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# Disability and Healthcare Access in Morocco: Social and Cultural Influences

Christa Shipman  
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# **Disability and Healthcare Access in Morocco: Social and Cultural Influences**

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Fall 2021

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## Introduction

I stepped into the SIT Multiculturalism and Human Rights program as a pre-physical therapy student with experience working and volunteering in the disability rights arena. Striking personal encounters with Moroccans combined with these past experiences drew me to investigate how social and cultural factors influence access to healthcare for people with disabilities. I hypothesized that access to medical care is limited by social or cultural mindsets, perceptions, or beliefs for those in my target population. This subject is relevant to Morocco as a developing country and as a society with, in some cases, fixed social dynamics, while in other areas defined by rapidly changing and fluid social dynamics. Research from nearly a decade ago (2014) shows that 6.8% of the Moroccan population has a disability;<sup>1</sup> a different survey from the same year states 9.5% of adults<sup>2</sup> (whether the difference in percentage is because one includes children or because of disparities in obtaining data is not clear, both are quite possible). In addition to this, physical impairment will touch a majority of people at some point in their life, whether that be from accident, war, aging, or other reasons,<sup>3</sup> so not only health professionals or legislators benefit from timely information in this area, but nearly every family in North Africa and the world. In a country with one kinesiotherapist for every 2,000 children with a disability, access to resources is a pressing issue.<sup>4</sup>

Over the course of one month, I interviewed people with disabilities, healthcare professionals, and leaders of NGOs as well as conducted observations in therapy sessions, public

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<sup>1</sup> Review of *Enquete Nationale Sur Le Handicap 2014*. 2015. Royaume de Maroc - Ministère de la Solidarité de la Femme de la Famille et de Développement Social. <https://www.men.gov.ma/Ar/Documents/Rech-Nat2-FBilan-fr.pdf>.

<sup>2</sup> Hajjioui, A., N. Abda, R. El Guenouni, and M. Fourtassi. 2018. "Epidemiology of Disability and Participation in Morocco: Results from 2014 National Household Survey." *Annals of Physical and Rehabilitation Medicine* 61 (July): e548–49. <https://doi.org/10.1016/j.rehab.2018.05.1277>.

<sup>3</sup> "Colin Barnes: The Social Model." n.d. [www.youtube.com](http://www.youtube.com). Accessed December 6, 2021. Time 4:36-5:11.

<sup>4</sup> Braghini, Alessandra. 24 November 2021 Interview by Christa Shipman

places, and clinics and care centers. From this qualitative research I hoped to find insights into the struggles of children and adults living with a disability, and what holds them back from living full, healthy lives. This was a basic study, not in-depth, but still sufficient to reveal important clues as to the action steps needed to support this minority population's well-being and rights.

**Key terms:** disability, impairment, social model

### Literature Review

When stepping into the world of disability rights and disability activism, one stream of thought which is critical to understand is the social model. Simply put,

The social model is an inclusive approach. It asserts that the most significant barrier for individuals with disabilities is not the disability itself; rather the most significant barrier is the environment in which a person with a disability must interact. Society disables people through designing everything to meet the needs of the majority of people who are not disabled.<sup>5</sup>

The social model was first put forth by South African Vic Finkelstein in the 1970s and '80s as he campaigned against a kind of "social apartheid," or societal oppression experienced by people with disabilities.<sup>6</sup> Finkelstein's colleague Paul Hunt and later Mike Oliver (the latter created the phrase "social model of disability" in 1983) co-championed the development of this model. The social model distinguishes "disability" from "impairment," impairment being the

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<sup>5</sup> "The Social Model of Disability | Information Technology Systems and Services." n.d. Itss.d.umn.edu. Accessed December 6, 2021. <https://itss.d.umn.edu/articles/all-y-social-model-disability>.

