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# Health as a Human Right: An Analysis of Healthcare Delivery to Bidonvilles

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**Health as a Human Right: An Analysis of Healthcare Delivery to Bidonvilles**  
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## TABLE OF CONTENTS

<b>Abstract</b> .....	<b>3</b>
<b>Introduction</b> .....	<b>4</b>
<b>Methodology</b> .....	<b>4</b>
<b>Limitations</b> .....	<b>6</b>
<b>The Current Healthcare System in Morocco</b> .....	<b>8</b>
Governance and Ownership .....	<b>8</b>
Public and Private Sector.....	<b>9</b>
Human Resources .....	<b>10</b>
<b>Urban Health in Morocco</b> .....	<b>12</b>
<b>Frustration with Health Services</b> .....	<b>16</b>
<b>Social Security Schemes</b> .....	<b>17</b>
<b>RAMED</b> .....	<b>18</b>
Definition.....	<b>18</b>
Registration Process.....	<b>20</b>
Bidonville Members' Reactions.....	<b>20</b>
Living Without Health Insurance.....	<b>23</b>
<b>Alternatives for Healthcare</b> .....	<b>25</b>
<b>Reconciling the Disconnect</b> .....	<b>27</b>
<b>Conclusion</b> .....	<b>27</b>
<b>Recommendations</b> .....	<b>29</b>
<b>References</b> .....	<b>30</b>
<b>Appendix</b> .....	<b>31</b>

## **ABSTRACT**

Morocco is often characterized by its diverse geographical elements such as deserts, waterfalls, mountains, and beachfronts, but an element that Morocco may not be as proud of yet can be found throughout the country is the bidonville. These small communities that tend to compose sub-sections of major cities host an astonishing number of the urban poor who are forced to live in compromised health and social stigma. Through an investigation of the bidonville dwellers' experiences with the health care services, this paper attempts to assess the relationship between the Moroccan healthcare system and the marginalized people it endeavors to, but instead fails to, protect. The purpose of this research is to also show how a socio-spatial element, like life in a bidonville, determines the level of personal health and also informs health choices. The results illuminate the disconnect between those that offer healthcare and those that are in dire need of it. This study will hopefully aid in bridging the gap between the relatively ineffective government social services and the people who struggle to access them.

## **INTRODUCTION**

“Bi saha”, a Darija saying that positively punctuates daily encounters in Morocco, translates as “To your health.” It is clear that good health is prioritized in Moroccan culture; however, to what extent each social class has the capacity to protect its health depends highly on what social services are available, and more importantly, affordable. Though the government has been making a concerted effort in the last decade to ameliorate the public health system, some initiatives are mostly tainted with corruption or are not appropriate to repair the health inequity that is so apparent in urban areas.

What began as an investigation of health experiences in multiple bidonvilles evolved into a critique about social security and healthcare service delivery. Years of neglect and mistreatment of bidonville dwellers has bred feelings of distrust and disappointment in the government. Although these populations are eligible for the recently generalized medical insurance plan engineered to benefit them, most are still excluded from access or are wary to utilize it. Discussions with the inhabitants of Douar al Koura, Tabriquet, and Sahb al-Kaid bidonvilles illuminated their compromised health and human rights. This research will hopefully put a premium on the Moroccan government to execute better health service reforms for its citizens.

## **METHODOLOGY**

The primary goal of this research was to determine how successfully the Moroccan healthcare system caters to the vulnerable populations in urban areas. Therefore, it was necessary to conduct interviews with members who work in the health care system as well as those who purportedly benefit from it. The majority of the following research is comprised of informal interviews with bidonville inhabitants,

hospital employees, and key informants. Participant observation also offered insight but is regarded as less valid, because as an onlooker, I made assumptions that were never confirmed as correct. The majority of my interviews were conducted in the Rabat-Salé region. I chose to observe at four bidonvilles and conduct interviews at three; I conducted participant observation at Maternité Soussi hospital and Moulay Youssef, but received most information from Moulay Youssef employees.

When interviewing about health experiences in the bidonvilles, my original intention was to include a gender-diverse sample; however, depending on the time of day, sometimes women were more available and more willing to speak. Precautions to protect their identity were taken by introducing the reason for interviewing, explaining my identity, and verbally agreeing that names would not be used nor would photos be taken. To further ensure confidentiality, any names have been altered in order to maintain confidentiality. My interview sample was somewhat targeted, but often the best stories came from those who I did not approach directly. In other words, the snowball method played a large role--my translator and I approached one person, and once the interview was complete, he or she led us to a new person to interview. Different methods were used to record interviews, depending on the place, person, and translator. In the bidonvilles, a male translator was necessary for both Darija and for security. Bidonville interviews were recorded by note taking, and in one case, with both a recorder and note taking in order to capture the voices of all women who gathered in one setting to share their stories. Although skeptical that this medium might hinder the authenticity of the interviews, I was surprised to find that women encouraged me to record as they focused on the dialogue that my translators initiated with ease.

A stark contrast from the emotionally charged conversations with bidonville

members, interviews with hospital administration employees provided invaluable information about health care options available to the vulnerable populations with whom I spent time. At the hospitals, all communication was in French because no translator was present. It was both interesting and challenging to gather information from both perspectives since each contingent engages in completely different relationships with the Moroccan healthcare system.

