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Skirting the Patients: Women and Health Care in Morocco and Egypt

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## ABSTRACT

Skirting the Patients: Women and Health Care in Morocco and Egypt

by

Monali Shaina Lipman

Over the last few decades, women's health care worldwide has improved dramatically, yet disproportionately, between and within countries. This thesis explores the reasons for these variations in women's access to health care *between and within* Morocco and Egypt from the 1980s to 2000s. I argue that political and economic structures shape women's health, in terms of sexual and reproductive rights. In particular, I argue that at the national level, women's incorporation into political and formal economic spaces affords them a stronger voice and more opportunities to be financially independent, which increases their access to health services. At the sub-national level, I propose that women's location as urban or rural and their socioeconomic class has led to differential outcomes for access to health care in Morocco and Egypt. Both at the national and sub-national levels, this study finds state capacity, the ability of the government to deliver on its policies, to be the most important explanation for women's access to health care as the governments of Morocco and Egypt have historically been unable to meet their promises. This paper contributes to extant research using the theory of female autonomy and intersectionality framework in the Middle East. My evidence comes from a wide variety of databases like the United Nations, World Health Organization, World Bank, and Demographic and Health Surveys.

“Because communities and countries and ultimately the world are only as strong as the health of their women.”

– Michelle Obama (Ted Conferences, 2009)

## INTRODUCTION

15 to 71 percent of women worldwide are victims of physical or sexual violence by an intimate male partner (World Health Organization, 2011). Women also lack access to health education and resources; according to research by the World Health Organization (WHO), 1,600 women and over 10,000 newborns die from preventable complications of pregnancy and childbirth daily (World Health Organization, 2011). The situation in authoritarian regimes is even worse because women not only face limited access to healthcare, but also have nowhere to turn to demand change. This paper will adapt a comparative method and specifically focus on the phenomenon of reduced women’s access to health care in the authoritarian governments Morocco and Egypt and ask “what explains observed varying degrees of women’s access to health care services between and within Morocco and Egypt?”

Studying women’s access to healthcare is of vital importance for a number of reasons. To begin with, health, as defined by the World Health Organization, is “one of the fundamental rights of every human being” (World Health Organization, 2015a, n.p.). In order for a country to prosper, it needs a healthy and educated population. In the last thirty years, the meaning of security has expanded from military issues to include humanitarian issues such as gender, environment, and health (MacFarlane & Khong, 2006). Furthermore, as a component of human security, health is also necessary to maintain peace and security for both people and countries as a whole. For example, states such as Somalia, one of the most insecure countries in the world, has also one of

the lowest scores in terms of health care systems by the World Health Organization (World Health Organization, 2000). Understanding how a country regulates access to health care conveys its attitude about the value of its citizens and their role in society.

Access to health care is especially important for women. Despite improvements in health care in the last thirty years, many women still do not have adequate care, especially in sexual and reproductive services. For example, in 2012, 222 million women worldwide had an unmet need for contraception (Singh & Darroch, 2012). This group of women represents 26 percent of all women who wanted to prevent pregnancy. However, they also contributed to 79 percent of all unintended pregnancies. Preventing births early in a woman's life is vital to improve maternal health and reduce infant mortality. It also has the chance of improving a woman's socioeconomic status because she is more likely to continue her education and seek employment.

A woman's education and access to health care is directly related to that of her family, especially of her children (Richards, Waterbury, & Diwan, 2014). As the primary caregivers and sources of medical care, women have played an important role in the field for centuries. Historically and traditionally, women typically have held the responsibility of their family's health. Without access to health care, women would not be able to raise their children in the best circumstances for a better future.

In the Middle East and North Africa (MENA), women's access to health care is double-limited by the presence of an authoritarian regime that seeks self-preservation over women's healthcare and patriarchy. In terms of authoritarian regimes, women are often prevented from obtaining equal social, political, and economic rights. Because women are so often relegated to the domestic sphere, it is crucial to study the political

and economic dimensions of their access to health care services. In the past century, MENA has experienced the highest rate of population growth of any region of the world (Roudi, 2001). At 20 percent, women in the MENA region also have the highest rate of unemployment in the world (Roudi-Fahimi & Moghadam, 2003). In terms of patriarchy, women live in a society where almost every step of their health decisions is made by men. Women often need permission from a male family member or spouse to seek health care. They also rely on men in positions of power to determine what health care is available and to whom.

However, not all MENA countries are the same when it comes to women's access to healthcare. For example, 69 percent of Egyptian women report major barriers to accessing health services, whereas 49 percent of Moroccan women report similar barriers (UN Women, 2015b). Although almost all MENA countries are authoritarian, they differ in regards to women's participation in the legislature and in their economic make-up, both of which influence women's access to healthcare. First, women's involvement in politics has the ability to influence the economic and social aspects of their lives. The presence of women in legislature, political parties, and other political organizations gives them a platform to voice their concerns about their rights and policies that affect them. Middle Eastern governments have a history of male-dominated dictatorships that reduce rights of all citizens, men and women alike. The power elite dominating the government heavily influences legislation surrounding topics like health care. Women are further marginalized in these male-dominated systems because women's issues are not equated with political issues. Women's limited roles in this male-dominated system affect their health.



Second, development strategies and development policies affect women's employment and thus their access to healthcare. Existing research finds several effects of employment on women's health, such as poor working conditions, rising rates of mental illness, and maternal mortality and morbidity (Pascall, 1986; Papps, 1992). Development also has the potential to change the employment status of women. Economic policies of countries directly impact the changing demographics and rising unemployment that affect women's access to health care.

Access to health care also varies *within* MENA countries, particularly along urban-rural divisions and socioeconomic class lines. Rural and poor women are less likely to receive adequate health care than urban and rich women. Governments are more likely to focus health care on urban and heavily populated areas. This disparity underlines the inequity of health care distribution within countries, and often leaves some of the most disadvantaged people without access to safe and quality services.

To illustrate, the daily life of an average village woman in Morocco or Egypt consists of work, caring for children, and cooking. While the men work outside the house as farmers or day laborers, women most likely perform household chores, care for animals, or transform primary products (Hopkins, 1987). Even children work in the fields or household (Hopkins, 1987). The average girl age 15 to 20 in both Egypt and Morocco is married. These women often have the important task of managing the household and laying the foundation for economic activities, but are less independent economically (Hopkins 1987). Their day-to-day tasks revolve around life in the village, and some women never leave the village.

Meanwhile, the life of women in big cities like Cairo is only slightly different than that of women in rural areas. As in rural areas, women are often the heads of households, the main economic units (Singerman & Hoodfar, 1996). The family unit remains the most important institution in most people's lives for informal political and economic networks. Whereas women in rural areas are likely to work in the household and other agricultural duties, more women in urban areas seek formal employment. This expansion into the formal sector is partly due to the necessity of women to generate more income especially during times of economic decline. Although urban women may adopt different fertility patterns because of their involvement in the formal sector, many still adhere to traditional fertility beliefs found in villages.

The main difference between rural and urban women in Egypt and Morocco is their access to health. On the one hand, rural women travel to nearby cities to visit the doctor despite the presence of both private doctors and a government clinic in their village. And they do so most likely because they are seeking care for their children rather than themselves (Hopkins, 1987). This hints that the village health care systems may be present but are ineffective, or that the absence of health awareness prevents women from actively seeking those services. On the other hand, urban women have more access to and knowledge about contraceptive usage and delivery services. To give some numbers: in Morocco, 20 percent of births to rural women were attended by a skilled personnel in 1995 as compared with 80 percent of urban women (Roudi-Fahimi, 2003). Egypt had similar results in 2000 with 48 percent of rural women and 81 percent of urban women receiving professional delivery services (Roudi-Fahimi, 2003).

Not only does use of modern delivery differ between urban and rural women, but also within urban areas. In Morocco, 70 percent of women of low assets used modern delivery methods while 81 percent of women of high assets used those services (**Figure 5**). This hints at disparities within urban areas. Socioeconomic class may prevent some urban women from seeking and receiving services. Urban poor, especially slum-dwellers, often lack access to sanitation, clean water, and other basic necessities. In these situations, health is not a priority so few choose to spend money on health services.

To address these variations, this paper will adapt a comparative method of difference and look at the variations between and within the authoritarian regimes of Egypt and Morocco in regards to women's access to healthcare from the 1980s to 2000s. In doing so, I aim to address a previously unaddressed issue, namely women's access to health care in MENA. Although extant literature has focused on women's rights in MENA, it has not focused on health care. I argue that in both countries state capacity, the ability of the government to implement the policies it enacts, to be the main determinant of women's rights. It influences whether female parliamentarians can pursue healthcare policies, whether economic development projects are forthcoming, and whether the state can provide healthcare services it promised to everyone in the society, be it urban-rural, rich-poor, equally. In order to assess women's access to health care, I will use data provided by sources such as the World Bank, United Nations, World Health Organization, and Demographic and Health Surveys.

To discuss these points further, section two discusses previous literature concerning women's health and MENA. The third section explains the case selection and research design, while the fourth section proposes the theoretical framework, the

independent variables and the corresponding four hypotheses of this study. And the fifth section delves into the empirics to provide evidence for the theoretical framework.

Finally, the sixth section concludes the paper and offers suggestions for future areas of research.

## **II. Literature Review & Intended Contributions**

This research builds and expands on literature related to six areas: (1) policy literature on women's healthcare, (2) empirical literature on MENA, (3) theoretical literature resting on structural arguments, (4) intersectionality, (5) spatial explanations, and (6) state capacity.

### **i. Policy literature on women's health care**

I am pursuing the topic of women's access to health care services because I believe that as women's rights movements gain traction and expand, women's health will become a major focus of these groups. In Morocco, women's groups already succeeded in reforming the *Moudawana*, family law, and are now working to expand female education and improve women's employment (Sadiqi, 2010). With improvements in women's employment, the Moroccan government is considering legislation to regulate health insurance of domestic servants. Furthermore, in 2007 women became the heads of the Health Ministry and Ministry for Social Development, Family, and Solidarity. In Egypt, the Regional Centre for Women's Health and Development in Alexandria was established in 2006, with the goal of improving women's health and development not only in Egypt, but also in the wider Middle Eastern region (Alexandria Regional Centre,

2013). With these advancements, women's access to health care in the region has the potential to improve.

The policy literature on women's health care discusses women's health care in the Western World, but fails to address women's health care in MENA, which this paper aims to address. To understand the recent developments of women's access to health care, it is first necessary to acknowledge the history of women's access to health care in these countries. A country's past political and economic agendas can convey much about the status of women within that system, and the status of women suggests the importance of ensuring their access to health care services. There is also little scholarship on the specific topic of women's health care in MENA, as scholars have typically focused on the broader question of women's rights in the region. By engaging this study, I hope to add to the scholarship on women's access to health care by determining how the past political and economic structures affected women in Morocco and Egypt in order to determine the health care reforms needed today.

Normative theory has extended its ideas of human rights to include a gender component by institutionalizing women's social, political, and economic rights and forming gender standards to which countries are held accountable (Clark, 2001; Neville, 1995). Although the United Nations attempts to ensure practices of equality, in no country in the world do women celebrate complete gender equality. Scholars have studied this phenomenon through analysis of political, economic, societal, and cultural factors. In this paper, I will analyze research from a comparative politics perspective on first the relationship of political and development policies to health care on the national

level and second the impact of location and socioeconomic class on health care on the subnational level.

## **ii. Empirical literature on MENA**

I am specifically interested in women's access to health care in MENA. The region is plagued by health concerns and violence against women. Women in the region face common diseases such as heart disease, diabetes, stroke, as well as domestic violence attacks, genital mutilation, rape, and unsafe abortions (The World Bank, 2013). Furthermore, North Africa had one of the largest percentages of increasing populations in the world at two percent (Population Reference Bureau, 2013). The issue of women's access to health care is therefore concerning not only for women, but for the children who are the future of the region.

The empirical literature on MENA addresses domestic policies and health care but fails to address the specific relationship of domestic policies and health care to women, which this paper aims to address. Both international and domestic political attempts have tried to regulate and improve women's health rights (Cook, 1994; Peters & Wolper, 1995). Most scholars agree that there is a relationship between domestic politics and development policies to women's empowerment (Abu Nasr, Khoury, & Azzam, 1985; Breslin & Kelly, 2010; Cook, 1994; Charrad, 2001; Haghghat, 2014; Hessini, 2007; Moghadam, 2005; Musgrove, 2004; Nelson, 1994; Papps, 1992; Peters & Wolper, 1995; Richards et al., 2014; Ross, 2008; Roudi-Fahimi, 2003; World Bank, 1995). Some of this research includes the specific component of women's access to health care, but does not address these issues from a comparative viewpoint. While health is often an indication of women's rights, there is little literature on how political and economic

policies specifically affect women's access to health care in MENA. Studies may briefly mention or give an overview of health, but do not provide in-depth analysis of the health care services of countries like Morocco and Egypt. Many of the studies provide empirical data concerning health, but do not seek to explain what causes these results. On the other hand, some of this research focuses specifically on examining women's rights from political, economic, social, and cultural theories, but do not focus on health. I hope to combine the focus on women's access to health care with some of the theories previously used to explain women's rights in general.

### **iii. Theoretical Literature**

Theoretical literature resting on structural arguments addresses gender gaps in power positions, but fails to address the connection of these gaps with health care legislation, which is discussed in this paper. A major concern is that the political gains made by women in the past few decades have not translated into greater public participation in the Middle East. Legal gaps in women's rights are still prevalent in MENA even though there is greater inclusion of gender equality provisions in constitutions. Bowles and McGinn argue that the gender gap in leadership and claiming authority is due to four dominant explanations: gender bias, lack of experience, lack of motivation, and familial responsibility (Messick & Kramer, 2005). It is true that women may not have the qualifying experience to be elected in the legislature, but an increasing number of women in the Middle East are employed and as fertility rates fall, familial responsibility is decreasing. Although these explanations may be true for women in MENA, this analysis fails to acknowledge the underlying causes of the lack of women's

participation: bias in the national constitutions. Most countries in the region, including Morocco and Egypt, have ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), but many have made reservations about the most important points such as Article 2 which requires countries to acknowledge the equality of men and women in the national constitution (OECD, 2015). This systematic exclusion of women from politics and lack of acknowledgement that women should have the same political rights as men hinders women's ability to have an influence on the political workings of their governments.

