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**Analysis of the Moroccan Government & NGOs Responses to Migrant
Health Crisis**

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Abstract:

Healthcare access in Morocco for migrants has been a topic of growing interest. With the implementation of migration reforms in response to Morocco becoming a destination for migrants, it is important to assess the effectiveness of government policies in aiding migrant health. Additionally, assessing other political actors' influence in government policies is equally important. Through research of existing scholarship, I theorize that the biggest issue impacting migrant access to health is the illegalization of migrants. Without being a legal resident, let alone in asylum or a refugee, migrants cannot access public health services without the fear of deportation. Local and International NGOs currently play a large role in facilitating health care visits for migrants, but it is limited. Additionally, with the refugee determination process being under the UNHCR and not the ministry of health, the jurisdiction between national law and the UN becomes blurred. Nevertheless, both actors must collaborate to continue increasing access to healthcare services while streamlining the process of legalization in Morocco.

Introduction:

The 20th and 21st century has been a monumental time for the development of human rights and healthcare access. Especially after the independence of multiple countries in Africa, South America and Asia in the mid 20th century, healthcare access is an ever evolving topic that needs to be researched. According to the United Declaration of Human Rights written in 1948, human rights includes “right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education”¹. Specifically, a case study in Morocco would be of special interest to understand nationally, and globally.

In my study abroad program, my focus of study was Multiculturalism and Human Rights. I learned about the development of human rights in Morocco and the impact of gender, race, and ethnicity on access to those rights through in-classroom learning and talking to experts on the topics within human rights. Field work was also fundamental to the program; we visited NGOs and talked with migrants about their experience migrating and living in Morocco. It is through these discussions that I curated my interest in healthcare access in Morocco.

An NGO visit to 100% Mamas in Tetouan prompted my interest in healthcare access for migrants in Morocco. In the visit, there was a discussion on the hindrances women face entering the healthcare system. A big issue was the stigmatism surrounding STD testing, especially if one is divorced or single. Their relationship status comes into question, which exposes how women’s identity is perceived in healthcare. There is where I realized the complexity of healthcare access went beyond race, ethnicity, and class, but also social stigma for women.

¹ “Human Rights.” United Nations. United Nations. Accessed December 5, 2021. <https://www.un.org/en/global-issues/human-rights>.

Additionally, my interest to pursue healthcare access stems from my passions in healthcare overall. I am on the pre-medicine track, and have intent to become an Anesthetist. I have already researched public health topics through my religious studies major. Therefore, it was natural to research healthcare access in Morocco. Healthcare access in Morocco looks much different from many parts of the world for various reasons. Most importantly Morocco is in a position as a destination country for migrants, and a country in passing for migrants going to Europe.

Morocco sits at an important intersection between human rights and migration. Morocco is situated at the border between Europe and Africa, making it an easy point for migration. In fact, the Moroccan and Spanish border is the second most funded border in the world, right after the United States and Moroccan border. Morocco faces pressure from the European Union to keep migrants and integrate migrants into society. This is evident through the additional \$157 million USD the EU gave to Morocco to support border control². Integration of migrants requires implementing various programs to provide food, shelter, health, and job opportunities for migrants. Due to the nature of migrant conditions, it would be interesting to explore how the government and NGOs are effective in providing. Just as in any country, there is often a gap between legislation that aims to help marginalized people and the in-vitro experiences of migrants. Through my research, I am to see how migrants experience match up to the types of healthcare access they should be receiving under law. I hope to expand on the narratives of migrants provided through historical scholarship by including contemporary views and opinions on the topic.

² Ana Garcia Valdivia. "The Externalization of European Borders: Morocco Becomes a Key EU Partner in Migration Control." *Forbes*. *Forbes Magazine*, December 26, 2018. <https://www.forbes.com/sites/anagarciavaldivia/2018/12/26/the-externalization-of-european-borders-morocco-becomes-a-key-partner-for-the-eu/?sh=51137c922657.%29>.

