SOCIOCULTURAL DIMENSIONS TO IMPROVE UPTAKE OF MIDWIFERY CARE IN MOROCCO

SOCIOCULTURAL DIMENSIONS TO IMPROVE UPTAKE OF MIDWIFERY CARE IN MOROCCO:

A SCOPING REVIEW

By

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Abstract

Despite improvements in health care services there are poor perinatal outcomes in the rural and remote regions of Morocco. A national plan was adopted as part of a WHO, UNICEF and UNFPA initiative to reduce maternal and neonatal deaths in underserviced regions. Strengthening the profession of midwifery was identified as a key component of the initiative. In 2008, a Moroccan framework for midwifery education, regulation and funding was established. There is evidence that funded midwifery care is not being accessed by women in rural regions. A scoping review was undertaken to examine the social barriers. The review was conducted using the Arksey and O'Malley's 2005 framework for scoping reviews. The research stages included 1) identifying the research question; 2) identifying the relevant studies; 3) study selection; 4) charting the data; 5) collating, summarizing and reporting the results. The aim was to identify how the socio-cultural context can impede the uptake of midwifery care and thus impact maternal and neonatal outcomes. Language barriers, cultural differences and gender inequality were identified as key barriers that impact the acceptability of midwifery care in Morocco.

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List of Abbreviations

ALARM	Advances in Labour and Risk Management
AMSF	Association des Sages-Femmes Marocaines
AP	Action Plan
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
FIGO	International Federation of Gynecology and Obstetrics
GDP	Gross Domestic Product
HCP	Health Care Provider
ICM	International Confederation of Midwives
IMR	Infant Mortality Rate
MDG	Millennium Development Goal
MENA	Middle Eastern and Northern Africa
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MOH	Ministry of Health

MSA	Modern Standard Arabic
NGOs	Non-Governmental Organizations
NMR	Neonatal Mortality Rate
SDG	Sustainable Development Goal
SRMNH	Sexual, Reproductive, Maternal and Newborn Health
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
U5MR	Under Five Mortality Rate
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UHC	Universal Health Coverage
WB	World Bank
WHO	World Health Organization

Declaration of Academic Achievement

The following is a declaration that the content of the research in this document has been completed by Mona Abdel-Fattah and recognizes the contributions of Dr. Patricia McNiven and Dr. Anne Niec in both the research process and the completion of the thesis.

1. Introduction

1.1. Scope of the Problem

In Morocco, large disparities in health equity remain despite ongoing political efforts to improve access to health care for women and children. Economically disadvantaged, rural and remote communities are the most disadvantaged in national statistics addressing poverty, education, maternal mortality ratio (MMR), infant mortality rate (IMR) and child mortality rates. In 2010, the MMR in Morocco was reported as 112-240/100,000 live births, the highest MMR among North African nations (A. Boutayeb & Helmert, 2011; UNFPA & Ministry of Health Morocco, 2012).

The same year, the United Nations Development Programme (UNDP) reported that Morocco had the lowest Gross Domestic Product (GDP) per capita of $4628, the lowest adult literacy rate 56.4 (illiteracy rates as high as 87% for rural women), and the second lowest proportion of urban population 58.2% for the North Africa (A. Boutayeb & Helmert, 2011; Skalli, 2001). Maternal mortality in rural areas is more than double that of urban areas of Morocco, although estimates are based on limited and incomplete data (Abdesslam, 2011; Abouchadi, Belghiti Alaoui, Meski, & De Brouwere, 2013).

Nationally, the neonatal mortality rate (NMR), IMR and under 5 mortality rates (U5MR) are 21.7, 28.8 and 30.5 per 1000 live births, respectively (Abdesslam, 2011). However, the ratio of rural to urban rates is rising from 1.2 in 1992, to 1.5 in 2010, reflecting widening inequality (Abdesslam, 2011). Rural Moroccan women are attended at birth by midwives or other skilled personnel at only 55% of births, vs 92.1% in urban areas (W. Boutayeb, Lamlili, Maamri, Ben El Mostafa, & Boutayeb, 2016). Only 60% have at least one prenatal visit vs 91.6% in urban areas, and only 13.3 % have any postnatal visits compared to 30.5% for their urban counterparts (Abdesslam, 2011; W. Boutayeb et al., 2016). The lower rate of care and poorer perinatal outcomes for rural communities is alarming, especially since these data show that this is the case even when midwives are available and accessible in the community. Previous efforts have focused on improving accessibility and quality of midwifery care in Morocco; however, a sociocultural exploration is needed to address the potential barriers to care uptake.

1.2 Research Questions

What are the social and cultural barriers that impede the uptake of maternity care from trained and publicly funded midwives in rural Morocco?

Secondary research question: *What strategies can improve uptake of midwifery care, and thus improve outcomes for rural Moroccan mother-baby dyads?*

1.3 Study Aims

i. Identify how the social-cultural context can impede the uptake of midwifery care in Morocco.
ii. To review the existing literature describing the global body of evidence on midwifery quality of care, the profession in Morocco and the sociocultural barriers to effective rural maternity care.
iii. To identify gaps in research to identify areas of focus for future research.
iv. To identify strategies that may increase midwifery care in underserviced populations.

1.4 Significance of the Study

This scoping review highlights the political, historical, social and gendered factors that influence the choices of Moroccan childbearing women. By examining the social context in rural Morocco, the barriers to accessing fully trained maternity care are explored, particularly since midwifery care is regulated, funded and integrated into the health care

system and where midwives are educated to international standards. Global evidence shows that midwifery is a key component to improve maternal and newborn health, achieve universal health care coverage and develop a sustainable health care system. The exploration of the social-cultural context of maternity care in rural Morocco, will shed some additional and necessary light on barriers to care. It will also assist with strategies to achieve the sustainable development goals of health and well-being as designated by the World Health Organization (WHO) and United Nations (UN).

2. Methodology

In order to achieve the aims of this study, a scoping review methodology as described by Arksey and O'Malley (2005) was used to examine the available evidence on midwifery care and the social and cultural barriers and facilitators that may impact choices related to uptake of trained maternity care. This methodology was adopted for its ability to examine "key concepts underpinning a research area and the main sources and types of evidence available" (Arksey & O'Malley, 2005). It is well suited to answering research questions that are broad, where the research area is complex or has not previously been comprehensively

reviewed (Arksey & O'Malley, 2005). Arksey and O'Malley (2005) identified four reasons why a scoping study might be undertaken:

1. To examine the extent, range and nature of available research
2. To determine the value of undertaking a full systematic review
3. To summarize and disseminate research findings
4. To identify research gaps in the existing literature.(Arksey & O'Malley, 2005)

Here the first two reasons for conducting a scoping review are as part of an ongoing research process, with an ultimate goal of producing a full systemic review. However the second two reasons, posit the scoping review as a method in its own right and aim to disseminate research findings which may be of interest to policy makers, practitioners or consumers (Arksey & O'Malley, 2005). A scoping review also identifies research gaps and draws conclusions from existing literature regarding the overall state of research activities on the topic (Arksey & O'Malley, 2005). This aligns with the study aims: "*To conduct a broad review of the existing global evidence on midwifery quality of care, midwifery in Morocco and the barriers to effective rural maternity care; to identify gaps in research and areas of focus for future research and to identify strategies to improve uptake of midwifery care in underserviced populations*". The

methodology includes five stages aimed to achieve a comprehensive, broad and in-depth review. The steps are as follows:

Framework Stage 1: Identify the Research Question

Framework Stage 2: Identify Relevant Studies

Framework Stage 3: Study Selection

Framework Stage 4: Charting the Data

Framework Stage 5: Collating, Summarizing and Reporting the Results

Framework Optional Stage: Consultation Exercise (Arksey & O'Malley, 2005).

The optional consultation exercise was not carried out due to language, financial and time constraints.

2.1 Stage 1: Identify the Research Question

The research question identified was: "*What are the social and cultural barriers that may impede the uptake of maternity care from trained and publicly funded midwives in rural Morocco?*". In this stage it was recognized that "social and cultural barriers" is a wide and encompassing term, and major themes of gender, culture and language emerged throughout the review of the literature. It was also identified that the health care system is complex, including public and private funded

systems and a broad scope of practice for midwives which was not limited to maternity care. Women sometimes had a combination of different types of regulated and unregulated care providers, including midwives, doctors and/ or traditional birth attendants (TBAs). The question was thus adapted to focus on maternity care provided by trained and publicly funded midwives. Lastly, it was identified that there are significant differences between urba and rural maternity care delivery and outcomes, and thus a focus on underserviced areas was adopted into the question.

2.2 Stage 2: Identifying Relevant Studies

In this stage, a broad approach to searching for research evidence was conducted in an iterative manner. Different sources and search terms were redefined and adjusted in a reflexive way, as proposed by Arksey and O' Malley (2005). Articles were gathered by searching electronic databases including CINAHL and OVID, producing a wide range of research articles from within Morocco and internationally. Additionally, the World Health Organization, United Nations Population Fund, International Confederation of Midwives and the Moroccan Government websites were searched for additional grey literature resources. Reference lists from identified studies and grey literature were reviewed for additional relevant sources and studies. Lastly, networks and organizations were contacted,

including L'Association Marocaine de Sages Femmes and Association Nationale des Sages Femmes au Maroc.

2.3 Stage 3: Study Selection

The initial perusal of citations from the electronic databases picked up many irrelevant studies, mostly related to non-maternity women's health issues, Moroccan migrants receiving care in Europe or were not related to midwifery care. This is a challenge in scoping studies which aim to seek a breadth of literature rather than a narrow search (Arksey & O'Malley, 2005). Initial database search of CINAHL and OVID, produced 1268 results for the broad keywords "Moroc*", "wom*" and "health". A subsequent search, using key words "Maroc*" and "midw*" generated another 85 sources. Thus, inclusion and exclusion criteria were used to focus the search to relevant studies to address the central research question, these were devised *post hoc*, as familiarity with the topic evolved. Studies were included which were in English an exception was made for government literature and personal correspondence, was published after 1990, and addressed midwifery quality of care, maternity care in Morocco and maternity care in rural Moroccan regions. Citations were reviewed for these criteria, and selected studies were obtained in full

for closer review. Twelve articles were selected for inclusion in the review based on relevance to the research question.

2.4 Stage 4: Charting the Data

Charting the data involved synthesizing and interpreting the data according to key issues and themes. Mendeley reference and research management software was used to import articles and organize literature into emerging themes. This also allowed for identification and removal of duplicate articles and grouping papers by author and organization. Themes that evolved included a historical examination of midwifery in Morocco, gender analysis of the profession of midwifery and gender norms that pose barriers to seeking types of maternity care, cultural ideology on birthing and language.

2.5 Stage 5: Collating, Summarizing and Reporting the Results

The final stage was to collate, summarize and report the results to present a narrative review of the existing literature. This scoping review was organized in accordance with the three aims of the study. The first sections focus on framing the components of the scoping review, including the research question, scope of the problem, methodology and significance of the review. Subsequent sections address the first aim, of

reviewing the existing literature describing the global evidence on midwifery quality of care, the profession in Morocco, and the barriers to the uptake of rural maternity care. The final sections identify gaps in research and areas of focus for future research and strategies that may improve uptake of midwifery care in underserviced populations.

3. Background

3.1 Political Background

The Kingdom of Morocco, is a low-middle income country (LMIC)[1] in Northwest Africa, also called the *Maghreb* (World Bank Data Team, 2018). The native inhabitants of Morocco are the Amazighs, who were well established in North Africa prior to 1000 BC (Guerch, 2015). Morocco's early history is significant for many migrants, traders and invaders, due to its geographic location on the Northwest corner of Africa, just 14 km from Spain across the Strait of Gibraltar and long coastal borders on the Mediterranean Sea and Atlantic Ocean (Appendix A) (Guerch, 2015). Morocco, and its Amazigh people, suffered invasions by the Phoenicians, the Romans, the Vandals, the Byzantines, the Arabs and the Europeans (Guerch, 2015). Arabs began settling in the region in the 6th century AD, and Arabs conquered Indigenous Amazigh tribes as early as the seventh century A.D. and the region as a whole fell into successive Arab forces from 1559 onwards (US Library of Congress, 2006). The French influence and presence in Morocco started at the beginning of the nineteenth century, and by 1912, most of Morocco had become a French protectorate under the Treaty of Fèz (US Library of Congress, 2006). At

[1] As classified by the World Bank.

the same time, Spain was given control of parts of Morocco in the far north and the south (US Library of Congress, 2006). The Arabs, French and Spanish have had the most lasting and significant impacts, with lasting political, religious, linguistic and economic legacies of the colonial practices and policies (Guerch, 2015; US Library of Congress, 2006).

Morocco gained independence in 1956 after successful negotiations between Sultan Mohammed V and the French and Spanish protectorates, at that time the monarch was established, and Mohammed V became King (US Library of Congress, 2006). The new government was based on a constitutional monarchy with a democratic form of government. However, the Arab monarchy has maintained an active political role and holds ultimate authority (US Library of Congress, 2006). Due to the history of colonialism, Morocco remains a multilinguistic and multiethnic country. Political, administrative and business activities are conducted in Arabic, the official language, in French and the Northern regions, in Spanish (Guerch, 2015; Sadiqi, 2008). Judicial and legal systems in Morocco incorporate aspects of French and Spanish civil law, and Islamic Law (US Library of Congress, 2006). These systems based in colonial European and Arab influences continue to disadvantage the Amazigh people, who make up the majority of the rural population (Guerch, 2015). Despite Moroccan independence, there are border

disputes with Spain and neighbouring Algeria which have negatively impacted the national economy (US Library of Congress, 2006).

The current King, King Mohammed VI, has ruled since 1999, and holds ultimate authority despite an elected bicameral parliament (US Library of Congress, 2006). He has been credited with leading Morocco towards political, social and economic reforms and modernization (US Library of Congress, 2006). Political reforms included increased transparency in political and business activities, actions towards reducing corruption, improvements in election processes and increasing authority and responsibilities of parliament and local governments (Royaume Du Maroc Ministere de la Sante, 2016a; US Library of Congress, 2006). He has recognised the inequities in Morocco and made some concessions and reforms to recognize some Amazigh rights, including language rights (US Library of Congress, 2006). A number of action plans and strategies have been developed to reduce inequities related to poverty, education and literacy, health access and outcomes and infrastructure improvements (W. Boutayeb et al., 2016). Programmes were implemented to improve conditions in rural areas, including improvements in access to clean drinking water, electricity and addressing issues of transportation in rural and remote regions (W. Boutayeb et al., 2016). Some attention has also been given to gender equity, through reforms to the Moroccan Family

Code, Action Plans to reduce maternal mortality and improve access to maternity care (W. Boutayeb et al., 2016). Initiatives related to improvements in access to quality maternity care are discussed in more detail in subsequent sections of this paper. Despite the political commitments and projects and related progress, inequities remain for the Amazigh people, and particularly rural Amazigh women.

3.2. Midwifery the Profession

Preventing maternal and newborn deaths and adverse outcomes remains a significant challenge internationally. One of the key interventions to improve maternal newborn health (MNH) outcomes is increasing the proportion of skilled attendance at birth (United Nations, 2003, 2015b, 2015c). However, MNH outcomes are substantially improved by the provision of a complete package of sexual, reproductive, maternal and newborn health (SRMNH) services when provided by midwives (Lerberghe et al., 2014; Renfrew et al., 2014; World Health Orgnization, 2018). In order to understand the evidence supporting this, it is important to first define the terms ‘midwifery care’ and ‘midwife’, discuss the underlying philosophy that guides the provision of care, and review the evidence on the quality of midwifery care and barriers to the provision of effective maternity care.

3.2.1. Defining Midwifery Care

Midwifery care is defined as the "skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum, and the early weeks of life" (Renfrew et al., 2014). The International Confederation of Midwives (ICM) definition of the midwife is the standard definition which should be used by midwives trained to international standards, set by the ICM, who are regulated and or licensed. The ICM defines 'midwife' as:

> *"A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery"* (ICM, 2017c).

This definition has been adopted by the WHO and International Federation of Gynaecologists and Obstetricians (FIGO). Unfortunately, multiple definitions and differentiations in scope, education, and abilities continue to exist as evidenced by the multiple classifications listed in the International Labour Organization (ILO) (ILO, 2012, 2016). These are based on the data collection of the various occupations, related tasks and

associated common titles (ILO, 2012, 2016). The variety in scope of practice, training and abilities, can cause confusion among pregnant people and their families when navigating the health care system. It can also make interpretation of research related to MNH and midwifery more complicated, when professional and lay designations are not clearly outlined. This was the case when reviewing literature from Morocco, where untrained traditional birth attendants (TBAs) and trained midwives are included in research without clear definitions. In Morocco, a variety of midwifery training programs and related professional titles have been available from the 1950s to the present in Arabic, French and English (Temmar, Vissandjée, Hatem, Apale, & Kobluk, 2006). The Arabic titles are sometimes used interchangeably for TBAs and trained midwives. These will be discussed further later in the review.

