100,000 conservative, and mostly fundamentalist, citizens.

Gender-based violence: In 1998, the Ministry of Justice was reported to be reviewing its records to gauge the extent of violence against women. At the same time, and as a result of pressure from NGOs, the secretary of state in charge of Social Protection, Family and Children decided to launch a national campaign to combat gender-based violence.[92]

[91] LDDF, 1998; Belouali and Guédira, 1998; Kattiri, Jebbor, and Oubnichou, 2001; Benjelloun, 2001.
[92] Belouali and Guédira, 1998.

5 ARH PROGRAMS

The public health sector and public-private partnerships

Reproductive health programs specifically targeting adolescents primarily comprise population and health education efforts. Population education was introduced in Morocco following the 1974 ICPD in Bucharest and the subsequent creation of a population education coordinating body made up of the Moroccan Family Planning Association (AMPF) and the ministries of the Interior; Public Health; Employment and Social Affairs; Education; and Youth and Sports. Since 1994, this body has been publishing a bulletin, *At-Tarbiya As-Sukkaniya* (Population Education). In the public sector, population and health education is therefore carried out by various ministries, with formal health education implemented by the ministries of Youth and Sports and Education, and informal health education offered by the other ministries.[93]

In addition, the Ministry of Public Health has a national school health program to provide basic health services to students. These focus on eye exams, vaccinations, and control of respiratory infections, omitting reproductive and sexual health counseling and services.[94]

Youth center-based health education: The Ministry of Youth and Sports describes a reproductive and sexual health education program that it implements through summer camps, sports clubs, youth centers in poorer neighborhoods, vocational training institutions, and halfway homes or training centers for troubled youth. The program focuses on STIs and disease prevention, personal hygiene, and life skills and discourages "unnatural sex acts." In 1997 and 1998, a large component of this program, which focused on popular education through conferences, seminars, and theatre, reached 111,000 youth—about 50,000 more than planned. An evaluation of this program is not available. However, informal assessments have found that local leaders and other influential persons in communities reached by the program were in favor of this kind of education and that it generated discussion about these issues between men and women, which is an achievement in its own right because this occurred among circles of men and women who had not been inclined to communicate with each other.[95]

The Ministry of Youth and Sports, through the leadership of the youth directorate, also reportedly offers sessions on reproductive health and its social aspects to adolescents in their homes. The youth directorate recognizes and openly acknowledges the fact that Moroccan youth are now typically sexually active long before marriage. This alone is remarkable in a social program and policy context that is typically too reserved to acknowledge the sexuality of unmarried youth, especially young women.[96]

School-based health education: Morocco was the first country in the region to introduce population education into the national high-school science curriculum. The Ministry of Education continues to implement this curriculum component, which reviews basic information on human reproduction, contraception, and STIs.[97] Health education is introduced through a number of standard school subjects rather than as a subject of its own. But an examination of the sections of the school textbooks that cover health education, combined with some studies of the adolescents' desires for education, reveal that the

[93] Dialmy 1998.
[94] Bezad, 2001; Maasri, 2001.
[95] The program does not necessarily target all youth in these summer camps and other venues. An interview with one teenage girl who attended a summer youth camp in 1999 revealed that she knew nothing about this program.
[96] Mounabih, 2001; Reynolds, 1999.
[97] Tyane, 2001.

current health education program is not satisfying adolescents' needs.[98] Explicit reproductive health and sexual health education for youth is lacking, and students are "famished" for this kind of information.[99]

The Ministry of Education at one time planned to introduce sexual health education in schools but ran into opposition. In response, it cut back the new topics it was adding to the STI and HIV/AIDS education curriculum and started to slowly implement the curriculum in 1999 in collaboration with the Pan African AIDS Control Organization (OPALS) through teachers acting as facilitators in school-based health clubs. A new and related intervention that the Ministry of Education was piloting in 2001 aimed to build awareness of ARH among mothers in rural areas.[100]

Outreach and advocacy: The Ministry of Public Health in 2000 organized a "Week on Reproductive Health" that reached 1.2 million youth with health messages. In 2002, the ministry was planning to organize another such theme week with the regional Maghrebine Commission on School and University Health. An evaluation of the 2000 campaign is not available.[101]