Background Literature:

Migration:

The rise in migration to Morocco is something to be noted in the last decade. Morocco has been existing as a transit country into Europe through Spain. Nowadays, Morocco is becoming a destination country for migrants from Sub-saharan Africa. According to Morocco Trends, in 2010 there was a total of 70,909.00, which was a 30.4% increase from 2005.³ Additionally, there was a 24.82% increase from 2010 in immigration with there being a total of 88,511.00 migrants.⁴ The majority of migrants coming to Morocco are not sub-saharan, as they make up a small percentage of total immigration each year.⁵ It is actually difficult to track undocumented migrants, so the most accurate data is not available. However, according to the Migration Policy Institute, there are an estimated 700,000 sub-saharan migrants in Morocco. Hence, they should have an impact on government policies and programs, which is evident through various legislation in Morocco.

In 2014 Morocco initiated migration reform. Under those reforms the National Strategy on Immigration and Asylum (NSIA) was passed. The program integrated the healthcare system, education, housing and employment. Immigration reform also prompted the legalization of approximately 24,000 migrants, refugees, and asylum seekers. There would also be another wave of integrating migrants in 2017, which in total allowed 50,000 irregular migrants to get

³ “Morocco Immigration Statistics 1960-2021.” MacroTrends. Accessed December 13, 2021. <https://www.macrotrends.net/countries/MAR/morocco/immigration-statistics>.

⁴ “Morocco Immigration Statistics 1960-2021.”

⁵ Cherti, Myriam, and Grant, Peter. “The Myth of Transit: Sub-Saharan Migration in Morocco.” London: Institute for Public Policy Research, June 2013.

residency.⁶ These programs were within the “ framework of efforts renewed by the international community in favor of safe, orderly, and regular migration.”⁷ Politically, this was great for Morocco because they were a “ regional exception” for leading in the region for promoting human rights. However, in practice, the implementation of human rights is not fully effective, which is evident through lack of housing, healthcare, etc.

Migrants escape their home country for various reasons including civil unrest, economic and financial crisis. Migrants seek a better life in Europe, but with increasing difficulties of crossing the border, that dream becomes harder. Therefore, there is an increase in migrants remaining in Morocco, which puts a strain on the Moroccan government and international agencies. Investigating different social factors like healthcare is imminently important because more migrants would need healthcare access.

Healthcare in Morocco:

After Morocco became independent in 1956, healthcare access was limited. Initially, there were approximately 400 private practitioners and 300 public health physicians throughout the country.⁸ By 1992, approximately 70 percent of the population had access to healthcare. Alongside increased healthcare access, Morocco was able to make important steps in reducing prevalent infectious disease through campaigns and programs. Additionally, campaigns on

⁶“National Strategy on Immigration and Asylum: Global Forum on Migration and Development.” National Strategy on Immigration and Asylum | Global Forum on Migration and Development. Accessed December 13, 2021.

⁷ “National Strategy on Immigration and Asylum,” Global Forum on Migration and Development.

⁸ Wikipedia contributors, "Health in Morocco," *Wikipedia, The Free Encyclopedia*, https://en.wikipedia.org/w/index.php?title=Health_in_Morocco&oldid=1019489571 (accessed December 5, 2021).

nutrition, maternal health and child care, and obesity have helped to improve the health of the overall population.

The healthcare system is divided into two sectors under the Ma overarching system, Mandatory Health Insurance (AMO). AMO is broken up into the CNNS (private) and the La CNOPS(public).⁹ Under the public sector is the RAMED, which is an insurance program for people living in poverty. Under RAMED, migrants are supposed to receive healthcare access. In reality, this is much more complicated. In 2003, the Moroccan government passed Law n°02-03, which “ guarantees most of the fundamental rights of asylum seekers and refugees, especially access to health care and education, and the right to remain and to work under certain conditions.¹⁰” What this law does not highlight is that there is a process to filing for asylum or being recognized as a refugee. It is actually within the UNHCR jurisdiction to conduct the Refugee Status Determination process and not with the Moroccan ministry. This makes improving legislation for refugees and asylum seekers more complicated. So in regards to healthcare, migrants may face issues even using RAMED because of these discrepancies. Luckily, there has been a gap being filled through the catholic church and international NGOs.