Furthermore, academic readings supplemented field research for the purpose of locating objective information about the realities of Morocco's overall health, urban health, and the healthcare system. Key informants also played a role in offering objective information about bidonvilles and Morocco's healthcare system, and these interviews were conducted in English through the medium of note-taking.

## **LIMITATIONS**

Most limitations for this project stemmed from the allotted time. If possible, it would have been best to include more bidonvilles in less fortunate areas. Because Rabat is known for having comparably less bidonvilles, I feel that I did not get an encompassing sample of the country's situation. I can only speculate what other shantytown situations must be like, and if Rabat is a major leader in healthcare, I can assume that situations are more dire in other areas.

Often times I was limited by the language barrier; without a translator, it was difficult to communicate my questions, and I may not have reached full understanding of what my interviewee hoped to convey. There is always risk of misinterpretation, even with a translator present. In other words, when translating bidonville members' stories into English, often summaries were given instead of exact wording, and perhaps that

resulted in the loss of key facts. With regards to interviewing, it was challenging not to project the answers onto the interviewee; I knew what I endeavored to know, and so sometimes my questions were targeted to retrieve an answer instead of letting stories take their own shape.

Gaps in academic understanding persisted as well; because of time and availability, it was difficult to meet with experts who could inform me about the truth of government functionality and other factors at play. If more time were available for this project, I would have explored organizational and political influence in the bidonvilles in greater detail, but it was difficult to locate any political party or organization that worked directly in those areas.

There was always the risk of danger—a research opportunity in Tangier was rendered impractical because of factors beyond my control. Finally, research was slow because it seemed that members of this area were wary to conduct research in the bidonvilles, and so this inaccessibility strengthens the case that a divide exists between the bidonville populations and the rest of society, and perhaps it is integral to break those barriers and consequent stigmas in order to effect change.

I believe that this paper in its totality does not reflect the quality of my research experience, as I conducted the most valuable interviews four days prior to the due date and could have expanded even more if time permitted. I would have liked to experiment more with the content of my questions. In other words, I asked about perceptions and experience with pain, HIV/AIDS, tuberculosis, and sexual health options, but answers were not efficient enough to speculate any conclusion from them.

Also, I could never know the true burden of diseases in these bidonvilles even though I originally intended to make that discovery. For example, each bidonville had a



communal, make-shift water source provided by REDAL; it is essentially a large stone structure with a plastic pipe that distributed the water. After observing, I made friendly, informal conversation with those that gathered around the source to wash a dish, wash clothes, or fill up a glass, and I inquired if they ever got sick from the water. Each person was adamant that they were satisfied with the water, and I did not know if they were withholding information, as if they were wary that I was investigating a topic that could endanger their opinion. In hindsight, that question was biased because I had previous knowledge of poor sanitation and water services in bidonvilles at large. There was also no way that I could have determined the burden of water-borne diseases from a question and sample size used in this project.

### **The current healthcare system**

To understand why it is so difficult for marginalized populations to access health care services, it is first necessary to clarify the composition of the Moroccan healthcare system.

#### *Governance and Ownership*

Health services in Morocco widely proliferated after gaining independence from French colonialism in 1956. The public sector is the largest domain, offering free services to Moroccans. The State is a key player for these services, as it serves as the primary financer, administer, and provider of healthcare<sup>1</sup>. The Ministry of Health also plays a major role; it is in charge of the Basic Health Care Network, or the combined total of 2,552 health facilities that offer both curative and preventive care<sup>2</sup>, the Hospital

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<sup>1</sup> Hassar, Mohammed. 2010. Morocco Health Facts. Powerpoint.

<sup>2</sup> WHO. Country Cooperation Strategy for WHO and Morocco 2008-2013. 2009. Pg. 13.

Network, or the major hospitals found in the major cities of Rabat, Casablanca, Marrakesh, Fes, and Oujda<sup>3</sup>, and the national institutes and laboratories. The Ministry of Health is also the primary employer of physicians for these units. According to Dr. Hassar, physicians comprised nineteen percent of the Ministry of Health staff as of 2010. The private sector has developed independently, but offers beneficial services to Moroccan citizens, with high technology equipment.

### *Public and Private Sector*

It is necessary to distinguish between public and private systems of healthcare in Morocco. The public health sector caters to members who employ the services of the previously mentioned Basic Health Care Network and the Hospital Network. The sector is not-for-profit because it contains facilities that operate under mutual benefit insurance plans.<sup>4</sup> In the public sector, primary healthcare can be found in clinics, urban and rural health centers, and local hospitals in rural districts. At a secondary level, there exist provincial and prefectural hospitals. The tertiary level of care is comprised of regional hospital centers. Finally, university hospital centers, referred to as C.H.U, are found in the five major cities, and in the Rabat-Salé region alone, ten hospitals comprise this fourth level, under the name of Centre Hospitalier Ibn Sina.

Because the members in my interview sample are not involved with the private sector, research has been excluded for this particular study, but it is still pertinent to explain its function relative to the public sector. Private healthcare is for-profit, as opposed to its public counterpart. Morocco possesses almost three hundred private

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<sup>3</sup> Mr. Bakkaly, Personal Interview. April 30, 2013.

<sup>4</sup> Hassar, Mohammed. 2010. Morocco Health Facts. Powerpoint.

healthcare facilities. It is interesting to note that about half of the private hospitals are concentrated in the regions that house the major cities of Rabat and Casablanca, and the other half are dispersed throughout the rest of the country. As well, the private sector struggles because it must compete with the public hospitals that offer social security services. Because it is common for private hospitals and clinics to be located in major urban areas, this conflicts with the financial demographic of its inhabitants. In other words, urban poor, especially those included in this research study, afford only public health services. Private sector facilities include medical offices and infirmaries on the primary level, specialist offices on the secondary level, and clinics on the tertiary level.

