Proactive versus Reactive Sexual and Reproductive Health Rights: A Comparative Case Study Analysis of Morocco and Tunisia

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Introduction

Morocco and Tunisia are two of the most progressive countries in the Middle East and North Africa (MENA) region. Their laws and public policies affecting women's sexual and reproductive health rights (SRHR) provide insight into the contentious nature of SRHR across the MENA region. Sharing a French colonial past and Maliki Islamic tradition, Morocco and Tunisia diverge on SRHR. Tunisia is an emerging democracy with a long history of *top-down* advances in women's rights and state promoted SRHR. Since independence, Tunisian women have benefitted from sexual and reproductive health (SRH) education, access to contraception, and state-funded first trimester abortion in public facilities. The state holds fathers accountable for out-of-wedlock children. Lastly, Tunisia's SRH policies have also targeted vulnerable populations, such as unmarried, minor, rural, and poor women. In contrast, the religious identity of the Moroccan monarchy prevented major legal reforms and policy shifts, until feminists demanded *bottom-up* change. Nevertheless, Morocco's SRHR provision is circumscribed and exclusionary, largely limited to married couples. The criminalization of extramarital sexual relations and most abortions limit the options of single – and married – Moroccan women when they are faced with an unwanted pregnancy.[1] As a result, many women resort to *unsafe abortion*.[2] Meanwhile, Moroccan men who father children outside of marriage enjoy social and legal impunity. The moderate Islamic Ennahda Party's short tenure in Tunisian leadership from 2011-2014[3] and the electoral success of the Justice and Development Party (PJD) in Morocco in 2011 and 2016 parliamentary elections intensified the conflict between feminists and conservative Islamists. In Tunisia, some Ennahda members pushed to reinstate polygamy and complementary gender roles, according to former President of the Tunisian Association of Democratic Women (ATFD) Ahlem Belhadj. In Morocco the PJD raised lowering the minimum marriage age. The Islamic parties' public policies, however, showed a mixed response to women's issues, especially SRHR. Morocco and Tunisia registered new emergency contraceptives (ECPs), but they require a prescription. Morocco expanded abortion rights to cases of rape, incest, and fetal malformation under the PJD, but without instituting public policies to implement the reform. Under Ennahda, the state apparatus tasked with abortion provision experienced personnel changes and supply problems. These events warrant further analysis of the impact Islamic parties and conservative religious discourses have on SRHR.

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The literature comparing the intertwined trajectories of post-independence state-building and women's rights in Tunisia and Morocco shows that Tunisia dismantled religious and tribal networks, which facilitated the development of a rational-legal bureaucratic system and ambitious modernization schemes. Consequently, the Tunisian state enjoyed *top-down* policy maneuverability without having to negotiate with preexisting power structures. In contrast, the Moroccan monarchy reinforced the religious elite by grounding monarchical identity and authority with Islam (Charrad 2001). Therefore, Moroccan feminists have been the driving forces behind progressive policy promotion in Morocco and they have faced pushback from conservative Islamists and patriarchal state structures.

The following analysis couples UN and government document analysis with elite interviews and focus group discussions with leading Moroccan and Tunisian women's rights associations[4] across the political spectrum to answer two central questions. First, how and why do Morocco and Tunisia differ in their approach to SRH provision? Second, what role, if any, do conservative Islamic discourses play in constraining SRHR? This analysis demonstrates that the Tunisian state's *top-down* laws and policies empower women to exercise their SRHR, reducing unwanted pregnancies, unsafe abortion, and maternal mortality rates. Conversely, Morocco's punitive laws and exclusionary policies – based on religious references – discriminate against women, particularly single women, denying them the information and resources to make informed SRH decisions.

Institutionalizing SRHR and Establishing Legal Parameters

Upon independence, Tunisia began to modernize through women's socioeconomic empowerment and increased SRHR. The state instituted compulsory education and increased women's workforce participation, while limiting family allowance benefits to four children. In the 1956 Personal Status Code (PSC), the state banned polygamy and repudiation, while granting women equal divorce rights. With the 1998 Patronymic Law, Tunisia equalized parental responsibilities for children born outside of marriage. Tunisia was a first adopter in providing information and services to help women control their reproductive health: legalizing contraception, ECPs, and first trimester abortion.