The Catholic church has a large presence in aiding migrants, despite their small population. Since the early 2000s, more than 45,000 migrants have been treated through the organization Caritas. The organization provides a form of psychosocial support, the facilitation of access to education and the health system, as well as care and financial assistance in the

⁹ Wikipedia contributors, "Health in Morocco," *Wikipedia, The Free Encyclopedia*, https://en.wikipedia.org/w/index.php?title=Health_in_Morocco&oldid=1019489571 (accessed December 5, 2021).

¹⁰ “Morocco.” Migrants & Refugees Section. Migrants-Refugees, May 24, 2021. <https://migrants-refugees.va/country-profile/morocco/>.

prevention of HIV/AIDS.”¹¹ Additionally, in 2016 they created a 3 what project called Qantara, and the objective of the program was to help migrants and fully exercise their rights through supporting access to law services like health.¹²

A Similar organization to Carnitas is the Diocesan Delegation of Migrations (DDM). However this program is a part of the National Strategy of Immigration and Asylum, created by the Moroccan government. DDM “operates within the framework of the various conventions signed by Morocco for the protection and integration of migrants”.¹³ This is important because the ultimate goal is to make sure there is no confusion between the rights Morocco can provide to migrants and what these NGOs can also provide. There are much larger organizations that also contribute to helping migrant health. This includes , International Organization for Migration (IOM), International Labor Organization (ILO), UNHCR, Arab League, African Union (AU) and Doctors without Borders¹⁴. Even the WHO created a pact with the MENA countries to promote healthcare access for migrants. However, this is “ in-vitro” in that we know what these organizations are expecting to produce. However, we need to understand and research whether these organizations and the government are actually meeting these expectations.

Gendered Experience for Women:

Scholarship on women’s experience during migration is limited. Most researchers have focused on theorization of migration through mens experience.¹⁵ Researchers justified lack of research to lack of access, or women being the minority in camps. However, that makes women’s

¹¹ “Morocco.” Migrants & Refugees Section.

¹² “Morocco.” Migrants & Refugees Section.

¹³ “Morocco.” Migrants & Refugees Section, Migrants-Refugees

¹⁴ “Morocco.” Migrants & Refugees Section, Migrants-Refugees

¹⁵ Elsa Tyszler, “ From controlling mobilities to control over women’s bodies: gendered effects of EU border externalization in Morocco,” *Comparative Migration Studies*,2019, 7. 25. 10.1186/s40878-019-0128-4.

experience unexposed. If there is research on women's experience during migration, then it is centered on trafficking, domestic work, sexual violence and prostitution. This is problematic because this work does not always include a gendered perspective, which just reproduces the normative "migrative woman-victim with no agency" narrative.¹⁶ Additionally, the lived experience of women is left out when the conversations are only limited to smuggling and trafficking.

Women's experience in traveling is also important to separate because there is male dominance throughout the migration journey. Women are vulnerable to unfavorable power relations, which could lead to gender violence against women by fellow migrants, boarder patrol, or native Moroccans.¹⁷ This is important to consider in the analysis of women's experience in healthcare. Given this information, I infer that contemporary research will show that women enter healthcare settings primarily for sexual violence. However, given that research on women focuses primarily on trafficking and smuggling, scholarship will not highlight other healthcare issues as frequently.

¹⁶ Elsa Tyszler, "From controlling mobilities to control over women's bodies"

¹⁷ Elsa Tyszler, "From controlling mobilities to control over women's bodies"

Methodology/Limitations:

Due to the Pandemic, traveling to various NGOs or hospitals to conduct interviews was unfavorable. Additionally, due to leaving Morocco suddenly because of the lockdown, the time to receive interviews were cut short. This posed a major obstacle because it limited my ability to conduct interviews that could reflect more present trends on migrant experience in healthcare settings. Additionally, because my topic is very niche, it was difficult finding very specific academic works on my topic. There are various studies on the private and public healthcare options, and the constitutional laws on healthcare access. However, since data on migrants overall is limited, finding accurate sources on migrant healthcare experience would be difficult. Other limitations through my study include the biases presented in reports from institutions under the Moroccan government. The government would inherently want to present human rights issues in a positive light for various reasons. Therefore, they may imply that the issue does not begin with.