In this paper, the political components discussed are specific health care policies and women's involvement in policymaking. Policymaking is key in determining what health care is available and who can access it. Most concerning to scholars is that half of the world's population is only represented in twenty-two percent of the formal positions of political leadership, only doubling in size in the last twenty years (Nelson & Chowdhury, 1994; UN Women, 2015a). This means that the majority of women have male policymakers determining their health rights, which ultimately affects the availability of that health care. Feminist political theory offers insights into how societal gender roles integrated into political life lead to gendered legislation. It attempts to explain women's functions in society by analyzing traditional gender roles and how the political and economic spheres integrated those roles. Feminist political theory maintains that gender shapes women's political roles and how political leaders understand women's involvement in the political system (Evans, 1986; Randall, 1982; Sapiro, 1983).

Two concepts that can help explain this phenomenon are marginality and integration. Sociologist Helen Hacker defines "marginality as the state in which one



‘lives in two different worlds simultaneously, is a participant in two cultural systems, one of which is... regarded as superior to the other’” (Sapiro, 1983, pp. 5-6). Marginality can be applied to the public-private split because women are marginalized to the private sphere of homemaking and by nature cannot be involved in politics. The opposite of marginality is integration, in which femininity and politics are integrated. In this case, there is no distinction between women’s issues and political issues. Family concerns would be public concerns, and women are fully integrated into the political sphere. Unfortunately, this is not the reality in any country of the world. Family law may convert private issues to public issues in MENA, but does not equate women’s issues with political issues. Until recently, family law restricted women’s inheritance rights, women’s divorce rights, and women’s custody of her children after divorce (Moghadam & Roudi-Fahimi, 2005). Rather, marginality remains the prevailing concept, and from this lens I will examine women’s effect on the political processes of Morocco and Egypt.

Because women’s issues are marginalized in most political systems in MENA, defining women's roles in these male-dominated systems is difficult. Women have rarely held positions of political leadership and decision-making in the past, so political scientists and policymakers often generalized women’s political behavior. Even as women’s presence in political arenas increased in the region in the past few decades, scholars still question the impact that their representation has in terms of gender. This debate, between descriptive representation (the physical numbers of women in office) and substantive representation (representation of women’s interests), argues that substantive representation is more important than descriptive representation. Carroll (2001) notes that as long as women are “struggling for survival in institutions unaccustomed to their

presence, it seemed unlikely that women public officials would or could have much of a distinctive, gender-related impact” (pp. xii). Because political institutions and the people who run them are unaccustomed to women’s presence in the arena, female policymakers make minimal advancements on gender equality. Moreover, several analyses have found that women who are in government or leadership positions are often inhibited by the context set by their peers (men) (Baldwin, 1996; Carroll, 2001; Tollenson-Rinehart, Stanley, & Reynolds, 1995). However, even a step toward women’s inclusion in legislation has the potential to empower women by giving them a platform to voice their opinions. Although descriptive and substantive representation are important for women’s issues, they cannot be achieved without the presence of a female constituency. It is difficult to quantify descriptive and substantive representation in authoritarian governments because the concepts arose from female’s participation in democracies. While both are authoritarian governments, the parliament plays different roles in Morocco and Egypt. In Morocco, the King reserves the right to intervene when necessary, but leaves everyday politics to parliamentarians, resulting in a relatively functioning parliament. On the other hand, Egypt’s military regime uses the parliament to govern according to ideals of the state. Consequently, there is no functioning parliament or party system in Egypt. Hence, while some degree of substantive representation is present in Morocco, it is hard to quantify in Egypt. Instead this paper will attempt to explain how the absence of women in policymaking and the inability of women to contribute to policymaking even in authoritarian governments leads to flawed health care.

Past research concerning MENA does not discuss descriptive and substantive representation, but examines how legislation such as family law affects women’s rights

(Moghadam, 2005; Welchman, 2007). Family law has some of the most important social consequences for women in Morocco and Egypt. Islamic law, interpreted by Islamic clerics and scholars, formed family law. Family law dictates policies such as marriage, divorce, and inheritance. Islamist feminists argue that the Islamic laws behind these male-dominated family law policies must be reinterpreted to fit the modern context. Although important, family law has little direct effect on health care. Because family law does not determine women's political participation or participation in the economy, it is beyond the scope of this paper. What is important to understand is that in Egypt family law is controlled and implemented by Egyptian elites (Abu-Odeh, 2004). Additionally, Morocco family law is controlled by a coalition of monarchy and tribal elites (Charrad, 2001). Mills argues that power elites are in a position to make decisions that have major consequences for everyday lives (Mills, 1956). They dominate the major organizations of modern society, control the military establishment, and constitute strategic positions in the social structure. This paper examines the power elite to understand the formation of policies which directly affect women's access to health care.

In addition to emphasizing the role of women in positions of political power, another important component of the structural argument in determining women's access to health care is women's involvement in economic development. Previous examination of economic development's effect on women focuses on modernization theory. Modernization theory argues that women's rights, including women's access to health care, will improve as the economy develops. Modernization in the economy means a "growth in productivity and a more equal distribution of economic benefits [such as healthcare]" (Almond & Powell, 1978). Inglehart and Welzel (2009) argue that

modernization espouses social change that transform social and political institutions and results in rising education, life expectancy, and rapid economic growth. Furthermore, Bhagwati (2004) argues that “women, as a class, are not destined to lose from progress any more than other groups are” and that helping women with policy responses actually blocks progress and is counterproductive (pp. 87-88). Modernization does not focus on the gender component to development because it assumes that progress will benefit everyone. Some scholars acknowledge that the process of modernization in developed countries is different from developing countries, as well as between democracies and authoritarian governments (Abu Nasr et al., 1985; Haynes, 2002; Richards et al., 2014). For example, Egypt and Morocco took similar paths to development, but women’s access to health care differs between the countries. Modernization theory cannot explain the existing gender disparities that have continued even as Morocco and Egypt pursued development policies. Gender disparities cannot be eliminated as long as modernization means only adopting “modern” economic methods without restructuring the country’s political institutions to ensure the benefits of development are evenly distributed. Therefore, this theory is not effective in analyzing gender and gender disparities in developing countries.

Some political economists and other scholars who studied the socioeconomic status of women argue that women’s health, and health of the population in general, is important for production (Haghighat, 2014; McElmurry, Norr, & Parker, 1993; Musgrove, 2004; Richards et al., 2014; World Bank, 1995; White, Merrick, & Yazbek, 2006). These studies show that women’s employment has important implications for the economy. Fee and Waldron (1983) argue that there are three links between employment

and health: effects of employment on health, effects of health on employment, and effects of a common factor, like education, on both health and employment. Health has a significant impact on whether a woman decides to enter the workforce or not, employment can lead to worsening health such as injury or improved mental health from social support, and overall socioeconomic status affects health care. Unfortunately, the current literature on socioeconomic development in MENA fails to include the gender dynamics involved in those policies (Bayat, 2002; Ismael & Ismael, 1995; Sorenson, 2008). Additionally, education is often cited in these analyses as a key to employment and access to better health care (Haghighat, 2014; Fee & Waldron, 1983; White et al., 2006). With healthy and educated people, the state is more likely to succeed in its national development plans. However, in MENA there is a “reverse” gender gap in education, in which girls actually outscore boys throughout most of elementary and middle school (The World Bank, 2014). This paper will not examine education as a factor in obtaining health services because despite an increasing number of educated women, they still face barriers in accessing health care services.

The arrangement of relevant political and economic institutions indicates the effect of development on women’s access to health care. The combination of state policy and economic development can be seen in most MENA countries. These states employed different combinations of methods such as agro-export-led growth, mineral-export-led growth, import-substituting industrialization, growth by manufactured exports, and growth by agricultural development to reach a state of development (Richards et al., 2014). It is important to examine how the state tools that lead to development have either removed women from or encouraged women to join the economic sphere. Because they

are not involved in creating or implementing development policy, women's input is isolated. This isolation extends into women's roles in the economy even when they are employed.

Feminist studies of political economy claim that societies are characterized by a division of labor roles that lead to the inequalities between men and women. Due to globalization, women are increasingly involved in the economy. However, working women are often still responsible for taking care of the household, so women's work exceeds men's by at least two hours per day (Barker & Feiner, 2004). This household care often involves childcare, which translates into future investment, but is not considered in the paid value of women's work. Gender inequality is the direct result of the sexual division of labor: the division of paid and unpaid and productive and reproductive labor. In this system, women's access to resources, such as health care, is more restricted than men's. The theory of female autonomy claims that because employment outside the home provides alternative sources of social interaction and economic support, it reduces women's dependence on men and increases sexual and reproductive autonomy (Dixon-Mueller, 1993). When women provide their own income they are able to support themselves which makes them more independent and gives them more opportunities. Employment outside the home also translates to less obligation to household duties and the traditional role of women as caregivers and practice sexual autonomy. This paper applies the theory of female autonomy to the cases of Morocco and Egypt.

In terms of cultural arguments, some scholars argue that some cultures, specifically those of developing countries in MENA, promote the division of men and

women and thereby maintain gender inequality. Literature available on women's rights in MENA often focuses on how the patriarchal aspects of Islam contribute to fewer women's political, social, and economic rights (Cammack, Pool, & Tordoff, 1988; Moghadam, 2005; Kandiyoti, 1991; Wiarda, 2003). These scholars argue that this aspect of the culture explains the sexual division of labor that perpetuates male dominance. In the traditional sexual division of labor, men are the leaders and decision-makers whereas women are relegated to the domestic position of homemakers. However, the Islam argument is overstated; women are underrepresented in politics in many developed countries as well as developing countries, regardless of religion. For example, in 2012 in the United States, women held just above seventeen percent of seats in the House of Representatives and only twenty percent in the Senate (Catalyst, 2016). Therefore, culture may matter, but the argument that only the Muslim-dominant cultures exhibit gender inequalities ignores other components of gender issues. Additionally, culture is not a reliable explanation of variations in women's health in this case because both Morocco and Egypt have 99 percent Sunni Muslim majorities, yet Morocco's women have better access.

Moreover, scholars like Ross (2008) and Obermeyer (1993) argue that other characteristics of Arab states like oil and the political context of health, not Islam, are the main factors in reducing women's involvement in the economy, and by definition, politics. Ross (2008) finds that oil is linked to patriarchy because economic growth based on oil exports "diminishes their [women's] role in the workforce and the political sphere" (pp. 120). The limited presence of women in the workforce prohibits them from having political influence to change the patriarchal laws and institutions. Aside from

religion, another argument is that the political culture of the two countries prevented women from demanding equal access to health care. The Egyptian military regime was founded on the ideology of Arab Socialism and thus equality for everyone, while the Moroccan monarchy was built on traditional, tribal, Berber culture and thus supported traditional gender roles for women. For instance, Morocco did not have family law reform until 2004 and instead used Moudawana, religious family law written in the 10<sup>th</sup> century. Rather than focusing on the role of culture, this paper attempts to explain how lack of women's involvement in policymaking processes and the job sector affects women's access to health care in Egypt and Morocco by adopting the aforementioned concepts of marginality and integration and applying the theory of female autonomy.

#### **iv. Intersectionality**

Scholars have used the intersectionality framework to examine the social and structural forces that interact to shape experiences at the individual level. Previous literature has not used intersectionality to examine specific case studies on health, which this paper attempts. This paper proposes that gender, class, location, and state capacity all interconnect to shape a woman's health experiences. I will use the intersectionality framework to examine the interconnectedness of these variables. The emergence of intersectionality converged with the second wave of feminism and the multiracial feminist movement. Kimberlé Crenshaw coined the term "intersectionality" in 1991 in a study in which she argued that a variety of factors such as race, ethnicity, and class all needed to be considered in order to fully understand violence against women (Zambrana & Dill, 2009). Previous literature uses intersectionality to study class, race, and gender, typically in the United States (Guidroz & Berger, 2009; Hankivsky, 2012; Kvasny,



Trauth, & Morgan, 2009). I believe intersectionality has the potential to expand beyond its origins in race issues in the United States. I hope this research contributes to intersectionality by applying it to understand how the independent variables of urban-rural location and socioeconomic class within the urban area affect the dependent variable of women's access to health care.

Previous literature suggests that intersectionality is a beneficial framework for studying women and minorities in public health (Bowleg, 2012). Bowleg (2012) values intersectionality as a framework for studying women's experiences in public health because it has the ability to "elucidate and address health disparities across a diverse array of intersections" (pp. 1270). She also suggests that because intersectionality examines social and structural factors beyond the individual level, it provides a more comprehensive understanding of health experiences (Bowleg, 2012). She acknowledges the usefulness of applying intersectionality to issues of public health in America, but Bowleg does not actually apply intersectionality to a specific case study. Few studies actually examine case studies of the intersectionality of health and gender, and there is an absence of intersectionality research examining women in MENA (Hankivsky, 2012).

Scholars apply intersectionality to study how class affects women's experiences in professional settings (Brunn, 2009; Kvasny et al., 2009). One study found that the intersectionality of socio-economic class, gender, and race explained the experiences of both low and high income Black women in the workplace (Kvasny et al., 2009). Another study found that socio-economic status combined with race and gender affects the four-year graduation of students in post-secondary schools (Brunn, 2009). A third study found that class position limited economic and educational resources for women, but racial

discrimination limited work positions and undercut education benefits (Guidroz & Berger, 2009). These studies are valuable because they provide evidence of the connection of socio-economic class with women's experiences by adopting the intersectionality framework. However, all three included race and none examined health or countries other than the United States. This paper attempts to broaden previous intersectionality research on gender and socio-economic class by studying their effects on women's access to health specifically in Morocco and Egypt.

Few studies use the intersectionality framework to study gender and location. One study examines how gender, race, and location interconnected to affect a woman's occupation in post-apartheid South Africa (Parashar, 2014). It did not find that women in urban settings were more likely to have "male-type" occupations than women in rural settings (Parashar, 2014). However, it acknowledges that race is privileged in South Africa and therefore overshadowed the effect of the urban-rural divide on occupation. Because there are no significant racial divisions in Morocco or Egypt, the effect of race would not dilute that of location, especially regarding access to health services. Other research not based in the intersectionality framework provides the basis for studying gender, health, and location.