### *Human Resources*

A major issue that detracts from the efficacy of services in both sectors is limited trained personnel. The World Health Organization lists Morocco as one of the fifty-seven countries experiencing critical shortages of human resources. To illustrate this, WHO provides the statistic, “the density of trained birth attendants is below 2.28 per 1000 population, WHO’s critical staffing threshold”.<sup>5</sup> It states that a major priority of health reform in Morocco should include increased staffing of the healthcare sector, and Dr. Hassar agrees that it is necessary to improve the training at basic and specialist levels.<sup>6</sup> Not only that, but it is necessary to redistribute healthcare personnel; most physicians and other human resources are concentrated in the Rabat and Casablanca regions, and Dr. Hassar states that The Ministry of Health creates no incentive for physicians in both the public and private sector so that they will practice in

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<sup>5</sup> Who

<sup>6</sup> Hassar, Mohammed. Personal Interview. April 16, 2013.

disadvantaged areas.<sup>7</sup> This situation was encapsulated in my interviewees' stories about their dissatisfaction with healthcare services in the Rabat-Salé region; prolonged wait periods are characteristic of a hospital visit and prior relationship with doctors is almost necessary to be seen. In regards to this study, this pertinent point illuminates the grave issue at hand--if interviews and research conducted in the Rabat-Salé area, which contains the highest doctor-to-patient ratio, reveal the acute shortage of personnel, then to speculate about other less fortunate regions puts a premium on Morocco to reform its healthcare at large. To illustrate this with statistics, as of 2010, there were 3957 medical doctors (in both public and private sectors) available to the Rabat-Salé region, compared to the 1293 available for the Tangier-Tetouan region, and 404 available for the Tadla Azilal region. Additionally, data collected from the Ministry of Health in 2010 shows that there were 689 people per doctor in the Rabat-Salé region, compared to the national average of 1633, and compared to 3711 in the Tadla Azilal region.<sup>8</sup> What is surprising is that there are more general practitioners in the private sector than in the public sector, which a WHO report states "reflects a lack of complementarity between the two sectors".<sup>9</sup> Another report created by the World Health Organization emphasizes the necessity of mixing the public and private sectors in order to render Morocco's overall healthcare system: more efficient:

The rationale for involving the private sector is the fact that this sector accumulates resources, competencies and management styles sufficiently innovative to contribute to the improvement of the health system performance. The growing need to modernize

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<sup>7</sup> Hassar, M. Powerpoint.

<sup>8</sup> Hassar, Mohammed. Powerpoint.

<sup>9</sup> WHO. Country Cooperation Strategy. Pg. 13.

public services and to respond with efficiency to population expectations is incentive for the public sector to turn to the private or nongovernmental organization sector.<sup>10</sup>

### **Urban Health in Morocco**

In order to clarify the capacity of Morocco's healthcare system and to determine its efficacy in caring for its population, I chose to examine how the public sector cares for the vulnerable populations in urban areas. Although Morocco's rural healthcare desperately requires reform, I found it necessary to define how an area with the relatively best and most available healthcare manages to cater to the marginalized. Because of this, I chose to visit bidonvilles, a place in which health is undoubtedly compromised as a result of its structure. Now a ubiquitous element of Morocco, these slums proliferated in the mid-1900s during the French colonial period when workers fashioned temporary housing out of tin and cement--*bidonville* literally translates to "tin town".<sup>11</sup> Now hosting hundreds of thousands of people in Morocco, these cramped spaces are characterized by sheet metal, tires, rubble, trash, bed sheets as doors, narrow pathways, and sour stench. Their environment lends itself to health problems as well. One interviewee noted that rain comes through the roof, and it gets unbearably and dangerously hot in the summer.

People who live in bidonvilles are experiencing what Dr. Hassar explains as multidimensional poverty. "Multidimensional poverty is made up of several factors that

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<sup>10</sup> WHO. Morocco: The role of contractual arrangements in improving health sector performance. Pg. 2.

<sup>11</sup> Howe, Marvine. 2005. Morocco: The Islamist Awakening and Other Challenges. Oxford: Oxford University Press.

constitute poor people's experience of deprivation – such as poor health, lack of education, inadequate living standard, lack of income, disempowerment, poor quality of work and threat from violence.”<sup>12</sup> Interview results from each bidonville illustrated that life inhabitants' lives are characterized by all of these factors.

Both proximity and stigma combine to threaten the physical and mental health of bidonville inhabitants. A study conducted by the WHO about urban health concludes that, “The urban setting itself is a social determinant of health. The living and working conditions (e.g. unsafe water, unsanitary conditions, poor housing, overcrowding, hazardous locations and exposure to extremes of temperature) create health vulnerability especially among the urban poor and vulnerable sub-groups.”<sup>13</sup> As a result of these social factors, communicable diseases can easily breed. Morocco has undergone an epidemiological transition since 1992, in which there has been a reduction of communicable diseases as a result of increase in immunization delivery. However, there is evidence of a persistence of diseases like tuberculosis and HIV. Both Tibari Bouasla and Mohammed Hassar commented on this phenomenon in relation to urban living in Morocco. Cramped spaces foster both promiscuity and ease of transmission. It was explained to me on a number of occasions in both Rabat and Salé bidonvilles that “cold, cough, and trouble breathing” are the most common sicknesses that inhabitants encounter.<sup>14</sup> Although this may solely refer to a cold, it is possible for tuberculosis to develop in these settings; however, my research did not allow confirmation. A nurse from Moulay Youssef commented that the most common sicknesses that the poorest

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<sup>12</sup> Hassar, Mohammed. Powerpoint.