Considering all these factors, I decided to proceed by using academic scholarships available through bi-partisan organizations when possible. Unfortunately, I was unable to interview experts in academia who have conducted research, so I heavily relied on interviews and research conducted through well-recognized NGOs and news articles. Lastly, since I am not directly interviewing migrants, I will always encounter possible bias from any interviewer that communicates migrants' experience.

Analysis:

Médecins Sans Frontières/ Doctors without Borders:

MSF conducted a census to research pathologies most affecting migrants. The census occurred in Nador, Oujda, Casablanca, Salé and Rabat, which are hubs for NGOs and government organizations aiding migrants. 95% of the interviews were conducted in Casablanca or Rabat, which means migrants in the far North or South may not be accurately represented.¹⁸ Additionally, this study only included sub-saharan migrants without legal residency status, which allows for migrants in full need to be recognized and heard.¹⁹ The medical problems can be most attributed to violence and abuse, constantly changing living conditions, a draining journey, and

¹⁸ Doctors Without Borders- USA, “*Sexual violence and migration*,” (March, 26, 2010). Retrieved December 13, 2021, from <https://www.doctorswithoutborders.org/what-we-do/news-stories/research/sexual-violence-and-migration>. ,5

¹⁹ Doctors Without Borders- USA, “*Sexual violence and migration*,” 3

lack of access to health services.

Main pathologies among the patients attended by MSF in 2009

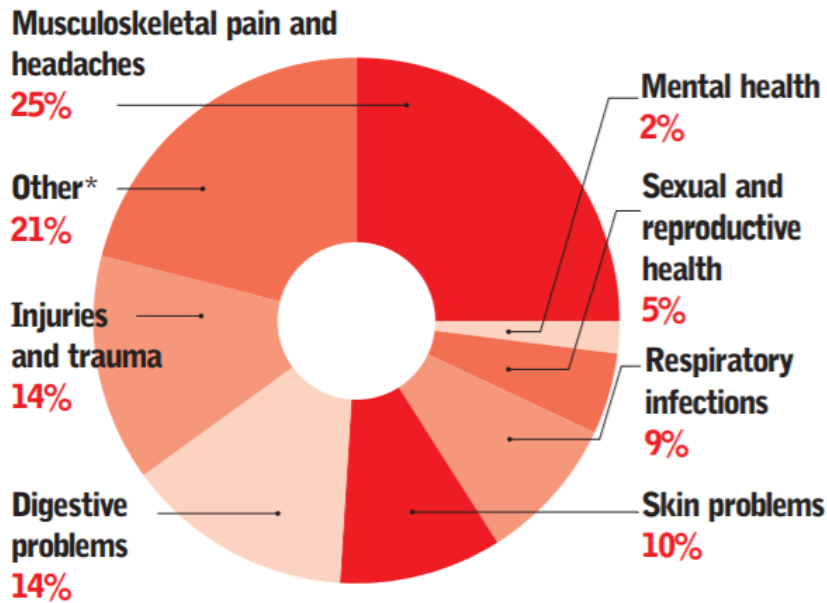


Figure 1: Main Pathologies among the patients attended by MSF in 2009 ²⁰

The highest recorded pathology in 2009 was musculoskeletal pain and headaches at 25%. This is not surprising considering the long and treacherous journey migrants take. However, an interesting statistic is the sexual and reproductive health is only at 5%. The low percentage of sexual reproductive health could indicate two phenomena. One is that the percentage of women covered in this study was much lower in comparison to men. The other possibility is that women are underreporting. The latter is the most probable reason. Sexual violence is a traumatizing

²⁰ Doctors Without Borders- USA, “Sexual violence and migration,” 5

experience for women, and women can be stigmatized for getting pregnant or contracting diseases. Women had to trust in men who were supposed to help them cross the border, but in turn these men turned their backs on these women and assaulted them. MSF reported that common criminals, smuggling and human trafficking networks mostly perpetrated sexual violence against women. However, boarder patrol on the Morocco/Algerian boarder also participated in sexual violence against women, which makes migrant women even more vulnerable. Such atrocities must have been a re-traumatizing process to constantly endure. One story that encompasses this re-tramatization is the story of BB, a 25 year old Woman interviewed by MSF.