<sup>6</sup> "Movement Mourns Father of Social Model." 2011. Disability News Service. December 3, 2011. <https://www.disabilitynewsservice.com/movement-mourns-father-of-social-model/>.

physical or mental aspect whereas disability is the experience of a disabled person due to society's view of them.<sup>7</sup>

Many helpful ideas and approaches in disability studies have emerged as a result of the social model; for one, inclusive education. A Moroccan researcher, Mounir Kheirallah, shared with me the shift that this model brings to the field of education. He pointed out how the special education mindset is that a person with an impairment is “disabled” because they lack essential abilities and must be rehabilitated to reach a normal state. In contrast, the inclusive education mindset is that an impaired person is complete and worthy of acceptance as they are, simply needing encouragement to reach their full potential.<sup>8</sup> A 2018 Canadian study on healthcare access among indigenous peoples takes a similar stand on pointing out problematic societal mindsets. They use the comparison of “biomedical” vs. “postcolonial” to conceptualize the idea that underlying assumptions accompany the biomedical theory of healthcare access, and they encourage healthcare providers to seek a more holistic perspective (the “postcolonial perspective”) which includes social, political, and historical influences on the subject.<sup>9</sup>

The counterpart to the social model is the medical or individual model, which categorizes disability as a medical diagnosis from which a person suffers. Although the social model has been hailed as a revolutionary, vital step, there are criticisms of it as well. Lord Norwich, who is himself visually impaired, pointed out that “it is one thing to attribute the disadvantage of a disabled person only to individual characteristics, it is quite another to exclude the role of

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<sup>7</sup> Barnes, Colin.

<sup>8</sup> Kheirallah, Mounir. 7 December 2021.

<sup>9</sup> Horrill, Tara, Diana E McMillan, Annette S H Schultz, and Genevieve Thompson. 2018. “Understanding Access to Healthcare among Indigenous Peoples: A Comparative Analysis of Biomedical and Postcolonial Perspectives.” *Nursing Inquiry* 25 (3): e12237. <https://doi.org/10.1111/nin.12237>.

individual characteristics.”<sup>10</sup> Besides breezing over the impacts of impairment in a person’s life, other flaws which have been pointed out are that the social model assumes disabled people are oppressed, it is very difficult to distinguish between what marks “impairment”(the medical diagnosis and biological limitations faced) versus “disability” (social limitations), and the idea that we can reach a state with no barriers is erroneous.<sup>11</sup> In a simple effort to avoid nomenclature nitpicking, the terms “impairment” and “disability” are used interchangeably in this paper.

Two other increasingly relevant models of disability are the human rights model and the WHO model. The human rights model is contained in its thesis that “Disability is a natural part of human diversity that must be respected and supported in all its forms. People with disability have the same rights as everyone else in society,” and “Impairment must not be used as an excuse to deny or restrict people’s rights.”<sup>12</sup> The World Health Organization (WHO)<sup>13</sup> model seeks to integrate the medical and the social model in a balanced approach to all aspects of disability, a framework which “understands functioning and disability as a dynamic interaction between health conditions and contextual factors, both personal and environmental.” It is being called the “bio-psycho-social model.”<sup>14</sup>

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<sup>10</sup> Cigman, R. 2010. *Inclusion*. In *International Encyclopedia of Education (Third Edition)*, 158-163. Edited by Peterson, P; Baker, E.; and McGaw, B. Elsevier. <https://doi.org/10.1016/B978-0-08-044894-7.00588-1>

<sup>11</sup> Shakespeare, Tom. *The Social Model of Disability*. In *The Disability Studies Reader*, 6-11. Edited by Lennard J. Davis. New York: Routledge, 2010.

<sup>12</sup> “Introducing the Human Rights Model of Disability.” 2019. Disability Advocacy Resource Unit (DARU). January 30, 2019. <http://www.daru.org.au/how-we-talk-about-disability-matters/introducing-the-human-rights-model-of-disability>.

<sup>13</sup> World Health Organization. 2021. “Disability.” [www.who.int](https://www.who.int/health-topics/disability#tab=tab_1). 2021. [https://www.who.int/health-topics/disability#tab=tab\\_1](https://www.who.int/health-topics/disability#tab=tab_1).

<sup>14</sup> World Health Organization. 2011. Review of *World Report on Disability*, 4. [https://www.who.int/disabilities/world\\_report/2011/chapter1.pdf](https://www.who.int/disabilities/world_report/2011/chapter1.pdf).