#### **v. Spatial Explanations**

Health care decisions depend on the quality of service, distance, time, and overall cost of care (McLafferty, 2003). Studies examine the link between spatial setting and access to health care (Hyndman, Holman, & de Klerk, 1999; Kinman, 1999; McLafferty, 2003). They find that usage of health clinics and other services depends on the

individual's distance from the location. The farther away the individual, the less likely they were to seek out those services. McLafferty (2003) acknowledges that this is especially true in developing countries. These studies are useful in identifying causes of rural and urban inequalities in access to health care, but none are focused on MENA. None address the political environment of the countries, inequality differences between men or women, or the specific impact of distance on women. In this paper I hope to outline the effect of physical distance on available health care services to women and women's health choices. In order to fully understand the connection between health choices and location, it is also important to assess state capacity. When examining urban and rural divides and distance, the government's allocation of health resources and funding seem to be significant factors for both Moroccan and Egyptian women because it determines where health facilities are located and the quality of those facilities.

#### **vi. State Capacity**

State capacity is the ability of the government to meet its policy objectives (Barillas, 2010). Not only is it important that a government legislates policies ensuring basic necessities like health care, but also that it is capable of providing those promised resources or funding for those policies. Although Morocco and Egypt enacted family planning programs and other initiatives to provide tools to women, they may not have the capacity to fully implement those programs. Previous studies have examined the importance of state capacity in health and welfare programs (Barillas, 2010; Qarakhani, 2014). One study finds significant correlation of state capacity and health policy in Iran from the 1980s to 2009 (Qarakhani, 2014). By defining state capacity as the

government's fiscal strength, Qarakhani (2014) found that an increase in the fiscal capability of the state resulted in an increase in health funding. Hendrix (2010) recommends that researchers evaluate "revenue-generating capacity" rather than military strength when using conventional measures of military capacity in conflict situations (pp. 274). A limitation of defining state capacity as fiscal strength alone fails to consider the other factors that could affect state capacity, such as military involvement and political unrest. While acknowledging this limitation, Hendrix's method will be adapted in this paper to examine the fiscal capability of the government to provide for health spending.

### **III. Case Selection & Research Design**

In this study, I examine women's access to health care in two countries of North Africa, Morocco and Egypt, because it allows me to adapt a comparative method of difference.<sup>1</sup> On the one hand, Morocco and Egypt share a similar socio-political context. Both are North African countries that are predominantly Sunni Muslim, and most importantly, neither of the countries are reliant on oil, which has proven to have an effect on women's rights in terms of employment (Ross, 2008). During the 1980s to the 2000s, both Morocco and Egypt were authoritarian governments and underwent a series of economic changes. It is possible to examine how these governments and economic changes during this time period affected women in the country. Morocco was a constitutional monarchy whereas Egypt was a military dictatorship, but both were run by

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<sup>1</sup> John Stuart Mill's method of difference, or the most similar systems design, examines similar social systems, in this case countries, that may share political, social, economic, cultural characteristics, etc. These characteristics can be held constant in order to explain why a certain phenomenon, in this case better women's access to health care, occurs in one country but not the other (Lim 2006).

authoritarian elites. In Morocco, the monarchial elites were an artifact of the preceding French colonial rule. In Egypt, the military leaders who overthrew the British-controlled monarchy took power. Both governments promised equality of women's political and economic rights, but Morocco has a better record of upholding those rights. Finally, both Egypt and Morocco were signatories to the CEDAW, and had reservations about the same article (2). Both countries have also enacted family planning programs that affected women's access to health care. From the 1960s onward, countries in the Middle East and North Africa witnessed major improvements in health care. Especially during the 1960s, the leaders of Egypt and Morocco wanted to reduce the population growth to further economic development and develop health policies. In the 1980s to the 2000s, the countries underwent several economic changes, which impacted employment status of many women. Infant and maternal mortality rates in the region have decreased considerably. Because they are so similar, it is important to study why they differ regarding women's access to health care.

On the other hand, Morocco and Egypt vary in regards to women's healthcare access despite sharing similar backgrounds. Egypt's health care system is better organized, better funded because of the country's larger GDP and ability to spend on public health care, and staffed by a larger number of trained health workers. Surprisingly, this paper finds that although Egypt had a better health care system, Moroccan women had better access to health care in terms of family planning and sexual and reproductive tools because of the more effective family planning programs and women's employment in sectors other than agriculture. Thus, the first part of this paper

will address what explains the observed varying degrees of women's access to health care services in the authoritarian countries of Morocco and Egypt.

The second part of this paper will turn to the sub-national level and address what explains variation in women's access to healthcare within Morocco and Egypt. In particular, it will look at the influence of urban-rural divisions and socioeconomic class. The sub-national level evaluates individual choices, experiences, and decisions. The first part will consider urban and rural divisions. As explained earlier, urban areas tend to be more developed and modern than rural areas. This means that women are more financially independent and can spend their money on health care. Additionally, health centers are often more concentrated in urban areas. However, access within urban areas also depends on socioeconomic class. Despite their proximity to health centers, urban poor women do not have the necessary assets to access services. The second part of the paper will address the explanation for the observed varying degrees of women's access to health care *within* authoritarian countries of Morocco and Egypt.

I will examine the political and economic aspects of this paper in the time period of the 1980s to the 2000s. Due to the lack of data from the 1980s to the 1990s, the research on location and socioeconomic class within the countries focuses on the 2000s to 2013. This serves to assess how the policies of the 1980s and 1990s changed the picture of health care in the two countries for the decades following. Data and measurements are collected from the UN, WHO, World Bank, USAID, SWMENA, CIA, and DHS and government reports.

To measure the dependent variable of this study, namely women's access to health care, this paper will look at women's access to sexual and reproductive services.

This includes antenatal and delivery care services, contraceptives, health care programs, and knowledge of family planning tools. I will compare the health systems of the Egypt and Morocco, which differ in organization, but face similar setbacks such as inefficiency and poor facilities. The specific measurements used to determine access to health care are health insurance, infant and maternal mortality rates, use of antenatal and delivery care services, availability and knowledge of sexual and reproductive services, the amount of women using contraceptives, and maternity leave using data from the WHO, World Bank, and DHS data.

To measure female involvement in the legislature (IV1), I will analyze the constitutional provisions for women's political involvement and the percentage of women in legislature using the constitutions of the country and data from the International Institute for Democracy and Electoral Assistance (IDEA), World Bank, and WHO. In terms of women's participation in the economy (IV2), I will evaluate diversification of the economy, percentage of women in the labor force and how women's work is divided among sectors using data from the WB and studies of the political economy of the two countries. Location (IV3) is measured by women's physical location, distance from the city, and the government's definitions of urban and rural. Finally, socioeconomic class (IV4) is measured by income and household expenditures.

#### **IV. Theoretical Framework**

Building on the literature discussed above, I will use 4 independent variables, some of which measure state capacity. The ability of the government to implement economic policies that include women, carry out rural development programs, and offer

affordable services is important to understanding the full relation of economics and location to women's access to health care. To understand variation in women's access to health care between Egypt and Morocco, I will look into the influence of (1) Female involvement in the legislature and (2) Women's participation in the economy, on women's healthcare. And to understand variation in women's access to health care within Egypt and Morocco, I will look into the influence of (1) Urban and rural location and (2) Socioeconomic class, on women's healthcare. **Figures 1 and 2<sup>2</sup>** are causal diagrams of the variables.

**i. Independent Variable #1: Explaining variation between Morocco & Egypt through female involvement in the legislature**

If women are barred from political participation, they are unable to voice their concerns and decisions about topics that affect them, such as access to health care. The implementation of family planning programs increases women's access to family planning tools. Development policies have the potential to shift women's work to different sectors, thus affecting employment and wages. When unemployed, women are reliant on a family member for health services and are less likely to challenge their patriarchal surroundings.

Colonial rule in most countries favored certain groups over others, and these people often rose to the status of elites in the post-colonial era. These groups often benefitted from education, military service, and administrative posts (Waterbury, 1970). The ruling elites are in the position to appoint specific parties or individuals to positions

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<sup>2</sup> All figures are found in Appendix A.



of power, and flood the government with party supporters. These political elites control all aspects of legislation and determined policies of the government. Laws and policies, even the constitution itself, are often gender-biased toward men while restricting women in political life. This has implications for the constitutional provisions for women's political involvement. Some constitutions made it easier for women to become involved in political life than others. Women's voter registration was restricted, limiting their influence on the politicians elected and women's access to political parties. Because of the institutional barriers to women's political participation, small numbers of women were elected to the legislature. Often those women who were elected were used as pawns to create a façade of a progressive government. These women did not represent a gendered constituency so this could not be considered substantive representation. Although women were present in the parliament, they did not challenge the status quo of the authoritarian regimes because they, as elite women themselves, benefitted from the existing political system. They did not face the same problems to accessing health care or other services as non-elite women. Therefore, elite identity of the women elected took priority over their female identity, so they did not pursue legislation on behalf of women, and instead sought to preserve the status quo. Thus, women relied on elites to write the health care policies that directly affected their access to health care and reproductive tools.

In light of these theoretical discussions, this first hypothesis of this paper is:

**H1:** *In countries where there is more women's representation in the legislature, women will have more access to health care services.*

## **ii. Independent Variable #2: Explaining variation between Morocco & Egypt through Female involvement in the economy**

Political integration alone is insufficient to achieve gender equality. Gender equality can be defined as equal political rights and equal access to services, resources, and economic opportunities (OECD, 2015). Often in MENA, women are the last to be hired and first to be fired. Employers discriminate against employing unmarried women because of the high probability that they will leave their jobs once pregnant or married and are unlikely to hire married women (Abu Nasr et al., 1985). In order to understand the connections between women's employment and health care, I will employ the theory of female autonomy summarized earlier. This theory states that employment outside the household reduces women's dependence on men, but only in non-agricultural work (Dixon-Mueller, 1993). Without employment, women do not have economic security and rely on their families or husbands for access to health care, including sexual and reproductive tools and contraceptives.

It is necessary to analyze the development policies of the countries in order to understand women's employment within those systems. Development in this paper is considered as growth in modern sectors such as manufacturing, with the relative decline of more traditional sectors such as agriculture. Thus, this paper's second hypothesis is: **H2: *Women who are employed in the formal sector rather than agriculture will have better access to health care.***

### **iii. Independent Variable #3: Explaining variation within Morocco & Egypt through rural/urban divisions**

The private sphere is often associated with women while men dominate the public sector. Previous research by Sadiqui and Ennaji (2006) found that rural women have less access to powerful public space than urban women in Morocco. While rural women were only present in agriculture and the corresponding market, urban women's formal jobs gave them access to an individual identity, separate from their families, in the public space (Sadiqui & Ennaji, 2006). When women move from rural to urban, the likelihood that they will work in the formal sector increases. This dichotomy can be attributed to differential modernization. Urban areas are considered progressive and related to the public space whereas rural areas are associated with traditional, private space (Sadiqui & Ennaji, 2006). During the colonial period, centralized administration led to the growth of urban areas (Costello, 1977). After the colonial period, national development plans often focused resources on urban areas because the most direct political and economic pressure on the government came from these populations (Costello, 1977).

I propose that the dichotomy between progressive versus traditional views between rural and urban areas is also valid with health care. Because the governments of Morocco and Egypt are focused on urban development rather than rural development, more resources are dedicated to urban health care. Urban women are more likely to live close to hospitals or other health care clinics than rural women. Because of physical proximity to health care providers and the government's focus on urban areas, urban women are more likely to have access to quality health care services than rural women. Hence, the third hypothesis of this paper is:

**H3:** *Urban women are more likely to have access to health care than rural women due to their location and the government's limited capacity to effectively implement health care programs.*

**iv. Independent Variable #4: Explaining variation within Morocco & Egypt through socioeconomic class**

In densely populated cities, individuals often lack facilities with basic sanitation and infrastructure, which leads to the spread of disease. Furthermore, people living in slums in urban areas are less likely to have health insurance and consequently receive poor care. Socioeconomic class further contributes to this cycle of poverty and poor health care. This is due to a combination of inadequate resources to pay for services and failure of the government to implement and maintain health services. Because the governments of Morocco and Egypt invest inadequate funds for health services, those services are costly and most people of lower income do not use them. They are consequently more likely to only seek out care at advanced stages of the disease or illness. Additionally, in rural areas women are responsible for their children's health care, and they report seeking services for their children but rarely seek out services for themselves (Hopkins, 1987). I posit that socioeconomic class greatly affects women's access to health care, and that urban women may have less access to health care than their rural counterparts. Hence, the last hypothesis of this paper is:

**H4:** *Access to health care among urban women varies along with socioeconomic class.*

## V. Empirical Section

This section will begin with an examination of the political and economic institutions of Morocco and Egypt in regards to the elitist contexts in which they were formed to try to answer why women's access to health care services differs between these two authoritarian governments in the Middle East. **Figure 3** is a table summarizing the values on the first two independent variables and the dependent variable for both Egypt and Morocco. Even though women in Egypt were elected to legislature before women in Morocco, women did not necessarily support these candidates. In 2000 there was a slight increase in women elected because of the establishment of the National Council of Women. Suzanne Mubarak, the Egyptian first lady, controlled laws of and appointment of officers to elect women. Because of the lack of women who actually supported these candidates, the election of these women could not be considered substantive representation as they were tokens of the regime and did not necessarily represent a gendered constituency. Conversely, there was a huge increase of women elected in Morocco in 2002 due to the direct efforts of women. Political parties responded to the mobilization of women and opened all national ballots to female candidates, so the women who were elected did represent a gendered constituency.

There was a huge increase in employment in agriculture of Egyptian women between 1980 and the early 1990s (**Figure 3**). As discussed in the next section, this accompanied a decrease in the percentage of women using prenatal care services. Female employment in agriculture decreased slightly in Morocco and increased slightly in industry and services.

The section goes on to discuss the sub-national explanations for differences in women's access to health care. It uses the intersectionality framework to analyze the following intersections: 1. Urban location and health, 2. Rural location and health, and 3. Class and health. It finds that urban versus rural location makes a significant impact to whether a woman is in proximity to a health care center in Morocco, whereas rural and urban women in Egypt are all in close proximity to a health care center. Rather, in Egypt there are regional differences. Socioeconomic class seems to be a major factor in women accessing health care in Egypt, while the urban-rural difference in Morocco trumps socioeconomic class differences.

As stated earlier, Morocco and Egypt differ in their health services and family planning programs. Though the two countries adopted family planning programs around the same time and implemented reforms at the same time, Egypt had no method to educate women about contraceptive use and an ineffective method to deliver those services to rural women. This greatly impacted the effectiveness of Egypt's family planning programs in comparison to Morocco's.