Against this legal backdrop, Tunisia established the National Office of Family Planning (ONFP) to develop and implement its SRH policy. ONFP established 340 family planning clinics in public health facilities. To meet the needs of the rural population, 20 mobile teams traveled to rural areas with assistance from the Tunisian Sexual and Reproductive Health Association (ATSR) (Lecomte/Marcoux 1976). To accommodate vulnerable populations, Tunisia opened clinics for unmarried and minor women to receive pre-natal and abortion services without social judgement (Foster 2016).

In Morocco, the Ministry of Health (MOH) oversaw family planning with assistance from the Moroccan Family Planning Association (AMPF). The MOH established

280 family planning units in public health centers and maternity wards, complimented by six AMPF clinics. Morocco, however, did not send mobile teams to rural areas (Lecomte/Marcoux 1976). In 2008, high rates of unsafe abortion and maternal mortality prompted the gynecologist Chafik Chraibi to establish the Moroccan Association for the Fight against Clandestine Abortions (AMLAC), a key player in raising awareness of the consequences of unsafe abortion. By 2016, AMPF expanded its presence across the country, offering family planning, contraceptives, and ECPs at 29 clinics (AMPF 2016).

Postcolonial Morocco did not prioritize women's socioeconomic empowerment, leading to high female illiteracy rates and women's economic dependence on men. An all-male council of religious leaders ('*ulama*) formulated Morocco's 1958 PSC based on *shari'a* law, making women perpetual minors and obliging wives to obey (*taa*') their husbands. Morocco's PSC underwent no major revisions until the 2004 reforms, which eliminated *taa*', increased the minimum marriage age, granted wives the right to divorce, and restricted polygamy.

Morocco's 1962 Penal Code criminalized extramarital sexual relations (Arts 490-491) and most abortions (Arts 453-454), creating an intersecting axis of gendered discrimination. As a result, Moroccan women face a moral and legal double standard, living in a society that values female chastity and male virility, with parallel recriminations and impunity. Association Voice of the Moroccan Woman (AVFM) President Aicha Sakmassi states: "(I) f both partners are single, men often deny their involvement in the relationship or discredit the woman as a prostitute to avoid prosecution." If the man is married, but his wife does not file a complaint, he is not prosecuted (PC Arts 492-493). Association Anaouat President Amina Byouz asserts "a man remains a man, so (society believes, GF) the problem is the woman who accepts an illegal sexual relationship." Even in rape cases, Moroccan society blames the woman and constrains her options in the event of an unwanted pregnancy. Initiative for the Protection of Women's Rights (IPDF) activist Amine Baha says, until recently, "if an unmarried woman delivered in a hospital, she risked prosecution, as she carried the proof of her crime in her belly". Association of the South in the Fight against AIDS (ASCS) sociologist Fatima El Allaoui argues, "if an unmarried woman gives birth in a hospital, the police is called to document the birth. Since she has broken the law, she must appear before the attorney-general, who sentences her to one-month imprisonment, but commutes her sentence."[5] Byouz adds, "if a single mother files a complaint against the child's father, asking him to marry her or to give the child his name, she can serve up to nine months in prison." A single mother and former prostitute at the Association in the Fight Against AIDS (ALCS) clarifies the choice, "in seeking justice, an unmarried woman forfeits her rights and those of her child. If she is arrested, there will be no one to care for her child, who risks homelessness."

Conservative Islamic activists, on the other hand, view abstinence as the ideal and, therefore, do not promote access to SRH education and services for minors or unmarried women. On the contrary, religious activists vilify illicit sexual relations be-

cause they are forbidden in the *Qur'an* 23, 5-7.[6] Forum Azzaharae for the Moroccan Woman (FAFM)[7] President Aziza el-Bakali Kassimi states, her association "is not for extramarital sexual relations and does not support their decriminalization in order to protect the integrity of the marital institution, the family, and society." Moroccan society considers a woman who has extramarital sexual relations a prostitute, which the legal codes reinforce, so society maligns, even persecutes, women – but not men – who have extramarital sex. The conservative Islamic Association al-Hidn[8] activist Imane Belghiti attributes the rise in single mothers, illegitimate children, and prostitution to the increased minimum marriage age promoted by feminists. Instead, the religious activists advocate lowering the marriage age and early marriage, especially for poor rural girls. Belghiti believes criminalizing extramarital relations is a deterrent to debauchery and provides wives an economic safety net: "Marriage – monogamous or polygamous – protects the woman and her child/ren, while a mistress has no rights. If a man really loves a woman, then he will marry her and give her rights. He will give her his name and legal children with paternal filiation." Conversely, Belghiti adds, "when young people are attracted to one another, have sexual relations, and a child, afterwards the girl has neither studies, nor family, nor social framework." Kassimi agrees, "as an Islamic association, FAFM prefers a girl marry at 17, rather than having an extramarital affair and becoming a single mother. Lowering the marriage age may be the best solution to fight prostitution."