AMPF has been very active in the area of outreach for youth and, by all indications, is the lead institution in Morocco for specifically targeting adolescents with ARH interventions.[102] These are primarily information, education, and communication (IEC) efforts. The AMPF works with the Ministry of Youth and Sports to provide family planning information through 340 public-sector youth houses around the country. AMPF and the Ministry of Youth and Sports also work together to mobilize youth around community development projects (e.g., numbering all the homes in a community, cleaning up the streets, etc.) that help not only attain their immediate objectives of community development but also to initiate public discussion and acceptance of ARH initiatives. AMPF also works with the Ministry of Education to offer counseling to youth through a network of "cellules de l'éducation sur la santé reproductive," or reproductive health education centers, in the ministry's school health clubs.[103]

One of AMPF's major undertakings, in collaboration with UNFPA, has been a series of two-year IEC campaigns culminating in youth festivals, "Festival National de Creativité des Jeunes," based on peer education and the ideas of entertainment education targeting youth. Attendance at festivals has increased dramatically with each new one, and now there is pressure from youth groups to organize new ones. Perhaps what needs a careful appraisal is the competence and knowledge of the peer educators; there is conflicting anecdotal evidence of the degree of their understanding and skills for educating their peers on sexual and reproductive health.[104]

A new outreach initiative of the AMPF is a "cyber health" education project for youth through cyber-cafés (sites where youth can get access to the Internet at a lower cost than through regular outlets). In the process of accessing the Internet, users have to first go through a reproductive health website that also has links to additional information on the subject. This website was prepared specifically for youth by the AMPF.

[98] AMPF/Experdata, 1995; Dialmy 1998, which also appears as section of CERED, 1998.
[99] National STD and AIDS Control Program, 2001; Kattiri, Jebbor, and Oubnichou, 2001.
[100] Bezad, 2001.
[101] Tyane, 2001.
[102] See, for instance, CERED 1998.
[103] Graigaa, 2001; Dukali, 2001.
[104] Dukali, 2001; Graigaa, 2001; Wright, 2001.

The NGO sector

A number of program managers in the public sector readily acknowledge that they turn to NGOs to target certain populations and execute particular programs that go beyond the standard and accepted target population and programming offered in the public sector. NGOs, not being under the same political and social scrutiny as public institutions, have the freedom to take on difficult issues such as ARH.[105]

An outspoken NGO that is well regarded by development professionals and that is making incursions into some areas of ARH is the Casablanca-based Association de Lutte Contre le Sida (ALCS—Association for the Prevention of AIDS). This organization has been bringing the topics of STIs and HIV/AIDS, high-risk sexual behaviors, sex work, and other sensitive but pressing issues to the attention of policymakers and into public discourse through awareness-raising and advocacy efforts involving the news media and conferences. The ALCS targets students and sex workers with information and prevention messages.[106] It has also investigated issues about which little is said or known, such as prostitution and sexual behaviors.

Another Casablanca-based organization, the Institution Nationale de Solidarité avec les Femmes en Détresse (INSAF—National Institution of Solidarity with Women in Crisis), helps single mothers and their children. In 2000, it helped 200 women and 200 babies. INSAF carries out awareness-raising and policy advocacy efforts aimed at preventing the abandonment of children by promoting family planning, sexual education, and legislation to stop sexual violence against women. INSAF helps faciliate pre- and postnatal care and support to single mothers, and works to give them literacy and vocational training and help them find jobs.[107]

The PASA Project of the Association Marocaine de Solidarité et le Développement (AMSED—the Moroccan Solidarity and Development Association) has what appears to be an exemplary community-based, needs-driven social development program similar to the Horizons Project in Egypt.[108] At its core is an in-depth adult education curriculum on reproductive health that has successfully and explicitly introduced issues such as STIs, HIV/AIDS, sexuality, and contraception in communities by first gaining the trust of the target populations. The target populations include sex workers and youth. In response to target community or implementing organization sensibilities (or both), however, the curriculum for youth leaves out key topics such as contraception and pregnancy.[109]