“BB left her country due to war. She crossed Mali and then Algeria with another Malian woman. She was forced to work as a prostitute in an Algerian town to pay to continue her journey. Some time later, BB managed to leave. In Oujda they told her how to get to Casablanca and that someone would be waiting for her there with accommodation. But BB did not find anyone in the place she had been told. After a while, she asked a Sub-Saharan man for help. This man put her up in his house and from the first night he raped her. According to BB, the sexual abuse became habitual. She was not able to leave the house and if she said no, the man hit her and left her without food for days. Finally, BB fell ill and the man had to contact an NGO to take her to the hospital. That day she managed to talk to a Congolese woman who helped her escape.”²¹

Many women like BB encounter multiple barriers in the migration process that put them in a vulnerable position. Men take advantage of their migrant status, which has a massive impact on women. Of the women who provided testimony, 35% presented pathologies related to sexual violence.²² That is much higher than the 5% represented in the overall statistics of migrant health consultation in 2019. Additionally, 33% percent of women showed psychological manifestations of sexual violence trauma which includes the following “ insomnia, anorexia,

²¹ *Sexual violence and migration*. Doctors Without Borders - USA. (2010, March 26). Retrieved December 13, 2021, from

<https://www.doctorswithoutborders.org/what-we-do/news-stories/research/sexual-violence-and-migration>,

²² Doctors Without Borders- USA, “Sexual violence and migration,” 8

nightmares, stress, anxiety, depression, emotional passivity, strong feelings of guilt and shame and suicidal thoughts.”²³This is a devastating problem that cannot be simply solved through legislation. Luckily, there has been a focus from ministerial departments, in collaboration with organizations like MSF, but also other local organizations. There was an attempt to implement “ legal protection cells in some courts and protection cells in hospitals,” but this is not well known to migrants.²⁴ But even with the creation of these policies, MSF claims that it is not enough for migrants. The most important factor for migrants accessing better healthcare services is through the legalization of migrants.²⁵ Migrants are not guaranteed protection without legal status. MSF draws on the hindering migration policies that lead to the increasing violence and deteriorating health conditions for migrants.

When migrants cannot integrate into society through accessing legal status in Morocco, migrants are forced to rely on local and international agencies. As stated early, because UNHCR has jurisdiction to conduct the Refugee Status Determination process, and not the Moroccan government, agencies that are supposed to promote the living conditions of migrants fail to do so. This finding is intriguing because it questions the motives of western government in providing support to Moroccan governments. The burden is placed on joint efforts between international NGOs and local agencies, and leaves the government unaccountable, since they do not control the determination process. Additionally, strengthening migration policies while claiming to support migrants puts into question the border issues between EU and Morocco. Not only is Morocco to blame, but the European Union as well. Restrictive asylum and migration

²³ Doctors Without Borders- USA, “Sexual violence and migration,” 9

²⁴ Doctors Without Borders- USA, “Sexual violence and migration,” 9

²⁵ Doctors Without Borders- USA, “Sexual violence and migration,” 10

policies in Spain directly affect migrant access to services²⁶. The solution to this issue has to include placing more joint efforts between UNHCR and the Moroccan government to streamline refugee status and asylum processes, so that burden is removed from international and local NGOs in Morocco.

United Nations Agency for Migration in Morocco:

The UN International Organization for Migration (IOM) created a three phase program in coordination with the UN agency for Migration in Morocco called “Fostering Health and Protection to vulnerable migrants transiting through Morocco, Tunisia, Egypt, Yemen and Sudan.” This program aims to improve vulnerable migrants’ health and wellbeing, and to advocate towards universal health coverage.”²⁷ The third phase in particular focuses on improving migrant health. The program provided assistance to 89,326 migrants, but only 30%, 26,767, were treated in Morocco.²⁸ Through the program, the UN wants to improve “capacity of respective countries' Ministry of Health (MoH) and local responders,” through a focus on public health and protection of migrants. The program has three intended outcomes.