SRH Education: A Feminist Rights-Based Approach

SRH education is the first step in women's enjoyment of SRHR. Nevertheless, Morocco and Tunisia's response to SRH education is drastically different. Tunisia took an inclusive, almost intersectional approach to SRH education, with special provisions for at-risk populations. Since the 1960s, mobile teams have provided rural women with access to SRH education and services. In the 1990s, Tunisia established counseling facilities in high schools with youth-friendly services, such as access to contraceptives, ECPs, and abortion. Tunisia incorporated this program into its National Adolescent and Young Adult SRH Program (Foster 2012), institutionalizing its comprehensive response. As a result, Tunisia reduced unwanted pregnancies, (adolescent) fertility rates, and maternal mortality rates. (For a comparison of Tunisian and Moroccan SRH indicators, see Table 1 below.)

Table 1: Comparison of SRH Indicators in Morocco and Tunisia

Comparison of SRHR Health Indicators												
	Contraceptive Prevalence, any methods (% of women ages 15-49)		Unmet Need for Contraception (% Married Women 15-49)		Adolescent Fertility Rates (births per 1,000 women ages 15-19)		Fertility Rate, total (births per woman)		Maternal Mortality Ratio (per 100,000 live births)		Government Health Expenditure (% GDP	
Country	1980/ 1978	2018/ 2012	1987/ 2001	2018/ 2012	1980	2017	1980	2017	200	2017	2010	2016
Morocco	19	71	22.1	13.8	86	31	5.65	2.45	188	70	169	171
Tunisia	31	63	12.1	7	33	8	5.24	2.22	66	43	244	257

Source: World Bank (2020)

Due to religious sensitivities, Morocco does not provide, or even inhibits, SRH education. In the 1960s and 1970s, the rural population, representing 65% of Moroccans, had little access to sex education and contraception (Lecomte/Marcoux 1976). The state did not incorporate SRH education into school curriculums or launch awareness campaigns in rural areas. Instead, the state actively prevented women's associations and political parties from filling the gap. Sakmassi explains, "the criminalization of extramarital sex in Morocco constrains the proper treatment of sex education in homes, schools, and even with medical professionals, as the *Qur'an* considers extramarital sexual relations *haram* (forbidden), and thus, even its discussion is taboo." Association Ennakhil's Hassan Naji agrees, "assuming single women are sexually active is *hchouma* (shameful)," which inadvertently restricts women's access to information and services. Feminist associations are hesitant to provide SRH education and services for fear of being prosecuted for encouraging prostitution (PC Art 497). Association Zitoune President Souad Benhammou asserts, "if adolescent girls had sex education, they could protect themselves." Nevertheless, health clinics and pharmacies limit SRH education and services to married women. Naji warns, "without SRH education from their families or schools, young people turn to the internet, which is uncontrolled and often inaccurate." As a result, adolescents and single women have limited information regarding family planning. One ALCS beneficiary confided that her boyfriend told her *he* was on birth control, leading to her out-of-wedlock pregnancy and resort to prostitution. Despite taboos preventing sex education, 33% of Moroccan women and 67% of men admitted to being sexually active before marriage (Bordat/Kouzzi 2010). At universities, students enter temporary ('*urfi*) marriages or religious (*fatiha*) marriages to have sexual relations (Mdidech 2007), but such arrangements provide women little legal recourse in the event of an unwanted pregnancy because the state only recognizes registered marriages.