There are a number of other nongovernmental institutions in Morocco that are carrying out innovative interventions, policy advocacy, and legal reforms for youth, including sex workers, unwed mothers, and children of unwed mothers. An example of these is Solidarité Féminine (Feminist Solidarity) and the Ligue Marocaine pour la Protection de l'Enfance (the Moroccan League to Protect Children).[110]

New initiatives

Plan for Women's Development: A comprehensive, large program that could effectively begin to fill in sexual and reproductive health services and information gaps in the national family planning and education sectors is one that is in the planning stages as part of the "plan for the integration of women in development." The reproductive health component is wide-ranging and has a life-cycle approach to reproductive health such that reproductive health counseling for youth and strategies for priority issues—

[105] Maasri, 2001 ; Mounabih, 2001; Alami, 2001; Graigaa, 2001.
[106] Boushaba and Himmich, 2000; CERED, 1998.
[107] Joutei, 2001.
[108] CEDPA, 2000, and see Egypt ARH profile for a description of the New Horizons project.
[109] Moussaoui, 2001.
[110] For examples of the work of Solidarité Féminine, see Ech-Channa, 2000.

maternal mortality and morbidity, family planning, and STIs and HIV/AIDS—are included.[111] The plan proposes establishing a national reproductive health-specific program with regional programs and provincial cells. It outlines the following actions to improve reproductive health care in the country:

- Conduct outreach (provide information and education) to vulnerable groups.
- Manage unwed mothers' abortions and pregnancies.
- Improve training for health care professionals.
- Put in place an information management and dissemination system.
- Improve information.
- Increase the proportion of births that take place in hospitals.
- Increase pre- and postnatal care.
- Strengthen epidemiological surveillance.
- Improve STI case management for women.
- Decrease the rate of self-medication.
- Improve condom distribution.
- Improve case management of sterility.
- Decentralize case management and services for prevention of reproductive cancers. [112]

Future HIV/AIDS and STI prevention for youth: The Ministry of Public Health reports that it plans to make young adults an explicit population target of peer and other education efforts to influence sexual behaviors, although there are no such plans to provide youth-centered HIV/AIDS and STI services.[113]

[111] Bezad, 2001; Fauveau, 2001.
[112] LDDF, citing *La vie économique* of 26 November 1999.
[113] Alami, 2001.

6 OPERATIONAL BARRIERS TO ARH

In examining operational barriers to reproductive health programs, it is useful to refer to a framework presented by Cross, Hardee, and Jewell that outlines the different levels—from national policies to local programs—at which policies influence health management and services. At the highest level, this framework identifies national laws and health policies. These directly influence operational policies, which the authors define as "rules, regulations, guidelines, operating procedures, and administrative norms that governments use to translate national laws and policies into programs and services."[114] Operational policies in turn shape public sector regulations, which in their turn help shape health systems management. Ultimately, this affects reproductive health service delivery. [115]

Public sector regulations

Some of the key national-level policies—constitutional or other—that directly or indirectly affect ARH in Morocco have already been identified in this paper. In terms of a national health policy, however, there is none that explicitly addresses youth, as was mentioned earlier.[116] Accordingly, at the level of public sector regulations, there is no funding for ARH programs despite the fact that funding for reproductive health care in general more than doubled in Morocco following the ICPD in 1994.[117] (In fact, if a new area of reproductive health care is to receive public sector funds, indications are that it will be for interventions targeting menopausal women rather than young adults.[118]) Notably, however, the funding increase was greater among donors (230%) than the Ministry of Public Health (77%). The heavy reliance on donors to fund operating costs for reproductive health care, particularly where family planning is concerned, could place reproductive health programs in a precarious position.[119] In addition, much of the increase in reproductive health funding has gone toward investments to expand basic infrastructure and transport measures, so the annual rate of growth in reproductive health care spending in the 1990s was about 26 percent.[120] Thus, on one hand, the country has shown a commitment to developing reproductive health services. On the other hand, the withdrawal of donors such as USAID, combined with the uncertain state of the economy, could hamper the country's ability to operate programs. In fact, while new health facilities are being built there are insufficient funds to staff all these service delivery points. A stark example of this could be found in the southern city of Ouarzazate, where in 1998 a newly built facility remained unopened.[121]