The scope of practice of midwives, as defined by the ICM, encompasses the continuum of SRMNH. Guiding the international landscape of midwifery practice, are the ICM's *Core Documents: Global Standards for Midwifery Regulation* (ICM, 2011), *Global Standards for Midwifery Education* (ICM, 2013a), *Essential Competencies for Midwifery Practice* (ICM, 2019), *Philosophy and Model of Midwifery Care* (ICM, 2014a), *International Code of Ethics for Midwives* (ICM, 2014b) and the

Bill of Rights for Women and Midwives (ICM, 2017a). The ICM describes the scope of practice of the midwife as follows:

> "*The midwives is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.*
>
> *The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.*
>
> *A midwife may practise in any setting including the home, community, hospitals, clinics or health units"* (ICM, 2017c).

The scope of midwifery practice defines the work and necessary skills and responsibilities of midwifery care and incorporates the philosophical foundations of the profession.

3.2.2 Philosophy of Midwifery Care

At the core of midwifery practice is the philosophy of care, which is rooted in promotion of normal physiological processes of pregnancy and birth, recognition of the profound significance and meaning of the childbearing experience for women, their families and communities, and

the promotion of holistic and continuous care which values the social, emotional, cultural, psychological and physical experience of childbearing (ICM, 2014a). The Lancet's review on midwifery care, a key piece of international research, identified core characteristics of midwifery practice including "optimising normal biological, psychological, social, and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women's individual circumstances and views; and working in partnership with women to strengthen women's own capabilities to care for themselves and their families" (Renfrew et al., 2014). These characteristics of midwifery practice have been proven to contribute to enhanced quality of care, satisfaction with care and improved outcomes for women and infants (FIGO, 2015; Homer et al., 2014; Lerberghe et al., 2014; Mortensen et al., 2019; Renfrew et al., 2014; Ten Hoope-Bender et al., 2014).

3.2.3 Evidence of Quality Care

International health organizations recognize that midwifery care as provided by trained, educated, regulated midwives, according to ICM guidelines and definitions is a key component to improving maternal newborn health (MNH) outcomes across settings (FIGO, 2015; Renfrew et al., 2014; Ten Hoope-Bender et al., 2014; United Nations Population

Fund; International Confederation of Midwives; World Health Organization, 2014; World Health Organization, 2019). In 2014, the Lancet published a comprehensive and systematic analysis of midwifery care and development of a framework for assessing quality maternal and newborn care which used a mixed-methods approach to identify the benefits of midwifery care (Renfrew et al., 2014). Their approach was to review the best available evidence on what women and newborns need and what constitutes effective care practices and to develop a framework based on qualitative and quantitative evidence (Renfrew et al., 2014; Ten Hoope-Bender et al., 2014). An examination of 461 systematic reviews of effective practices for quality maternal newborn care, as well as, midwifery scope, current practice, women's experiences and workforce focus groups informed the research (Renfrew et al., 2014). Their four-part series on midwifery has become a key piece of rigorous international research that comprehensively establishes the quality, efficacy and sustainability of midwifery care and is frequently cited in publications and guidelines from the WHO.

In the Lancet framework, specific practices were identified that effectively improve MNH care and outcomes (Renfrew et al., 2014). They identified 122 effective practices. Of these, 46 (38%) that were relevant for the health and well-being of all childbearing women and their infants

and 26 (21%) first-line management for women and infants with complications (Renfrew et al., 2014). Fifty (41%) of the practices required the input of a medical practitioner with advanced skills in obstetrics, neonatology or medicine for serious complications (Renfrew et al., 2014). Of the total 122 effective practices, 72 (59%) were within the scope of midwifery (Renfrew et al., 2014). The specific aspects of midwifery care that were examined related to organization, health promotion, assessment and care planning, promotion of normal processes, prevention of complications, first-line management of complications including emergencies. Of the 72 effective midwifery practices, 61% supported normal processes of reproduction and neonatal health, 14% were intended to support women's own capabilities with information or advice that could empower them in their own care (Renfrew et al., 2014). The Lancet Midwifery Series also identified 56 outcomes improved by the combination of practices that fall within the scope of midwifery (See Table 1) (Renfrew et al., 2014). These included outcomes for women with serious negative sequelae such as mortality, serious morbidity, pre-eclampsia, eclampsia and postpartum haemorrhage requiring blood transfusions (Renfrew et al., 2014). Outcomes included reduced rates of interventions such as induction of labour, pharmacologic pain management; amniotomy, episiotomy, instrumental and caesarean births

(Renfrew et al., 2014). Psychological outcomes such as anxiety, postpartum depression, experience of pain, feelings of control during childbirth and satisfaction with pain relief and the overall childbirth experience were all improved with midwifery care (Renfrew et al., 2014).

For the fetus and newborn, outcomes are also improved (Renfrew et al., 2014). Serious outcomes such as perinatal, neonatal and infant mortality, fetal loss before 24 weeks gestation, preterm birth, neural tube defects and mother to child HIV transmission rates were all reduced (Renfrew et al., 2014). Other neonatal outcomes which can have significant impacts on neonatal and infant health, especially in low resource settings, such as low birth weight, small for gestational age, low 5-minute APGARS, infection, hypothermia and hyperbilirubinemia were also reduced (Renfrew et al., 2014). In addition to healthier mothers and babies, they identified several additional individual health and public health outcomes that were improved (Renfrew et al., 2014). These outcomes included increased contraceptive use and birth spacing, shorter hospital stays, improved mother baby interaction, increased immunization uptake and decreased number of admissions and shorter length of stay in the neonatal intensive care unit (Renfrew et al., 2014).

Table 1: Outcomes Improved by Midwifery Care[2]

Categories	Maternal Outcomes Improved	Neonatal Outcomes Improved
Reduced Serious Negative Sequela	• Mortality • Serious morbidity • Pre-eclampsia • Eclampsia • Severity of eclampsia • Postpartum haemorrhage requiring blood transfusions	• Perinatal mortality • Neonatal and infant mortality • Fetal loss • Preterm birth • Neural tube defects • Mother-to-child HIV transmission rates
Reduced Additional Health Sequela	• Maternal infections including malaria and HIV • Anemia • RhD alloimmunization • Perineal trauma • Postpartum haemorrhage requiring blood transfusions	• Low birth weight • Small for gestational age • Low 5-minute APGARS • Risk of infection • Risk of hypothermia • Serum bilirubin
Reduced Rates of Interventions	• Induction of labour • Augmentation of labour • Pharmacologic analgesics in pregnancy, childbirth and postpartum[3] • Regional analgesia or epidural • Amniotomy • Episiotomy • Perineal suturing • Instrumental birth • Caesarean section • Therapeutic uterotonics • Blood transfusions • Use of uterine massage • Pregnancy > 41 weeks gestation	• Admissions to neonatal intensive care units • Shorter hospital stays • Fewer babies in special care baby units more than 7 days
Psychological Benefits	• Reduced anxiety during 1st stage of labour • Reduced risk of postpartum depression • Improved experience of pain • Improved feelings of control during childbirth • Improved satisfaction with pain relief	• Reduced crying • Improved mother-baby interaction

[2] Adapted from The Lancet Series research on quality of midwifery care(Homer et al., 2014; Lerberghe et al., 2014; Renfrew et al., 2014; Ten Hoope-Bender et al., 2014)

[3] Not including regional analgesia or epidural

	• Improved satisfaction with childbirth experience	
Additional Benefits	• Increased contraceptive uptake • Increased attendance by a known midwife during birth • Increased referrals for pregnancy complications • Reduced smoking in pregnancy	• Increased immunization uptake • Increased average birth weight
Breastfeeding	• Increased breastfeeding initiation • Increased breastfeeding duration	
Benefits to the Mother-Baby Dyad	• Shorter hospital stays on labour ward • Increased birth spacing • Improved mother-baby interaction • Reduced crying	
Health System Benefits	• Leads to positive outcomes for mothers and newborns • Accessible quality maternity care services responsive women's needs • Delivers most of the effective MNH interventions and enables access to specialist and comprehensive emergency care when necessary • Delivers an effective SRMNH package of care, which is likely more effective than individual interventions • Increased use of contraception is a significant benefit at micro and macro levels • Long term public health and individual benefits from improved MNH outcomes, reduced sequela including mental and physical health which can have long term impacts on women, their children and their families • Cost effective, affordable and sustainable SRMNH care	

Midwifery maternity care services tend to optimize normal processes and are an acceptable and sustainable solution for health care systems. The Lancet reported that 61% of the 72 effective services provided within the scope of midwifery support normal processes of reproduction (pregnancy, birth and postpartum) and also early life for the newborn (breastfeeding, skin to skin, infection prevention) (Renfrew et al., 2014). Optimizing normal processes have been found to increase

women's satisfaction with care and reduce health care expenditures. A recent systematic review conducted to inform WHO intrapartum guidelines reported that across 19 countries, most women desire a physiological labour and birth, while acknowledging that interventions may be recommended (Downe, Finlayson, Oladapo, Bonet, & Metin Gü lmezoglu, 2018). Furthermore, high rates of interventions tend to put women at risk by exposing them to potential iatrogenic complications and various poor perinatal outcomes (Renfrew et al., 2014). The Lancet Series explored case studies of developing countries with rapid economic growth and where the contribution of midwives was either absent or had been eliminated. They found a trend in such countries toward pathologizing pregnancy and birth leading to a high rate of elective caesarean section without medical indication (Renfrew et al., 2014). India, Brazil and China are good examples of such countries; they account for over 35% of all births globally (Renfrew et al., 2014). However in 2010, Brazil had a caesarean section rate of 52% and in urban China the rate was estimated at 54-64% (Renfrew et al., 2014). In India, wide disparities were evident; the overall caesarean section rate was within the WHO recommendations at 15.1%, but the rate in the poorest rural areas was 1.5% versus 34.6% percent in private hospitals (Renfrew et al., 2014). The shift in LMIC towards medicalization of pregnancy and birth is especially troubling as it

diverts resources from scarce resources, while increasing health and financial inequalities (Renfrew et al., 2014). Cochrane Reviews, the Lancet Maternal Health Series and a recently published review on what women prefer, reinforce that women do not want to have labour interventions unless they are medically necessary (Downe et al., 2018). Brazil and China are now taking steps to rectify this problem by reintroducing midwives to reduce mortality, morbidity and unnecessary interventions (Renfrew et al., 2014). This evidence supports basing maternity service design and care provision on what women want and need as essential to maximize uptake of, and continuing access to service provision (Downe et al., 2018; Renfrew et al., 2014).

Midwives provide high quality care that is cost-effective, affordable, and sustainable and is considered to be a “best buy” in primary care (Renfrew et al., 2014; Ten Hoope-Bender et al., 2014; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014). In the high-income settings in which resource use has been examined, there are indications that “midwife-led care for women in the context of an interdisciplinary team is a more cost- effective option than medically led care” (Renfrew et al., 2014). In the USA for example, the cost of unnecessary interventions in maternity care has been estimated to be approximately 18 billion USD annually (Renfrew et al.,

2014). When examining LMICs, the empirical evidence is scarce. However, when examining the costs of increased utilization of maternity care led by obstetricians without midwives the cost is increased and becomes unsustainable (Renfrew et al., 2014). Investing in midwifery education, with community-based services could yield a 16-fold return on investment in terms of lives saved and costs of caesarean sections avoided (United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014). Investing in midwives also frees other health care providers (HPCs), such as nurses, doctors, and obstetricians to focus on pregnancies with complications requiring surgical or high-risk specialist care and other health care needs in the community.

Only midwife-led continuity of care models and community-based care packages were able to provide effective care across the whole continuum from prenatal care through intrapartum, birth and postpartum and neonatal periods (Renfrew et al., 2014). The WHO, UNFPA, UNICEF and ICM advocate for midwifery-led care by midwives as defined by the ICM (Garg, Moyo, Nove, & Bokosi, 2018; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014; World Health Organization, 2019). Renfrew et al, also compared these services as provided by midwives working in physician-led models of care, versus those provided by midwives in midwifery-led models of care, with

midwives working autonomously (2014). Their findings have synthesized the evidence and show that quality midwifery care, provided by midwives in midwife- led continuity of care (CoC) models, was associated with the greatest improvements for women and newborns (Renfrew et al., 2014). The ICM states that “investment in midwives is essential to ensure high-quality midwifery care is available to all women and their newborns, not only to reduce unnecessary interventions and preventable maternal and neonatal deaths, but to improve and protect their health outcomes on a global scale and achieve the United Nations Sustainable Development Goals” (ICM, 2017b).

The evidence is clear and has led to consensus among public health organizations that midwifery care by midwives has an important contribution to make to high quality maternal and newborn services in all settings (Homer et al., 2018; Hoope-Bender et al., 2014, 2016; Lerberghe et al., 2014; Renfrew et al., 2014; Ten Hoope-Bender et al., 2014; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014; World Health Organization, 2018). This consensus stems from the growing body of evidence from randomized controlled studies, qualitative and quantitative research, systematic reviews and practical experience in low-income, middle-income and high-income countries (Renfrew et al., 2014). The evidence not only supports

the contribution to high quality SRMNH care, but also clarifies that educated, regulated midwives integrated into the health care system are associated with rapid and sustained improvements in the quality of SRMNH care and reductions in morbidity and mortality (Renfrew et al., 2014; Ten Hoope-Bender et al., 2014).

3.2.4 Barriers to the Provision of Effective Midwifery Care

There are several components that have been identified as necessary to facilitating the ability of midwives to provide high-quality effective care. The necessary components have been identified by the ICM, WHO, FIGO and supported by the Lancet authors through the development of their framework. Midwives require effective regulation, licensing, a professional association, integration into the health care system and standardized education to attain the international competencies defined by the ICM (Filby, Mcconville, & Portela, 2016; ICM, 2011; Renfrew et al., 2014; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014; World Health Orgnization, 2016). Several key documents to assist midwives, associations, and governments to support a strong midwifery profession were developed by the ICM. These include *Global Standards for*

Midwifery Regulation (ICM, 2011), *Global Standards for Midwifery Education* (ICM, 2013a), *Essential Competencies for Midwifery Practice* (ICM, 2019), *Philosophy and Model of Midwifery Care* (ICM, 2014a), *International Code of Ethics for Midwives* (ICM, 2014b) and the *Bill of Rights for Women and Midwives* (ICM, 2017a). These requirements apply to all midwives working in all settings, regardless of the country status as a high-income country or a LMIC. In LMIC settings, additional factors may be required to enable midwives to carry out high quality work in a safe and sustainable manner. In LMICs, inadequate numbers of staff, lack of affordable transport, weak facility management and poor working conditions are barriers that contribute to the inability of midwives to provide high-quality effective care to their communities (Table 2) (Filby et al., 2016).

In addition to these system and professional requirements, significant social and cultural barriers to effective care have been identified (Filby et al., 2016; World Health Orgnization, 2016). These barriers contribute to moral distress, burn out, poorer quality care and reduced access to care (Filby et al., 2016). Low social status of the midwifery profession, cultural ideology which constructs assisting at childbirth as unskilled, unclean work, negative associations with female reproductive

functions and systems, and societal traditional practices regarding prenatal and newborn care were all found to decrease the ability of

Table 2: Requirements and Barriers to Effective Midwifery Care[4]

Effective regulation Licensing Professional association Integration into the health care system Standardized education	Inadequate numbers of staff Lack of affordable transport Weak facility management Poor working conditions Gender discrimination Low social status of the profession Cultural ideology negatively viewing women's health and birth work Negative associations with female reproduction Traditional practices related to pregnancy, birth and newborn care
Facilitate capacity for an effective midwifery workforce in all settings	Result barriers to effective midwifery care due to moral distress, burn out, poorer quality care and a reduction in access to care

[4] Adapted from ICM documents, WHO and Filby, McConville and Portela (Filby et al., 2016; ICM, 2011, 2019; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014; World Health Orgnization, 2016)

midwives to provide effective quality care (Filby et al., 2016; World Health Orgnization, 2016). The gendered discrimination that is attributed to women, as the clients of midwives, and attributed to the midwife, as a woman providing care, is the root of these barriers (Filby et al., 2016; World Health Orgnization, 2016). Furthermore, where midwifery had been professionalized, and integrated, midwives experienced prejudice for transcending traditional gender roles, and becoming too educated, leading to resentment, distrust, and potential threats and attacks (Filby et al., 2016; World Health Orgnization, 2016). In some contexts, midwives may be extremely vulnerable to sexual and physical abuse, due to their low status as midwives and as women, late and overnight working hours and attendance to clients at home (Filby et al., 2016; World Health Orgnization, 2016). Lastly, midwives, also are expected to fulfil their gendered domestic and reproductive roles along with their professional roles, which could pose exceptional challenges (Filby et al., 2016; World Health Orgnization, 2016).

Economic issues stemming from gender discrimination and the low resources of LMICs also can contribute to burnout, moral distress and poor-quality care. Economic barriers include low and sometimes absent wages, informal payments and lack of government financial commitments (Filby et al., 2016; World Health Orgnization, 2016). Midwives across

Africa have reported struggling to survive on wages below the basic costs of living, infrequently and unpredictable salaries or wages, being paid up to six months in arrears, or not at all (Filby et al., 2016; World Health Orgnization, 2016). Midwives required to purchase their own essential and protective equipment from themselves, were not always able to do so (Filby et al., 2016; World Health Orgnization, 2016). If earning potential is greater in urban centers, it contributes to lower retention of midwives in rural areas, as is the case in Indonesia and Peru (Filby et al., 2016). Where renumeration from fee-exemption schemes or other publicly funded sources was difficult, midwives sometimes had to prioritize self-paying clients, or ask for upfront payments (Filby et al., 2016; World Health Orgnization, 2016). These difficulties lead to distrust and resentment from local communities, lack of access to the most marginalized, low motivation, low self-worth and job satisfaction (Filby et al., 2016; World Health Orgnization, 2016). Economic difficulties contribute to the low status of midwives, and reinforce midwifery as an unvalued profession to public and professional populations (Filby et al., 2016; World Health Orgnization, 2016). The review of the literature from Morocco, was able to identify many of these barriers including these economic issues (Abou-Malham, Hatem, & Leduc, 2015a).