Access to Contraception and Emergency Contraception (ECPs)

Tunisia ensures that women have the resources to manage their family size. In 1961, Tunisia overturned its ban on the advertisement and sale of contraceptives and began providing them free of charge as part of its aggressive family planning program (Foster 2012). By the 1970s, Tunisia's contraceptive provision focused on long-term remedies, such as male and female sterilization and intrauterine devices (IUDs), the most prevalent form of birth control (MOH 2011). Tunisia also declassified condoms as pharmaceutical products, facilitating their sale in various settings (Ben Said/Abdallah 2010).

In 2001, Tunisia was the first Arab country to register an ECP, NorLevo, which is taken after unprotected and underprotected sex to prevent unwanted pregnancies. The state quickly expanded public access to ECPs and incorporated them into the national SRH program. In 2005, Tunisia made NorLevo available at pharmacies without a prescription or restrictions based on marital status (Foster 2012). Moreover, the International Consortium for Emergency Contraception (ICEC) website notes that Tunisia has regulated ECP prices since 2013, so ECPs are not cost-prohibitive[9] and pharmacies are the primary distributors. Although individual pharmacists may refuse to sell ECPs to unmarried or minor women, Tunisia's national policy is committed to universal access (Foster 2012). During Ennahda's tenure, Tunisia approved the sale of a second ECP, the EllaOne, but requiring a prescription (Foster 2016).

In Morocco access to contraception was slower and more circumscribed, targeting exclusively married couples.[10] In 1966, Morocco launched its family planning program, which included oral contraceptive pills (OCPs), IUDs, male and female condoms, and contraceptive injection through AMPF clinics, pharmacies, and medical centers (Lecomte/Marcoux 1976). By the 1980s, Morocco offered Household Delivery of Contraceptives (VDMS), which systematically excluded singles (MOH 1993), so unmarried women often visit associations for SRH services (Capelli 2019). From 1993-2004, the MOH ran the Pill of the Moon (*Kinat al-Hilal*) campaign promoting OCPs and targeting rural areas, where the unmet need for contraception was the greatest (Chopyak 2016). Nevertheless, Moroccan women rely on short-term, less reliable contraception, with 72% using OCPs, 6% IUDs, 6% other modern birth control methods, and 16% traditional methods, such as the "rhythm method" or withdrawal (MOH 2011). Additionally, few Moroccan couples use condoms, the most reliable protection against HIV/AIDS and other STIs. Although 71% of married Moroccan women age 15-49 use modern contraceptives (World Bank 2020), only 59% of all Moroccan women use them (UNFPA 2018). This disparity indicates an unmet need for contraception based on marital status that puts minor and unmarried women at greater risk of unwanted pregnancy and unsafe abortion.

In 2008, Moroccan Minister of Health Yasmina Baddou approved the registration of NorLevo, the first ECP registered in Morocco. NorLevo is available, alongside a second ECP, Postinor 2, at most pharmacies.[11] The ICEC website indicates that all

ECPs in Morocco require a prescription. Hence, Morocco constrains minor and unmarried women, even rape victims, from purchasing ECPs. Campaigns to raise awareness of sexual violence against women and its consequences allowed ECP distributors to promote their use among single women in the event of rape or incest, as an alternative to abortion or an unwanted pregnancy (Chopyak 2016). These campaigns stereotyped ECP use as relegated to nonconsensual sex, rather than promoting ECPs in cases of unprotected or underprotected sex. Although ECPs are not exorbitant at 95 MDH (9.85 US dollars), even this price is cost-prohibitive for economically disadvantaged women. One ALCS beneficiary explained, she prostitutes herself for 100 MDH (10.37 US dollars). If a "customer" refuses to wear a condom, she must decide whether to use the money to purchase an ECP or feed her child. Although she knows the risks, she sometimes buys food instead.

Liberal Versus Restrictive Abortion Laws

Concerning abortion, Tunisia is an example of legislation and public policies assuring access to safe abortion, while Morocco demonstrates the dire consequences of restricting a woman's right to control over her body. Medical abortion, which represents the majority of all abortions and generally occurs during the first trimester, relies on one of three different regimes: mifepristone/misoprostol, methotrexate/misoprostol, and misoprostol alone. In the first and preferred method mifepristone is taken as a pill, followed by the second medication, misoprostol, which is taken at home 24-48 hours later to induce an abortion. In the second method, methotrexate is taken as a pill or injected, followed again by misoprostol to induce an abortion. The third method relies on misoprostol alone to prompt an abortion (WHO 2012). Countries with restrictive abortion laws often ban mifepristone,[12] while methotrexate is more widely available as it is used in the treatment of rheumatoid arthritis. This article focuses on misoprostol, the medication required in all three types of medical abortion.