These observations will be further elaborated in the following sections.

### **i. Morocco: Women's Political Participation**

In order to understand the situation of women in Morocco from the 1980s to 2000s, it is first necessary to gauge the political atmosphere when the country gained sovereignty in 1956. During the colonial period, the French adopted a method of indirect administration in Morocco in which they controlled local power structures. To quell uprisings, they gave tribal leaders special status, and thus tribal communities were not as weakened as they had been in other North African countries (Charrad, 1990).

Additionally, only a small percentage of the Moroccan population benefitted from the French educational system and military and administrative posts, and this group became the elites in post-colonial Morocco. These elites filled the power vacuum after 1956, and had a major influence on decision-making because of their representation in political parties and economic organizations (Waterbury, 1970). Because of the country's small population, the Moroccan elite could directly influence norms and the political agenda which was not possible for larger-sized countries such as Egypt (Waterbury, 1970). After attaining sovereignty in 1956, a monarchy formed based on political support from the elites. The monarchy created systems of patronage to maintain the support of these elites. The combination of tribal communities and the elites uniquely influenced Moroccan social organization, political authority, and economic activity (Charrad, 2001).

King Hassan II, an authoritarian ruler, ascended to power in 1956 and used his position to control the army, Islamists, and the rural and urban elite (Davis, 2005). He employed *Makhzenian* politics, combining cooptation and repression to deal with opposition groups, especially opposition political parties (Maddy-Weitzman & Zisenwine, 2007). From the beginning, reform of legislation like family law stemmed from the regime rather than the people. The elites, who permeated every level of Moroccan government, highly influenced decisions taken at this level because of their positions of authority in the political and economic institutions. Consequently, this group had direct control of policy legislating women's rights. Analyzing provisions made for women in the constitution is integral to understand how this power elite affects women's access to health care.

Since 1956 Morocco had three separate constitutions. In 1965 a state of national emergency suspended the constitution and human rights, in order to end the stalemate between the factionalized legislature and the king (Nelson, 1986). After a coup attempt in 1971, King Hassan II agreed to implement reforms, and a new constitution was adopted in 1972. All three of the constitutions guaranteed equal political rights, right to education, and right to employment for men and women (Nelson, 1986). Despite these assurances, Morocco had a reservation about Article Two<sup>3</sup> of CEDAW, which was adopted by the United Nations General Assembly in 1979, stating that:

“The Government of the Kingdom of Morocco express its readiness to apply provisions of this article provided that:- [sic] They are without prejudice to the constitutional requirement that regulate the rules of succession to the throne...do not conflict with the provisions of the Islamic Shar’ia” (Morocco, 2011).

The government had reservations about the personal status of women, specifically the cause about abolishing discriminatory customs, but not about political rights. This is key to understand why it was easier for women to mobilize in the 1990s.

Article 9 of the Constitution of 1972 also granted all citizens the right to join any political or social organization (“1972 Constitution of Morocco,” 2012). Despite the provisions for women’s political rights, they were not reflected in actuality; measures

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<sup>3</sup> Article 2 of CEDAW maintains that states condemn all discrimination against women and implement plans to eradicate discrimination against women by: a. Granting equality of women and men in the national constitution or other legislation, and to ensure the practice of this principle, b. Enact legislative measures such as sanctions prohibiting discrimination against women, c. Create legal protection of the equal rights of women with men and ensure this protection through national and public institutions, d. Refrain from any action or practice of discrimination against women and ensure the compliance of public authorities and institutions, e. Eliminate discrimination by any person, organization, or enterprise, f. To modify or abolish existing laws, regulations, customs, and practices through appropriate measures such as legislation, and g. To repeal national penal provisions that discriminate against women (UN Women, 2009).



such as quotas were not provided to women to gain access to elective institutions or political parties. **Figure 4** shows the disparity between the number of women candidates and the number of women elected in various legislative elections. Women were elected in local elections in 1976, but it was not until 1993 when the first two women were elected to the legislature (Tahri, 2003). Beginning in the 1990s, women in Morocco mobilized to demand rights and political inclusion (Castillejo & Tilley, 2015). This mobilization was possible because of elite-led efforts to open the political system during the late 1990s under Hassan II and accelerated under Muhammad VI. Because the elites accepted the new political opening, women succeeded in their efforts to change their political status. This set a trend for women to make further claims. For example, in 2002 the number of women elected spiked to 10.77 percent because political parties agreed to reserve all spots for female candidates on the national list, a response to complaints from women (Tahri, 2003). This success empowered women and led to further mobilization. Not only is it significant that women won elections, but also that they were elected and supported by women. Women were able to demand change and gained descriptive representation.

According to the research of scholars like Celis and Childs (2008) and Carrol (2001), the number of women elected cannot alone account for substantive representation of women. There was a possibility of improvement in the area of women's access to policy-making because those women elected represented a gendered constituency and catered to that constituency. Especially in the area of family law, women in Morocco succeeded in introducing reforms through the early 2000s. Because of these gains, a platform opened up for women to request further reforms, like those in health care.

However, local elective institutions and political parties in Morocco remained male-dominated, and women were far outnumbered by men, and had little, if any, voice. Because of the lack of women in the entirety of the policy processes, the necessary legislation to mainstream gender, to move from marginality to integration, and to ensure equal access to services such as health care was missing. The elites in government institutions such as political parties prevented women from realizing their full political rights, and these elites have created the legislation surrounding the health care system in Morocco.<sup>4</sup>

The Moroccan health care system is comprised of a large public sector and a private sector (Semlali, 2010). The public sector provides the majority of health care for Moroccan citizens. It includes the Ministry of Health, the Royal Armed Forces, Local Communities, and other Ministerial Departments (Semlali, 2010). The Ministry of Public Health (MPH) controls the direction of hospitals and pharmacy, regulation and litigation, planning and financial resources, and other vital components of the health care system (Ministere De La Sante, 2013). The MPH also provides access to clinics, health centers, diagnostic centers, and public hospitals. However, less than twenty percent of the population is covered by health insurance, and most lack even basic health care coverage

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<sup>4</sup> Despite the inability to show real substantive representation from the 1980s to 2000s, women have made significant strides through the 2000s. The initial reforms won to expand women's rights created more opportunities for women to further voice their opinions in the formal sector. In 2003, a reform of the labor code criminalized sexual harassment in the workplace (Castillejo & Tilley, 2015). In 2006, female parliamentarians advocated Gender-Responsive Budgeting to hold the state accountable to equity in public spending and service provision (Castillejo & Tilley, 2015). Women were more effective in demanding rights than other marginalized groups because of their organization and support from the monarchy, suggesting the elite structure discussed in this paper was a significant obstacle.

(El-Idrissi, Miloud, & Belgacem, 2008). None of the political institutions like the Ministry of Health provide basic health insurance, but legislation created centers that provide health services to women all over Morocco.

The Basic Health Care Centers provided by the public sector provide specific services related to birth, medical consultations, and hospitalization (Semlali, 2010). The birth statistics and figures on the use of prenatal care (**Figure 5**) provides a glimpse into women's access to health care services. **Figure 5** shows the percentages between rural and urban women with both low and high assets who used prenatal care and modern delivery services in Morocco from 1990 to 1995. The rural total was far below the urban total for both the prenatal care and modern delivery, but the majority of rural women who had the necessary tools (high assets) used modern prenatal care. This hints that other reasons besides cultural practices and norms prevent women from accessing these services. This could be due to the lack of necessary legislation to make the health care system of Morocco more efficient. There were several challenges to the health care system of Morocco: use of services heavily depended on financial ability, lack of coordination and poor quality of care plagued the public hospitals, and programs for education were scarce (Semlali, 2010). Lack of use of available maternity resources could be attributed to the poor ability of the public sector to make those resources available to all women by improving the quality of health care services.

The public sector regulates family planning and contraceptive delivery and information better than it regulates its hospitals. A national and local population commission established family planning in Morocco in 1966 (Ayad & Roudi, 2006). The first major reform was the 1967 repeal of the French Law which prohibited

advertisement, distribution, and sale of contraceptives. The government's main focus was the Household Delivery of Contraceptives (VDMS). In this system, a nurse travelled to rural areas to distribute contraceptives (Semlali, 2010). This ensured that women who did not have access to health care facilities in close proximity could still access necessary contraceptive and family planning tools. By 1983, ninety-nine percent of married women ages fifteen to forty-nine had some form of knowledge about contraception (DHS Program, 1993).

Despite the improvement of knowledge of contraceptives, there remained a disparity between the desire to control family planning and the availability of contraceptives and abortion. Of the ninety-nine percent of married women who knew about contraceptives, only forty-two percent were using them (DHS Program, 1993). Though women had information about contraceptives and family planning programs, there was a prevalence of unmet needs for family planning. In a survey of men and women, almost equal amounts- 43 percent of men and 49 percent of women- wanted to limit the number of children they wanted to have (DHS Program, 1993). It is clear that there was a desire for family planning among both men and women, and a cultural or religious explanation alone is unsatisfactory. Instead, the government institutions' regulation of public facilities and services had a systemic problem. Despite this setback, Morocco's population growth between 1980 to 1985 and 1995 to 2000 fell from 2.53 to 1.62 percent a year (Maddy-Weitzman & Zisenwine, 2007). Additionally, the infant and maternal mortality rates for this time period steadily decreased (**Figure 6, Figure 7**). This shows that the basic dissemination of health care services through education and provisions like the household delivery system already in place had an impact on the

health lives of women. It is clear that improvements in the public health services could ensure the availability of family planning methods to a larger number of families to meet the desire from men and women. The increasing femininity of public space in Morocco is one step closer to ensuring women have access to health care services, a phenomenon that does not apply in Egypt.

## **ii. Egypt: Women's Political Participation**

Similar to Morocco, Egypt had a colonial history. In 1952, a coup led by a group of Egyptian military officers ousted the corrupt King Farouk, a puppet to the British occupation of Egypt. Praetorianism defined the new state: the military dominated the political system, leadership, and institutions (Perlmutter, 1974). This state emerged after citizens failed to protest the previous government because of a variety of reasons, including lack of resources, so the military enacted a coup. In 1954, Gamal Abdel Nasser initiated the long rule of military dictators in Egypt, preceding Anwar Sadat in 1970, Hosni Mubarak in 1981, and Abdel Fattah el-Sisi in 2014. The officers were quick to limit individual landholdings, taking power from the wealthy landowners and redistributing the land to the rest of the population who lived in poverty (Tignor, 2010). These military leaders created a new military elite, replacing the old structure of wealthy landowners. These military elite, who were closest to the regime, controlled the parliament, major security organizations, and businesses. This ultimately had implications for the future of Egypt's women.

From the beginning, women had reduced political rights when compared with women in Morocco. The 1956 Constitution granted women the right to vote and run for

political office, but did not grant women full equality. It stated that “all men who have the right to exercise their political rights must be registered to vote. It is also necessary to register those women who request [that right]” (Nelson & Chowdhury, 1994, pp. 234). This means that women had to petition the state and overcome bureaucratic loopholes to be included as registered voters, an obstacle to many disadvantaged women. The Constitution of 1971 removed the restriction on women’s voter registration, replacing men with the generic term “citizens” (“The Constitution of the Arab Republic”, 1993). This change did not translate to more women in the legislature as their numbers remained low. In 1979, Law no. 188 set a quota of 30 seats for women in parliament (Mustafa, Abd Al-Ghaffar, & Rabi’, 2005). Women gained substantial seats in the legislature, jumping from 2.5 percent in 1971 to 9 percent in 1979. This law was repealed in 1986, and the percentage of women in legislature fell from 8.25 percent in 1984 to 1.6 in 1990 (**Figure 9**). Also in 1979, Egypt signed the CEDAW, but like Morocco did not ratify Article Two.<sup>5</sup> Like Morocco, Egypt touted equality for women while in actuality held reservations and created obstacles to their access to the legislature.

Although women in Egypt faced more restrictions to vote than Morocco’s women, they were represented in legislature long before Morocco’s women. In 1957 the first two women were elected to Egypt’s parliament, and in 1971 women comprised 2.5 percent of the candidates elected to parliament (Nelson & Chowdhury, 1994). However, this was a façade; the state wanted to maintain its legitimacy among women, and those elected were supported by the state rather than female voters. In 1957, when the first two women were elected, only one percent of the registered voters were women (Nelson &

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<sup>5</sup> See Footnote on Page 35.

Chowdhury, 1994). Because of the lack of women who actually supported these candidates, the election of these women could not be considered substantive representation. They did not consider themselves as representing a gendered constituency, but instead as representatives of both men and women on behalf of the state. Their time in office could not be considered substantive representation as they did not promote any legislation, such as health care, that would specifically benefit women. The Mubarak regime furthered this tactic by promoting “Suzanne’s laws.” These were laws espoused by the first lady, Suzanne Mubarak, as a public relations campaign supporting women’s inclusion in Egyptian politics. This was another elitist, hierarchal tactic to bring women’s rights to the forefront. Suzanne, acting on behalf of Mubarak’s regime, controlled the laws of and appointment of officers to the National Council of Women, a governmental organization that promoted women’s social, political, and economic empowerment (Dewedar, 2010). “Suzanne’s laws” was not a grassroots movement among the Egyptian people, and instead was a ruse to show the international community the “progressive” agenda of Mubarak’s regime.

Articles 16 and 17 of the Constitution of 1971 maintained that the Egyptian State provided social and health services, had a duty to “raise their standard” especially in villages, and guaranteed social and health insurance services (“The Constitution of the Arab Republic,” 1993, n.p.). As in Morocco, the Ministry of Health and Populations (MOHP) was the largest provider of health services. It provides public rural and urban health centers and hospitals, as well as maternal and child health centers (Ministry of Health and Population, 2015). The Health Insurance Organization of Egypt (HIO) is a government organization established in 1964 and supervised by the MOHP to provide

social health insurance (Abd El Fattah et al., 1997). It was originally intended to provide universal health insurance, but under legislation only covered government employees, pensioners, widows, and school children. Consequently, in 1990 health insurance covered only 10 percent of the population (World Health Organization, 2006). Similar to Morocco, the health system faced several problems, such as poor distribution of resources, lack of coordination within the system, and fragmentation of management. Since the 1960s, Egypt spent more money for the military than for health and education combined (United Nations, 1991). The military elites of the government were involved in three wars with Israel from the 1960s to the early 1970s and the Gulf War in 1990, and were concerned with funding the military and security operations of the country, rather than providing adequate health care for the citizens. Even though the constitution promises free medical care as a basic right for all citizens, the government did not provide adequate or efficient services. This disparity between promised services and actuality of implementation along with elite influence are key dimensions of women's reduced access to health care services in Egypt.