3.3. Maternity Care in Morocco

In Morocco, maternity care is largely provided by midwives who are integrated into the health care system. Efforts to improve maternal health and pregnancy outcomes in Morocco include strengthening the midwifery profession and increasing access to maternity care. Thus, this section aims to review of the history of the profession of midwifery in Morocco and the national strategies developed to improve maternity care and reduce MMR. This forms the background political and historical knowledge required in order to answer the research question, "*What are the social and cultural barriers that may impede the uptake of maternity care from trained and publicly funded midwives in rural Morocco?".*

3.3.1. History of Midwifery in Morocco

Midwifery as practiced in Morocco is the product of a complex history of varied forms of education, training and influence (Temmar et al., 2006). This has resulted in an organized, large midwifery workforce, which is legislated, integrated into the health care system, has a standardized education program, professional associations, government funding and government support in ongoing strengthening. However, prior to 1950, obstetric care in rural and semi-urban areas was only provided by

traditional birth attendants (TBAs), called *kabla*[5], in the homes of women (Temmar et al., 2006). The TBAs lacked formal education, but were highly respected in their communities for their maturity, role as confidants and the woman-centred care they provided (Temmar et al., 2006). In urban areas, there was an increasing shift toward institutional birth and an emphasis on prenatal care. This care was the responsibility of female health care workers including nurses and auxiliaries, under medical authority (Temmar et al., 2006). Male physicians seldom provided obstetric care, which was not lucrative, and traditionally considered the domain of women (Temmar et al., 2006). As the demand for maternity care grew, due to increased numbers of pregnancies in urban centres, more medical officers and nurses took over the responsibilities of midwives and TBAs in the urban centres, regardless of their training in obstetrics and gynecology (Temmar et al., 2006).

Training was instituted in 1950 for women interested in attending births, who were to be called *moualidates*[6]. This was a two-year program. This is the earliest Moroccan midwifery training, and was only available in the capital, Rabat (Temmar et al., 2006). As TBAs continued to be

[5] *Kabla* is the Arabic word for midwife and is sometimes spelled '*qabla*' or 'qabila'

[6] Moualidates is an Arabic word with a meaning similar to the French noun "accoucheur"

responsible for the care of pregnancy and birth in rural areas, and due to the increased medicalization of birth at the time, a law was instituted in 1960 that required the *kabla* to report to a medical officer to direct the care of the *kabla* (Temmar et al., 2006). This law was the first law regulating the practice of midwifery, and coincided with the first revision to the training expected of midwives or *moualidate*s, which added another year of education and training in order to receive a Professional Aptitude Certificate (PAC) (Temmar et al., 2006). This certificate permitted midwives to attend births and provide prenatal care (Temmar et al., 2006). Between 1963 and 2003, several health care cadres were trained in obstetrical care, resulting in the *infirmière accoucheuse*, a nurse with one year of training, *CAP en obstétrique*, certificate in obstetrics, *spécialiste en obstétrique*, a nurse-midwife with graduate level training, and the *sage-femme 'nouveau regime'*, a nurse-midwife with three years of undergraduate level training (Table 3) (Temmar et al., 2006). Throughout this history, midwives worked as an extension of the medical profession, with medical officers and physicians having the final authority, regardless of whether they are trained or not in gynaecology and obstetrics (Temmar et al., 2006).

Table 3: Midwifery Care Providers and Training in Morocco

Health care Cadre	Education	Location of training	Years	Duties
Kabla / Qabla	Informal	Not applicable	Not applicable	Attend birth and report to medical officer
Moualidates	A two-year certificate program	Rabat only	1950s-1960s	
Moualidates with PAC	Moualidates training plus additional year	Rabat only	1960-1970	Attend births in rural areas
Moualidates with PAC?	Moualidates training plus additional 2 years	Rabat only	1970-1970	Attend births in rural areas
Infirmière Accoucheuse	Nurse with an additional one year of training at the undergraduate level for a total of 2 years of training		1986-1988	Conduct obstetric care under medical authority
CAP en Obstétrique	Entry level program in nurse-midwifery. 2 years at undergraduate level		1988-1991	
Spécialiste en Obstétrique	Three-year undergraduate degree in nursing and allied health topics, followed by a 2-year midwifery graduate program	École de Cadres in Rabat	1962-1995 (239 graduated in total)	Conduct obstetric care under medical authority expected to go to rural areas, but most did not
	A nurse-midwife with an undergraduate degree			
Sage-femme 'Nouveau Regime'	A three-year undergraduate training program for health professionals including nurses	Agadir, Casablanca, Fes, Marrakech, Meknes, Oujda, Rabat and Tetouan	1993-	Conduct obstetric care under medical authority

Midwife	Entry-level bachelor degree resulting in competency-based education and training to ICM standards			

Source: (Temmar et al., 2006)

In 1990, the first professional association was established, the *Association des Sages-Femmes Marocaines* (AMSF), and became an ICM member at its inception (Harrizi, 2019; Temmar et al., 2006). The main focus of the AMSF, was continuing education for midwives, in association with the American College of Midwives and USAID (Temmar et al., 2006). AMSF has been active in the recruitment, training, curriculum planning and reviews and in the career development of midwives (Temmar et al., 2006). The AMSF has also further developed partnerships with non-governmental agencies, international professional associations and other national associations in order to strengthen the profession and promote midwifery (Temmar et al., 2006). Partnership with international associations, in addition to the ICM, including the International Secretariat of Nurses in the French World and the Midwives of the World, have enabled the AMSF to understand the challenges encountered by the midwifery profession elsewhere, leading to positive outcomes for the association and midwives (Temmar et al., 2006). The AMSF has also partnered with the Moroccan Association of Nursing and

Allied health to establish a framework for the promotion of the midwifery profession, including professional recognition, autonomy and visibility (Temmar et al., 2006). Currently, the AMSF has 13 regional and provincial offices throughout Morocco (Harrizi, 2019). Another professional association, l'Association Nationale de Sage Femmes au Maroc, was established in 2011, and is also an ICM member association. The profession is regulated by the Ministry of Health, and legislation from 1960 was updated in 2016 and details the scope of practice, educational requirements, responsibilities, places of practice as well as potential consequences of non-adherence to the legislation (Royaume Du Maroc Ministere de la Sante, 2016a). The AMSF is advocating for the development of an Order of Midwives to establish an autonomous regulatory body (Zalim, 2019).

Today, Moroccan midwives have a wide scope of practice and work in multiple settings. The scope of practice for midwives in Morocco includes a full spectrum of SRMNH care from adolescence, preconception and prenatal care, through birth, postpartum to menopause and for the newborn to the age of 5 years (Hatem, Temmar, & Vissandjée, 2009). Midwives have greater autonomy in their practice than previously, and are no longer subject to the final authority of the medical officer when conducting routine care (Harrizi, 2019; Royaume Du Maroc Ministere de la

Sante, 2016a; Temmar et al., 2006). Care is provided in a range of hospital settings from the larger university hospitals to small community health centres and birthing houses (Hatem et al., 2009). Most recent legislation allows for midwives to work in private hospitals and clinics also (Royaume Du Maroc Ministere de la Sante, 2016a). Midwives are expected to collaborate with physicians and facilitate consultations and transfers when complications arise (Hatem et al., 2009; Temmar et al., 2006). Most midwives in Morocco are assigned to triage rooms, labour wards, post partum services, or mother and child health units, rather than continuity of care models of practice (Hatem et al., 2009). Limitations of midwifery roles and scope are especially likely when working in interdisciplinary perinatal care teams in larger centres (Hatem et al., 2009). In this context the midwife is often considered a “technician of birth” and an auxiliary to the physician (Hatem et al., 2009). In rural settings, the Moroccan midwife is more likely to provide continuity of care, and depending of the community may have very high or more manageable workloads (Hatem et al., 2009). In rural settings, however the midwives lack support and access to health care resources such as transportation, ambulance and physician assistance (Hatem et al., 2009).

3.3.2. Identified Challenges for Midwives in Morocco

It is estimated that there are currently 4000 midwives in Morocco, which is insufficient to meet the estimated number of births (Zalim, 2019). The State of the World's Midwifery report of 2014, estimated that the Moroccan need in 2020 would be approximately over 12,000 midwives to meet 99% of the need, if the trajectory of population growth continues (United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014). Midwives in Morocco continue to meet resistance from the medical profession, difficult working situations, poor resources, and potential for fines and criminal charges due to care provision (Capelli, 2011; Newman, 2019; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014). New legislation governing midwifery was announced in 2016, and is the first update since the original legislation of 1960 which regulated nurses, midwives and other HCPs and was non-specific to midwifery (Abou-Malham et al., 2015a; Moroccan Ministry of Health, 2016). The new act defines the professional role of the midwife, with defined responsibilities and greater autonomy, as well as, the ability to practice in private or public health care systems (Royaume Du Maroc Ministere de la Sante, 2016a). It is seen as an improvement over the previous inadequate legislation (Harrizi, 2019). However, it still places punitive

measures on midwives who conduct birth outside of approved clinical settings, and midwives are liable under criminal law for clinical care (Royaume Du Maroc Ministere de la Sante, 2016a). Furthermore, some of the documents requiring approval for the implementation of the legislation have not yet been approved, and the establishment of a self-regulating body was not implemented (Harrizi, 2019).

Despite the history of midwifery as an organized, educated and integrated health care profession in Morocco, the hierarchical relationships and social dynamics have contributed to a lack of recognition of midwifery skills and contributions to SRMNH (Temmar et al., 2006). The fragmentation of the midwifery role, combined with insufficient staffing and heavy workloads has been identified as contributing to poor relationships with patients including lack of communication, respect and generally poor treatment (Hatem et al., 2009). Negative perceptions and misunderstanding of the midwives role and image are prevalent at the community level, and the midwife is often perceived as a physician's assistant, a nurse or an untrained TBA (Abou-Malham et al., 2015a). Hierarchical relationships between obstetricians and midwives, and the predominant societal focus on biomedical approaches to maternity care have contributed to difficult inter and intra professional relationships (Abou-Malham, Hatem, & Leduc, 2015b; Temmar et al., 2006). Poor

collaboration, lack of regard for peers, contemptuous attitudes, fear and distress were been reported in 2006 by the National Health Survey, and again in 2008 in an assessment of midwifery conducted by the Moroccan Ministry of Health (MOH), UNFPA and Université de Montréal, as contributing to this lack of recognition (Temmar et al., 2006). There was fierce opposition from the Moroccan College of Gynecologists and Obstetricians, particularly in the private sector, to actions taken by the midwifery association the AMSF to promote midwifery at that time (Temmar et al., 2006). Gender inequity has inhibited the growth of the midwifery workforce, in part due to social values on education and employment for women and the acceptability of women moving away from their households for training or work (Temmar et al., 2006). Inherent systems of widespread gender inequality also contributed to the 'invisibility' and low status of midwives, and the women they care for (Temmar et al., 2006). Social norms limit the visibility of women's sexual and reproductive health needs and reduce their autonomy over their SRMNH contributing to the difficulty of accessing and providing effective midwifery care (Temmar et al., 2006).

3.3.3. National Strategies and Actions to Improve MNH

While there had been efforts to improve maternal and child health since the 1970s in Morocco, it was not until the 1990s, as international discourse on goals for the new millennium were being discussed and planned by the United Nations (UN) member nations, that Moroccan policy makers began to explicitly tackle maternal mortality (UNFPA & Ministry of Health Morocco, 2012). In 1992, a national survey estimated maternal deaths in the country for the first time (UNFPA & Ministry of Health Morocco, 2012). In 2000, Morocco, along with 188 other countries, signed the Millennium Declaration, committing to the UN Millennium Development Goals (MGDs), including Millennium Development Goal (MDG) #4 and MDG #5; reduce child mortality and improve maternal health respectively (UNICEF, 2014; United Nations, 2000, 2003, 2015b). However, maternal mortality did not become a top priority in political discourse until 2008, as international focus on MMR as a measure of human development increased (W. Boutayeb et al., 2016; UNFPA & Ministry of Health Morocco, 2012). In that year, and approximately halfway to the MGD deadline, the Moroccan government launched the National Action Plan to Reduce Maternal Mortality 2008-2012 and subsequently created a maternal mortality surveillance system (See Table for a timeline of MNH

policies and programs) (W. Boutayeb et al., 2016; UNFPA & Ministry of Health Morocco, 2012).

Table 4: History of MNH Strategies and Programs[7]

Year	Program	Strategies and Aims
1970	Mother Protection Program	Ministerial decree to provide contraception, antenatal care and immunization in all health care facilities
1974	Child Health Protection Program	Introduction of three prenatal and one postnatal visit
1977		Consolidation of the Mother Protection Program and the Child Health Protection Program
1987	Monitoring of Pregnancy and Childbirth Program	Reduction of maternal mortality and morbidity. Set targets for antenatal care and birth in monitored settings
1995	Emergency Obstetric and Neonatal Care Program	Adoption of the three delays model and the launch of emergency obstetric and neonatal care. Improved availability of quality care for obstetric and neonatal emergencies.
2005	National Initiative for Human Development	Reduce poverty and health inequities by reducing poverty in rural areas, combating social exclusion in urban areas, and combat vulnerability. This was due to commitments to the MDGs and the result of a national report on human development released in 2004.
2005	Assurance Maladie Obligatoire	Institution of mandatory health insurance policies for public and private employees
2007	Free Delivery Policy	Government program to provide funding for childbirth, vaginal and caesarean, for

[7] Adapted from UNFPA, Abou-Malham, Hatem and Leduc and Boutayeb et al. (Abou-Malham et al., 2015b; W. Boutayeb et al., 2016; UNFPA & Ministry of Health Morocco, 2012)

		all women regardless of socioeconomic or insurance status
2008-2012	National Action Plan to Reduce Maternal Mortality	Implementation of this plan to reduce MMR from 227/100,000 live births to 50/100,000 live births. Key components of improving access, quality of care and governance
2009	Maternal Mortality Surveillance System Launch	National maternal death notification and data collection surveillance system. Including confidential enquiry, socio-demographic, obstetric and medical information.
2011	Régime d'Assistance Médicale RAMED	Implementation of a health insurance strategy for the poor
2012-2016	National Action Plan	Consolidate the results achieved from the previous Action Plan, reinforce proximity management, target efficient actions for rural areas and disadvantaged regions
2015	Student Health Insurance	Health insurance for students

The National Initiative for Human Development was the first national program aimed at reducing poverty and health inequities and focused on poverty in rural areas, combating social exclusion in urban areas, and combating vulnerability. This initiative was in part, a result of the Moroccan government's commitments to the MDGs which focused on poverty alleviation, human development and improved health (W. Boutayeb et al., 2016; UNFPA & Ministry of Health Morocco, 2012). Many of the actions related to this initiative impacted the social determinates of health and had positive impacts on MNH. The results improved overall

social and economic conditions for rural communities, including; improved access to drinking water, access to electricity and road improvements to rural areas (W. Boutayeb et al., 2016). For example, access to drinking water increased 92% in 1999 to 96.5% in 2011 in urban areas, and 15.5% to 48.8% for rural areas (W. Boutayeb et al., 2016). At the same time, access to electricity increased from 89.3% to 98.5% for urban areas, and from 23.2 to 88.2% in rural areas (W. Boutayeb et al., 2016). Unfortunately, access to sanitation is an ongoing problem, as 89.3% of those in urban and only 5% of those in rural areas have sanitation (W. Boutayeb et al., 2016). Thus, waterborne infections remain a public health problem (W. Boutayeb et al., 2016). While it is evident that many gains have been made in these areas, health disparities remain between urban and rural areas in all aspects of the social dimensions of health and maternal and child outcomes (Abdesslam, 2011; Abou-Malham et al., 2015b; A. Boutayeb & Helmert, 2011; W. Boutayeb et al., 2016; Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006; UNFPA & Ministry of Health Morocco, 2012).