Jonas-Sebastian Beaudry from the University of British Columbia writes a thorough, even-handed review on the social model of disability.<sup>15</sup> However, it is easy to notice that his debate is highly theoretical and academic as opposed to pragmatic. For anyone doing work on the ground, face-to-face with people, such a purely conceptual approach becomes frustrating, and Beaudry acknowledges this.<sup>16</sup> The research in this project was birthed out of a desire to seek practical, useful knowledge related to influences on healthcare access, so I will refrain from establishing any one model as the basis of my approach, although the human rights model comes closest. I agree that “As a researcher, I find the social model unhelpful in understanding the complex interplay of individual and environmental factors in the lives of disabled people.”<sup>17</sup> Yet, it is a good model insofar as recognizing the fundamental problem and providing an alternative approach, namely: people should be treated kindly and fairly on the basis of shared humanity. Professor Colin Barnes gets rights down to it when he states, “Disabled people are just like everybody else in the sense they have a right to a decent quality of life.”<sup>18</sup> I entirely agree, and as I have come at this research project from a human rights perspective, this is clearly the matter at hand.

While disability rights is a relevant issue in every country of the world, Morocco faces unique challenges in this area due to its situation and colonial history. One striking example is the epidemic of paralysis which occurred in late 1959 in Meknes and around the whole country. My project advisor remembered the details well: Doctors and scientists were puzzled as to the cause—could it be polio? A virus? After some research they noticed that only the poor were

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<sup>15</sup> Beaudry, Jonas-Sebastien. 2014. “Beyond (Models Of) Disability?” SSRN Electronic Journal of Medicine and Philosophy. 41: 210-228. <https://doi.org/10.2139/ssrn.2418431>.

<sup>16</sup> Beaudry, 225

<sup>17</sup> Shakespeare, 11

<sup>18</sup> Barnes, 10:48-10:58



being paralyzed. It turns out that shortly before there was an incident of oil poisoning, and this oil containing toxins was mixed in with cooking oil and consumed. Poverty had pushed families to use the toxic oil because they could not afford to buy fresh, and they did not realize how dangerous it was.<sup>19</sup> After fact-checking this story, I found it to be entirely true, except that the oil was not mixed in by individual families, but by a wholesaler looking to increase his profit margin. The oil came from the US Air Force base near Casablanca; it was used jet engine lubricating oil which contained triaryl phosphates and cresol phosphates.<sup>20</sup> The toxins damaged the motor neurons of the spinal cord and caused partial paralysis for thousands of Moroccans, of which 80% were unskilled laborers, now unable to work. WHO estimated that “a probably 10,000 cases, including small children, will be completely paralyzed for the rest of their lives, and their upkeep will depend on the good will of their neighbors or the State.”<sup>21</sup> Other sources say that out of the 10,466 victims identified, 85 percent had been completely cured, with only 272 requiring further treatment after June 30, 1961.<sup>22</sup>

### Legislature

So, what role does the State play in care for the disabled? The Moroccan government as well as international human rights organizations have demonstrated involvement on this front, although legislation has been characterized by lack of action on the ground, adding to the complexity of the issue. For instance, the 2019 “Project de l’education inclusive” by

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<sup>19</sup> Dr. Mohammed Hassar, Interview 16 November 2021 by Christa Shipman.

<sup>20</sup> Segalla, Spencer D. “Poison, Paralysis, and the United States in Morocco, 1959.” In *Empire and Catastrophe: Decolonization and Environmental Disaster in North Africa and Mediterranean France since 1954*, 78. University of Nebraska Press, 2020.

<sup>21</sup> Segalla, 84.

<sup>22</sup> Babas, Latifa. “Poisoned Cooking Oil, Morocco’s Most Tragic Sanitary Catastrophe.” En.yabiladi.com. Accessed December 10, 2021. <https://en.yabiladi.com/articles/details/92915/poisoned-cooking-morocco-s-most-tragic.html>. 2020.

l'Observatoire Marocain de l'Education Inclusive (OMEI) showed that 55.1% of children with a disability are not enrolled in school, but it did not change much in practicality.<sup>23</sup>