<sup>13</sup> WHO Commission on Social Determinants of Health. WHO Centre for Health Development. “Our cities, our health, our future: Acting on social determinants for health equity in urban settings”. *Report of the Knowledge Network on Urban Settings*, Kobe, Japan. Pg. 29.

<sup>14</sup> Kareema. Personal Interview. May 1, 2013.

people have when they come to the hospital are “maladies sociales”, or sicknesses that form as a result of socio-spatiality. She explained the ease at which tuberculosis could be transmitted because it is often difficult to detect. Quarantines that last over a one-month period are often necessary to render the patient no longer contagious.<sup>15</sup> This may be difficult, then, to manage, if the infected patient lives closely to non-infected people. This reflects WHO’s study that poor ventilation alone can cause the communicable disease of acute respiratory infections, and non-communicable diseases like heart disease, lung cancer, perinatal defects, heart disease, chronic lung disease, fire/burns, and poisoning.<sup>16</sup>

Mental health problems are a silent attacker, yet they were illuminated through interview questions targeted to discover health perceptions. Each interviewee was asked to explain if they had a headache or stomachache, how did they treat it, and where did they think it came from? This was rooted in my initial assumption that cultural elements and rituals influenced beliefs about personal health. For example, a study done by Tyler Martinson revealed that Moroccans often associate the spirit *jinn* with infection because it is often found in unsanitary locations like stagnant waters, latrines, hammams, wells, et cetera.<sup>17</sup> However, I was surprised to find different results, as each interviewee, including men and women of different ages from different places, stated that a headache or stomachache results from stress and anxiety. A forty-one year old woman in Doura al Koura admitted that she has to take medication for her high blood pressure, which is a

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<sup>15</sup> Nurse. Personal Interview. April 30, 2013.

<sup>16</sup> WHO KNUS. pg. 26. Chart.

<sup>17</sup> Martinson, Tyler, "Medical Pluralism in Morocco: The Cultural, Religious, Historical and Political-Economic Determinants of Health and Choice." (2011). Independent Study Project (ISP) Collection. Paper 1001.

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result of her anger and stress about her living situation. When I confronted her neighbor, a sixty-one year old man, asking where he perceived his headaches to come from, he answered, “Poverty, the main thing is poverty. If you are comfortable in your mind, then you are healthy and free.”<sup>18</sup>

I also wanted to know how it made each person feel to live in the respective bidonville. Each answer encapsulated the social stigma and humiliation that members must face, which strengthens the case that chronic stress and anxiety are not uncommon in bidonville inhabitants.

A boy at age twenty-one stated, “There is no life here. There is nothing to do but surrender our destiny to God.” A man forty years older than him mirrored his statement, saying, “I cannot breathe; it is an obligation to live here—there is nothing to do.” I wondered what it meant when people mentioned how it was compulsory to live there, and results showed that often a bidonville was the only solution if they could not pay rent in the city or if they relocated from the countryside. One woman commented, “It is not comfortable for my children; having a small house makes it hard for the family to fit.” This alludes to the health information published by World Health Organization; it can be assumed that her family’s health is compromised by living in close proximity.

Other answers, especially from Sahb al Kaid, illuminated absolute neglect:

“We stay clean, we eat the best we can, but how long will we live? Being silent is better than complaining. It’s life. We just want something better.”

“No one takes care, no one asks; we try to adapt to the situation because no one is going to help or care.”

“Who doesn’t want to live in a big house? I just want something small, normal,

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<sup>18</sup> Interviews. April 25, 2013. Tabriquet slum.



and clean with a good reputation.”

It was especially difficult to hear the youth comment on their experience. A girl no older than thirteen explained how people refer to her only as ‘the girl from the slum’. Her friend, around my age, admitted to losing a friend because she was afraid to show her where she actually lived; often she would get off at an earlier bust stop and walk so that others could not see that she was from Sahb al-Kaid.<sup>19</sup> This illustrates a point that Tibari Bouasla made, that youth who still live in bidonvilles are ashamed and humiliated of their address, and it results in poor mental health. He commented on the relodging program, “Villes sans Bidonvilles” launched by King Mohammed VI in 2004 in order to eradicate the slums. However, this initiative has detrimental implications and often corruption prevails through methods of administering apartments.<sup>20</sup> A woman named Miriam in Sahb al-Kaid explained why she will not be able to relocate:

“My family must pay 90,000 dirham to get one from Ministry of Housing, and people go because they want get rid of the reputation, don’t go for health reasons—the situation is just as bad there. We don’t have any source to borrow from to get money for an apartment. We have just enough for food and even then we struggle to get it. Even if we get money for bank we would have to pay monthly--if you don’t pay, you go to court, so you can’t save enough for an apartment.”<sup>21</sup>

### *Frustration with health services*

Because social determinants victimize the urban poor, it is necessary to have available services that can ideally combat the health problems that arise. However,

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<sup>19</sup> Interviews. May 1, 2013. Sahb al-Kaid slum.