Some of the major health care concerns from the 1960s throughout Mubarak's reign were the large rate of population growth and high maternal and infant mortality. The government established the National Family Planning Program in the 1960s, but it was not a priority for the government. When Mubarak came into power, he attempted to revive the family planning program and created the National Strategy Framework of Population, Human Resource Development, and the Family Planning Program (Fogarty, 2008). The main focus of the program was to increase contraceptive usage among married women. The government's renewed efforts to expand and strengthen family



planning delivery doubled the contraceptive prevalence among married women from 1980 to 1982 (The World Bank, 2016). With the new accessibility to contraceptives, the percentage of women in rural areas using contraceptives more than doubled from 1980 to 1992. As with Morocco, a cultural or religious explanation for lack of contraceptive use clearly is insufficient.

In 1977, the Egyptian government instituted the Population and Development Project (PDP) that proposed delivery systems to provide improvements in rural communities. Like Morocco, Egypt implemented a type of delivery system to disseminate information to rural women. Female volunteer workers, Raiyda Riyfia, visited villages to deliver information and education about contraceptives and other family planning tools (Fayek, 1991). A study in 1980 showed that the impact of PDP was insubstantial because few women knew about the Raidya Riyfia (Fayek, 1991). Use among rural women severely lagged behind that of urban women. In a study in 1984, women who obtained contraceptives from government clinics were more likely to stop using the contraceptives and were less informed about how to properly use them (Carr, 1996). Moreover, the 1992 Egyptian Demographic Health Survey reported that 66.8 percent of married women in Egypt wanted to stop having children, but only 47.1 percent were using contraceptives (Chichakli et al., 2000). Additionally, Egypt's population growth rate remained considerably higher than Morocco's and only declined from 2.46 to 1.90 percent between 1980 and 2000 (Maddy-Weitzman & Zisenwine, 2007). So although there was an increase in the availability of contraceptives, there were still barriers for rural women and women who could not afford those services.

The MOHP also focused on reducing maternal and infant mortality. Maternal and infant mortality steadily declined between 1980 and 2000 (**Figures 6 and 7**).

Conversely, the number of maternal deaths actually increased between 1995 and 2000. In the early 1990s, there were no protocols regarding obstetric emergencies, and junior staff members were often in charge (World Health Organization, 2015c). This led to women's perception that public health facilities offered poor quality, and consequently, an increasing number of women stopped seeking those services. It also meant that an increasing number of women did not have access to antenatal and delivery services. Between 1992 and 1995, the percentage of pregnant women receiving prenatal care dropped from 52.9 percent to 39.1 percent (The World Bank, 2016). Women who could afford to do so switched to use of private sector rather than public sector health services. By 2000, the private sector provided three times as much antenatal care as the public sector (El-Zanaty & Way, 2001). Reform of the public sector health care system is only part of the solution to provide disadvantaged women, particularly rural women, with adequate health care services. Integration and involvement of women into the public work force and formal economic sector also equips women with the tools to make independent health care decisions.

### **iii. Morocco: Women's Employment**

Legislation alone cannot account for women's access to health care services. It is also necessary to take into consideration the economic standing of women. As shown earlier in **Figure 5**, women's use of prenatal and delivery care not only depended on their location, but also on their economic assets. Financial ability determines the amount of

social services accessible, such as health care. To be financially stable, women must either be married to a wealthy man or be employed. However, only the latter ensures a woman's independence and is likely to give her sexual and reproductive autonomy. The following research examines the changing development policies of Morocco and how they affected women's employment and women's access to health care.

Before the 1980s, Morocco's economic plan heavily depended on minerals, specifically phosphates. Morocco had substantial phosphate reserves and large exports, supplying 40 percent of the world's total (Richards et al., 2014). The country also had a considerable amount of agricultural exports as well. In this economy, women were mainly employed in the agricultural sector (**Figure 8**). The heavy reliance on phosphates and agriculture subjected the majority of the country's exports to a fluctuating and unstable market. The fall in price of phosphates devastated Morocco's economy. The government adopted a three-year economic plan from 1978 to 1980, with the goal of improving the deteriorating financial situation; in reality, the GDP only rose an average of 4 percent per year. Combined with a population growth of 3 percent a year, the economic growth remained stagnant and the standard of living decreased. Moreover, social programs remained unchanged so a variety of sectors broke out in protests and strikes (White, 2001).

A new five-year plan was formulated for 1981 to 1985. This plan aimed to add 900,000 new jobs and train workers in modern agricultural and industrial sectors, and it outlined an increase in hospitals and schools (USAID, 1984). Public investments, including those in health care services, reached a record high. By the end of the Five Year Plan, the public sector comprised about 50 percent of Morocco's economy, playing

an important role in the economy and employment (Maddy-Weitzman & Zisenwine, 2007). In order to improve the economy, the government adopted a neo-liberal economic policy, cutting inflation and increasing foreign trade. Morocco adopted structural programs recommended by the World Bank and International Monetary Fund in the late 1980s and early 1990s. This structural adjustment comprised of medium to long-term policy aimed at increasing the efficiency of the economy to maintain growth and reduce government intervention (Maddy-Weitzman & Zisenwine, 2007). Specifically, this aimed to encourage private sector activity and investment in more stable economic markets, such as industry and services, expanding into new labor markets and creating opportunities for new job formation. Overall, the percentage of GDP stemming from the private sector doubled between 1976 and 2000, especially from the manufacturing sector (Maddy-Weitzman & Zisenwine, 2007). The growth rate of the economy from 1986 to 1991 was about 4.4 percent a year (Maddy-Weitzman & Zisenwine, 2007). Morocco's plan for development mainly focused on modernizing agriculture and increasing manufactured exports. These expansions required a large workforce, which women often filled as the main source of cheap labor.

One of the largest employers of women in Morocco was the textile industry. By 1980, Morocco's textile workforce was 75 percent female (Ross, 2008). Young, unmarried women were more likely to be employed in the textile industry than married women (Cairolì, 1999). Although there was a crash in the market in the late 1970s due to European market closures, the government's structural reforms in the late 1980s and early 1990s revived the industry. It was especially important in the 1990s, when it alone accounted for 75 percent of the growth in female employment (Ross, 2008). The

important question to consider is how these changes and the expansion of the economic sector affected women, and specifically women's access to health care.

With the growth of the economic sector in the 1980s to the mid-1990s, female participation in the labor force shifted from agriculture to industry and services (**Figure 8**). This reflects the change from focus on agriculture to emphasis on manufacturing. According to the role incompatibility hypothesis, female employment decreases the fertility rate where contraception is available and the roles of worker and mother are incompatible (Dixon-Mueller, 1993). The shift of women's employment from the agricultural sector to services and the textile industry reflects the idea that there is a positive relationship between fertility and non-agricultural employment (Abu Nasr et al., 1985). This increase in female employment also increases women's desire to engage in family planning practices. Especially among young, unmarried women, employment often encourages a delay in fertility. Contraceptive usage between 1987 and 2002 increased by almost 26 percent (Do & Agha, 2006). Because of these changes, it is clear that more women had a need for health care services and more women were using these services.

Because more women were employed in the non-agricultural sector, more women had access to health benefits through their employment. In the public sector, all employees and their dependents were guaranteed basic health care. Regarding maternity leave, women received 100 percent of their daily wage for up to fourteen weeks ("Morocco," 2011). The minimum legal benefit was 66.7 percent of the legal minimum wage, which was 1,433 dirhams a month in agriculture and 2,028 dirhams in the non-agricultural sector. Those women who shifted from agriculture to non-agriculture

benefitted from the increase in maternity benefits. Furthermore, women who worked in the industry sector were more likely to interact with other educated women who exposed them to new information and ideas about sexual autonomy and other women's health issues.

Work for wages also encourages women to challenge the patriarchal controls of their sexual and reproductive lives. Not only were these women at an advantage by receiving health care benefits from their employer, but they were also granted some form of economic stability. Rather than depending on their father or husband for income and health care, they were able to produce an income to support themselves. According to the theory of female autonomy, employment outside the home, and not in agriculture, can reduce women's dependence on men (Dixon-Mueller, 1993). Although women in Morocco had previously been working, it was in the agrarian sector where they might be unpaid or underpaid, which does not lead to independence as does work in services or industry. Also, as Ross (2008) suggests, women who are employed are more likely to invest in their children through education and health. The fertility limitation of parents has an effect on their daughter's standard of living and access to health care.

As outlined, family planning programs and development policy in Morocco had both adverse and positive effects on women's access to health care. Because the political system was dominated by the monarchical elites, Morocco's women had little access to political parties and did not gain access to the legislature until almost forty years after the country gained independence. Because of women's mobilization, they gained access to the legislature and implemented successful reforms in family law, with hopes for reforming health care. The family planning programs provided services like the VDMS,

which gave women- rich, poor, urban, and rural alike- the access to contraceptives and sexual education. Moreover, with the development plans to expand into manufacturing, more women were employed in higher paying sectors. This gave them the opportunity to become more financially independent, which leads to control over their own sexual and reproductive lives instead of relying on a male family member. Young, unmarried women still lack reproductive education and access to contraceptives, hinting that there are still significant areas for involving women in the public work force. Unfortunately, as in the case of Egypt, many women are still employed in the agricultural sector without the income or ability to control their own sexual and reproductive lives.

#### **iv. Egypt: Women's Employment**

In Egypt, as in Morocco, financial ability is a major contributor to increased access to health care. For example, only 40 percent of women in the lowest income bracket received regular antenatal care compared with 90 percent in the highest (World Health Organization, 2015c). Clearly, women's access to health care is dependent on their financial ability and income. The following research will explore the economic reforms after 1980, the path taken to development, sectors in which women were employed, and how these factors affect women's access to health care.

The Soviet Union and its plans for rapid industrialization heavily influenced Nasser. The British exploited Egypt as an agricultural producer and exporter, and the new government attributed the lack of development of Egypt's economy to those colonial policies. The new government combined central planning, land reform, and focus on industrialization (Tignor, 2010). The state engaged in large nationalization projects, and

by the 1960s it owned almost all large-scale businesses. From 1960 to 1965, the government pursued import substituting industrialization. It hoped that increasing use of Egyptian cotton rather than imported cotton would lead to development of the manufacturing component of the industry (Richards et al., 2014). However, by the late 1960s the economy was dragging and, as in Morocco, Egypt found itself importing necessities.

In 1970, Anwar Sadat became president and enacted *al-infitah*, “the opening up,” that aimed at opening the economy to freer trade, foreign investments and market economies (Osman, 2010). He emphasized the development of the private sector over the public sector with the help of foreign investment. This plan did not succeed in creating a more open economy; instead, it further empowered the government elites by granting them concessions on land and commodities (Osman, 2010). Furthermore, *al-infitah* did not have a significant impact on the overall growth of the private sector, as previously expected.

The first few years of Mubarak’s regime continued the policies of *al-infitah*, but ultimately the regime adopted the same ISI policies as Nasser (Nagarajan, 2013). Investment in public works such as health care was put on a backburner, and health care services suffered as a result. Before 1980, the growth rates of the industrial and service sectors exceeded that of the agricultural sector. This reflects the data in **Figure 8**, in which 56 percent of women were employed in the services sector, whereas only 8 percent were employed in agriculture. By the early 1980s, Egypt had to import about three-fourths of its agricultural necessities (Lewis, 2008). The government made policy reforms that refocused the economy on food production. As shown in **Figure 8**,



women's employment in agriculture drastically surged from 8 percent in 1980 to 43 percent in 1994.

As **Figure 10** shows, employment in agriculture remained significantly higher for women in Egypt than women in Morocco throughout the early 1990s. Although more women in Egypt worked in agriculture from 1990 to 1994, only 16 percent worked for wages while 88 percent were unpaid (Kishor & Neitzel, 1996). This is corroborated by data in **Figure 11** that shows direct correlation of employment in agriculture and female's employment in vulnerable jobs. Women in vulnerable employment faced the most economic instability and were at high risk of falling into poverty. They were also the least likely to have access to health care and reproductive services because they did not have a steady source of income and were often underpaid or even unpaid. This period of increased employment in agricultural work was the same in which the percentage of pregnant women receiving prenatal care dropped from 52.9 percent to 39.1 percent (The World Bank, 2016). Combining this observation with the theory of female autonomy, it is clear that the government's shift to agriculture directly impacted women's access to health care because they did not have a stable or independent source of income.

Almost 94 percent of women in Egypt worked away from home from 1990 to 1994, but growing unemployment accompanied rising female participation in the agricultural sector because of the sector's instability. Female unemployment increased from 17.3 percent in 1988 to 32.2 percent in 1995 (The World Bank, 2016). This increase in unemployment meant decreased wages and that fewer women had access to a steady income to pay for health care services (Papps, 1992). Additionally, the HIO only provided health insurance for government employees. As discussed earlier, a large

majority of women were unpaid agricultural workers. So not only were these women reliant on their husbands or fathers for an income, but also they most likely did not have health insurance. In the Egypt DHS of 2000, women reported that the biggest problems for obtaining health services were getting permission, presumably from a male family member, to go to the doctor, and obtaining adequate funds to pay for the services (El-Zanaty & Way, 2001). Women in Egypt had less autonomy than women in Morocco because of the lack of an independent income, and were less likely to use necessary health care services.

Maternity leave is another area in which women in Morocco had more benefits than women in Egypt. In Egypt, the law mandated 100 percent of wage paid maternity leave for 12 weeks, but the benefits were paid for by the employer rather than the government (OECD, 2015). Most employers refused to provide paid maternity leave in practice or guarantee return to former jobs after delivery. Compared to Moroccan women who were provided maternity benefits from the government, Egyptian women were more likely to be fired and not given the necessary maternity leave. Because employers had to provide the funds for maternity leave, they were more likely to discriminate against hiring both married and unmarried women, as the former were likely to become pregnant and the latter were likely to get married. This left pregnant women without health insurance and without benefits, increasing the probability that they would not receive antenatal care or delivery services. Not only did this affect the woman, but it also impacted her daughters. A study in Egypt found that fewer girls were immunized than boys and that girls had a lower chance of receiving care to manage illness than boys (The World Bank, 1995).