Efforts to improve MNH continued with the launch of the 2008-2012 National Action Plan to Reduce Maternal Mortality. This Action Plan aimed to reduce maternal mortality from the estimated 227 deaths per 100,000 live births to just 50/100,000 and reduce neonatal mortality from

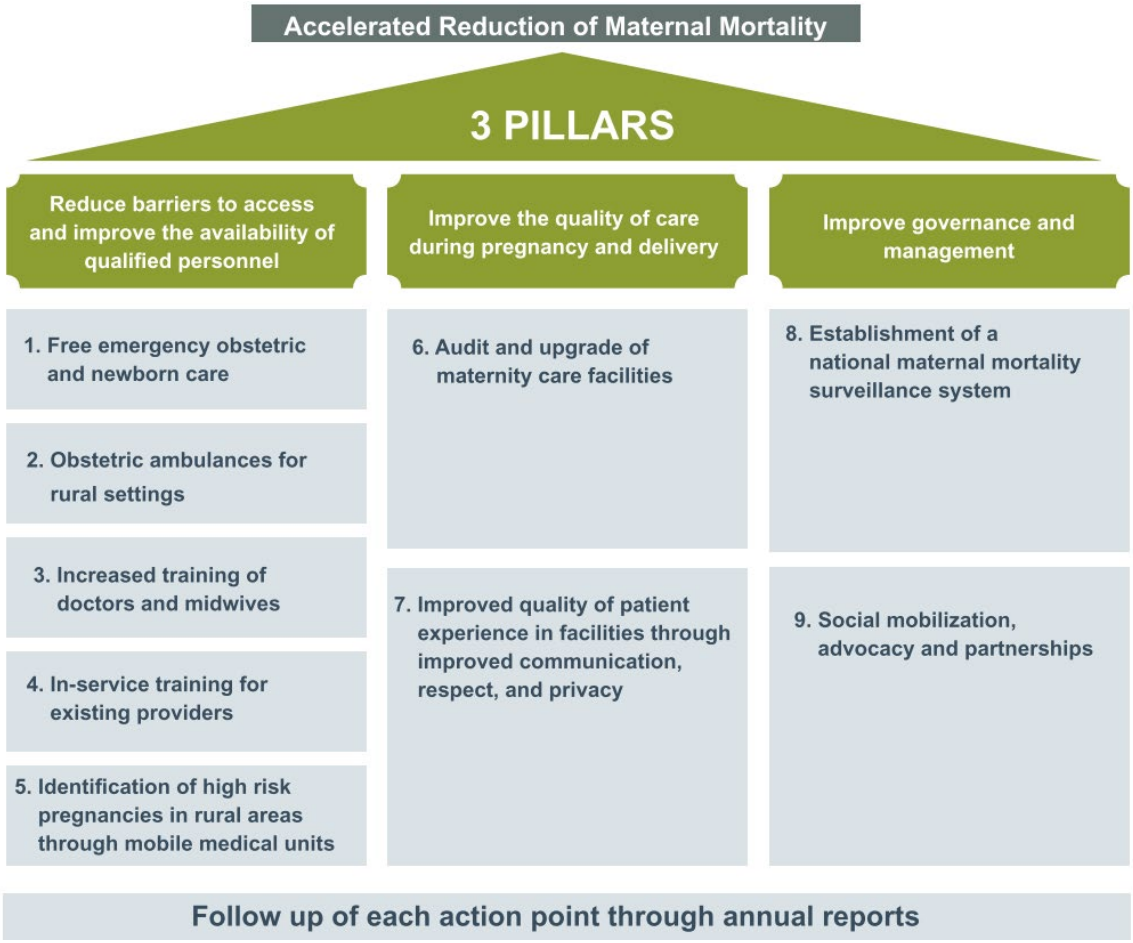
27/1,000 to 15/1,000 live births by 2015 (Abou-Malham et al., 2015b; W. Boutayeb et al., 2016; UNFPA & Ministry of Health Morocco, 2012). An ongoing national committee was established to develop strategies and then oversee the implementation (UNFPA & Ministry of Health Morocco, 2012). The key components included 3 main areas of the intervention called 'pillars' with 9 action levels and 28 main decisions covering the system of maternity care delivery (Abou-Malham et al., 2015b; UNFPA & Ministry of Health Morocco, 2012). It was meant to address the identified obstacles to care, including infrastructure, equipment and drugs, human resources, health information, quality of care and costs related to maternity care (UNFPA & Ministry of Health Morocco, 2012). The goals of this strategy included: improving access, quality of care and governance (UNFPA & Ministry of Health Morocco, 2012), national action plans and strategies, improvement of maternal and newborn outcomes (W. Boutayeb et al., 2016). Unfortunately, after the launch of the maternal mortality surveillance system, the analysis of the data revealed that the goal of a maternal mortality rate (MMR) of 50 was not achievable by the deadline date of the MGDs in 2015 (W. Boutayeb et al., 2016). However, several health care system reforms resulted in an improvement of MMR and MNH. Increased funding and audits were implemented for maternity care facilities and, in 2008, 90 new maternity hospitals and 518 health care

centres with maternity units were established (UNFPA & Ministry of Health Morocco, 2012). The results of the audits revealed the need to upgrade the physical equipment and renovate spaces for patient privacy, respect and comfort (UNFPA & Ministry of Health Morocco, 2012). Additionally, the ability of women to receive 48 hours of postpartum care became a mandatory requirement for women delivering in these institutions (UNFPA & Ministry of Health Morocco, 2012). Resources such as equipment, supplies and medications were assessed and misoprostol, magnesium sulfate and prostaglandins access were improved (UNFPA & Ministry of Health Morocco, 2012). Health insurance programs were introduced and no-fee vaginal and caesarean section were available for all (W. Boutayeb et al., 2016; UNFPA & Ministry of Health Morocco, 2012).

The National Action Plan to Reduce Maternal Mortality of 2008-2012 included in its three pillars the reduction of barriers to access and improvement in the availability of qualified personnel including physicians and midwives (Abou-Malham et al., 2015b; Hatem et al., 2009; Royaume Du Maroc Ministere de la Sante, 2016b; UNFPA & Ministry of Health Morocco, 2012). The Action Plan aimed to improve the quality of maternity care and governance to facilitate social mobilization, advocacy and partnership as well as the establishment of the national surveillance system (UNFPA & Ministry of Health Morocco, 2012). Strengthening of

the midwifery profession is a key component to improving MNH, reducing MMR and IMR, improving efficiency of maternity and neonatal care and improving health care systems (Lerberghe et al., 2014; Miller et al., 2016; Renfrew et al., 2014; Ten Hoope-Bender et al., 2014; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014; World Health Organization, 2018, 2019). This Action Plan was subsequently followed by strategies and actions aimed specifically at strengthening the midwifery profession, which will be discussed in the next section. Subsequent to the 2008-2012 National Action Plan to Reduce Maternal Mortality, an Action Plan was launched for 2012-2016. This plan aimed to build on the successes of the 2008-2012 plan, reinforce proximity management and target efficient actions to meet

Table 5: Action Plan to Reduce Maternal Mortality



the needs of rural areas and marginalized people (W. Boutayeb et al., 2016). In 2015, Morocco committed to the ongoing UN development goals and the Sustainable Development Goals (SDGs), which included specific targets to improve health and address the SRMNH needs of women (see Appendix C) (United Nations, 2015a)

The period from 1990-2012 saw many improvements in the Moroccan health care system, as well as other socioeconomic factors that facilitate good health and well-being of mothers, children and the population as a whole (W. Boutayeb et al., 2016). The improvements in reproductive health and child health cannot be attributed to a single strategy; but rather to the interconnected and at times overlapping strategies aimed at improving the socioeconomic and health status of the population. The WHO Commission on Social Determinants of Health's overarching recommendations are 1) to improve daily living conditions, 2) tackle the inequitable distribution of power, money and resources and 3) measure and understand the problem and assess the impact of action (Commision on Social Determinants of Health, 2008). This is based on the evidence that "the circumstances in which people grow, live, work, and age and the systems put in place to deal with illness" contribute to health inequities seen globally and within countries (Abdesslam, 2011; Commision on Social Determinants of Health, 2008). Additionally, the conditions in which people live and die, are shaped by political, social and economic forces (Commision on Social Determinants of Health, 2008). Thus, available literature from Morocco explores the *direct* heath care and *indirect* social and economic causes which contribute to MMR, infant mortality rates (IMR) and under 5 mortality rate (U5MR) (Abdesslam,

2011; Abou-Malham et al., 2015b; A. Boutayeb & Helmert, 2011; W. Boutayeb et al., 2016; Hatem et al., 2009; Temmar et al., 2006). This can be seen in the review of the national actions taken by the Moroccan government to improve MNH outcomes.

3.3.4. National Action Plan Impacts on Midwifery

As part to the commitment to the 2008-2012 National Action Plan to Reduce Maternal Mortality, and MDG #5, an assessment of the state of midwifery in Morocco was carried out by the Moroccan Ministry of Health (MOH) with support from the UNFPA and in collaboration with the Université of Montréal (Abou-Malham et al., 2015b). In 2008, the assessment revealed that significant changes to the education, legislation, practice environment and professional image were needed to strengthen the profession (Abou-Malham et al., 2015b). The foundation of midwifery in Morocco was within the medical model with a philosophy of illness, rather than that of wellness, and in contrast to the philosophy of midwifery (Abou-Malham et al., 2015b). Specifically, the analysis found a lack of congruence of the midwifery education curriculum with international standards and a poorly defined scope of practice which was not consistent with the ICM definition of the midwife and did not allow midwives to

provide woman-centred care (Abou-Malham et al., 2015b). Furthermore, they found that there was a negative image of midwifery among both the professional community and society at large, and that midwives worked in 'unfavourable' practice environments (Abou-Malham et al., 2015b, 2015a). The assessment of the midwifery profession led to the development of a strategic action plan specific to strengthening the professional role of midwives (Abou-Malham et al., 2015b, 2015a). The plan consisted of three main objectives, first to address education and develop and implement a competency-based education program to educate midwives to international standards (Abou-Malham et al., 2015b). The second objective was aimed at professional tasks such as to revitalize the current midwifery association (Abou-Malham et al., 2015b). Lastly, the plan addressed the sociopolitical and legal aspects and involved activities such as a social campaign to market midwifery services and proposed changes to midwifery legislation (Abou-Malham et al., 2015b, 2015a). This was based on an evidence-based philosophy that by stronger education, attaining regulation and association, and enabling qualified midwives to work in an enabling environment integrated into the health care system, the quality of MNH care outcomes are improved (Abou-Malham et al., 2015b; Bharj et al., 2016; Lerberghe et al., 2014; Miller et al., 2016; Renfrew et al., 2014; Ten Hoope-Bender et al., 2014).

Following the development and implementation of the Action Plan to strengthen the midwifery profession, a study of the barriers and facilitators and efficacy of the Action Plan was undertaken by Abou-Melham, Hatem and Leduc (Abou-Malham et al., 2015b, 2015a). Their analysis was conducted just 18 months after the launch of the Action Plan identified many barriers and some facilitators to the implementation (Abou-Malham et al., 2015b). They found that the educational objective had been implemented, which included training in the Advances in Labour and Risk Management (ALARM) program by Canadian Instructors, train-the-trainer sessions on competency-based approaches, and implementing a competency-based education program (Abou-Malham et al., 2015b). The implementation process faced numerous challenges, including low adherence to the planned activities, poor timelines for carrying out the activities, and a lack of engagement in the process (Abou-Malham et al., 2015b). For instance, many clinicians, including midwives were unaware of this Action Plan and only three ALARM International workshops were held (Abou-Malham et al., 2015b). Midwives and midwifery educators were not consulted on their training needs, and only three sessions involving only six midwifery educators, from one institution, led to the development of the competency based midwifery education program, but not its implementation (Abou-Malham et al., 2015b). The Action Plan was

constrained due to limited funding, bureaucratic and centralized organizational issues and lack of coordination with training facilities (Abou-Malham et al., 2015b). In addition, outdated and non-specific legislation was identified as limiting the ability of midwives to fulfil an expanded role, assume additional roles, or apply new knowledge from the education activities (Abou-Malham et al., 2015a). The legislation was criticized for failing to provide legal protections for midwives that aligned with the new competencies (Abou-Malham et al., 2015a). The consultant who conducted the 2008 analysis and contributed to the plan for action, and the MOH, lacked the involvement and engagement of midwives and midwifery educators (Abou-Malham et al., 2015b). Unfortunately, in sociocultural aspects of the Action Plan aimed at marketing and elevating the perceptions of the public regarding midwives and midwifery care were not implemented, nor were the legal and political changes that had been planned by the end of the 18 months (Abou-Malham et al., 2015b). The researchers concluded that a participatory, non-hierarchical approach involving a broad range of stakeholders would contribute to better implementation, promote collaboration and engage and empower midwives, and create ownership over the projects improving interprofessional culture and relationships and increasing the efficiency and efficacy of the Action Plan (Abou-Malham et al., 2015b).

Subsequent to the 2008 Action Plan, the 2012-2016 Action Plan to Accelerate the Reduction of Maternal and Neonatal Mortality continued its focus on strengthening the midwifery profession (Royaume Du Maroc Ministere de la Sante, 2016b). In 2013, in preparation for the State of the World's Midwifery report of 2014 by the UNFPA, a consultation took place and a new five-year strategic plan for promotion of the midwifery profession was developed (Royaume Du Maroc Ministere de la Sante, 2016b). The midwifery curriculum was once again revised making competencies the main target of training, promoting the ICM standards and developing a better match between training and skills for employment (Royaume Du Maroc Ministere de la Sante, 2016b). This time, a National Committee for the Management and Monitoring of the Implementation was developed, and local committees including teachers from all seven educational institutions were engaged (Royaume Du Maroc Ministere de la Sante, 2016b). Efforts were made to improve communication, and to facilitate decision-making by consensus, engaging midwives as essential and decisive participants in the development and ownership of the competency-based training program (Royaume Du Maroc Ministere de la Sante, 2016b). The new program was developed for graduates of a bachelor's degree program in sciences, and involved three years of post-graduate training, including 48% clinical internships in hospital and

community settings, bringing the program in line with the *ICM Global Standards for Midwifery Education*, and the *ICM Essential Competencies for Midwifery Practice* (ICM, 2013b, 2019; Royaume Du Maroc Ministere de la Sante, 2016b). This curriculum was implemented in 2013 and is currently offered in 23 institutions throughout Morocco. Additionally, reforms followed to the legislation giving more autonomy and clear representation of the role and responsibilities of midwives (Royaume Du Maroc Ministere de la Sante, 2016a).

The national action plans of 2008 and 2012 had significant impacts on strengthening the profession of midwifery and bringing the profession in alignment with the global standards set by the ICM. However, despite the strong profession, issues related to sociocultural dynamics, including gender, language and culture, continue to impact midwifery care uptake.

4. Uptake of Midwifery Care: Language, Culture and Gender

In Morocco, midwifery care has been integrated into the health care system for over 70 years, and significant efforts have been made to strengthen and expand the profession. Nationally, maternal and newborn health (MNH) outcomes have improved significantly since the 1990s. Many of the improvements can be attributed to declining fertility rates and improved overall access to skilled attendance at birth. However, large disparities in MNH outcomes remain in rural areas and among marginalized groups due to preventable perinatal morbidity and mortality.

Quality maternity care, including midwifery care, has been proven to have a positive impact on MNH. However, uptake of midwifery services, including the full spectrum of sexual, reproductive, maternal and newborn health (SRMNH) care remains a concern in rural Moroccan communities. This is seen in low numbers of antenatal care appointments, few to no postnatal appointments and women giving birth without a skilled attendant present. Indeed, social exclusions and discrimination have a very direct impact on sexual and reproductive health due to social restrictions, lack of financial security and decision-making autonomy within the household, inequitable access to education and health promotion information (Department of International Developement (UK), 2004). These factors limit women access to quality care, choice to

use available services and their ability to adopt informed and effective SRH behaviours (Department of International Developement (UK), 2004). Through a review of the available literature, three themes emerged that impact women's experiences in the health care system and their decision to access midwifery care. The themes include: language barriers, local and institutional cultures that are incongruent and gender discrimination.

4.1. Language and Sociocultural Impact

Morocco is a multilinguistic county and is ethnically diverse. The main languages are French, Modern Standard Arabic, Spanish, Moroccan Arabic (*Darija*), and Amazigh languages (often referred to as "Berber"[8]) (Guerch, 2015, 2017; Sadiqi, 2008). French, Modern Standard Arabic and Spanish, due to the legacy of colonialism, are the languages of government, education and public administration (Guerch, 2015, 2017; Sadiqi, 2008). The Amazigh languages are a group of ancient oral languages used by the Indigenous Amazigh tribes of North Africa (Sadiqi, 2008). In Morocco, the main Amazigh languages include Tachelhit in the

[8] Berber is considered a derogatory term due to its origins in Greek "Barbaroi" and Latin " Barbari" to designate "aliens to Greco-Roman civilization" (Belahsen et al., 2017). Amazigh, which means 'free human" is preferred, and rejected by the Amazigh people due to the barbaric connotations (Belahsen et al., 2017; Guerch, 2017). Variations include Imazighen (pl) and Tamazight (f) (Belahsen et al., 2017).

South, Tamazight in Central Morocco, Tarifit in the Rif region, as well as at least a dozen others (Belahsen, Naciri, & El Ibrahimi, 2017; Guerch, 2017). Figure 1 represents the percentage of Amazigh languages speakers by region. The variety of languages and dialects impacts SRMNH care due to the history and values ascribed to the language and the potential for language barriers between HCPs, including midwives, and women. The impact of language is most significant for rural populations in provision of SRMNH care.