<sup>20</sup> Bouasla, Tibari. Personal Interview. April 16, 2013.

<sup>21</sup> Miriam, Personal Interview. May 1, 2013.

bidonville dwellers' stories reveal the opposite. Frustration stems from inadequate delivery of both treatment in hospitals, and, most importantly, the insurance scheme that is purportedly engineered for the people I chose to study.

Exogenous factors merge to thwart proper medical delivery. The most primary element is the privatization of health services and the consequent emphasis of biomedicine as the ultimate curative measure. This phenomenon, popularized in the 1980s during the neoliberalism movement spearheaded by Margaret Thatcher, relegated doctor-patient dialogue to a less important level than radiological tests for determining a patient's problem. Dr. Hassar believes that although testing is sometimes necessary for determining a problem, it is not always the ultimate solution, yet doctors choose this method because it monetarily favors them. He noted that vestiges of neoliberalism exist in Morocco's health care system, and this negatively affects the patients seeking proper care. This is exemplified by the morbidity of tuberculosis cases among the urban poor.<sup>22</sup> A nurse at Moulay Youssef informed me that it is necessary to conduct various tests, especially a saliva analysis, in order to determine if the case is positive.<sup>23</sup> These tests are expensive, and so often people are denied care because it is unaffordable.

### *Social Security Schemes*

Contrary to initial belief, the hospital administration employees stated that it was necessary to have some form of insurance in order to be seen by a doctor. However, anecdotes from members of the bidonville and from members of the Rabat medina show that it is possible to see doctors without insurance, but it is too expensive to be

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<sup>22</sup> Hassar, Mohammed. Personal Interview. April 16, 2013.

<sup>23</sup> Nurse. Personal Interview. April 30, 2013.

sustainable. Nevertheless, the Moroccan government seeks to insure all of its citizens through l'Agence Nationale de l'Assurance Maladie, or the National Health Insurance Agency (ANAM). Morocco provides different schemes based on social class. l'Assurance Maladie Obligatoire, or Compulsory Health Insurance (AMO), was founded in 2002 in order to provide basic medical coverage for public and private sector employees. It is comprised of the National Fund for Social Security Bodies (CNOPS), or insurance for civil servants, National Social Security Fund, (CNSS) or insurance for private sector employees, and MAFAR, or insurance for military personnel. All of these insurance schemes under AMO guarantee “the coverage of risks and the cost of health care associated with disease or accidents, maternity and physical and functional rehabilitation.”<sup>24</sup> At present, it provides medical coverage for over 8.5 million people. There is a different sector that protects white-collar employees called Assurance Maladie Independent, or Independent Health Insurance (AMI).<sup>25</sup>

### **Regime d'assistance medicale**

#### *Definition*

The insurance scheme that is most important for this study because it affects the interviewed sample is Regime d'assistance medicale, (Medical Assistance Regime), referred to generally and in the paper as RAMED. Piloted in 2008 in the Tadla Azilal region, it was generalized for all hospitals beginning in April 2012.<sup>26</sup> Mandated by the same juridical code as AMO, RAMED seeks to provide free healthcare for disenfranchised populations. Serving as an element of healthcare reform through the

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<sup>24</sup> WHO. Country Cooperation Strategy. Pg. 51.

<sup>25</sup> Bakkaly. Personal Interview. April 30, 2013.

<sup>26</sup> Ibid.

National Initiative for Human Development<sup>27</sup>, it seeks to replace the process of presenting a carte d'indigence (literally translates to card of poverty) in order to receive care<sup>28</sup>. An interministerial commission conducted studies to ensure its success, and results suggested that another 8.5 million people are eligible to benefit from RAMED. Although it is designed to especially target the 4 million people living in absolute poverty as well as offer aid to persons who have no permanent residence, those who live in the bidonvilles mostly expressed vehement dissatisfaction with this relatively recent medical coverage plan.

### *Parameters*

Members of the administrative staff at Moulay Youssef hospital explained the ease at which one could register for a RAMED card. He noted that in order to have access to care, it is necessary to have the card. One must fill out the form (found on the RAMED website), deposit it, wait up to three months for approval, and then one will receive insurance. If one does not receive approval, the family may still have access to urgent care. Depending on annual household income, the person applying should pay a registration fee scalable to their income. For instance, those who earn 3,767 dirham per year do not have to pay a registration fee, but those who earn above 5,650 dirham per year must pay a yearly fee of 120 dirham. This is partially how the insurance coverage is funded. The State funds the majority (seventy-five percent); local collectives fund nine percent; and the beneficiaries of RAMED, or those who apply and pay this yearly fee, comprise another sixteen percent of the funding for the scheme. One's financial

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<sup>27</sup> WHO. Country Cooperation Strategy. Pg. 16.

<sup>28</sup> Financial Employee. Interview. April 30, 2013.

situation, however, determines the length at which one may benefit from RAMED. For example, literature published about RAMED delineates two categories: those that are in situations of poverty, and those that are in situations of vulnerability. Those that identify with the former can utilize the RAMED card for three years before it expires. Those that identify in the latter category can access the card for one year before expiration, and in order to renew it, must pay the fixed annual fee of 120 dirham per person in the household that utilizes the insurance plan. However, the family would pay no more than 600 dirham per year.