Compared with Morocco, Egypt's legislation and development policies posed large barriers to women's access to health care services. Unlike Morocco, in which the government supported sexual and reproductive programs for young people, the Egyptian government did not offer education about contraceptives and made it difficult for women, especially rural women, to access family planning services. The original constitution did not grant women equal access to voting, and the quota system that granted women 30 seats in the parliament was declared unconstitutional. Mubarak's tactics of appointing women to office and promoting "Suzanne's laws" only served to make the regime progressive in the eyes of international powers, but did not translate to any tangible advancements. In terms of the economy, the seeming increase of employment of women in the agricultural sector actually led to an increase in female unemployment. Although it seemed like women were making progress in reaching equality, women's rights actually regressed from the 1980s to 2000s. In both Morocco and Egypt, women's access to health care services is heavily affected by their socio-economic status along with rural or urban residence.

### **Morocco: Urban vs. Rural**

Since the 1980s and 1990s, health care in Morocco has improved across the board. Moroccan health officials strived to achieve the United Nations' Millennium Development Goals 4 and 5<sup>6</sup>, and the country realized significant improvements in maternal and infant mortality. From 1990 to 2015, the maternal mortality ratio decreased

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<sup>6</sup> The UN's Millennium Development Goal 4 was to reduce child mortality and Goal 5 attempted to improve maternal health.

from 317 to 121, an annual rate of about 4 percent (World Health Organization, 2015b). In 1992, 61 percent of urban women received prenatal care while only 18 percent of rural women received the same care (Abdesslam, 2012). By 2004, due to the government's push in family planning and slightly improving access to health services, 85 percent of urban women and 48 percent of rural women received prenatal care (Abdesslam, 2012). Despite the improvements in overall health care, social health disparities remain prevalent. Rural areas significantly lag behind urban areas. The following section will discuss how gender, location, and government capacity intersect to affect women's access to health care.

During the 1990s, Morocco made impressive gains in improving family planning and basic health care. For more than 50 years, the U.S. Agency for International Development (USAID) and the Moroccan government have cooperated to provide education, promote economic growth, and improve health. Programs provided supplies, training, and infrastructure to deliver contraceptives to women throughout the country (Hotchkiss, Magnani, Lakssir, Brown, & Florence, 1999). From 1980 to 1995, the number of married women using contraceptives increased from 19.4 to 50.3 percent (Hotchkiss et al., 1999). Population concerns became a focus in development planning when the Ministry for Economic Forecasting and Planning renewed the national population commission in 1996 (Ayad & Roudi, 2006). The improvements in women's reproductive health led USAID to gradually withdraw its contraceptive aid. The Ministry of Health started purchasing its own contraceptives by 2003 (Ayad & Roudi, 2006). **Figure 12** shows the overall improvement by wealth quintile from 1992 to 2003/4 in areas such as contraceptive usage and prenatal and delivery services. As the graph

shows, there remain significant disparities between the percentages of poor women receiving delivery and prenatal services and those of middle-income and rich women (**Figure 12**). To understand this phenomenon, it is necessary to examine socio-economic status and the government's capacity to provide services to rural areas.

**Figure 13** details the overall trends in poverty from 1984 to 1999. A 2001 World Bank report found that 84 percent of the increase in poverty at the national level in the 1990s resulted from slowed economic growth (Morocco: Poverty Update, 2001). Declining GDP and droughts during the 1990s were the main contributors to the slowed agricultural growth and consequently the increase in poverty. In 1998, the total number of poor people increased to 19 percent from 13 percent in 1990 (Morocco: Poverty Update, 2001). Not surprisingly, poverty in Morocco largely affects rural areas; 66 percent of Morocco's poor live in rural areas (Morocco: Poverty Update, 2001). Poverty affects access to basic infrastructure like health care, resulting in less rural women receiving care than urban women. At the intersection of gender and location, access to health services is more likely when the woman is located in urban rather than rural areas due to cost and availability.

A large factor for people seeking health care is cost. In a survey of 2000 women, 54 percent with a high income reported they have access to a health care provider while only 16 percent of low income women said the same (SWMENA, 2011). Upper income women were also six times more likely to seek basic services like annual checkups and preventative care than low income women (SWMENA, 2011). Not only are poorer women less likely to have access to health care services, but they also are more likely to report that they receive bad or very bad health care (**Figure 14**). Poor women are

therefore marginalized because of the combination of their socioeconomic status and the poor quality of services available to them. Government capacity specifically plays a large role in this phenomenon.

The poor-rich divide in women's health care is exacerbated by the government's focus on urban rather than rural areas. The majority of public health programs target urban areas, and specifically high and middle income households. The government installed some facilities in rural locations, but they often lack in quality and staff. For example, six regions of Morocco have rural birth centers without qualified midwives (Semlali, 2010). In order for some rural women to access a health care facility, they have to walk to a nearby city. **Figure 15** shows the distribution of the urban and rural populations living within certain distances of health care facilities (Semlali, 2010). All urban women live 5 kilometers or less away from a health care facility, while the most rural women live 5 to 10 kilometers away (**Figure 15**). Because of the physical distance from a health care provider, the cost of receiving care greatly increases. For the average rural woman, the cost of making the trip may outweigh the benefit of the service. Many hospitals in Morocco are understaffed and some are only partially functional, giving way to poor quality of care (Semlali, 2010). Location, gender, and quality of services are interconnected and can explain why rural women are less likely to access health care than urban women.

During the 1990s, the Moroccan government proposed several improvements it would carry out through the 2000s, including setting a goal of extending basic infrastructure to 60 to 70 percent of the rural population by 2004 and expanding medical insurance to the poor (Morocco: Poverty Update, 2001). Some of these goals remained

unmet; in 2010, 17 percent of women in rural areas said they had access to health care while 42 percent of urban women said the same (SWMENA, 2011). Largely, most women in Morocco reported that health services were not easily available or even completely lacking (SWMENA, 2011). Much of the unavailability of services stems from the lack of health care professionals. This is exacerbated by the unequal distribution of health care workers between urban and rural areas. Stepping back to look at the government's capacity to provide services gives a better understanding why these proposals failed although the policy was implemented.

From 2001 to 2006, Morocco's GDP per capita increased by 10.45 percent, but the percentage of health expenditure to GDP was only 5.3 percent (Semlali, 2010). Compared to countries with similar GDPs and levels of development in the region, Morocco's government expenditure on health was significantly lower (Semlali, 2010). Although the government aimed to improve the quality of living for the rural and poor populations, it simply did not spend the necessary money to ensure quality and effectiveness. Today, 58 percent of health care spending is by households while the government spends 34 percent on health care (World Health Organization, 2014). This means that for every dollar the government spends to provide health care, the average person is paying almost double for services. Rural women are three times more likely than urban women to report that they cannot afford regular medical visits and medicine (SWMENA, 2011). Rural women are not only limited by their location and gender, but also by the cost and quality of services. As the next section discusses, rural women in Egypt are not as disadvantaged by their location as Moroccan rural women, but they do face similar cost and quality setbacks.

#### **v. Egypt: Urban vs. Rural**

Like Morocco, Egypt has significantly improved health care since the 1980s. By 2007, infant mortality had lowered to 19.2 per 1000 and the maternal mortality rate was 44.6 per 100,000 live births (World Health Organization, 2010). Overall, fertility declined, but remains higher for rural women than urban women. The amount of women using prenatal care actually decreased slightly for rural women and only slightly increased for urban women from 1992 to 2000 (El-Zanaty & Way, 2001). As in Morocco, social disparities remain prevalent despite the improvements in health care. The following section will examine the intersection of gender, location, government capacity, and health in Egypt.

A large factor in success of health care reform is the government's commitment to improving and spreading family planning services, tools, and knowledge. In 1996 the government hosted the International Conference on Population and Development (ICPD) in Cairo (Forman & Ghosh, 2001). It led to reevaluation of past family planning programs and boosted awareness for women's issues. Due to these efforts, the government established the Ministry of Health and Population (MOHP) in 1996. The goals of the MOHP were to integrate population policy, family planning, and reproductive services. Between 1980 and 2000, contraceptive usage doubled (El-Zanaty & Way, 2001). The government has succeeded in spreading knowledge about family planning; more than 90 percent of women had knowledge of family planning from messages on the television and radio (El-Zanaty & Way, 2001). However, only 10 percent of women discussed family planning with staff at a health care facility even though about 50 percent of surveyed women had contact with a worker (El-Zanaty &



Way, 2001). Rural women remain disproportionately in need of family planning. According to the DHS survey of 2000, two-thirds of women who say they are in need of family planning reside in rural areas (El-Zanaty & Way, 2001). Rural women in Upper Egypt are also more likely to report need of family planning than those in Lower Egypt. From 2000 to 2003, prenatal care coverage in Upper Egypt improved more than in Lower Egypt, but the number of medically-assisted deliveries increased in Lower Egypt rather than in Upper Egypt (El-Zanaty & Way, 2004). **Figure 16** shows the contribution to inequality of specific characteristics, including region. Although physical distance from a health facility does not significantly contribute to inequality, region is a major contributor of inequality for all measurements. Despite the continued efforts of the Egyptian government, location in terms of region and socioeconomic class affect women's access to health care.

**Figure 17** shows the overall trends in poverty. Interesting to note is that urban and rural poverty rates were about the same except during the early 1990s, when urban poverty skyrocketed due to economic stagnation. Although household expenditures increased during the 1990s, poverty fell from 20 to less than 17 percent in Egypt (El-laithy, Lokshin, & Banerji, 2003). Poverty rates in rural areas reached 22.1 percent, whereas the poverty rate in urban areas was 9.2 percent in 1999 (El-laithy et al., 2003). What then explains higher numbers of rural women reporting less access to health care than urban women? Location is not a viable explanation for Egypt; 95 percent of the population lives within 5 kilometers of a health care facility (World Health Organization, 2006). Rather, government capacity can explain this phenomenon.

The Egyptian health care system is comprised of public, nongovernmental organizations, and private health facilities. **Figure 18** shows the breakdown of each type of facility in 2007. There are a significant number of rural health facilities vis-à-vis urban facilities. Despite the large number of rural health facilities, the government remains focused on urban rather than rural healthcare. The Health Ministry of Egypt installed specialized national teaching hospitals that provide mostly free care (Rannan-Eliya, Blanco-Vidal, & Nandakumar, 1999). These hospitals are located in urban areas, and due to proximity, mainly serve higher income urban households. The high revenue that the government distributes to finance these hospitals further demonstrates its bias toward urban and high income households. Rannan-Eliya, Blanco-Vidal, and Nandakumar (1999) also found that social insurance expenditures not only benefit richer groups, but also favor urban over rural and men over women. The Health Insurance Organization (HIO) grants men three times the benefits than it does women (Rannan-Eliya et al., 1999). This is in part due to the larger labor force participation rates of males, but is mainly due to a pro-male bias in health spending. Pro-male bias cannot be attributed to a wider usage of health care by men because in Egypt, as in most countries, women are more likely to seek health services. Egyptian rural women are doubly disadvantaged due to the government's bias toward funding urban facilities and favoring males.

The government did attempt to improve health care for rural women. As stated earlier, the Egyptian government instituted the Population and Development Project (PDP) in 1977 to provide health improvements in rural communities. The Raiyda Riyfia, visited villages to deliver information and education about contraceptives and other

family planning tools (Fayek, 1991). Ultimately, the impact of the PDP was minimal because few women actually knew about the the Raidya Riyfia (Fayek, 1991). So although the government instituted the delivery program, it failed to encourage and advertise women to seek those services. Additionally, most roads in rural Egypt are made of silt and are impassable in the rain (Fayek, 1991). The government did not supply the necessary infrastructure, like roads for medical care to reach rural areas. By 2008, 81 percent of urban women and 57 percent of rural women received prenatal care (UNICEF, 2011). Although this is a significant improvement from previous years, rural women still lag far behind urban women. Despite the government's programs and proposal to improve health care, it did not effectively implement them due to oversight of other factors such as physical access and equal distribution.

In rural Egyptian society, children are an economic advantage because they earn money at a young age cotton-picking or doing household chores (Fayek, 1991). Fertility in these societies is highly valued. Contrary to the trend of higher income translating to lower fertility, families with higher incomes in rural Egypt also had higher fertility (Fayek, 1991). This may signify a status symbol as the family would be able to provide for an extra child. Women usually manage the household, which is the main economic unit for most families in rural society. Most of these women perform household chores or transform primary products and are therefore not independent economically. The number one reason most women leave their village is to seek health services for their children in larger cities (Hopkins, 1987).

Cost affects the number of these women seeking health care. Because of the cost of health care, women rarely seek it for themselves. 33 percent of rural women reported

that getting money for treatment was a major problem in accessing health care (El-Zanaty & Way, 2001). In 2013, households spent 58 percent of total health care costs while the government only spent 41 percent (World Health Organization, 2014). As the country's GDP fluctuated throughout the 2000s, health expenditure as a percentage of total GDP remained relatively constant at about 5 percent (The World Bank, 2016). Compared to other countries in the region, the government's expenditure is significantly higher. However, government spending was not enough to alleviate rural grievances against public health care. Due to financial shortages and inefficient use of resources, the government cannot properly maintain the facilities (World Health Organization, 2010). People are disillusioned with the public health system and are turning to the private sector. The 2008 DHS found that 19 percent of women used the public health sector and about 55 percent used the private sector (El-Zanaty & Way, 2009). Rural households were more likely to access private clinics in times of illness, citing good quality and nearness to home as their reasons (Galal & Al-Gamal, 2014). Overall, government capacity, location in terms of region, and socioeconomic class heavily affect rural women's access to health care.

#### **vi. Morocco: Socioeconomic Class within Urban Areas**

Within urban areas a wide variety of socioeconomic classes often translates to disparities in access to basic necessities. The slowed economic growth increased urban poverty from 27 percent to 34 percent of total poor from 1990 to 1999 (Morocco: Poverty Update, 2001). It also led to an increase in unemployment of urban poor households, from 30 to 32 percent in the 1990s (Morocco: Poverty Update, 2001). Today urban

unemployment rates in Morocco remain four times higher than rural rates (Richards et al., 2013). So why do urban poor women seem to have better access to health care than rural women, no matter what their socioeconomic class (**Figure 5**)?