Another cost-related barrier to reproductive health care is the taxation of contraceptive commodities, which increases their cost to programs and, to some degree, users. While the public sector offers contraceptives at no cost and social marketing initiatives between the private and public sectors have made these commodities generally affordable, any adolescents that may turn to pharmacies for help because they don't have access to formal service delivery centers could find the added cost of contraceptive or STI prevention methods prohibitive.[122]

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[114] Cross, Hardee & Jewell, 2001.
[115] Cross, Hardee & Jewell, 2001.
[116] Fauveau, 2001; Lakssir, 2001.
[117] Based on a comparison of the periods 1991–1993 and 1995–1997.
[118] Cakir, 2001; Bezad, 2001.
[119] Fauveau, 2001.
[120] Looking at the same period before and after the ICPD. Belouali and Guédira, 1998.
[121] Belouali and Guédira, 1998.
[122] National STD and AIDS Control Program, 2001; various Agadir workshop participants; Belouali and Guédira, 1998.

Health systems management

The public sector's reticence to deal with a topic as sensitive as adolescent sexuality and reproductive health translates into a dearth of services for youth. Morocco's public sector has no services for unmarried adolescents, including those who are pregnant. Youth-centered information and education on sexual and reproductive health is extremely limited, particularly in rural areas. The Ministry of Public Health considers that youth are covered by the general reproductive health services in the public sector, which in principle are available to all. However, services are decidedly not designed or implemented to target and serve adolescents, access to services that do exist is severely restricted for adolescents, and there is no institutionalization of "adolescent-friendly"care. While women seeking services at public clinics do not have to provide proof of marriage, they do have to fill out forms that ask for the name and profession of their husband, creating a barrier for unmarried young women.[123] Adolescents, therefore, do not have any explicit client rights.

Although health care coverage has been increasing overall, there are significant disparities in coverage. For instance, in 1996, there was an average of 1.2 doctors for every 10,000 people in the poorest provinces and 4.2 in urban centers. More than half of the country's physicians work in the private sector, and while the care they provide may be considered superior to that available in public institutions, private physicians are less affordable and therefore less accessible to the poor. With little or no earning power, adolescents are ill-equipped to seek care from private sector doctors.[124]

Although the nongovernmental sector does not face the same political obstacles as public institutions do in dealing with sensitive issues such as ARH, NGOs lack the human resources needed to effectively carry out large-scale programs that reach more than just small segments of the adolescent population. NGO staff are in need of training and their programs need to be standardized. Furthermore, while the potential for effective partnerships between government and nongovernmental bodies exist, there is still inadequate communication and coordination between the two sides.[125] One example is the shortage of condoms among NGOs working in HIV/AIDS and STI prevention. Although the public sector usually has sufficient supplies to share with nongovernmental groups, these projects complain that they cannot get the quantities they need for their operations. Part of the problem appears to be in the shaky relationship between the public institutions and NGOs.[126]

Service delivery

Although it can be argued that barriers to family planning services for adolescents are perhaps the biggest problem facing ARH,[127] the case of HIV/AIDS and STIs illustrates how barriers at the level of health systems management translate into operational barriers to providing services for adolescents. Because it is not socially acceptable for unmarried adolescents to be sexually active, services are not designed to reach this population that lacks the confidence and knowledge to seek out services or insist on using condoms during intercourse. With regard to young women in particular, the fear of STIs is considered to serve as a deterrent to premarital sex, resulting in little incentive to offer these young women the means to prevent STIs. Program managers and health care providers face another great barrier to treating and controlling STIs: Even married couples rarely seek STI treatment together, so when only one partner is treated for an STI it will continue to be passed back and forth between the treated and infected partner.

[123] Various, including Belouali and Guédira, 1998; Reynolds, 1999; Fauveau, 2001; Tazi Benabderrazik, 2002.
[124] Belouali and Guédira, 1998; MSP and AIDSCAP, 1997.
[125] Various (interviews).
[126] Various, including Agadir workshop.
[127] Kattiri, Jebbor, and Oubnichou, 2001.