### *Registration*

The staff seemed very proud of this new medical coverage, and boasted how easy it was to obtain. During an interview with an administrative employee in charge of financial affairs for Moulay Youssef, I wondered out loud how so many people in bidonvilles and in Morocco at large do not have health insurance, and he noted that it is a problem of communication but could easily be fixed with media initiatives and a concerted effort by outside organizations to publicize both the insurance and how to easily obtain it. Upon learning about the application process of RAMED at Moulay Youssef and after observing the extent at which RAMED dominated the waiting room atmosphere at both Maternité Suissi and Moulay Youssef, the interview questions of my next bidonville visit were more tailored to shed light on the inhabitants' relationship with this new medical insurance scheme.

### *Bidonville Members' Reactions*

The results were somewhat surprising. Every interviewee had heard about

RAMED, and so it was not a problem of poor broadcasting by organizations like my hospital interviewee had noted. From their perspective, RAMED is yet another government tool saturated with corruption because of the barriers to access that are associated with it. Most interviewees did not have RAMED, and those that did had to pay more than expected to obtain it or needed a personal connection to someone in the health sector in order to register. For example, Khadija, a woman from Douar al Koura recently received RAMED because her husband's friend brought the registration papers to them. Her friends who I also interviewed did not have the insurance. It was more common in Douar al Koura to not have RAMED because it was necessary to pay, and I speculated that perhaps it was because their household incomes were higher; it is highly likely that these families are classified as the situationally vulnerable, and thus must pay about 600 dirham annually in order to maintain insurance benefits. Another man with whom I interviewed had been living in Douar al Koura for fifty years. He noted that he had a RAMED card, but he did not go directly to the hospital to register or else he would have had to pay more than necessary. He often tried to avoid hospital services, only access them when totally necessary. Instead he buys medication from the pharmacy. Although attempts were made to coax him to describe an experience in which he was very sick and needed to use the hospital, his stories mostly illustrated discontent and disappointment with the Moroccan government at large.

His wife Fatimzahra also agreed to interview, and her story strengthened the case for lack of personnel and ubiquitous corruption. She described how people that she knows obtain RAMED through friends who work closely with the administration. When she and her neighbors attempt to access health care services, there are two levels. First, they visit the local hospital that is walking distance from the bidonville. According to her

and confirmed by other interviewees, consultations with doctors result in short visits and written prescriptions for medicine that is often too expensive. No medicine is given to them from these hospitals. If testing needs to be done, they are referred to the larger public hospitals, like ones part of the C.H.U. There, it is necessary to have a reference note from the doctor of the smaller public hospital expressing the urgency of illness as well as confirming that they have a RAMED card, otherwise a consultation at the larger hospital may be delayed by at least two months. As an Amazighi woman, she also described her life in the Rif Mountains before she relocated to the city, noting that there is often no place to go when sick because of the road infrastructure. Hospitals are far, and she stated that public hospitals were closed around her area. This lends itself to the phenomenon of greater maternal mortality, a serious problem that affects Morocco at present. She punctuated her comments stating that associations are not enough to help—the government needs to find solutions because at present, she and other bidonville members are humiliated by the government. Fatimzahra’s neighbor, a sixty-one year old Amazighi woman, noted that she doesn’t have RAMED because she “needs to pick up a lot of papers to get it and no one can do it for her”. Therefore, she has not accessed the hospital in a relatively long time; if she is sick, she purchases medicine from the pharmacy. It is interesting to note that only one interviewee out of the fifteen people described satisfaction when questioned about her relationship with health services and health insurance. In her particular case, she is pregnant with her second child. She did not have RAMED when she gave birth the first time, but now that she is medically covered, she does indeed pay less. Services that utilize a monitor are not included in her benefit package and she does have to pay for acute illnesses, but for the most part she is satisfied. Her only complaint was the prolonged waiting periods during

each hospital visit which again illuminates the problem of trained personnel shortage.

### **Living without Health Insurance**

If one does not have health insurance, which was a common occurrence in both the Sahb al Kaid and Tabriquet bidonvilles, my interviewees expressed the harsh realities of how services do not favor them, and they are marginalized even when attempting to access healthcare facilities. A woman named Sanae from Sahb al Kaid offered a poignant account about her experiences with healthcare.

“When I go to the administration to get papers or to go to the hospital, I am never treated in a good way; these people don’t care about me. Doctors don’t treat us in a good way--I only know one that does. I don’t go to public hospitals for that reason. Instead, I save money for ‘the bad situations’. Sometimes I will borrow money from my friend if I really need it, but it’s not worth it because I will not get seen [by a doctor]. It is better to go to a pharmacy. Even there you have to know people though because it’s based on trust—if I can’t pay for medicine, I could give them my identity card for medicine until I get money to repay them....No, I don’t have RAMED. Even if I did, I am not going to benefit from it because I still would have to pay for the sicknesses that aren’t covered, so what’s the use. I am often tired because I have to get up and go to work at four in the morning. I work as a maid and the family does not treat me well. They give me 500 dirham per month. It is spent immediately on food for my family. I’m telling you the truth. All the people living here, not only me, have the same situation. Because we don’t have a real salary, how can we live? We have to work.”

Her story is unfortunately similar to others that I interviewed. Free healthcare is



foregone because the fixed costs exceed their salary. It is a matter of choosing food and sustenance over sub-par healthcare.

Her friend Miriam also shared her experiences. I will never forget her stunning green eyes filled with fatigue and sadness, as she rested her head up against up the cement wall cuddling her toddler son under her arm as she spoke. She is pregnant.