In 1965, Tunisia relaxed its abortion law (PC Art 214) to allow couples with more than five children a first trimester abortion, so long as there was spousal consent and the abortion was performed by a medical professional in a hospital or clinic. In 1973, due to feminist advocacy, Tunisia legalized first trimester abortion for all women, requiring neither spousal consent nor medical authorization. Abortions are free in public health centers and can take place after the first trimester if the woman's health is in jeopardy. As with other medical procedures, minors require either parental consent or judicial approval. In 2001, Tunisia became the first MENA country to register mifepristone and to incorporate the mifepristone/misoprostol regime into its national SRH program. In Tunisia, 16,000 abortions are performed annually, 85% in government centers and 15% in private facilities, with medical abortions comprising 80% of them (Foster 2016). ONFP runs abortion centers where unmarried women may go to avoid public scrutiny. Complications are rare (Duma 2016). Despite the

liberalization of Tunisia's abortion services, abortion rates have been low with 11% of urban women and 3% of rural women reporting they had had at least one abortion, reflecting the strength of Tunisia's family planning program (Cochrane/Guilkey 1992). Under Ennahda's short tenure, abortion services experienced some setbacks, including ONFP personnel changes, medical staff discouraging abortion, and limited supplies of mifepristone and misoprostol (Foster 2016), which prevented some medical abortions.

Morocco has more restrictive abortion laws than Tunisia (see Table 2), leading to higher rates of unsafe abortion and maternal mortality.[13] In 2012, Morocco's maternal mortality rate was 120 per 100,000 births, almost triple that of Tunisia at 46 (WHO 2012). In Morocco a person can receive up to two-years imprisonment, plus fines, for undergoing an abortion (PC Art 454) and up to five-years imprisonment, plus fines, for providing an abortion (PC Art 449). Until 2016, abortion was only legal in Morocco if the mother's health was in danger and required either spousal consent or medical authorization (PC Art 453). Most abortions in Morocco are illegal, performed in the private sector, and cost 300-3,000 MDH (30.55-305.50 US dollars) (Harti 2012), which is cost-prohibitive for many women. Likewise, without spousal consent, an unmarried woman must obtain written authorization from a medical authority, in effect, acknowledging her criminal activity. As a result, many single women do not pursue a legal abortion for fear of going to prison for illicit sexual relations. Even with such deterrents, AMPF reports that 35% of Moroccan women have at least one abortion during their lifetime with 600-800 women – only 52% of whom are married – having an abortion each day (AMPF 2008). In 2018, Morocco prosecuted 73 women for having an abortion (MOJ 2018).

In 2016, at King Mohamed VI's request and after surveying the population, the PJD-led Parliament amended the abortion law to include cases of rape, incest, and fetal malformation (Law 10-16). Despite this reform, no public policies have been enacted to implement the new law. Moreover, AMLAC asserts, the previous abortion law only covered 5-10% of cases and the reform an additional 5-10%, excluding 80-90% of the reasons Moroccan women pursue an abortion (Achraf 2015). Thus, the current codes have yet to address the majority of issues associated with Morocco's restrictive abortion laws.

Table 2: Comparison of the Legal Grounds for an Abortion in Morocco and Tunisia (1996 and 2013)

Legal Grounds for Abortion								
	In Case of rape or Incest		Because of Fetal Impairment		For Economic or Social Reasons		On Request	
Country	1996	2013	1996	2013	1996	2013	1996	2013
Morocco	No	No	No	No	No	No	No	No
Tunisia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Source: UNDESA (UN Department of Economic and Social Affairs) (2014)