In the 1990s, the Moroccan government attempted to alleviate the rise of poverty with increased social spending (Morocco: Poverty Update, 2001). It focused on education, health, insurance, and basic infrastructure, among other government programs. Ultimately, public spending was insufficient to relieve the effects of poverty because it was too little and was poorly planned. The majority of social programs were urban-biased and designed for the rich and upper income families. The poor and disabled were marginalized because they had no health insurance or benefits. Because of this prevalent bias, the rural poor lacked access to quality public services and did not seek out those facilities. However, urban poor women maintained access to health care services. Urban households with low assets lagged behind those with more assets in prenatal care only slightly (**Figure 5**). Rather, the 20 percent difference between the rural with high assets and the urban with low assets using prenatal care is shocking (**Figure 5**). Despite their economic disadvantage, urban poor women have better access to health care than their rural counterparts and even rural women with higher assets. This leads to the conclusion that proximity to health care facilities grants a significant advantage to women, no matter their socioeconomic status. Thus, the locational division trumps socioeconomic class divisions in Morocco, a situation that does not hold true in Egypt.

### **vii. Egypt: Socioeconomic Class within Urban Areas**

As with most developing countries, people constantly flee rural villages to seek jobs and better opportunity in urban areas. About 43 percent of Egypt's population lived in urban areas by 2007. Parts of Cairo and Alexandria had more than 100,000 people per square kilometer, extremely crowded conditions (World Health Organization, 2010). Slums comprise 30 percent of Egypt's residential area, and access to health and other services in these areas is limited. **Figure 17** shows poverty in urban areas. Urban poverty from 1995 to 2000 decreased from about 23 percent to 9.3 percent, much faster than the decrease in rural poverty. Despite the decrease in poverty, urban poor women in Egypt face more restrictions to accessing health care than rural women.

Children's health care conveys their parents' ability to access health care. As stated earlier, women were more likely to seek health care for their children rather than themselves. **Figure 19** shows the anemia among children among poor urban and rural populations. Especially for the very poor and near poor, moderate to severe anemia is similar in urban and rural populations. This hints that poor women in urban areas are almost equally unable to access health care as poor urban women. Urban poor often live in slums where they lack access to sanitary water and face health hazards daily. Other studies show that urban dwellers are not only more susceptible to health risks than their rural counterparts, but also require more recovery time (Abdel Azim, 2011; Galal & Al-Gamal, 2014). Urban families were also more likely dissatisfied with their health services, citing maltreatment by providers and overcrowding as the two main reasons (Galal & Al-Gamal, 2014). Combining these findings, it is clear that although urban

families and women may seek health services more often than rural women, rural women receive better quality of care than urban users.

The large amount of people seeking health services in urban areas is juxtaposed with the fact that urban users are more likely to use public rather than private services. Public facilities are the only feasible choice for low income households. Despite this fact, health care systems in Egypt often charge user fees, meaning that women of lower income status would not be able to afford or access care (Rannan-Eliya et al., 1999). Even when they access the public facilities, urban poor women face disadvantages because of the inefficiency and poor quality of public care. They rarely seek private care because of the large cost of services. In some areas of Egypt, such as Lower Egypt, fewer urban married women use contraceptives than rural women (El-Zanaty and Associates, 2014). However, for the most part, urban and rural percentages of married women using contraceptives are similar. This hints that similar trends in socio-economic class within urban and rural areas correlates with access to health care.

One area where public is preferred to private is contraceptives. The source of contraceptives depends on the type of contraceptive; women report using the private sector more to get the pill while using the public sector more for IUDs (El-Zanaty & Way, 2009). Overall, there was an increase in the number of women receiving contraceptives from the public sector from 1995 to 2008 (El-Zanaty & Way, 2009). Contraceptives are cheaper at public facilities, compared with the private sector (including NGOs). Making the pill more available in the public sector would probably increase the amount of women using contraceptives. Overall, urban poor women face

poor quality of health care, high costs, and overcrowding, which puts them at a disadvantage vis-à-vis their rural counterparts.

#### **IV. Conclusion**

Women's involvement in legislature and employment of women make a distinct improvement in women's access to health care if women in legislature represent a gendered constituency, women are employed in non-agricultural sectors, and the government effectively maintains health programs. From the evidence presented above, despite Egypt's better organized health care system, Morocco's women enjoy greater access to sexual and reproductive tools. However, both systems need to improve the overall distribution of these services to young and rural women who are often disadvantaged and provide basic health insurance coverage for all citizens.

Both countries are similar in a number of aspects, but Morocco's inclusion of women in the political sphere and effective development policies improved the status of women within the country, which thereby improved women's access to family planning tools, confirming H1. The elites of Morocco were more willing to undergo policy changes because they were not as focused on security and military issues as were the Egyptian elites. The policy changes opened up the formal sector for women to become involved in making demands. The elites of Morocco invested in the public infrastructure, whereas there was more private investment in Egypt. Thus, women who were elected in Morocco represented a gendered constituency and used their position to influence legislation toward gender equity in public spending.



The increase of use of health care services in Morocco as employment increased in non-agricultural sectors supports the theory of female autonomy and H2. Because Moroccan women were employed in areas other than agriculture, they were more likely to make independent financial decisions. Because agricultural employment in Egypt is directly linked to vulnerable employment, women are less likely to have a stable job and therefore less likely to be financially independent. As the research shows, it was more likely for women in Morocco to have access to health care because of their employment.

In both Morocco and Egypt, the government's capacity to provide and maintain health care services greatly affected women's access to health care. In Morocco, the long distance to a health care provider disadvantaged rural women. In Egypt, most women live within five kilometers of a health care provider, but the government pours all its resources into the urban hospitals. Services throughout Egypt also greatly depend on the region in which women live. This leads to the conclusion that H3- urban women are more likely to have access to health care than rural women due to the government's limited capacity to effectively implement health care programs- is true. However, women still face great obstacles to accessing health care at the intersection of gender, location, and government capacity.

This research could not confirm H4. The hypothesis stated that access to health care among urban women varies along with socioeconomic class. In Morocco, the results showed that urban poor women actually had better health care than their rural counterparts. Although they were at the same socioeconomic level as some rural women, they reported better access to health care than rural women of all socioeconomic levels. However, this does confirm H3: urban and rural women of the same economic class had

different access to health care because of their specific location as urban and rural. Additionally, urban poor women did have better access to health care than their rural counterparts, but had less access to health care than urban, rich women. This hints at disparities within the urban community, suggesting that socio-economic class is an important factor. However, in Egypt H4 maintains. Because of overcrowding and poor quality of care at public hospitals, urban poor women had less access to quality health care than their rural counterparts. In Egypt, unlike in Morocco, socioeconomic class had more of an effect on women's access to health care than their urban or rural location. Rural women with assets were able to afford private care that urban poor women could not. Socioeconomic class is clearly an important factor for accessing health care in Egypt.

The difference in H4 between Morocco and Egypt could be attributed to state capacity. Without the capacity to reach the slums, the Egyptian government was unable to provide urban poor women adequate care. Egypt does not spend enough on healthcare, considering its larger GDP than Morocco and better ability to fund those health care services. Thus, we find socioeconomic class is a significant barrier for poor women to access healthcare services. On the other hand, the Moroccan government provided affordable care to women even in urban areas, and thus urban poor women had health care almost on par with urban rich women. Thus, because of the state's capacity to provide for urban women but inability to reach rural areas, location and not socioeconomic class poses a significant obstacle to accessing healthcare in Morocco.

This paper lends itself to further research in the topic of women's access to health care services. One consequence of studying health care in Egypt and Morocco was the

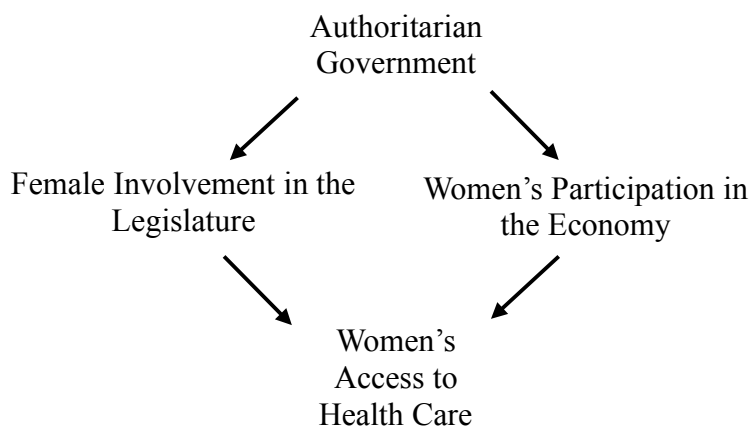
lack of data. Most of the current health research in Egypt focuses on urban and rural and socioeconomic classes separately, so future research should combine urban and rural and socioeconomic class. This would lend better data about the variation of access to health care within different groups in Egypt and would improve this research. Quantitative data and interviews with women in these two countries would also paint a better portrait of individual attitudes toward health care. This research also did not examine how the type of government and economy- specifically in these two cases, authoritarianism and non-oil reliant- affects women's access to health care. Future studies could look at different types of regimes and oil versus non-oil economies. Although addressed briefly in this paper, future research could explore specific women's health movements within these countries and how the government responded to them. This paper also only examined access to health care in general, but not access to *quality* care. As discussed previously, Egyptian women were able to receive contraceptives from public clinics, but many would discontinue use because they did not know how to properly use them. Women in Morocco who report bad or very bad quality of health care would also be less likely to continue use of those services because the cost outweighs the benefit. Future studies could examine the divide between access to health care in general and access to quality health care. As countries are still developing and reforming their health care systems, theories such as female autonomy and the intersectionality framework implemented in this paper are relevant no matter the time period and can be applied to women's health care throughout the world, not just in the Middle East.

In the future, it is clear to see the areas in which Morocco and Egypt need to improve their health care. Morocco should focus on expanding health facilities to reach

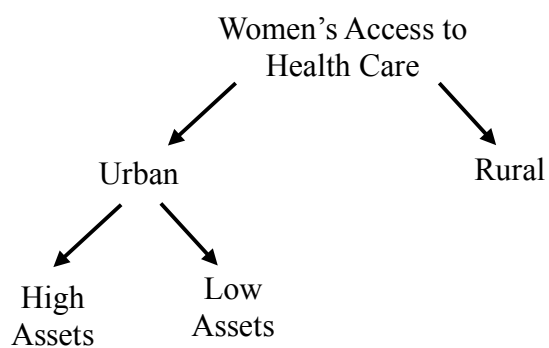
women in rural areas. Egypt needs to decrease the cost of health care for households, which would encourage more women to seek health care services. Improving the efficiency of public care, enhancing the infrastructure of the Health Ministry, and offering equal services to all segments of the population would greatly increase the number of women using the health care systems. Both countries need to expand health insurance coverage and encourage trained health workers to practice in their country rather than leaving. Ultimately, by providing adequate women's health care and encouraging women from all spheres of life to seek health services, Morocco and Egypt would move a step closer to empowering women in their countries.

It is my hope that this paper made significant theoretical, empirical, and methodological contributions to this area of research. First, it expanded current research on the theory of female autonomy by explaining how it also applies to the cases of Morocco and Egypt. Second, it broadened intersectionality by applying it to cases outside of the United States and race issues, showing that this framework is useful for explaining multiple causalities. This paper also integrated empirics from a wide variety of sources, from world wide databases to scholarly works and country surveys. By examining the countries from a comparative perspective both between and within, I was able to fully develop a glimpse of what causes variations in women's access to health care. Finally, this paper contributes to the current research of gender in development that has only gained traction in the past few decades. I was able to gender the argument and discussion on health care in these two countries with the goal of understanding what contributes to gender disparities in health.

## Appendix A



**Figure 1: Causal diagram of variables 1 and 2.**



**Figure 2: Causal diagram of variables 3 and 4.**

Case	IV1- Women in Parliament		IV 2- Women's Employment				DV- Women's Access to Health			
	Females in Legislature, %		Women in Agriculture, %		Women in Industry and Services, %		Contraceptive Education Programs		Family Planning Program	
Year			1980	1994	1980	1994	1960s	1980s	First Implemented	Reformed
<b>Egypt</b>	1.6 (1990)	2.49 (2000)	8	43	66	40	No	No	1960s	1980
<b>Morocco</b>	0.66 (1993)	10.77 (2002)	72	63	28	37	Yes	Yes	1966	1980s

**Figure 3: Case Comparison of Egypt and Morocco for the two national-level independent variables.**

	Women Candidates versus Women Elected in Legislative Elections, Morocco				
	1977	1984	1993	1997	2002
<b>Number of Female Candidates</b>	8	16	36	87	967
<b>Number of Women Elected</b>	0	0	2	2	35
<b>Percentage of Elected</b>	0	0	0.66	0.66	10.77

**Figure 4: Women Candidates versus Women Elected in Legislative Elections, Morocco.**

Source: Tahri, R. (2003). Women's Political Participation in the Commonwealth: Issues and Challenges. *Women's Political Participation: The Case of Morocco*. International Institute for Democracy and Electoral Assistance, 2004.

<b>Percentage of Women Using Modern Maternity Services, Morocco 1990-1995</b>		
<b>Type of Household</b>	<b>Modern Prenatal Care</b>	<b>Modern Delivery</b>
<b>Total</b>	51.2	40.9
<b>Urban Total</b>	81.5	74.4
<b>Low Assets</b>	78.0	70.3
<b>High Assets</b>	87.2	80.9
<b>Rural Total</b>	32.5	20.4
<b>Low Assets</b>	29.5	17.3
<b>High Assets</b>	58.1	46.7

**Figure 5: Percentage of Women Using of Modern Maternity Services 1990-1995, Morocco.**

Source: Hotchkiss, D. R., & Gordillo, A. (1999). Household health expenditures in Morocco: implications for health care reform. *International Journal of Health Planning and Management* 14,3, 201-217. Available from: *Wiley Online Library*.