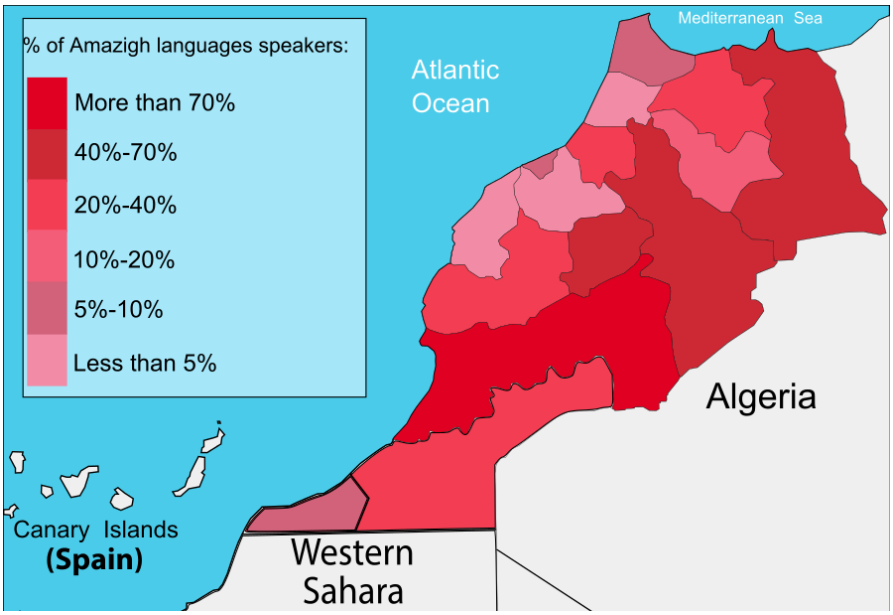


Figure 1: Percentage of Amazigh Languages Speakers

. Within the Moroccan health care system, issues related to language form barriers to high quality care for Amazigh women. Physicians are often trained abroad, in France and Belgium, and come from the dominant Arab speaking population (Guerch, 2015, 2017).

Similarly, pharmacists, nurses and midwives are predominantly Arabic speaking, urban, and educated in French and Modern Standard Arabic (Guerch, 2015, 2017; Hatem et al., 2009; Royaume Du Maroc Ministere de la Sante, 2016b; Temmar et al., 2006). A study by Guerch, found only 10 of the 70 interviewed health care workers spoke an Amazigh language (Guerch, 2015). Most spoke Darija, French and Modern Standard Arabic, some reported speaking Spanish or English, although, a third worked in rural areas with 100% Imazighen speakers, and the others worked in urban and semi urban regions with majority Imazighen speaking populations (Guerch, 2015). Only four nurses of the 70 health care professionals received training in cultural and linguistic specificities for the patients in the communities in which they worked (Guerch, 2015). Compounding this problem is the 'forced appointment' of Arabic-speaking physicians and midwives in Amazigh rural and semi-rural regions (Guerch, 2015, 2017; Temmar et al., 2006). Often contracts are short term with few resources or supports, and have high turnover rates, leading to a lack of continuity, challenges in integration into the community, lack of understanding of cultural and linguistic aspects particular to the community and lack of trust from the community members themselves (Capelli, 2011; Guerch, 2017; Hatem et al., 2009; Temmar et al., 2006).

In rural areas, the husband is needed for translation between the HCP and the parturient woman (Guerch, 2015, 2017). In urban and semi urban regions, a nurse, child, mother, mother-in-law or husband may translate (Guerch, 2015, 2017). Due to the presence of a third person, lack of an available interpreter, embarrassment, modesty, illiteracy, lack of knowledge about their bodies and language barriers, many Amazigh women do not disclose many aspects of their health concerns (Guerch, 2015, 2017). Domestic violence, gynecologic concerns and mental health concerns are largely undisclosed (Guerch, 2015, 2017). Language barriers limit the ability for midwives to provide quality maternity care, build trusting relationships, and contribute to a lack of acceptability of midwifery care.

4.2. Cultural Influences on Childbirth Choices

Pregnancy and childbirth are significant social and cultural events in women's lives, and as such, are governed by social norms. Dominant cultural norms are imbedded in social institutions, such as laws, education and health care. Dominant cultural norms integrated into health care, may be beneficial, neutral or detrimental to care provision. However, differences in the culture of health care services and service users has been identified as a concern with potential to negatively impact care and

care uptake (Coast, Jones, Portela, & Lattof, 2014; Renfrew et al., 2014). Such differences may lead to perceived or actual cultural insensitivity, professional incompetence and poor quality of care by the users of the health care services, resulting in lack of trust in services and HCPs (Coast et al., 2014). Cultural factors that impact maternity care include differences in biomedical and traditional childbirth approaches.

In Morocco, dominant biomedical culture has had a large influence on midwifery practice, moving midwifery away from traditional practices, knowledge and woman-centred care and towards a medicalized model. The health care system is rooted in Arab and biomedical culture, and regulated by legal and institutional policies that reduce the ability of midwives to care for the social, cultural and emotional aspects of care (Abou-Malham et al., 2015a; Temmar et al., 2006). In contrast, women, especially rural women, have a health culture that embodies a plurality of Islamic and Amazigh cultural and traditional health systems (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006). Several authors have noted influences of the Galenic and Prophetic beliefs on the traditional practices related to pregnancy and childbirth (Bakker, 1992; Capelli, 2011; Hatem et al., 2009).

The Galenic approach is based on philosophical notions of balance and natural remedies emphasising the use of hot and cold as well as

medicinal plants used by traditional herbalists and healers (Capelli, 2011). The Prophetic medicinal approach, is based on the ideology that illness is caused by an invasion of the spirit, potentially *jinn*[9], which can be managed through *fqih*[10], religious ceremonies, religious healers and *fuqaha*[11] (Bakker, 1992; Capelli, 2011). These concepts are intertwined with biomedical concepts, with women and families relying on heterogenous sources of knowledge to inform their choices, values and interpretations of maternity care (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006).

While the traditional and cultural beliefs and practices may differ, they are not entirely incompatible with evidence-based quality care (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006). Differences in the cultures of health care providers and service users has a negative impact on the acceptability of the maternity care offered by midwives (Coast et al., 2014; Homer et al., 2018). Capelli found that midwives were not trusted because of perceived alignment to state policies to

[9] A pre-Islamic, Arabian mythical being, such as a spirit, demon or genie, which features in Islamic mythology, also.
[10] The human understanding of Islamic jurisprudence, including *Sharia Law* and *Sunnah*, the teachings and practices of the prophet Mohamed (PBUH) and his companions, also spelled *fiqh*. *Fqih*, is considered fallible and changeable, whereas *Sharia Law* is considered immutable.
[11] *Fuquha* are people trained in *fiqh*, singular is *faqih*.

promote facility birth and disregard of the cultural norms and values of women (Capelli, 2011).

Temmar's analysis of midwifery in Morocco noted the patriarchal and biomedical cultures which impact women's clinical experiences and health outcome "underlie the reasons why home delivery often represents a form of reassuring refuge, especially for the most vulnerable women" (Temmar et al., 2006). Similarly, midwives may lack reciprocal trust in traditional knowledge, cultural practices which were not consistent with the medicalized approach to pregnancy and birth, even if they were compatible with 'safe' birthing processes (Capelli, 2011). This leads to lack of trust in health care services and HCPs, including midwives and has a negative impact on the acceptability and uptake of maternity services (Capelli, 2011; Coast et al., 2014; Homer et al., 2018).

Lastly, contributing to the problems of incongruent cultural influences in the Moroccan rural context, is the positioning of new graduates from the midwifery education programs into rural postings (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006). Due to the shortage of trained midwives, and the extreme shortages of skilled maternity care providers in rural areas, new graduates are often posted in rural communities where they may lack knowledge of local customs, practices and this may be compounded by language barriers (Capelli,

2011; Hatem et al., 2009; Temmar et al., 2006). These new midwives are often young, with no social connections to the community and lack health care resources (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006). The posts are often short-term with a high turnover rate, preventing the development of trust, continuity of care and development of culturally relevant knowledge (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006). The *kabla*, or local TBA tend to be older, have more experience with birth, have intimate knowledge of the cultural and traditional norms of the community and have gained their trust and respect because they are part of the community (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006). This can result in women choosing to access care from the TBA, rather than the trained midwife in the community (Capelli, 2011; Coast et al., 2014; Hatem et al., 2009; Homer et al., 2018; Temmar et al., 2006).

The impact of the differences in views on health care between care provider and the childbearing woman can be mitigated. Temmar notes that challenge for midwives in Morocco is the 'creative reconciliation, with women, of the best elements of the medical model and local knowledge and practices' (Temmar et al., 2006). In Morocco, midwives continue to informally work with TBAs, as TBAs are not recognized within the health care system (Capelli, 2011; Hatem et al., 2009). This is attributed in part to the trust and influence that is attributed to TBAs by women and their

families (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006). Midwives also continue to attend women who refuse or cannot attend a facility for birth to try to mitigate some of the risks related to unskilled or lack of birth attendants (Capelli, 2011; Hatem et al., 2009). However, midwives do so at their own risk, as the current legislation and infrastructure does not support home birth or working with TBAs, and midwives are subject to the current legislation as well as the criminal code (Royaume Du Maroc Ministere de la Sante, 2016a).

4.3. Gender and Feminist Activism in Morocco

Gender equity has been a recurring theme in the literature on maternity care in Morocco, impacting the agency and choices of Moroccan women, and the provision of midwifery care (Abdesslam, 2011; W. Boutayeb et al., 2016; Hatem et al., 2009; Temmar et al., 2006; UNFPA & Ministry of Health Morocco, 2012). As gender issues are not limited to maternity care, but impact the population as whole, female inequality has led to social movements and actions to improve conditions for women and girls. Since the late 1980s, the political and economic reforms in Morocco have encouraged the rise of a number of associational bodies, under the rubric of a civil society including several women's rights and gender equity

associations (Yachoulti, 2015). The organizations were defined as "voluntary organizations, whose ideological discourse aimed to defend women in a general framework of struggle and implement laws that enlarge public liberties and guarantee equality between the sexes" (Yachoulti, 2015). It is this activism that promoted women's roles in the public sphere and lobbied the Moroccan government toward several gender reforms, including reforms to the *Moudawana*, removal of reservations to the UN's Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and reforms to the constitution and penal code.

4.3.1. Moudawana

The *Moudawana*, or Family Code, governs the rights and obligations of families in Morocco, including those pertaining to marriage, divorce, inheritance, alimony and the custody of children (Hanafi, 2011; Yachoulti, 2015). The Code is rooted in Islamic Maliki[12] tradition, and provided for unequal rights based on gender, disadvantaging women in marriage, divorce, inheritance and child custody (Hanafi, 2011; Yachoulti, 2015). The organization of women's rights associations led to reforms to

[12] Maliki is one of four major schools of jurisprudence within Sunni Islam, which predominantly in practiced in North Africa

the *Moudawana*, a significant gain towards greater gender equity (Yachoulti, 2015). The reforms established a minimum age of marriage of 18 years, restricted polygamy, allowed women the right to initiate divorce and called for men and women to be equal partners in marriage and household responsibilities, eliminating the requirement of a male legal tutorship in marriage (Yachoulti, 2015). The organizations bypassed all the elected institutions in order to press for change of the *Moudawana*, following the failure of the government to implement the national plan for Integrating Women in Development, and instead directly addressed King Mohammed VI to bring about these changes (Yachoulti, 2015). The same strategy was employed in order to amend the Nationality Code in 2007, to allow Moroccan women to pass citizenship rights to their children (Yachoulti, 2015). Previously only Morrocan fathers could pass citizenship their children (Yachoulti, 2015). While these were important political and legal reforms, the *Moudawana* has been criticized for including loop-holes, a lack of comprehensiveness, cultural resistance and lack of enforcement (Hanafi, 2011; Yachoulti, 2015). Specifically, the *Moudawana* included a process for the marriage of girls under the age of 18 but did not address gender-based, domestic or sexual violence (Sabbe et al., 2015, 2013; Yachoulti, 2015). Thus, the reforms to the *Moudawana*, seen as top-down reforms, have not been widely implemented and were largely ignored

within the judicial system (Hanafi, 2011; Yachoulti, 2015). While the *Moudawana* by law applies to all Moroccans, in practice, rural women remain disadvantaged compared to their urban counterparts due to illiteracy, lack of awareness or access to the justice system and its procedures (Hanafi, 2011).

4.3.2. Feminist Spring for CEDAW

Feminist organizations in Morocco continued to fight for increased gender equity, and during the Arab Spring, Moroccan woman seized on the social momentum in what has been called the "Feminist Spring for Equality and Democracy" (Yachoulti, 2015). The Feminist Spring's main focus was to emphasize the necessity of the Moroccan government to implement democratic reforms based on international human rights and conventions and substantive gender equity including a representative democracy (Yachoulti, 2015). The Feminist's Spring movement, much like the Arab Spring, largely employed social media including Facebook, Twitter, YouTube and blogging (Yachoulti, 2015). Marches were also held in Casablanca and Rabat. On the ground, the activists were young women, belonging to various social strata and educational backgrounds and from urban and rural areas (Yachoulti, 2015). A coalition was created by a group of women's movement organizers in March of 2011,

called “Feminist Spring for Equality and Democracy”, which joined other feminist organizations in the Middle Eastern and North African (MENA) region (Yachoulti, 2015). Their ongoing aim was to unify against dictatorship, inequality and marginalization (Yachoulti, 2015). The same month, they launched a campaign pressuring the MENA governments, including Morocco, to withdraw reservations to the UN’s Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the ratification of its Optional Protocol (Yachoulti, 2015). These movements were significant in identifying and fighting against political barriers to achieving gender equity.

The Moroccan governments’ reservations to CEDAW highlighted the significant barriers to legal equity in rights for women and allowed ongoing systemic gender discrimination. CEDAW was adopted by the General Assembly in 1979. It was officially ratified in Morocco on June 21, 1993 with several reservations and substitutions (54,56) (See Appendix D). Initial reservations and substitutions were made to articles 2, 9, 15,16 and 29, which were discribed as the most improtant articles by the Democratic Association of Moroccan Women (Touahri, 2008; UN Committee on the Elimination of Discrimination Against Women, n.d.; Yachoulti, 2015). Article 2, condemns discrimination against women, in all forms and calls on govenments to embody the principle of gender

equality in national consititutions and legislation, abolishing laws, regulations, customs and practices which discriminate against women (United Nations, 1979). At the time, the Moroccan government argued this conflicted with Islamic Sharia law, and the Moroccan Family Code (United Nations, 1979). *Moudawana*, which afforded women different rights than men, allowed families to "strike a balance between the spouses in order to preserve the coherence of family life" (United Nations, 2006). Article 9, granted all women equal rights to acquire, change or retain their nationality, and equal rights for women and men with respect to the nationality of their children (United Nations, 1979).

The Moroccan government sought to maintain the limitations on women to acquire nationality for their children (Touahri, 2008; United Nations, 2006; Yachoulti, 2015). Article 16, elimated the discrimination against women in all matters relating to marriage and family relations (Touahri, 2008; United Nations, 1979). In particular, the equal right to enter marriage, within the marriage and in the dissolution of marriage regarding property and children (United Nations, 1979). This section also established the right of women to freely decide on the number and spacing of their children, and the right to access information, education and means to enable them to exercise these rights (United Nations, 1979). Lastly, this section sought to ban the betrothal and marriage of a child, a

practice which was relatively common and primarily resulted in the marriage of minor girls to older men in Morocco (United Nations, 1979; Yachoulti, 2015). The Moroccan government used its interpretation of Sharia law to object to the entirety of Article 16. However in their statement, they only noted the reservation to the right of a woman to divorce without the requirement of a decision based on Sharia law (Touahri, 2008; United Nations, 2006). The Moroccan government was criticized by feminist organizations for waiting 14 years to ratify CEDAW, emptying it of its purpose and then waiting another 8 years before publishing it to the Official Bullitin for national dissemination (Touahri, 2008). The Moroccan response to CEDAW highlights the extent of systemic gender inequity in legislation and the historical lack of political will to reduce discrimination against women.

Following the pressures from the *Feminist Spring for Equality and Democracy* and others, the Mococcan government formally withdrew its reservations to CEDAW and its Operational Protocol (Yachoulti, 2015). This set the stage for reforms to the constitution and penal code and laid groundwork for further refurms toward greater gender equality (Yachoulti, 2015).

4.3.3. Amendments to the Constitution

The Arab Spring and the Feminist Spring put pressure on the monarchy to reform the constitution and in government (Yachoulti, 2015). As a response to the civil movements, King Mohammed VI invited five women[13] to take part in the Consultative Commission to review the constitution and deliver recommendations for democratic reforms (Yachoulti, 2015). The women, four from the liberal bloc and one from the Islamists bloc, were all highly respected and accomplished experts in law and human rights working in national and international organizations (Yachoulti, 2015). Once Morocco withdrew its reservations to CEDAW, the constitution was amended and two new Moroccan laws were enacted to establish female representation in all political parties (Yachoulti, 2015).

[13] Amina Bouayach, President of the Moroccan Human Rights Organization and Vice President of the International Federation for Human Rights. Nadia Bernoussi, professor of constitutional law at the Law Faculty of Rabat and at the National School of Administration, Vice President of the International Association of Constitutional Law and International Consultant and former Special Advisor to the Director General of UNESCO. Amina Messoudi, professor of constitutional law at the Faculty of Law of Rabat-Agdal, member of the Moroccan Association of Constitutional Law and Iberian and Moroccan-Euro-Mediterranean Scientific Networks. Zineb Talibi a magistrate and a special assistant to the General Secretariat of Government and a former member of the Advisory Commission for Review of the *Moudawana*. Rajae Mekkaoui, a law professor at the Faculty of Rabat-Agdal, a member of the Higher Council of Ulema (ulema are scholars of Islamic law and theology) and a legal expert and consultant to several national and international organizations.