Although Morocco's restrictive abortion laws place all women in a precarious position in the event of an unwanted pregnancy, their effects on single women are compounded, compelling many single women to resort to clandestine, unsafe abortions. Association Solidarity Feminine (ASF) Director el-Baz indicates, "these abortions destroy the lives of single and married women, who take drugs, poison, and other substances to make themselves abort (…). When the abortion goes wrong, the consequences can be lethal." Most women who seek an abortion do so in cases of premarital sex, rape, incest, or mental health issues (El Amraoui/Naami 2018). The Moroccan Association of Human Rights (AMDH) member Najia Labrym suggests that "most illegal abortions are single women, who abort due to either unemployment or issues with their partner." Nevertheless, due to religious beliefs, the Moroccan state and society cast women who engage in extramarital sexual relations as prostitutes. Although consensus in Moroccan society is that the state should permit first trimester abortion in cases of rape, incest, or fetal malformation, "unmarried women are excluded since sexual relations outside of marriage are illegal" (Berer 2017). Therefore, Zitoune's Benhammou states, "a girl with the means prefers an abortion, not thinking about the impact on her health, just wanting to avoid a scandal." Consequently, single women are overrepresented in the cases of women being rushed to the hospital with severe injuries and complications resulting from unsafe abortions (Harvey 2014). The Union of Women's Action (UAF) General Secretary Nadia Nair says single women who become pregnant and do not get an abortion also "risk being killed by their families and often leave the family home, which frequently leads to total debauchery (…) prostitution, drugs, and illegal trafficking." The National Institute of Solidarity with Women in Distress (INSAF) (2010) reports that 90% of the 210,343 young Moroccan women who had children out-of-wedlock between 2003-2009 were rejected by their families. For these reasons, AMDH Labrym believes "the criminalization of abortion drives single mothers into prostitution to support themselves and their child." Moroccan women, especially single women, have few options when faced with unwanted pregnancies compared to their Tunisian counterparts.

In 2018, Moroccan women's access to abortion was further circumscribed when the Minister of Health suspended the sale of artotec, a misoprostol product used in medical abortion (Morocco News 30.11.2018). Prior to the ban, artotec was available in pharmacies without a prescription. The ban further constrains access to a medical abortion, forcing more women to resort to other means. Additionally, misoprostol is crucial in the treatment of postpartum hemorrhage (PPH), the leading cause of maternal mortality worldwide (WHO 2008). Although oxytocin is the drug of choice for PPH treatment, it must be injected, requires refrigeration, and is cost-prohibitive. The most viable alternative to oxytocin is misoprostol, which comes in a tablet form, is heat stable, and is inexpensive (Cook 2013). The ultimate effects of the misoprostol ban are still undetermined.

Paternal Accountability versus Paternal Impunity

Tunisia and Morocco are both states parties to the Convention on the Rights of the Child (CRC), which protects the child's right to paternal filiation regardless of the parents' marital status (Arts 2, 18). Tunisia enforces paternal accountability for out-of-wedlock children through its 1998 Patronymic Law. The National Union of Tunisian Women (UNFT)[14] President Radhia Jerbi says, "UNFT was instrumental in promoting this law, which allows single mothers to request DNA paternity testing from the man they say fathered their child." If the man is the child's father, the child has the same rights as a legitimate child, including the father's name, child support, a citizenship card, and inheritance rights" (Abiad 2008).

In contrast, Moroccan men who father children outside of wedlock enjoy impunity from paternal responsibility. The 2004 Family Law draws a moralistic distinction between legitimate and illegitimate paternal filiation (FL Art 142), effectively exonerating single fathers from paternal accountability. Legitimate paternal filiation (*nasab*) assures the child the father's name, maintenance, and inheritance (FL Art 198). Legitimate filiation is established by meeting one of three paternity requirements: a registered marriage, acknowledgement, or sexual relations by error[15] (FL Arts 144, 152). Illegitimate paternal filiation does not produce any of the effects of legitimate filiation (FL Art 148). Thus, Morocco places all parental responsibilities on the single mother because maternal filiation does not distinguish between legitimate and illegitimate (FL Art 146).

Conclusion

Without the strictures of a religious elite, the Tunisian state took proactive measures to provide comprehensive access to SRH education and services, making the necessary accommodations for vulnerable populations, including unmarried, minor, rural, and poor women. These measures include sex education in high schools, access to contraception, ECPs, and state-funded first trimester abortion. In compliance with CRC commitments, Tunisia holds fathers accountable for out-of-wedlock children. While Ennahda's tenure involved a conservative backlash, with key personnel changes in the ONFP and an interruption in the supply of misoprostol, affecting medical abortions and PPH, Tunisia's comprehensive approach to SRHR largely empowers Tunisian women to make informed decisions regarding their SRH minimizing unwanted pregnancies.