<b>Infant mortality rate (per 1,000 live births)</b>				
<b>Location</b>	<b>1981 - 1985</b>	<b>1986 - 1990</b>	<b>1991 - 1995</b>	<b>1996 - 2000</b>
Egypt	107	74	60	37
Morocco	84	67	53	44

**Figure 6. Infant Mortality Rates for Selected MENA Countries from 1981-2000.**

Source: United Nations. (2015). 2015 Revision of World Population Prospects. *United Nation, Department of Economic and Social Affairs*. Retrieved from <http://esa.un.org/unpd/wpp/>

Maternal mortality in 1990-2000								
Location	Maternal Mortality Ratio (By Year, Per 100 000 live births)			Maternal Deaths (By Year)			Live Births (By Year, Thousands)	
	1990	1995	2000	1990	1995	2000	1990	1995
Egypt	120	96	75	2100	1600	2100	1739	1635
Morocco	310	240	200	2300	1700	1300	740	691

**Figure 7. Maternal Mortality Rates for Selected MENA Countries from 1990-2000.**

Source: World Health Organization. (2015). Maternal Mortality in 1990-2015. Retrieved from [http://www.who.int/gho/maternal\\_health/countries/mar.pdf](http://www.who.int/gho/maternal_health/countries/mar.pdf)

Percentage of Women Employed in Various Sectors in 1980 and 1994						
Country	Agriculture		Industry		Services	
	1980	1994	1980	1994	1980	1994
Egypt	8	43	10	9	56	31
Morocco	72	63	14	19	14	18

**Figure 8: Percentage of Women Employed in Various Sectors in 1980 and 1994.**

Source: Doumato, E. A., & Posusney, M.P. (2003). Women and Globalization in the Arab Middle East: Gender, Economy, and Society. London: Lynne Rienner. Available from: *Google Books*.

	Women Candidates versus Women Elected in Legislative Elections (Egypt)				
	1979	1984	1990	1995	2000
Number of Female Candidates	-	-	42	87	109
Number of Women Elected	-	-	7	9	11
Percentage of Elected	9	8.25	1.6	1.9	2.49

**Figure 9: Women Candidates versus Women Elected in Legislative Elections (Egypt).**

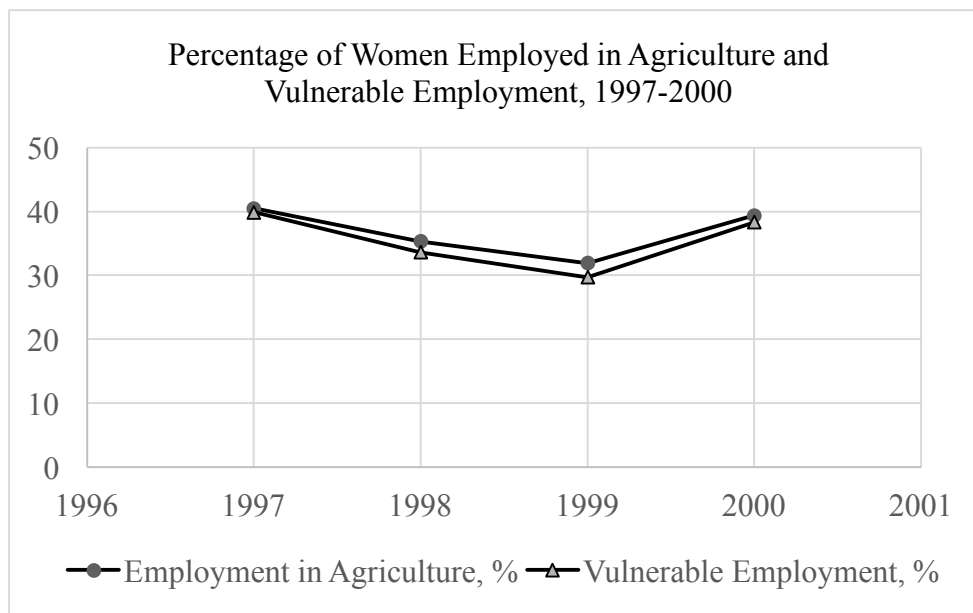
Source: Mustafa, H., Abd Al-Ghaffar, S., & Rabi' A. H. (2005). Building Democracy in Egypt: Women's Political Participation, Political Party Life and Democratic Elections. *Stockholm: IDEA*. Retrieved from [http://aceproject.org/regions-en/countries-and-territories/EG/case-studies/egypt\\_country\\_report\\_english.pdf/view](http://aceproject.org/regions-en/countries-and-territories/EG/case-studies/egypt_country_report_english.pdf/view)





**Figure 10: Percent of Women Employed in Agriculture.**

Source: The World Bank. (2016). World Development Indicators. Retrieved from <http://data.worldbank.org/data-catalog/world-development-indicators>



**Figure 11: Percentage of Women Employed in Agriculture and Vulnerable Employment, 1997-2000.**

Source: The World Bank. (2016). World Development Indicators. Retrieved from <http://data.worldbank.org/data-catalog/world-development-indicators>

Fertility and Reproductive Health Indicators for Morocco by Selected Wealth Quintile, 1992 and 2003-04						
Indicator/Survey year	Selected Wealth Quintiles					
	Poorest		Middle		Richest	
	1992	2003-4	1992	2003-4	1992	2003-4
% of married women (15-49) using modern contraceptives	18	51	38	55	48	57
% of married women with unmet need for family planning <sup>7</sup>	33	11	16	11	10	5
% of newly mothers who received antenatal care by trained personnel	8	40	31	71	74	93
% of deliveries assisted by trained personnel	5	30	28	70	78	95

**Figure 12: Fertility and Reproductive Health Indicators for Morocco by Selected Wealth Quintile, 1992 and 2003-04.**

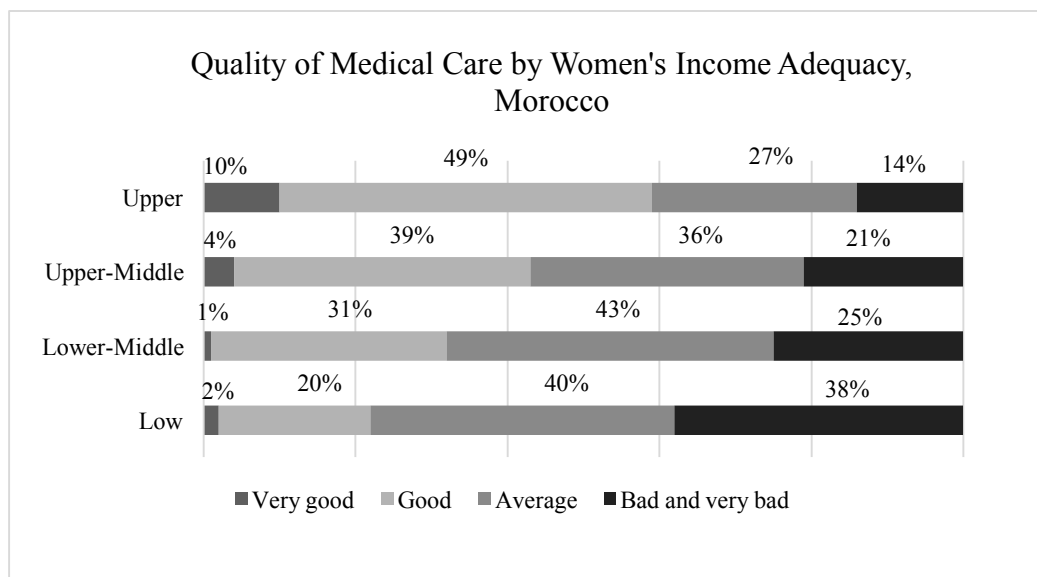
Source: Ayad, M. and F. Roudi. (2006). "Fertility Decline and Reproductive Health in Morocco: New DHS Figures." Population Reference Bureau. Retrieved from <http://www.prb.org/Publications/Articles/2006/FertilityDeclineandReproductiveHealthinMoroccoNewDHSFigures.aspx>

Poverty Trends in Morocco 1984-1999			
	1984/1985	1991	1999
Urban %	17.3	7.6	12
Rural %	32.6	18	27.2
National %	21.26	13.1	19

**Figure 13: Poverty Trends in Morocco 1984-1999.**

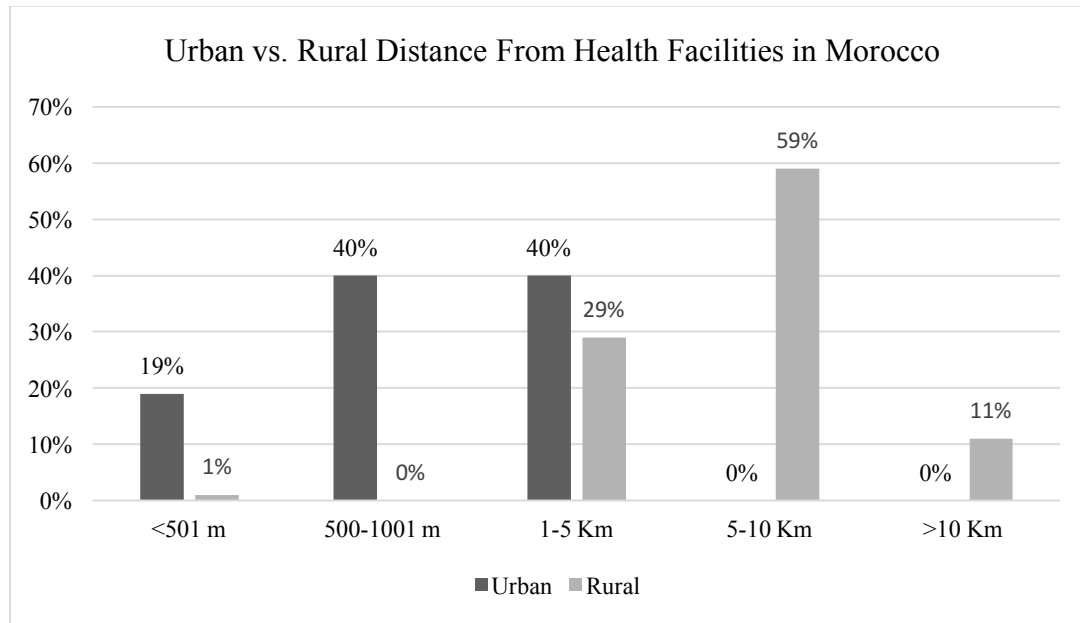
Source: Richards, A., J. Waterbury, M. C. Cammett, and I. Diwan. (2014). *A Political Economy of the Middle East*. Boulder: Westview.

<sup>7</sup> "Unmet need includes pregnant women whose pregnancy was mistimed or unwanted, amenorrheic women who are not using family planning and whose last birth was mistimed or unwanted, and fecund women who are neither pregnant nor amenorrheic and who are not using any method of family planning and say they want to wait two or more years for their next birth or they want no more children" (Ayad & Roudi, 2006, n.p).



**Figure 14: Quality of Medical Care by Women's Income Adequacy, Morocco.**

Source: The Status of Women in the Middle East and North Africa (SWMENA) Project: Focus on Morocco | Health Care Access Topic Brief. (2011). *SWMENA*. Status of Women in the Middle East and North Africa. Retrieved from <http://www.swmena.org/en/topic/11>



**Figure 15: Urban vs. Rural Distance from Health Facilities in Morocco.**

Semlali, H. (2010). The Morocco Country Case Study: Positive Practice Environments *World Health Organization*. Retrieved from [http://www.who.int/workforcealliance/knowledge/PPE\\_Morocco\\_CaseStudy.pdf](http://www.who.int/workforcealliance/knowledge/PPE_Morocco_CaseStudy.pdf)

<b>Contributions of Background Characteristics to Inequality, by Percentage, Egypt</b>					
	<b>Wealth</b>	<b>Mother's Education</b>	<b>Father's Education</b>	<b>Region</b>	<b>Distance to Health Care</b>
<b>Prenatal Care</b>	35.2	28.5	15.2	17.6	3.6
<b>Skilled Delivery</b>	36.1	23.6	10.2	28.8	1.3
<b>Neonatal Mortality</b>	15.8	28.8	3.2	25.0	n.a.
<b>Infant Mortality</b>	29.7	18.9	7.2	37.0	n.a.

**Figure 16: Contributions of Background Characteristics to Inequality, by Percentage, Egypt.**

Source: El-Kogali, S. & Krafft, C. (2015). *Expanding Opportunities for the Next Generation: Early Childhood Development in the Middle East and North Africa*.

Retrieved from

<http://documents.worldbank.org/curated/en/2015/01/23811898/expanding-opportunities-next-generation-early-childhood-development-middle-east-north-africa>

<b>Poverty Trends in Egypt, 1981-1996</b>			
	<b>1981/82</b>	<b>1990/91</b>	<b>1996</b>
<b>Urban %</b>	24.0-30.0	54.5	22.5
<b>Rural %</b>	22.0-30.0	35.9	23.3
<b>National %</b>	-	-	22.9

**Figure 17: Poverty Trends in Egypt, 1981-1996.**

Source: Richards, A., J. Waterbury, M. C. Cammett, and I. Diwan. (2014). *A Political Economy of the Middle East*. Boulder: Westview.

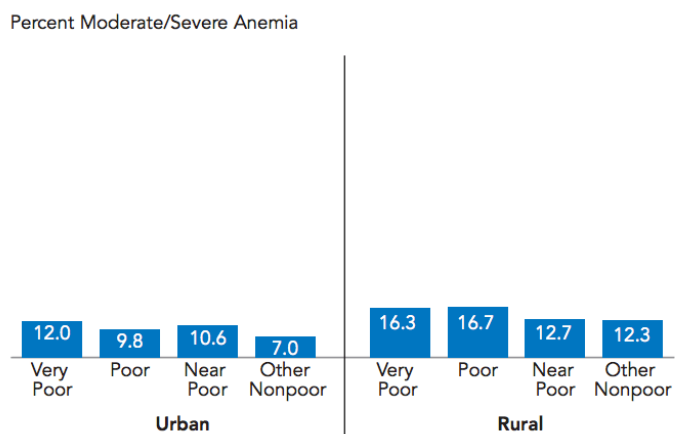
<b>Different types of health facilities for primary health care, Egypt (2007)</b>	
<b>Type of health facility</b>	<b>Number</b>
Rural health units	4254
Urban health centers	298
Urban health clinics	127
Maternal and child health units	237
Health offices	401
Mobile clinics	500+

**Figure 18: Different types of health facilities for primary health care, Egypt (2007).**

Source: World Health Organization. (2010). *Country Cooperation Strategy for WHO and Egypt 2010-2014*. Retrieved from

[http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_egy\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_egy_en.pdf)

### Anemia Among Children: Urban and Rural Egypt, 2005



**Figure 19: Anemia Among Children: Urban and Rural Egypt, 2005.**

Source: Montgomery, M. R. (2009). Urban Poverty and Health in Developing Countries. *PRB*. Retrieved from <http://www.igwg.org/pdf09/64.2urbanization.pdf>

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