Law No. 29-11 stipulated that all political parties work toward achieving one third representation of women in their governing bodies (Yachoulti, 2015). Additionally, Law No. 27-11 established a quota of 60 seats in the Chamber of Representatives being reserved for women, representing 15% of the total (Yachoulti, 2015). Unfortunately, these laws did not make the representation obligatory (Yachoulti, 2015). The new constitution, incorporated several provisions for gender equity in political, economic, cultural and social spheres, prohibition of sexism, and the safeguarding of these rights in states of emergency and from being protracted in future revisions of the constitution (Yachoulti, 2015). These reforms have set the groundwork of a significant and positive trajectory towards gender equality in Morocco (Yachoulti, 2015). Thus the Moroccan government committed to working towards gender equity and created an official framework for Moroccan women to take future action (Yachoulti, 2015).

4.3.4. Spring of Dignity and the Penal Code

The momentum toward gender equity and increased protections under the law continued with the mobilization of feminist activists in a series of protests coined the “Spring of Dignity” in 2012 (Yachoulti, 2015). The Spring of Dignity was a movement to address the lack of laws to address gender-based violence such as domestic and sexual violence. It

was a direct response to the suicide of Amina Filali, a sixteen year old who was forced to marry her rapist due to provision in the Penal Code that exonerated rapists if they married their victims (Yachoulti, 2015). The case drew national and international attention to the failure of the justice system to uphold the 2004 reforms to the *Moudawana* regarding child marriage, and the failure to protect victims of gender-based violence. In fact, it is criticized for promoting violence and trauma for the victims. Activists employed a wide variety of methods in their protests including organized demonstrations, sit-ins, social media, television and radio campaigns, press conferences and organized a 'human chain' between the Ministry of Justice and the House of Representatives in Rabat (Yachoulti, 2015). The pressure led to the unanimously amended Article 475 of the Penal Code on January 23, 2014 to no longer allow men who rape underage girls to avoid prosecution by marrying their victims (Yachoulti, 2015). More amendments to the Penal Code are required, as conjugal rape is not criminalized, and consensual sex between unmarried partners can lead to a prison sentence (Yachoulti, 2015). This reduces the ability of women to have agency over their sexual and reproductive health within marriage, and the ability to access SRMNH services outside of marriage. The ongoing regulation, control and criminalization of sexual contact, and lack of sufficient legal and practical protections has significant

implications which negatively impact the health and well-being of women. The inequality in the judicial system highlights and reinforces the gender inequity that contributes to poorer perinatal health outcomes.

4.4. Gender Discrimination Impact on SRMNH Care

. Gender-based discrimination is a root cause of health disparities and one of the most influential of the social determinants of health (Sen, Östlin, & George, 2007). It is directly linked to poorer maternal outcomes (Abdesslam, 2011; Committee on the Elimination of Discrimination Against Women, 2008; Sen et al., 2007; Skalli, 2001). Despite the gains in gender equity noted in the previous section, gender inequity remains a barrier to quality SRMNH care for many Moroccan women (Abdesslam, 2011; Newman, 2019; Skalli, 2001; Temmar et al., 2006). The UN Committee on the Elimination of Discrimination against Women reported concerns over the “traditional discriminatory practices and strong stereotypical attitudes that persist about the roles and responsibilities of women and men in family and society” in Morocco (Committee on the Elimination of Discrimination Against Women, 2008). Women are further disadvantaged in all areas including financial, political, basic human rights related to discrimination and sexual and reproductive health rights (Committee on the Elimination of Discrimination Against Women, 2008). This is illustrated

in higher rates of illiteracy, poverty, lower levels of education, lack of representation in decision making spheres, poorer employment opportunities, and lack of legal protection against gender-based violence for women (Committee on the Elimination of Discrimination Against Women, 2008; Skalli, 2001; Yachoulti, 2015). Gender discrimination impacts all aspects of Moroccan women's lives and has had repercussions in maternity care, the midwifery profession and midwives.

4.4.1. Impact of Gender on Moroccan Women Seeking Care

Achieving greater equity requires the promotion of the equal rights to health and well-being including the unique sexual and reproductive health needs of women. CEDAW states that women have the right "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" (United Nations, 1979). In addition, women have the right to access health care free of gender discrimination and the right to appropriate SRMNH including contraception, family planning services, prenatal, intrapartum and postnatal care for themselves and their infants (United Nations, 1979). Several barriers have been identified that discriminate against women and

limit the accessibility and acceptability of SRMNH care. These barriers include the social, cultural and legal regulation of extramarital sex, lack of recognition of traditional marriages legally and within the health care system, and the criminalization of SRMNH care (Newman, 2019). Sexual and reproductive behaviours are highly controlled, regulated and legislated in Morocco and deeply ingrained in the social culture (Newman, 2019; Sabbe et al., 2013; Yachoulti, 2015). Extra-marital sex, abortion and child abandonment are criminalized under the Penal Code, and the *Moudawana*, and adoption is not a legally recognized option for women (Newman, 2019; Sabbe et al., 2013). Thus women who are unmarried, or presumed to be unmarried, face scrutiny, social stigma, administrative and institutional barriers and legal consequences for seeking any SRMNH care, including contraception, emergency contraception and maternity care (Newman, 2019). Women can be criminally charged for acts of, extra-marital sex, called *zinā,* if they present for prenatal care, child abandonment if they indicate their desire to have their infant adopted or to surrender them (Newman, 2019). Seeking an abortion is also a criminal offence, and women can also be held legally liable to the father of the baby for acquiring a termination without their consent (Newman, 2019). When presenting for SRMNH care, unmarried women have been refused health services, redirected, or women simply 'disappeared', either leaving

before care was completed, or seemingly disappearing as a result of incomplete records (Newman, 2019). There can be distrust of women's reports, when seeking care for miscarriage, threatened miscarriage or preterm birth due to suspicions that it could have been self-inflicted or consequence of illegal abortion (Newman, 2019). When care was completed, it was impacted by discrimination related to the gendered perceptions and judgement regarding the roles, sexual conduct and morality of women (Newman, 2019). Poor quality of care is manifested in a variety of ways, such as, ambiguity in medical records, dismissal of concerns and disrespectful care (Newman, 2019). Discrimination in the provision of health care services, particularly SRMNH care, persisted even when women ascertained that they were married, if they could not present official marriage certificates (Newman, 2019). Thus, both married and unmarried women may face difficult decisions regarding accessing care and negotiations to mitigate health risks, risks of discrimination within the health care system, and criminal and civil liabilities.

Cultural marriage practices are incongruent with the law and thus many married women are unable to provide marriage certificates when accessing SRMNH care (Newman, 2019). Marriage is legislated by the *Moudawana*, and reforms in 2004 instituted a process whereby judges grant marriages and they are registered with the court (Committee on the

Elimination of Discrimination Against Women, 2008; Newman, 2019; Sabbe et al., 2013; UN Committee on the Elimination of Discrimination Against Women, n.d.; Yachoulti, 2015). Unfortunately, traditional and religious forms of marriage, especially common in rural regions and in Amazigh communities, are mostly not reported to the state, and are thus not recognized under the legislature (Committee on the Elimination of Discrimination Against Women, 2008; Newman, 2019; Sabbe et al., 2013). There is also concern that these unofficial marriages have been increasing in Morocco due to a result of the reforms which create procedural barriers and restrictions on marriage (Newman, 2019; Sabbe et al., 2013; Yachoulti, 2015). For instance, marriage is also not reported in cases of underage marriage, which is still widely practiced, due to the reforms of the *Moudawana* (Hanafi, 2011; Newman, 2019; Yachoulti, 2015). In these cases, the impact is especially significant for rural, marginalized and disadvantaged women.

The criminalization of *zinā*, abortion and child abandonment extend to HCPs reinforcing and institutionalizing this barrier to SRMNH. Midwives and other HCPs can be accused of promoting and facilitating *zinā* by providing contraception for unwed women, while providing prenatal care could be construed as involvement in illegal abortion or child abandonment, or the failure to report such crimes (Newman, 2019). Legal

and institutional policies require HCPs to call the police if a single woman plans to surrender her infant seeks a termination of pregnancy (Newman, 2019). Abortion is only legally allowed when it is deemed necessary to save the life of the woman and when performed HCPs, including midwives, face severe repercussions including jail time, fines and loss of employment if they are construed as having facilitated *zinā* (Newman, 2019). These policies place maternity care providers at odds with their patients by placing them in a position to having to manage the potential personal and institutional liabilities related to 'morality crimes' (Newman, 2019). These policies position the health care facility, and HCPs as enforcers of judicial systems rooted in religious and cultural ideals that are discriminatory towards women and restrict access to appropriate SRMNH care (Newman, 2019). This reduces the ability of women to access care, receive quality care, have honest discussions, and develop trusting relationships with care providers and places women and their maternity care providers at odds personally and legally.

4.3.1. Impact of Gender on Midwives

As a gendered workforce, midwives are also impacted by systemic gender inequity. There is evidence that systemic gender discrimination

has limited the growth of the profession, reduced social acceptance of midwifery and reinforced a gendered hierarchy in the health care system (Abou-Malham et al., 2015b, 2015a; Hatem et al., 2009; Newman, 2019; Temmar et al., 2006).

The development and growth of the profession of midwifery in Morocco has been hindered by difficulties recruiting and retaining midwives due to prevailing traditional views on the role of women. In response to high rates of illiteracy and low levels of educational attainment for women, the earliest training programs in the 1950s required only a primary school certificate to be eligible to enrol in midwifery training (Temmar et al., 2006). At that time, education for women was not highly valued and it was socially unacceptable for women to travel to the capital city for educational opportunities (Temmar et al., 2006). This resulted in low enrollment and even lower completion of early training programs (Temmar et al., 2006). Over the following decades, education and literacy for women improved substantially and it became more acceptable for women to achieve higher levels of education and maintain employment outside the home (W. Boutayeb et al., 2016; Temmar et al., 2006). Although the number of institutions providing midwifery training grew low enrollment and retention remained a problem (Hatem et al., 2009; Temmar et al., 2006). Attrition was related to marriage and being unable

to relocate for posts as well as the difficulties of balancing family responsibilities with midwifery work (Hatem et al., 2009; Temmar et al., 2006). This has created a shortage of midwives in all areas including clinical care, academics, policy and research. This, along with other systemic manifestations of gender inequity, such as discrimination in the workplace, insufficient professional resources, poor wages relative to earnings for male HCPs, lack of representation and visibility in health care governance and within institutions also negatively impacted the growth of the profession (Abou-Malham et al., 2015b, 2015a; Temmar et al., 2006).

The highly gendered hierarchical health care system limits the recognition of midwives as professional, autonomous, skilled HCPs, limits their role in a multidisciplinary setting and reduces their agency within the health care institution and the larger health care system (Abou-Malham et al., 2015b, 2015a; Hatem et al., 2009; Temmar et al., 2006). Poor interprofessional relationships, lack of trust, communication and consultation difficulties result and contribute to the negative perceptions of the midwives within the institution and among the community (Abou-Malham et al., 2015b, 2015a; Hatem et al., 2009; Temmar et al., 2006). This lack of recognition was identified as a barrier to providing high quality woman-centred care which meet the social, emotional, cultural and

physical needs of women, and that this reduced demands by women for care (Abou-Malham et al., 2015a; Temmar et al., 2006).

4.5. Summary of Cultural Barriers to the Uptake of Midwifery Care

A review of the literature review showed that language, culture and are barriers to the uptake of SRMNH including midwifery care. Culture and language differences between midwives and parturient women reduced the acceptability of midwifery and contributed to negative perceptions regarding care. Gender discrimination reduced women's autonomy and agency to access SRMNH care. It exposed women to systemic discrimination within the health care system, the legal system and health care facilities. Gender discrimination also worked against midwives, as a female profession, and contributed to their lack of recognition as trained, autonomous health care professionals and undervaluing of the services they provide. Lastly, gender discrimination disadvantaged the relationship between women and midwives by eroding the trust needed to contribute to the uptake of SRMNH services provided by midwives. These barriers are exacerbated in rural communities and significantly impede uptake of midwifery care.

5. Strategies to Improve Midwifery Care Uptake

In order for the uptake of midwifery to be improved, collaborative strategies need to be developed to provide women-centred care that includes local stakeholders, women, midwives and other HCPs (Downe et al., 2018; Downe, Finlayson, Tunçalp, & Gülmezoglu, 2019). Lack of participation of midwives in planning of the Action Plan to strengthen midwifery was noted to be a barrier to implementation. Recommendations from Morocco and internationally supports grassroots approaches. In addition, context-specific participatory action plans can improve implementation, adherence and success of strategies to improve SRMNH (Abou-Malham et al., 2015a, 2015b; Coast et al., 2014; Temmar et al., 2006). A review of the literature and exploration of international evidence has identified the key factors to improve the uptake of midwifery care. A Cochrane review on the provision and uptake of routine antenatal services concluded that initial and continued use of antenatal care depends on the perception that doing so will be a positive experience (Downe et al., 2019). Important aspects of improving the experience for women included continuity of care, personalized care that is kind, caring, supportive, culturally sensitive, and respectful of women's need for privacy (Downe et al., 2019). Similarly, in a systematic review evaluating what matters to women during childbirth, a positive experience in a clinically and

psychologically safe environment with practical and emotional support, competent, reassuring, kind clinical staff, and desire for physiological labour and birth were found to be of most importance (Downe et al., 2018). "Basing maternity service design and care provision on what women want and need is essential to the uptake of, and continuing access to, service provision" (Downe et al., 2018).

5.1. Language

Language is a central element of culture and an important determinate of uptake of health care services (Coast et al., 2014; Paulino, Vázquez, & Bolúmar, 2019). Linguistic differences between health care workers and patients in rural regions of Morocco has been identified as a barrier to acceptability and uptake of SRMNH care (Capelli, 2011; Guerch, 2015; Hatem et al., 2009; Obermeyer, 2000). Language barriers reduced the ability of rural Amazigh women to disclose personal health concerns, understand health information and make informed decisions (Guerch, 2015). International evidence has documented that poor health outcomes are more likely when language barriers between HCPs and patients exist (Paulino et al., 2019). Language barriers also contribute to negative

experiences and perceptions of quality of care (Coast et al., 2014; Guerch, 2015, 2017; Paulino et al., 2019).

Strategies to bridging language barriers and improve communication are needed to promote acceptability and uptake of health care services in rural Morocco. Strategies may include the use of professional translators or family members to assist HCPs and women in communication. Although, Guerch (2015) found that Amazigh women were less likely to divulge intimate or sensitive health information in the presence of a husband or family member. Alternatively, a high preference was noted for professional interpreters to assist with translation (Guerch, 2015). Recruitment and training of TBAs or other members of the local community may be a sustainable and effective strategy. Appropriate use of media and technology can assist in disseminating general and specific health information and support effective communication. Ideally, targeted recruitment and training of midwives with proficiency in Amazigh languages should be promoted. Strategies to address language barriers may have the dual benefit of improving communication and cultural acceptability of maternity care services.

5.2. Culturally Acceptable Care

Global research shows that even when SRMNH care is available from skilled care providers, including midwives, utilisation can be impacted by cultural factors (Coast et al., 2014). This is evident in the literature from Morocco, which noted cultural differences and ideologies between midwives and the families for whom they provide care they care for (Capelli, 2011; Hatem et al., 2009). Differences in culture have been attributed to perceived or actual cultural insensitivity and poor quality of care by HCPs (Coast et al., 2014). It is recommended that cultural factors are taken into consideration in the planning and delivery of health care services to effectively encourage uptake of services (Coast et al., 2014; Downe et al., 2019). However, Coast et al. (2014), note that culture should not be positioned as a barrier to utilization of maternal health services, but rather, an attribute of the community that care providers seek to serve. This framing recognizes and respects the culture, values, beliefs and traditions of a community and provides space to celebrate differences (Coast et al., 2014).

Culture is context-specific and the strategies to promote culturally appropriate approaches to SRMNH care provided by midwives may vary significantly based on the needs and desires of different communities (Coast et al., 2014; Downe et al., 2019). In the literature, two key findings

were noted that could be addressed in future strategies to increase uptake of midwifery care; 1) the problematic posting of midwives in new, unfamiliar and far away communities where they had little professional, social or cultural familiarity or support, and 2) the ongoing prevalence and utilizations of TBAs even in communities where trained and funded midwives were available.

In order to address cultural acceptability of midwifery care and reduce high turnover rates of staff in rural regions, strategic recruitment and training should be considered. Potential strategies include prioritizing the recruitment and training of midwives from wider cultural and ethnic backgrounds including those that have knowledge of Amazigh culture and traditions. Training midwives from rural communities who wish to work within their home communities could improve continuity of carer and relationship building within rural communities. Training midwives in their own communities may allow for increased representation of Amazigh, rural and remote midwives, and increased retention in their respective communities.

This strategy has been successful in other regions. For example, in the Canadian arctic regions of Nunavik and Nunavut, a training model has been developed and is globally recognized for promoting local Indigenous midwifery education and supports the return of birth to small remote

communities (Epoo, Stonier, Van Wagner, & Harney, 2012; Van Wagner, Epoo, Nastapoka, & Harney, 2007). Training needs to be accessible in smaller communities and not just in the capital and other large urban centres. Further exploration to identify specific requirements and the effectiveness of such an approach in Morocco is needed, however new technology can play a major role.