“At hospitals, they don’t treat us well because they don’t regard us as Moroccan citizens. It’s as if we’re from another part of the world. I bet even if people came from other countries [in Africa] they would get better treatment than people from Sahb al Kaid slum. I don’t have RAMED. Even if I did, I would still have to pay. It costs 60 dirham to get. We heard that we didn’t have to pay, but the administration said, ‘Yes, you must. That was a story—you have to pay.’ So I gave him 60 dirham. [It is unclear whether she exercised the option of withdrawing her RAMED card for no financial penalty, or if she is speaking of a friend that paid the administration instead.] Even if I want to have my baby, I have to pay. And if you want the operation, you must bring with you 400 or 500 dirham [bribe] to get any kind of care when you go into delivery.”

Another shocking encounter occurred in the Tabriquet area during my very first interview. After posing this question to my interviewee, “Are you satisfied with hospital services, why or why not? What is your relationship with doctors like?” He stated, “Not at all. They are oppressive. We are treated like animals. If you don’t have money, you can’t see a doctor. Doctors don’t spend time to see us.” Immediately after, his friend sitting with him asked to borrow a sheet a paper. I thought he was bored and wanted to doodle, so I ripped off a sheet from my notebook. He took my pen and sketched a box with a door. “You go in searching for hope that someone will pay attention, but you can’t find it.” He then drew an arrow to an adjoining box, made a comment, and all the boys

sitting around laughed. When I asked my translator what he had said, I was shocked to hear, “If they don’t help you in this first building, they direct you to the second one, the cemetery.”

### **Alternatives for Healthcare**

Interview answers strengthened the case that bidonville inhabitants must rely on alternatives to the public healthcare facilities when they are sick. Long waits, not enough money for bribes, and negative relationships with hospital staff devalue the option. Instead, most interviewees admitted that they buy medication from pharmacies if they ever feel sick: Dolabran is the common solution for a headache, and traditional herbs like cumin and zaater are the cure for stomach aches. If extreme sicknesses or emergencies occur, money will be directed towards employing the hospital services.

In regards to health education and health information, interviewees admitted they rely on life experiences to guide them as opposed to inquiring doctors for advice. Women at reproductive age admitted they learned about pregnancy and everything involved in that experience from their mother. Miriam noted, “Poverty teaches. We rely on our experiences and instincts; no one tells us what to do.” I was excited to learn that all children who went to school were receiving preventative health education, and some had received immunizations from visiting doctors.

In regards to visiting organizations and associations, however, results were grim. Previously under the impression that political parties provided social services for members of bidonvilles, I was surprised to find the opposite. Interviewees in Douar al Koura noted that once, a few years ago during Ramadan, political parties visited and donated sugar, oil, and wheat for bread in exchange for votes in the upcoming elections.

They promised to return to offer either financial aid or install services, but that never occurred. Not only did this disappoint the inhabitants and make them lose more trust in the government, but also it perpetuated the divide between classes. I also endeavored to know if inhabitants had any interaction with aid organizations since academic text confirmed that non-governmental health organizations serve to augment State action<sup>29</sup>; however, interviewees mostly agreed that no organizations are actively involved with providing services. Additionally, during the allotted research time, I was not able to locate any organization or party that is actively involved with the bidonvilles that I visited. In Sahb al-Kaid, one lady recalled that a ‘health truck’ offered services a few years ago, like immunizations and eye exams, but that action is unsustainable. Otherwise, the situation aligns with a sentiment expressed by a boy from Tabriquet: “No one is responsible for life here.”

Another question I initially had involved community health—to what extent is a community health system desired within these bidonvilles, or does one exist? A partial answer to this arrived when women participated in dialogue about alternatives to hospital care. One woman stated that proximity can benefit them because they take care of each other. If a family member is sick, they do not hesitate to reach out for a neighbor’s help. Sometimes, they will lend money to each other if necessary in order to pay for extreme illness or urgent care. This provided a beacon of hope for the suffering waged on them by the systematic oppression and their harsh living environment.

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<sup>29</sup> WHO. Contractual Health Care. Pg. 16.

## **Reconciling the Disconnect**

Emily Martin stated that often we can find class refracted through health.<sup>30</sup>

Results revealing the disconnect between bidonville populations in the Rabat-Salé area and the government are encapsulated by this statement. This was most apparent in the two-day period in which I interviewed the employees of the financial office at Moulay Youssef and then interviewed people in both Douar al Koura and Sahb al-Kaid the following day. One employee reminded me of a salesman as he reiterated the ease at which one can register for RAMED, and noted how it was completely free to do so. From his perspective, one had to pay the ‘small’ price of 120 dirham in order to renew it annually. From the perspective of the bidonville dwellers, that is a lofty price. With an already negative relationship with the administration, any paperwork seems daunting. Also, as the same employee admitted that perhaps the reason why not everyone has RAMED is because there is a lack of communication with the bidonville dwellers, I was not notified of any efforts by the Ministry of Health or by hospitals to bridge this gap in communication. It led me to wonder if the administration wanted to include the class that it purportedly advertises to protect. Because bidonville dwellers publicly admit to be disenchanted with the government services, perhaps a first step to banishing barriers to access would be for the hospital networks to lead communication initiatives. This could be revolutionary in removing stigmas attached to those areas and the populations that inhabit them.