In contrast, the Moroccan monarchy tied its future to the conservative religious establishment, which inhibits its maneuverability. Consequently, Morocco's approach to SRHR is conservative, and even punitive. Although Morocco has made progress toward ensuring SRHR for married couples, it denies SRHR to vulnerable populations: unmarried, minor, rural, and poor women. Some conservative Islamists cast single pregnant women as outlaws, threatening the institution of marriage, moral

order, and society as a whole. Thus, single mothers are reaping their just rewards for engaging in illegal sexual relations. Single fathers, however, enjoy social and legal immunity. Although the PJD has registered a new ECP and extended abortion rights to cases of rape, incest, and fetal malformation, the government has not enacted policies to implement the reforms. Finally, Morocco's recent ban on artotec/misoprostol is likely to exacerbate its restrictive abortion laws, reversing recent gains in reducing maternal mortality rates due to unsafe abortion and PPH. This analysis demonstrates that marital status acts as an intersectional category of discrimination in Morocco, denying single women access to SRHR due to conservative religious beliefs. Tunisia's intersectional approach to SRHR and targeting of vulnerable populations warrant further investigation as a potential regional, if not global, exemplar of proactive state response to SRHR.

Notes

1 In 2017, 25% of Moroccan women reported that their pregnancy was unwanted or they wished to delay it (Lahsini 2017).

2 Unsafe abortion occurs when a pregnancy is terminated either by a person lacking the necessary medical skills or in a non-medical environment that does not meet medical safety standards.

3 Ennahda stepped down from the Tunisian leadership in 2014 following mass demonstrations against a perceived Islamist threat to women's status, but, notably, Ennahda maintains its strong parliamentary presence.

4 Interviews and focus groups were conducted with more than 200 Moroccan and Tunisian women's and human rights associations and policymakers across the political spectrum from 2013-2018, using a snowball sampling. The author asked open-ended questions in Arabic, French, or English with responses in French or Arabic, based on the respondent's preferences. Each interview was recorded, transcribed, and translated for follow-on analysis. Mounir Yahyani helped with some of the transcripts, but all of the translations are the author's. The association leaders gave permission for their names and organizations to be identified in publications. Only a fraction of the interviews could be included in this article due to space constraints, however, any strengths in the analysis are attributable to the activists' expertise on these issues and their willingness to share freely of their time and insights.

5 It is notable that the woman is not pardoned and her crime is not waived, implying she is still guilty.

6 "And they who guard their private parts, Except from their wives or those their right hands possess, for indeed, they will not be blamed, But whoever seeks beyond that, then those are the transgressors. (Qur'an 23, 5-7, translated by Sahih International. https://quran.com/23/5-7).

7 FAFM is affiliated with the ruling party, the PJD.

8 Al-Hidn is a splinter group from former Minister of Women Bassima Hakkaoui's Organization to Renew Feminine Consciousness (ORCF), which is also affiliated with the PJD.

9 NorLevo costs 14.40 TND (8.79 US dollars) in all pharmacies.

10 See Table 1 for contraceptive prevalence and unmet need for contraception, but note, only married women are included in the statistics as "needing contraception."

11 NorLevo and Postinor 2 sell for 94 and 90 MDH (9.75 and 9.33 US dollars). AMPF clinics provide ECPs at a subsidized cost of 30 MDH (3.16 US dollars) (Chopyak 2016). More recently, Morocco registered the EllaOne.

12 Mifepristone is a registered abortion drug.

13 Maternal mortality is defined by the UN Millennium Development Goals as "the death of a woman while pregnant or within 42 days of delivery or termination of pregnancy" (UN 2013). The WHO attributes 4.7%-13.2% of maternal deaths due to complications from unsafe abortion (WHO 2019). (See Table 1 for comparisons of Moroccan and Tunisian maternal mortality rates).

14 UNFT is the Tunisian state's feminist organization.

15 Sexual relations by error are when an engaged woman becomes pregnant before officially registering the marriage.

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Association Solidarity Feminine (ASF) Director Hafida el-Baz (Casablanca) 2017.

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Forum Azzaharae pour la Femme Marocaine (FAFM) President Aziza el-Bakali Kassimi (Rabat) 2016.

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Tunisian Association of Democratic Women (ATFD) former President Ahlem Belhadj (Tunis) 2015 (main opposition feminist association).