Integration of midwifery and TBA care in communities where TBAs are present and preferred may be an effective strategy to increase midwifery care uptake. Several studies in Morocco identified midwives working with TBAs although this work was informal and not recognized (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006). There is evidence that TBAs influence sexual and reproductive health choices and the practices (Abou-Malham et al., 2015a; Coast et al., 2014; Hatem et al., 2009; Temmar et al., 2006). The WHO emphasises the importance of building links with TBAs and finding new roles so that they can continue to support women during pregnancy, birth and in the postpartum and provide a culturally appropriate link to formal health care services (Coast et al., 2014). TBAs can be a resource to midwives in the community and provide perinatal education, act as health care advocates, assist in health promotion, assist in aspects of health monitoring and may assist midwives at births (Coast et al., 2014; Titaley, Hunter, Dibley, & Heywood, 2010).

Where programs have been implemented to promote the collaboration of midwives and TBAs, they were preferred by women and their families and antenatal care was perceived to be better than when such collaboration and cooperation was lacking (Coast et al., 2014; Downe et al., 2019; Titaley et al., 2010). This is especially the case where the use of TBAs in partnership with midwives was initiated by the local community leaders and endorsed by local health care systems (Titaley et al., 2010). In remote areas, TBAs outnumber midwives, are closer geographically, socially, culturally and linguistically and are able to bridge gaps in care and cultural competence (Titaley et al., 2010). The strategy of TBAs and midwives cooperating in Morocco has been implemented informally in rural regions in various ways, and evidence from these areas could provide guidance to future initiatives. Midwifery education should address formal training for midwives to learn to work with TBAs. Institutional barriers to collaboration and support from TBAs should also be removed to facilitate cooperation. The critical factor that will determine the success of any strategy, is the involvement of the women within the various communities in identifying barriers, identifying strategies, facilitating research and project planning for increased uptake of the midwifery care (Abou-Malham et al., 2015b, 2015a).

5.3. Achieving Greater Gender Equity

Gender inequity has impacted both the women seeking SRMNH care and midwives as a female profession. Restrictive societal gender norms and gender inequalities are mirrored, reinforced, and perpetuated in health care and this compromises community health (Hay et al., 2019). Left unaddressed, gender inequality has the potential to weaken and even incapacitate a health care system's functioning (Hay et al., 2019). These inequalities result in poor care for women, men and gender minorities in different ways, but all are disadvantaged by health care services that do not recognise or respond to the negative impact of restrictive gender norms (Hay et al., 2019). For women seeking SRMNH, gender inequality in society results in barriers to access and acceptability of care due to health care system, institutional and personal barriers (Hay et al., 2019; Newman, 2019). The impact on midwives includes a lack of recognition of skills and knowledge, lack of representation or access to leadership roles, and disrespectful treatment or abuse in the workplace (Hay et al., 2019; Temmar et al., 2006; World Health Orgnization, 2016). Gender discrimination combined with overwork, results in work stress, job dissatisfaction, burnout and poorer quality of care, abuse and poorer outcomes for patients (Hay et al., 2019). Poor quality of care and disrespectful care disproportionately impacts the most socially

marginalised patients and communities, especially female, young, rural or economically disadvantaged people (Hay et al., 2019).

Research on strategies to improve gender equity and its impact on the uptake of SRMNH services provided by midwives is lacking. However, evidence from a Lancet series on gender equality has shown that gender inequalities in health systems can be disrupted from within through actions which support, value and promote the safety of workers (Hay et al., 2019). For example, improved treatment and interactions, value and respect for female workers, improved compensation and advancement opportunities and reduced emphasis on punitive measures has been shown to have a positive impact on gender equity within health care institutions (Hay et al., 2019). Outside forces are also effective in improving gender equality through social movements, which raise awareness and community pressure through activism, and lead to progressive policies for governments and institutions (Hay et al., 2019). Hay et al. (2019) conclude, the following aspirations for gender equitable health care systems 1) reflect and reinforce a gender equitable society; 2) address gender norms and root causes of inequalities across the life course; 3) provide equal opportunities for health care professionals to enter, thrive and advance within health systems, regardless of gender; 4) ensure equal access and usage of high-quality health care services for people of all

genders; 5) commit to being held accountable to address gender inequalities at all levels. These aspirations reflect the need for gender equity in health care to be implemented at all stages of policy, planning, management and care provision. Innovative approaches are needed as gender inequality in health care systems persist even with progressive policies and improved resources (Hay et al., 2019). As with other initiatives that aim to improve quality and uptake of health care services, involvement of stakeholders within the community, including midwives, women and their families must be involved thought the process.

In Morocco, evidence from the *Feminist Spring* highlighted the positive impact of social and feminist organizing and activism, which led to reforms to the *Moudawana*, the Criminal Code and the removal of the Moroccan governments reservations to CEDAW (Yachoulti, 2015). These significant accomplishments harnessed the media and social media, held protests and lobbied government to promote change (Yachoulti, 2015). The action plan for strengthening midwifery in Morocco, also included a strategy to harness the media to promote recognition of midwives as skilled, trained and professional HCPS (Abou-Malham et al., 2015b, 2015a). Unfortunately, this aspect of the Action Plan was not implemented effectively, and researchers and midwives continue to identify the need for this action to improve awareness of the midwifery role

and recognition of midwives as skilled and professional HCPS (Abou-Malham et al., 2015b, 2015a). This strategy, if implemented, would promote gender equity and midwifery care through representation of midwives as a skilled and valued professional asset to the health care system and to families requiring SRMNH care.

6. Research and Knowledge Dissemination

Further research and broader accessibility to data are needed throughout Morocco to improve MNH tracking, quality of care, accountability and inform policy. There is very poor perinatal data collection in rural and economically disadvantaged communities.

The implementation of the Maternal Mortality Surveillance System was an important first step in gathering accurate information on the rates, causes and locations of maternal deaths. However, underreporting of maternal deaths, particularly in rural areas and incomplete records have been identified as challenges to the accuracy and comprehensiveness of data collection and analysis (Abouchadi et al., 2013; Abouchadi, Zhang, & De Brouwere, 2018). Increasing the depth and breadth of the information gathered and addressing gaps in comprehensive use and collection of data could assist in gathering information to allow assessment of particular aspects of care. Additional data collection could include the number of antenatal and postnatal appointments, health status information, perinatal complications, consultations and facility transfers. This could identify specific indicators of quality care and perinatal outcomes for comparison across regions, facilities, and different HPs including midwives.

An electronic system such as, Ontario's Better Outcomes Registry & Network (BORN Ontario), a mandatory maternal, newborn and child health registry which is completed by midwives, nurses and physicians is a highly effective way to track outcomes. Data is collected, interpreted and shared via BORN, independent researchers and organizations, and has contributed to the publication of over 70 research studies (Better Outcomes Registry & Network Ontario, 2019). These data and research can be used to inform government strategies, support health care facilities, and track HCPs clinical care. Accurate, comprehensive and accessible statistics and information are needed to thoroughly identify, analyze and monitor outcomes and potential areas for improved maternity care, especially in rural regions.

There is also a lack of research on midwifery care in Morocco, and even less is available on midwifery care in the regions with the lowest rates of antenatal care and skilled attendance at birth. A review of the literature identified only four articles that explored the profession of midwifery in Morocco (Abou-Malham et al., 2015b, 2015a; Hatem et al., 2009; Temmar et al., 2006). Research which focused on other aspects of maternity care, such as single motherhood, and ideologies related to risk perception were explained (Capelli, 2011; Newman, 2019). One researcher, Capelli, noted the difficulties in conducting research within

government health services because of “complexity of the procedures to gain formal authorisations” (Capelli, 2011). She further noted that access to statistics and quantitative data was officially denied by public health services (Capelli, 2011). The lack of available evidence is partly due to bureaucratic processes, administrative procedures, gender inequality, and potentially other contributors. However, in order to promote a deeper understanding of potential barriers or facilitators to accessing midwifery care and evaluate the efficacy of actions to promote uptake, research from within Morocco must be available, accessible and ongoing.

7. Limitations of the Study

Limitations of this study include a lack of research on Moroccan midwifery, poor data on perinatal outcomes and no information on rural women's experiences of maternity care. In addition, professional translation services were not possible, and this limited the reviewed literature to English, except for the 2016 legislation regulating midwifery which was translated using Google Translate.

8. Conclusion

Sexual reproductive maternal newborn health (SRMNH) care, provided by midwives who are trained to international standards, regulated, and integrated into the health care system has been identified as a key to improving MNH outcomes globally (Homer et al., 2014; Lerberghe et al., 2014; Renfrew et al., 2014; Ten Hoope-Bender et al., 2014). It has been found that midwifery care optimises normal reproductive processes, improves health and psychosocial outcomes and can avert 83% of all maternal deaths, stillbirths and neonatal deaths (Homer et al., 2014; Hoope-Bender et al., 2014; Lerberghe et al., 2014; Renfrew et al., 2014). Furthermore, midwifery is an efficient and sustainable resource for health care systems (Homer et al., 2014; Lerberghe et al., 2014; Renfrew et al., 2014; Ten Hoope-Bender et al., 2014). The importance of midwifery to SRMNH was recognized in Morocco and strategic efforts by government and the health care system have resulted in a strong and integrated midwifery profession.

Progress has been made over the last quarter century by strengthening the Moroccan midwifery profession through funding and training. Thus reducing MMR and improving newborn and child health (Abdesslam, 2011; Abou-Malham et al., 2015b; Temmar et al., 2006; UNFPA & Ministry of Health Morocco, 2012). Midwives in Morocco attend

approximately 80% of the births in which a skilled birth attendant is present (Harrizi, 2019). Despite excellent training, funding and perinatal outcomes, uptake of SRMNH is low in rural settings (Abdesslam, 2011; W. Boutayeb et al., 2016). Both antenatal and intrapartum care remain attended by an untrained TBA or family member (Abdesslam, 2011; W. Boutayeb et al., 2016). Perinatal midwifery care uptake must be addressed to improve MNH outcomes.

There are large disparities, with rural, remote and majority Amazigh regions being the most disadvantaged (Abdesslam, 2011; UNFPA & Ministry of Health Morocco, 2012). In these regions, 55% of births are still unattended by a HCP (W. Boutayeb et al., 2016). Despite a well organized, trained, and regulated midwifery profession, outcomes for MNH are below Moroccan targets. In rural areas where midwives are available, acceptability of trained HCPs, including midwives, impedes uptake of SRMNH services (Capelli, 2011; Hatem et al., 2009; Temmar et al., 2006).

Several barriers relevant to uptake of SRMNH were identified from international research. Midwifery care should be available, accessible, acceptable and provide quality services to meet the health care needs of women and newborns in their community (United Nations Population Fund; International Confederation of Midwives; World Health Organization,

2014). In Morocco, government strategies focused on improving availability and quality of services though funding, health care infrastructure and professional midwifery education (Abdesslam, 2011; Temmar et al., 2006; UNFPA & Ministry of Health Morocco, 2012). However, the acceptability of midwifery care is dependent on planning and delivery of care that is sensitive and responsive to the social and cultural needs of individuals, families and their communities (Coast et al., 2014; Downe et al., 2018, 2019; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014).

Furthermore, acceptability has been strongly linked with gender for both the midwife as a female HCP and for female care seekers (Sen et al., 2007; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014). Gender inequity, lack of cultural sensitivity and language barriers reduce uptake of SRMNH services (Coast et al., 2014; Downe et al., 2018, 2019; Hatem et al., 2009; Temmar et al., 2006; United Nations Population Fund; International Confederation of Midwives; World Health Organization, 2014). It is this lack of acceptability of midwifery that has impeded the uptake of SRMNH care services delivered by midwives, even when they are funded, skilled and available.

Several strategies have been suggested based on the available evidence from Morocco and international guidelines and systematic reviews. However, initiatives to improve midwifery care uptake by addressing gender, social and cultural factors must be based on participatory action approaches so they are context specific and facilitate improved implementation and success (Abou-Malham et al., 2015b, 2015a; Coast et al., 2014; Downe et al., 2018, 2019). Initiatives should aim to identify local traditions, beliefs, values and preferences and existing facilitative factors which support improved uptake (Coast et al., 2014). This information should inform and guide planning and implementation of culturally appropriate strategies with input from a range of stakeholders including parturient women, their families, midwives, other HCPs and health care administrators (Coast et al., 2014). Research has shown that women and newborns benefit from midwifery care. However, in order for midwifery care uptake to be improved, what women want must also be considered in health care service planning. Developments and improvements aimed at increasing uptake of midwifery services must incorporate the social and cultural factors that influence the acceptability of midwifery care.

In order to reduce barriers, increase uptake of trained maternity care and ultimately improve perinatal outcomes, the integration of midwifery

must recognize the social context within which women and families make decisions about their care. Language, culture and gender issues play a significant role in the perinatal care decisions made by families and this impacts perinatal outcomes including maternal newborn mortality and morbidity. Midwifery is well established in Morocco and there is ample evidence of benefit both nationally and internationally. However, in rural Moroccan communities where perinatal outcomes are very poor, families still avoid fully trained and funded midwives for maternity care in favour of TBAs or family members. Further research is needed to document the extent to which women continue to give birth with TBAs or family members and the associated perinatal outcomes. This scoping review explored the social cultural factors that impeded the uptake of midwifery services. Clearly, more research is also need on rural women's experiences of childbirth and reasons for not accessing midwifery care. Qualitative research can capture their voices and inform future policy decisions.

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Appendix A: Morocco Regional Maps

Figure 2: Regional Political Map[14]

The geography of Morocco makes for a beautiful and richly diverse environment. Coastlines of the Mediterranean Sea to the north and the

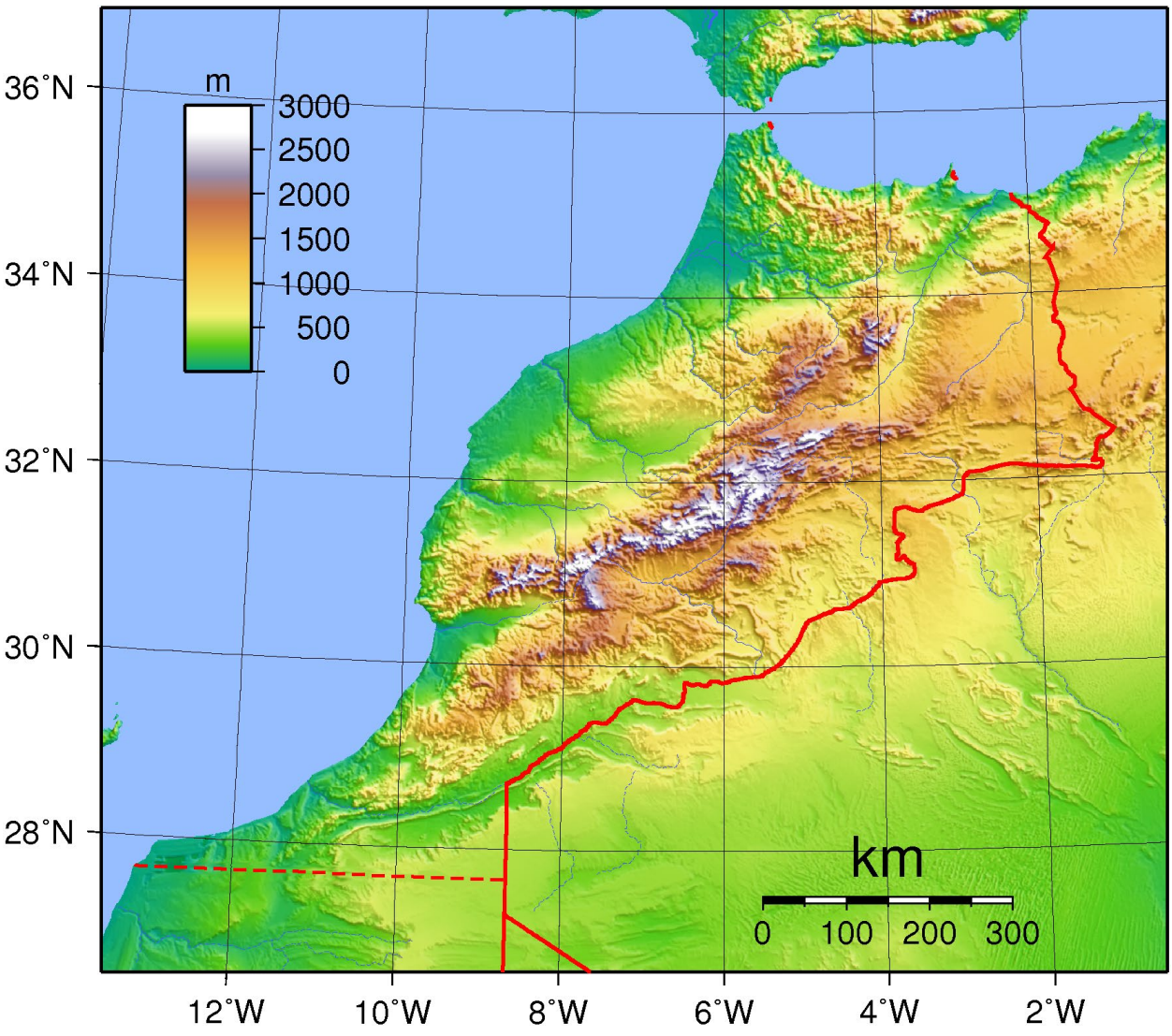
[14] Source: https://www.123rf.com/photo_89425215_stock-vector-morocco-map-high-detailed-vector-illustration.html

Northern Atlantic Ocean to the West comprise over 1835 kilometres (US Library of Congress, 2006). The country is divided by four rugged mountain chains, the Rif, Middle Atlas, High Atlas and Anti-Atlas Mountains. These mountain chains dominate a large part of the country and divide it into three major regions, the mountainous interior which include plateaus and fertile valleys, the Atlantic coastal lowlands, and the semiarid and arid areas of the country`s eastern and southern regions which descend gradually into the Sahara Desert (US Library of Congress, 2006). The northern ranges are the Rif Mountains which run parallel along the Mediterranean and coast. South of the Rif Mountains a series of three Atlas Mountain ranges run northeast and southwest, they are the from north to south, the Middle Atlas, the High Atlas and the Anti-Atlas. The population of 35 million, is mostly concentrated in the northwestern region west of the Atlas Mountains, however only 58% live in urban areas (Abdesslam, 2011). Transportation in Morocco is difficult especially within the rural and mountainous regions and access to many villages is very limited (US Library of Congress, 2006).