## **CONCLUSION**

During the first meeting with my project adviser, he sketched out the Moroccan

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<sup>30</sup> Martin, Emily. *The Woman and the Body: A Cultural Analysis of Reproduction*. Pg. 9.

healthcare system, touched upon the insurance schemes, and mentioned ways in which the system could be improved. As soon as I felt like I was finally piecing it together, he closed with the remark, “There is a challenge for Moroccans that even if you have an income, sometimes you cannot buy healthcare. There is free, available healthcare but not everyone can afford it.”<sup>31</sup> My notes from that meeting reveal that I did not understand how that could be possible: if it is free, why couldn’t my target population afford it? But now after having researched Morocco’s public healthcare system in greater depth and after having spoken with those that access it, the quote could not be clearer. Results from interviews and reviews of academic texts emphasize the barriers between Morocco’s healthcare and its poorest citizens. Evidence of corruption and bribery, a paucity of well-trained healthcare personnel, and a medical insurance scheme that excludes the audience it was engineered to protect all combine to thwart healthcare access for bidonville dwellers. The World Health Organization stated “Creating healthy urban living conditions is possible, as long as a supportive political structure exists and financial resources are applied in an appropriate manner.”<sup>32</sup> This can be applied to the case of bidonvilles in Rabat-Salé, and hopefully to bidonvilles at large; if the government makes a galvanized effort to accommodate this population instead of taking advantage of it, and if RAMED is revised to more appropriately include those in situations of vulnerability and poverty, then perhaps urban health can improve. If reform cannot be achieved in the regions of Rabat-Salé and Grand Casablanca where most governmental and health resource are available, then Morocco’s urban poor may continue to be victimized and ignored for an indefinite period of time.

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<sup>31</sup> Hassar, Mohammed. Personal Interview. April 16, 2013.

<sup>32</sup> WHO. KNUS. Pg. 11.

## **RECOMMENDATIONS**

Listening to the harsh realities illustrated by the members of the bidonvilles fostered a desire to find ways to overcome the inaccessibility that exists between the proffered financial services and the disenfranchised population whom they were designed for. Each interviewee noted that because hospital services are expensive or unsatisfying, the short-term solution is to buy from the pharmacy. From the perspective of hospital administration employees, they believe the reason that most people do not have RAMED is because of ineffective communication about the health insurance scheme within the bidonvilles. To what extent that may be true is unclear, but it sparked the idea of utilizing the pharmacy as a middle-man player in facilitating health insurance access to the most vulnerable urban populations. Not only could they proliferate information about the benefits of RAMED, but also a program could be installed that would assist pharmacy customers in registering for the insurance card.

However, this scheme has its limitations. In every case, bidonville interviewees were aware of RAMED, but they were not financially stable enough to obtain it. Even if a program in a pharmacy were to facilitate registration, it may receive lack of interest because its audience could not afford to employ the service. This would require a solution that boosted a family's income so that they could successfully invest in health. Therefore, I suggest a type of microfinance initiative for members of the bidonvilles in the Rabat-Salé area. Miriam noted that the pharmacy often serves as a banking institution, in which close relationships with the neighborhood pharmacists allow her to receive medicine on loan until her family can pay the store back. If microfinance was established, it could positively amplify the nature of the exchanges that she and her neighbors already make. Furthermore, economic empowerment would not only help the

women to afford the pricey medicine, but it could lend itself to improved mental health. Marvine Howe illustrated how bidonvilles in the Grand Casablanca area utilized microcredit programs for women in the early 2000s<sup>33</sup>; perhaps it could work in Rabat-Salé. As well, a lot of women admitted in the interviews that they embroider or sew in order to earn money to save for “bad situations”, mostly health-related. Therefore, in some ways, they already exhibit resourceful behavior and managerial skills. Therefore, I believe an initiative that would link healthcare product delivery and microfinance could reap benefits; however, corruption cannot be associated with the initiative in order for it to succeed.

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## **APPENDIX**

### **Interview Questions**

#### **Background:**

What is your age?

What is your occupation? / What is your year in school?

What about your father? Mother? Brother or sister?

What is your education? Where did/do you go to school?

How long have you lived here? What was the reason that you or your family moved to live here?

#### **Health Perceptions/Habits:**

What do you do to stay healthy?

What do you eat everyday?

When you have a headache, what do you do? Where do you think it came from?

When you have a stomachache, what do you do? Where you do think it came from?

When you have a toothache, what do you do? Where do you think it came from?

When someone has HIV, where do you think it came from?

When someone has TB, where do you think it came from?

When was the last time you were sick? Why do you think it happened?

What changes when you or a family member is sick?

How does it make you feel to live here?



**Health Services:**

Where do you go when you or a family member becomes sick? How do you get there?  
Are you satisfied with the hospital services? Why or why not? What is your relationship like with a doctor?  
Have there been any organizations to come here and help you? Who? What services do they provide?  
Do you have health insurance? How do you receive it? Are you familiar with RAMED?  
Where do you buy your medication?  
When you last accessed the hospital or pharmacy, and how did you pay for those services?

**Health Education:**

Where did you learn how to treat sickness?  
Did you receive health information in school?  
Where did you learn about HIV/AIDS?  
Where did you learn about sex?  
How do you teach your children about health?

**For Women:**

Do you have children? If so, how many?  
What method of birth did you use? Midwifery or Hospital?  
Where were they born?  
How old were you when you had your first child?  
How did you learn about pregnancy?  
When you have sex, do you use protection? Contraceptives? Where did you get them?  
Who do you talk to if you need advice about sex or anything related to it?