More generally, providers have traditionally stigmatized people with STIs, compromising quality of care. Furthermore, clinical exams to detect STIs are not consistently well done.[128] The censure of sex between men and of prostitution precludes measures for prevention and care for populations that are at particularly high risk of STIs as well as acts of aggression.[129] Quite significantly, STI and HIV prevention has not yet been integrated with family planning and other reproductive health care. And those working in the field lament the lack of standards for HIV/AIDS health systems management and service delivery, including for sexual health education, counseling, and quality of care assurance.[130]

The situation with abortion in Morocco also shows how national policy and health systems management affect ARH care at the service delivery level. The legal and social climate preempts the development of standards for managing abortion-related complications,[131] even though abortion services are available in the private sector to those who can afford them. Similarly, the public sector does not have the systems in place to manage sexual abuse cases, although there are several NGOs that provide legal, social, and medical assistance to women who have been abused.[132]

[128] Alami and Maasri, 2001.
[129] Boushaba and Himmich, 2000.
[130] National STD and AIDS Control Program, 2001; various Agadir workshop participants.
[131] MSP and LEA, 1999.
[132] Belouali and Guédira, 1998.

7 RECOMMENDATIONS

Clearly, there are pressing and substantial ARH issues in Morocco that require the immediate attention of policymakers, health program managers, service providers, and donors, among others. While care for adolescents is implicitly included in general reproductive health programs, the reality is that existing programs do not meet adolescents' reproductive health needs. There is a dearth of reproductive health services, information, and education for young, unmarried adults—the majority of adolescents. In fact, the needs of this large and growing population present a great opportunity for program expansion, innovation and modernization, and for promoting the well-being of the country's next generation of leaders, political constituents, parents, and workers. As with most, if not all, national reproductive health programs, there are many areas that could be improved, expanded, and strengthened. In particular, however, there are a number of ways that Morocco could specifically improve and tailor reproductive health interventions to meet the needs of adolescents. The following recommendations are based on actual or potential initiatives that key players consider the most promising or essential for ARH.

The Plan for the Integration of Women in Development: As described earlier, this current initiative outlines recommendations that could, among other things, improve ARH through reforms in policies affecting women's status, age at marriage, and marital relationships, and through pushing reproductive health services in new directions.

Sexual and health education: Adolescents are starved for sexual and reproductive health information. Physical maturation, reproduction, and sexuality are sensitive, even taboo, topics that are avoided even within families, and youth demonstrate a tremendous gap in their knowledge of and interest in learning about these issues. Dialmy, a scholar of adolescent sexuality and reproductive health in Morocco, makes a case for addressing and changing the unstable, "mercenary" character of adolescents' sexual activity by providing sexual education to youth. He calls on parents, teachers, and health professionals to take an active role in the health education of adolescents. He also maintains that the public sector needs to better educate adolescents on the prevalence, modes of transmission, and prevention of STIs and HIV/AIDS in Morocco. As part of this, he describes the pressing need to counter the many rumors and misconceptions surrounding STIs and HIV/AIDS, including the myth that AIDS originates in women and can only be passed from women to men and not vice versa. Furthermore, he recommends that the Ministry of Health, which advocates for those who are sexually active to use condoms, and the Ministry of Religious Affairs, which calls on unmarried youth to either abstain from sex or marry, engage in a dialogue, and define a coherent, rather than a contradictory, policy.[133] AMPF also recommends that youth be made aware of the existence of AMPF's 20 clinics, which do not discriminate against adolescents seeking care.[134]

Where health education interventions do exist (e.g., in the ministries of Education and Public Health, and with AMPF) rigorous evaluations would help raise the effectiveness of these efforts.

Counseling opportunities: The requirement for premarital examinations and counseling presents an excellent opportunity to provide useful information, referrals, and services to young couples.[135] Targeting couples engaged to be married or who have just been married is a socially acceptable intervention. While premarital counseling and limited services may be offered, they are generally not standardized and are instead largely dictated by physicians' priorities, capabilities, and capacities to provide them.

[133] Dialmy, 2000b; MSP and AIDSCAP, 1997.
[134] AMPF/Experdata, 1995.
[135] Nawar, 2001; Tyane, 2001; Bennour, 2001.