The first outcome is that Morocco, and other respective countries, make policies improving health needs and migrant rights in correspondence to international and regional

²⁶ Doctors Without Borders- USA, “Sexual violence and migration,” 10

²⁷ UN Migration “Fostering Health and Protection to Vulnerable Migrants Transiting throughout Morocco, Tunisia, Egypt, Libya, Yemen, and Sudan.” International Organization of Migration. UN Migration. Accessed December 4, 2021.
<https://morocco.iom.int/sites/morocco/files/Fostering%20health%20and%20protection%20to%20vulnerable%20migrants%20transiting%20through%20Morocco%2C%20Tunisia%2C%20Egypt%2C%20Libya%2C%20Yemen%20and%20Sudan.pdf>

²⁸ UN Migration, “Fostering Health and Protection to Vulnerable Migrants”

commitments by continuing dialogues on legal frameworks in the Moroccan healthcare system. The second outcome is to increase availability and “ use of health protection services by vulnerable migrants" by providing humanitarian assistance, and sensitize clinicians to advocate for migrant rights.”²⁹ The last outcome is to enhance existing partnership alliances through developing “ migration inclusive national policies, strategies, and programs” with the Moroccan government and its partners.³⁰

The first and third outcomes are especially interesting because they propose policies that the Moroccan government would enact. Therefore, the Moroccan government would have more responsibility in promoting migrants rights. However, given the role of the UNHCR in regulating refugee and asylum processes, the effectiveness of programs as such is questionable.

²⁹ UN Migration, “Fostering Health and Protection to Vulnerable Migrants”

³⁰ UN Migration, “Fostering Health and Protection to Vulnerable Migrants”

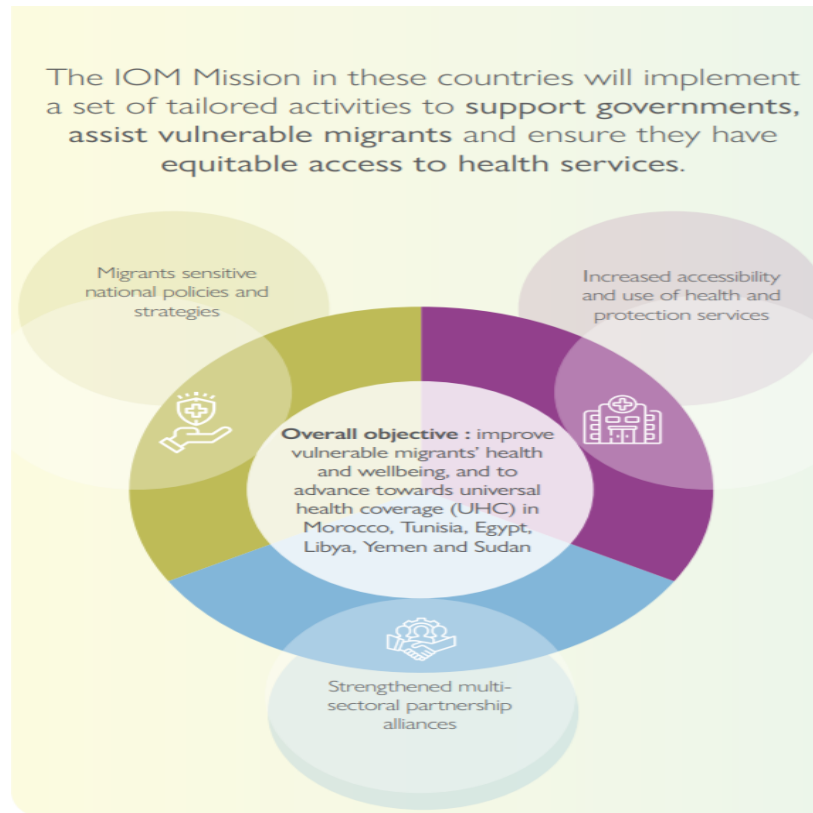


Figure 2: The IOM Mission and Overall Objective³¹

Questions that should be considered include How effectively can the UN IOM protect migrant rights while having other divisions of its organization maintain strict rules on asylum seeking individuals. An added factor is that with the European Union, specifically Spain, they are violating international law and forcing migrants back across the border. If countries cannot respect asylum laws in place, then the effectiveness of groups like the UN can be questioned. If time allotted for a long-term research project, tracking the ramifications of the phase III of this project could be fruitful.