Figure 3: Moroccan Mountains and Cities

Source: http://kmolsen4morocco.weebly.com/geography-and-environment.html.

Figure 4: Moroccan Topography



Source: https://upload.wikimedia.org/wikipedia/commons/3/30/Morocco_Topography.png

Appendix B: Millennium Development Goals: Targets and Indicators

Goal	Target	Indicator
#1: Eradicate Extreme Poverty and Hunger	1.A Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below $1 (PPP) per day 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
	1.B Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below $1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
	1.C Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
#2: Achieve Universal Primary Education	2.A Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24-year old, women and men
#3 Promote Gender Equality and Empower Women	3. A Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
#4 Reduce Child Mortality	4.A Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1-year old children immunized against measles
#5 Improve Maternal Health	5.A Reduce by ¾, between 1990 and 2015, the maternal mortality rate	5.1 Maternal Mortality ratio 5.2 Proportion of births attended by skilled personnel
	5.B Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least 1, and at least 4 visits) 5.6 Unmet need for family planning

#6 Combat HIV/AIDS, malaria and other diseases	6.A Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
	6.B Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
	6.C Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bed nets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
#7 Ensure environmental sustainability	7.A Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, total, per capita and per $1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used
	7.B Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
	7.C Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
	7.D By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums
#8	8.A Develop further an open, rule-based, predictable, non-	Some of the indicators listed below are monitored separately for the least developed countries (LDCs),

Develop a global partnership for development	discriminatory trading and financial system. Includes a commitment to good governance, development and poverty reduction - both nationally and internationally	Africa, landlocked developing countries and small island developing States. Official development assistance 8.1 Net ODA, total and to the least developed countries, as a percentage of OECD/DAC donors' gross national income 8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing States as a proportion of their gross national incomes Market access 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity Debt sustainability 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services
	8.B Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction	
	8.C Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)	
	8.D Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	
	8.E In cooperation with pharmaceutical companies, provide access to affordable	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis

	essential drugs in developing countries	
	8.F In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis

Adapted from (UNICEF, 2014; United Nations, 2015b)

Appendix C: Sustainable Development Goals

(United Nations, n.d.)

SDG #3 Health and Well-Being Targets and Indicators

Targets	Indicators
3.1 By 2030, reduce the global MMR to <70/100,000 live births	3.1.1 MMR 3.1.2 Proportion of births attended by skilled health personnel
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce NMR to ≤ 12/1,000 live births and under 5 mortality to ≤25/1,000 live births	3.2.1 Under-5 mortality rate 3.2.2 NMR
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations 3.3.2 Tuberculosis incidence per 1,000 population 3.3.3 Malaria incidence per 1,000 population 3.3.4 Hepatitis B incidence per 100,000 population

	3.3.5 Number of people requiring interventions against neglected tropical diseases
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease 3.4.2 Suicide mortality rate
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders 3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1 Death rate due to road traffic injuries
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods 3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1 Mortality rate attributed to household and ambient air pollution 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services) 3.9.3 Mortality rate attributed to unintentional poisoning
3.A Strengthen the implementation of the World Health Organization Framework Convention on Tobacco	3.A.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older

Control in all countries, as appropriate	
3.B Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	3.B.1 Proportion of the target population covered by all vaccines included in their national programme 3.b.2 Total net official development assistance to medical research and basic health sectors 3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1 Health worker density and distribution
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.D.1 International Health Regulations (IHR) capacity and health emergency preparedness

Adapted from (United Nations, 2015a, 2018).

Appendix D: Convention on the Elimination of All Forms of Discrimination against Women(United Nations, 1979, 2006)

Articles of CEDAW	Moroccan Response
Article I **For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.**	
Article 2 **States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:** **(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle;** **(b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;** **(c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;** **(d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;** **(e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;** **(f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;**	*"The Government of the Kingdom of Morocco expresses its readiness to apply* *the provisions of this article provided that:* *– They are without prejudice to the constitutional requirements that regulate the* *rules of succession to the throne of the Kingdom of Morocco;* *– They do not conflict with the provisions of the Islamic sharia. It should be noted that certain of the provisions contained in the Moroccan Code of Personal Status according women rights that differ from the rights conferred on men may not be infringed upon or abrogated because they derive primarily* *from the Islamic sharia, which strives, among its other objectives, to strike a balance between the spouses in order to*

(g) To repeal all national penal provisions which constitute discrimination against women.	*preserve the coherence of family life."*
Article 3 **States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women , for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.**	
Article 4 **1. Adoption by States Parties of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered discrimination as defined in the present Convention, but shall in no way entail as a consequence the maintenance of unequal or separate standards; these measures shall be discontinued when the objectives of equality of opportunity and treatment have been achieved.** **2. Adoption by States Parties of special measures, including those measures contained in the present Convention, aimed at protecting maternity shall not be considered discriminatory.**	
Article 5 **States Parties shall take all appropriate measures:** **(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;** **(b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.**	
Article 6 **States Parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.**	
Article 7 **States Parties shall take all appropriate measures to eliminate discrimination against women in the political and public life of the country and, in**	

particular, shall ensure to women, on equal terms with men, the right: **(a) To vote in all elections and public referenda and to be eligible for election to all publicly elected bodies;** **(b) To participate in the formulation of government policy and the implementation thereof and to hold public office and perform all public functions at all levels of government;** **(c) To participate in non-governmental organizations and associations concerned with the public and political life of the country.**	
Article 8 **States Parties shall take all appropriate measures to ensure to women, on equal terms with men and without any discrimination, the opportunity to represent their Governments at the international level and to participate in the work of international organizations.**	
Article 9 **1. States Parties shall grant women equal rights with men to acquire, change or retain their nationality. They shall ensure in particular that neither marriage to an alien nor change of nationality by the husband during marriage shall automatically change the nationality of the wife, render her stateless or force upon her the nationality of the husband.** **2. States Parties shall grant women equal rights with men with respect to the nationality of their children.**	Regarding paragraph 2 *"The Government of the Kingdom of Morocco makes a reservation with regard to this article in view of the fact that the Law of Moroccan Nationality permits a child to bear the nationality of its mother only in the cases where it is born to an unknown father, regardless of place of birth, or to a stateless father, when born in Morocco, and it does so in order to guarantee to each child its right to a nationality.* *Further, a child born in Morocco of a Moroccan mother and a foreign father may acquire the nationality of its mother by declaring, within two years of reaching the age of majority, its desire to acquire that nationality, provided that, on making such declaration, its*

	customary and regular residence is in Morocco."
Article 10 **States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:** **(a) The same conditions for career and vocational guidance, for access to studies and for the achievement of diplomas in educational establishments of all categories in rural as well as in urban areas; this equality shall be ensured in pre-school, general, technical, professional and higher technical education, as well as in all types of vocational training;** **(b) Access to the same curricula, the same examinations, teaching staff with qualifications of the same standard and school premises and equipment of the same quality;** **(c) The elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school programmes and the adaptation of teaching methods;** **(d) The same opportunities to benefit from scholarships and other study grants;** **(e) The same opportunities for access to programmes of continuing education, including adult and functional literacy programmes, particularly those aimed at reducing, at the earliest possible time, any gap in education existing between men and women;** **(f) The reduction of female student drop-out rates and the organization of programmes for girls and women who have left school prematurely;** **(g) The same Opportunities to participate actively in sports and physical education;** **(h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.**	
Article 11 **1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:**	

(a) The right to work as an inalienable right of all human beings; **(b) The right to the same employment opportunities, including the application of the same criteria for selection in matters of employment;** **(c) The right to free choice of profession and employment, the right to promotion, job security and all benefits and conditions of service and the right to receive vocational training and retraining, including apprenticeships, advanced vocational training and recurrent training;** **(d) The right to equal remuneration, including benefits, and to equal treatment in respect of work of equal value, as well as equality of treatment in the evaluation of the quality of work;** **(e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave;** **(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.**
Article 12 **1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.** **2. Notwithstanding the provisions of paragraph l of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.**
Article 13 **States Parties shall take all appropriate measures to eliminate discrimination against women in other areas of economic and social life in order to ensure, on a basis of equality of men and women, the same rights, in particular:** **(a) The right to family benefits;** **(b) The right to bank loans, mortgages and other forms of financial credit;** **(c) The right to participate in recreational activities, sports and all aspects of cultural life.**
Article 14 **1. States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the**

economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas. **2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:** **(a) To participate in the elaboration and implementation of development planning at all levels;** **(b) To have access to adequate health care facilities, including information, counselling and services in family planning;** **(c) To benefit directly from social security programmes;** **(d) To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency;** **(e) To organize self-help groups and co-operatives in order to obtain equal access to economic opportunities through employment or self employment;** **(f) To participate in all community activities;** **(g) To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes;** **(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.**	
Article 15 **1. States Parties shall accord to women equality with men before the law.** **2. States Parties shall accord to women, in civil matters, a legal capacity identical to that of men and the same opportunities to exercise that capacity. In particular, they shall give women equal rights to conclude contracts and to administer property and shall treat them equally in all stages of procedure in courts and tribunals.** **3. States Parties agree that all contracts and all other private instruments of any kind with a legal effect**	Regarding paragraph 4 *"The Government of the Kingdom of Morocco declares that it can only be bound by the provisions of this paragraph, in particular those relating to the rights of women to choose their residence and domicile, to the extent that they are not incompatible with articles 34 and 36 of*

which is directed at restricting the legal capacity of women shall be deemed null and void. **4. States Parties shall accord to men and women the same rights with regard to the law relating to the movement of persons and the freedom to choose their residence and domicile.**	*the Moroccan Code of Personal Status*."
Article 16 **1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:** **(a) The same right to enter into marriage;** **(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;** **(c) The same rights and responsibilities during marriage and at its dissolution;** **(d) The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;** **(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;** **(f) The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;** **(g) The same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation;** **(h) The same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property, whether free of charge or for a valuable consideration.** **2. The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.**	*"The Government of the Kingdom of Morocco makes a reservation with regard to the provisions of this article, particularly those relating to the equality of men and women in respect of rights and responsibilities on entry into and at dissolution of marriage. Equality of this kind is considered incompatible with the Islamic sharia, which guarantees to each of the spouses the rights and responsibilities within a framework of equilibrium and complementarity in order to preserve the sacred bond of matrimony. The provisions of the Islamic sharia oblige the husband to provide a nuptial gift upon marriage and to support his family, while the wife is not required by law to support the family. Furthermore, at dissolution of marriage, the husband is obliged to pay maintenance. In contrast, the wife enjoys complete freedom of disposition of her property during the marriage and upon its dissolution without supervision by the husband, the husband having no jurisdiction over his wife's property.*

	For these reasons, the Islamic sharia confers the right of divorce on a woman only by decision of a sharia judge."
Article 17 **1. For the purpose of considering the progress made in the implementation of the present Convention, there shall be established a *Committee on the Elimination of Discrimination against Women* (hereinafter referred to as the Committee) consisting, at the time of entry into force of the Convention, of eighteen and, after ratification of or accession to the Convention by the thirty-fifth State Party, of twenty-three experts of high moral standing and competence in the field covered by the Convention. The experts shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution and to the representation of the different forms of civilization as well as the principal legal systems.** **2. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.** **3. The initial election shall be held six months after the date of the entry into force of the present Convention. At least three months before the date of each election the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit their nominations within two months. The Secretary-General shall prepare a list in alphabetical order of all persons thus nominated, indicating the States Parties which have nominated them, and shall submit it to the States Parties.** **4. Elections of the members of the Committee shall be held at a meeting of States Parties convened by the Secretary-General at United Nations Headquarters. At that meeting, for which two thirds of the States Parties shall constitute a quorum, the persons elected to the Committee shall be those nominees who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.** **5. The members of the Committee shall be elected for a term of four years. However, the terms of nine of the members elected at the first election shall**	

expire at the end of two years; immediately after the first election the names of these nine members shall be chosen by lot by the Chairman of the Committee. **6. The election of the five additional members of the Committee shall be held in accordance with the provisions of paragraphs 2, 3 and 4 of this article, following the thirty-fifth ratification or accession. The terms of two of the additional members elected on this occasion shall expire at the end of two years, the names of these two members having been chosen by lot by the Chairman of the Committee.** **7. For the filling of casual vacancies, the State Party whose expert has ceased to function as a member of the Committee shall appoint another expert from among its nationals, subject to the approval of the Committee.** **8. The members of the Committee shall, with the approval of the General Assembly, receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide, having regard to the importance of the Committee's responsibilities.** **9. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.**
Article 18 **1. States Parties undertake to submit to the Secretary-General of the United Nations, for consideration by the Committee, a report on the legislative, judicial, administrative or other measures which they have adopted to give effect to the provisions of the present Convention and on the progress made in this respect:** **(a) Within one year after the entry into force for the State concerned;** **(b) Thereafter at least every four years and further whenever the Committee so requests.** **2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Convention.**
Article 19 **1. The Committee shall adopt its own rules of procedure.** **2. The Committee shall elect its officers for a term of two years.**
Article 20 **1. The Committee shall normally meet for a period of not more than two weeks annually in order to**

consider the reports submitted in accordance with article 18 of the present Convention. **2. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee.**
Article 21 **1. The Committee shall, through the Economic and Social Council, report annually to the General Assembly of the United Nations on its activities and may make suggestions and general recommendations based on the examination of reports and information received from the States Parties. Such suggestions and general recommendations shall be included in the report of the Committee together with comments, if any, from States Parties.** **2. The Secretary-General of the United Nations shall transmit the reports of the Committee to the Commission on the Status of Women for its information.**
Article 22 **The specialized agencies shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their activities. The Committee may invite the specialized agencies to submit reports on the implementation of the Convention in areas falling within the scope of their activities.**
Article 23 **Nothing in the present Convention shall affect any provisions that are more conducive to the achievement of equality between men and women which may be contained:** **(a) In the legislation of a State Party; or** **(b) In any other international convention, treaty or agreement in force for that State.**
Article 24 **States Parties undertake to adopt all necessary measures at the national level aimed at achieving the full realization of the rights recognized in the present Convention.**
Article 25 **1. The present Convention shall be open for signature by all States.** **2. The Secretary-General of the United Nations is designated as the depositary of the present Convention.**

3. The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations. **4. The present Convention shall be open to accession by all States. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.**	
Article 26 **1. A request for the revision of the present Convention may be made at any time by any State Party by means of a notification in writing addressed to the Secretary-General of the United Nations.** **2. The General Assembly of the United Nations shall decide upon the steps, if any, to be taken in respect of such a request.**	
Article 27 **1. The present Convention shall enter into force on the thirtieth day after the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.** **2. For each State ratifying the present Convention or acceding to it after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the date of the deposit of its own instrument of ratification or accession.**	
Article 28 **1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.** **2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.** **3. Reservations may be withdrawn at any time by notification to this effect addressed to the Secretary-General of the United Nations, who shall then inform all States thereof. Such notification shall take effect on the date on which it is received.**	
Article 29 **1. Any dispute between two or more States Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitration the parties are unable to agree on the organization of the arbitration, any one of those parties may refer the**	*"The Government of the Kingdom of Morocco does not consider itself bound by the first paragraph of this article, which provides that "[a]ny dispute between two or more States parties concerning the interpretation or application of the present Convention*

dispute to the International Court of Justice by request in conformity with the Statute of the Court. **2. Each State Party may at the time of signature or ratification of the present Convention or accession thereto declare that it does not consider itself bound by paragraph I of this article. The other States Parties shall not be bound by that paragraph with respect to any State Party which has made such a reservation.** **3. Any State Party which has made a reservation in accordance with paragraph 2 of this article may at any time withdraw that reservation by notification to the Secretary-General of the United Nations.**	*which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration". The Government of the Kingdom of Morocco is of the view that any dispute of this kind can only be referred to arbitration by agreement of all the parties to the dispute."*
Article 30 **The present Convention, the Arabic, Chinese, English, French, Russian and Spanish texts of which are equally authentic, shall be deposited with the Secretary-General of the United Nations.**	

Adapted from (United Nations, 1979, 2006).