In addition, discussions with youth reveal that once an adolescent has contracted an STI, he/she is highly motivated to practice safer sex.[136] Therefore, training health care providers to appropriately counsel STI clients could be an effective way to educate sexually active adolescents at a time when they are especially receptive to learning how to protect themselves and their partners.[137]

Pharmacy networks: As in Egypt and Tunisia, there is an extensive networks of pharmacies in Morocco that provides a rich opportunity to reach a very large proportion of young adults with appropriate information, counseling, and methods of contraception and disease prevention. In fact, youth more readily seek information or methods from pharmacies than from other sources,[138] and pharmacies seem to hold a monopoly on condom supplies in Morocco.[139] The typical barriers that young, unmarried persons encounter with services or education provided in the public sector are not present in pharmacies, and pharmacists could, and sometimes do, serve as reliable, confidential, and readily accessible sources of information and methods.[140] It has been found that pharmacists need training, however, to provide better information and counseling on HIV/AIDS,[141] so it may be safe to assume that they could also use training in other areas of reproductive health such as family planning.

Better understanding and addressing the needs of adolescents: First, there is a need for research on adolescents. In particular, there is an urgent need to learn more about the reproductive and sexual behaviors of youth. Sexual behavior is a very difficult subject to broach and the sexuality of youth, especially unmarried youth, is even more troublesome—so much so that even research on the subject is severely self-censored or stifled. Similarly, little is known about other subjects considered too sensitive to even investigate, such as unwanted pregnancy, abortion, gender-based violence, commercial sex work, trafficking of girls and young women, and, more generally, patterns of high-risk behavior, including those that increase the risk of HIV/AIDS.

In terms of research as well as program design, there is a marked lack of segmentation of the young adult population around the region. There is a number of specific groups—out-of-school youth, street youth, young sex workers, young clients of sex workers, drug users, rural youth, low-income youth, different age groups in the young adult population, young married and unmarried couples, and victims of gender-based violence (including sexual abuse)—who need to be better understood and who need targeted and tailored interventions.

[136] Dialmy, 2000b.
[137] MSP and AIDSCAP, 1997.
[138] AMPF/Experdata, 1995.
[139] Wright, 2001.
[140] Various, including Belayachi, 2001.
[141] MSP and AIDSCAP, 1997.

APPENDIX 1. Data for Figures 1 through 5

1. Adolescent Population (15–24) (000's)	2000	2005	2010	2015	2020
Males	3,150	3,328	3,436	3,375	3,238
Females	3,045	3,225	3,326	3,268	3,139

2. Level of Education (%)	1992 Females	1995 Females
No Education	49.8	45.9
Primary	21.5	20.5
Secondary and Higher	28.3	33.6

3. Employment (000's)	Males	Females
Employed	1,684	754
Unemployed	315	129

4. Pregnancy Outcomes (000's)	2000	2005	2010	2015	2020
Total Pregnancies	312	334	346	347	330
Births	238	255	264	266	253
Abortions	27	29	30	29	28
Miscarriages	47	50	52	52	50

5. Unmet Need (%)	1992	1995
Total Unmet Need (15–19)	16.2	11.8
Total Unmet Need (20–24)	19.6	12.2

Assumptions and Sources:

Figure 1. Adolescent Population Projections were made by entering the base year population estimates from the UN medium population projection, *World Population Prospects, The 2000 Revision*, into the POLICY Project's SPECTRUM Model and projecting the population to 2020.

Figure 2. Level of education for 1992 was taken from the 1992 Morocco Demographic and Health Survey (DHS) report, and for 1995 was taken from the 1995 Morocco DHS report. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Employment statistics were taken from LABORSTA, the Labor Statistics Database operated by the International Labor Organization (ILO) Bureau of Statistics. Unemployment and labor force size (by age and sex) were taken from the ILO Yearbook of Labor Statistics. Labor force size is defined as the labor force economically active. The number of employed was estimated by subtracting the number unemployed from the labor force size.

Figure 4. Births, abortions, and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., TFR, abortion, and miscarriages) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by

summing the total number of births, abortions, and miscarriages. Total fertility rate (TFR) and age-specific fertility rate (ASFR) for the base year were taken from the Morocco 1995 DHS report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. Abortion rate was assumed to be 9 per 1,000 (Profiles estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 5. Levels of unmet need were taken from the 1992 and 1995 Morocco DHS reports.

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