³¹ UN Migration, “Fostering Health and Protection to Vulnerable Migrants”

Policies Implemented By the Moroccan Government in Recent Years:

National Strategy on Immigration and Asylum

The most recent legislation passed by the Moroccan government was the National Strategy on Immigration and Asylum. The program was passed in 2013 and aimed to manage migrant flow while putting in institutional frameworks and improving existing ones since the passing of the Law 02 03 in 2003.³² The program has many important objectives, but the ones relevant to this project are the following: “Objective 5, Enhance availability and flexibility of pathways for regular migration; Objective 7, Address and reduce vulnerabilities in migration; Objective 9, Strengthen the transnational response to smuggling of migrants; Objective 10, Prevent, combat and eradicate trafficking in persons in the context of international migration.”³³ These objectives are especially critical because they broadly protect migrants' access to healthcare by encouraging easier routes to legalization. However, there is not an objective covering how to help those that are illegalized. The lack of resources for migrants is even more amplified for those who are illegal because they cannot access traditional public services. Eventually the UNHCR and the National Council of the Medical Association collaborated in May 2020 to improve access to healthcare services. The agreement is symbolically important according to Rebyet Degat, a UNHCR official, because it showed “ all the expressions of

³² “National Strategy on Immigration and Asylum: Global Forum on Migration and Development.” National Strategy on Immigration and Asylum | Global Forum on Migration and Development. Accessed December 13, 2021. <https://www.gfmd.org/pfp/ppd/2080>.

³³“ National Strategy on Immigration and Asylum,” Global Forum on Migration and Development.

solidarity and hospitality shown by Morocco and its people.”³⁴ Though this statement may be true in the efforts of passing legislation, in practice this statement appears to be empty.

This is however the most recent legislation that most clearly outlines progressing migrants healthcare access, so in due time, new research can assess the effectiveness of this new collaboration. This collaboration could bring a new facet to migration policy, which is using healthcare workers as actors in lobbying for migrants' health.

Conclusion:

The future of healthcare in Morocco appears to be promising. Considering the passing of legislation such as the National Immigration and Asylum Policy shows that the Moroccan government has an interest in asylum seekers and refugees. Scholarship from the last 20 years shows that in practice implementing policies is difficult. From the analysis, I conclude the most impeding barrier to healthcare access is the hurdles of legalizing migrants. Though local and international organizations have helped improve conditions of migrants' health, without access to basic services through public hospitals, illegal migrants will continue to have issues. I believe it is an issue with both the UNHCR and the Moroccan government. The UNHCR rightfully holds jurisdiction in processing migrants, but the most logical progression for the UNHCR and the

³⁴ Alraya News Network. “UNHCR, Morocco Sign Agreement to Improve Healthcare Access for refugees.” Already. May 20, 2020, <https://alrai.com/unhcr-morocco-sign-agreement-to-improve-healthcare-access-for-refugees>.

Moroccan government would be to provide funding to extend basic healthcare services to undocumented migrants. This would cut the issue of blurry lines between UNHCR jurisdiction and the Moroccan government in terms of services for migrants. Additionally, this would alleviate the pressure from smaller NGOs within Morocco. Lastly, it would prevent the length of time migrants have to endure various diseases without medical care, which would decrease the health crisis that migrants endure in the first place. Migrants would be more likely to remain in Morocco, which would benefit groups like the European Union. This would require delegating more money towards migrant health. This is unlikely for the Moroccan government to do on its own, given it would promote the duration of migrants stay. The European Union or other western countries would have to continue supporting these organizations to keep migrants safe.

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