In 2005, His Majesty King Mohammed VI launched “The National Initiative for Human Development,” (Initiative Nationale pour le Developpement Humain or INDH), which put in motion many social welfare projects for people with disabilities. INDH works “for the dignity of people with special needs, thus helping to promote their integration into society.” Part of the initiative enabled the setup and functioning of specialized centers across the nation, and a 2019 report stated that the INDH has led 1066 projects and invested 462 million dirhams to improve the lives of 150,000 people over the course of the three years prior.<sup>24</sup> INDH as a broad program serves not only the disabled, but populations of varied backgrounds, such as the vulnerable/those in precarious situations, the aged, and infants & young children.<sup>25</sup>

As far as international legislation goes, an important anti-discrimination law from the UN is the Convention on the Rights of People with Disabilities or CRPD. The CRPD outlines eight crucial principles of the law in Article 3,<sup>26</sup> and nations were invited to sign and ratify it after March 30<sup>th</sup>, 2007. Morocco signed it on April 8, 2009, three months before the United States.<sup>27</sup>

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<sup>23</sup> jm. 2021. “Maroc/Education Inclusive : La Scolarisation Des Enfants En Situation de Handicap En Hausse de 55,1%.” Journal Educ’Action. October 28, 2021. <https://eduactions.org/maroc-education-inclusive-la-scolarisation-des-enfants-en-situation-de-handicap-en-hausse-de-551/>.

<sup>24</sup> “International Day of People with Disability: INDH Reinforces Mobilization to Provide Care to the Disabled | MapNews.” 2021. Wwww.mapnews.ma. Accessed December 10, 2021. <https://www.mapnews.ma/en/actualites/social/international-day-people-disability-indh-reinforces-mobilization-provide-care>.

<sup>25</sup> “Programme 2 : Lutte Contre La Précarité.” 2019. INDH. Accessed December 10, 2021. <http://www.indh.ma/lutte-contre-la-precarite/>.

<sup>26</sup> World Health Organization. 2011. Review of *World Report on Disability*, 9. [https://www.who.int/disabilities/world\\_report/2011/chapter1.pdf](https://www.who.int/disabilities/world_report/2011/chapter1.pdf).

<sup>27</sup> Nations, United. 2014. “CRPD List of Countries: Convention, Optional Protocol Signatures, Ratifications.” Disabled World. Disabled World. September 22, 2014. <https://www.disabled-world.com/disability/discrimination/crpd-milestone.php>.

In 2009 the president of the National Council of Human Rights (Conseil national des Droits de l'Homme or CNDH) announced at an international convention that Morocco signed in law 62.09, a law which promotes the protection of persons with disabilities. However, this law was never adopted, but rather withdrawn with the reassurance that a new bill to defend the rights of persons with disabilities would be launched at the end of 2013.<sup>28</sup> A new bill was indeed created in June 2014, law 97.13, although it was “ultimately vague and ineffective.”<sup>29</sup>

The February 20<sup>th</sup> Movement of 2011 was a bold move as the Moroccan people demanded a new constitution and several radical changes. Among the various issues brought to the forefront, including recognition of the Amazigh culture and language, women’s rights, and promotion of democracy, fair and just treatment for the disabled was little mentioned. However, the new 2011 constitution following the movement outlined the rights of its citizens, and these included, in Article 31, the right to healthcare and the right to social protection (including medical coverage).<sup>30</sup> Additionally, Article 34 stated that it was the role of public powers “to rehabilitate and integrate into social and civil life the physically sensory-motor and mentally handicapped and to facilitate their enjoyment of the rights and freedoms recognized to all.”<sup>31</sup> Although these were grand steps forward, in reality, like other topics addressed by the new constitution, the application of such articles has been “too little, too late.”

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<sup>28</sup> Yassine, Benargane. 2013. Review of *Appel à La Mise En Place d'Une Stratégie En Faveur Des Personnes Handicapées. Au Fait Newspaper*, January 17, 2013. <https://www.morocco-foundation.org/appele-a-la-mise-en-place-dune-strategie-en-faveur-des-personnes-handicapees.html>.

<sup>29</sup> Beasley, Julia. 2019. “The Disabled Experience in Morocco: A Struggle Between Agency and Capacity,” 9-10. Rabat, Morocco. Used by permission of SIT Academic Director Taieb Belghazi.

<sup>30</sup> *Morocco's Constitution of 2011*, 11. 2012. [https://www.constituteproject.org/constitution/Morocco\\_2011.pdf?lang=en](https://www.constituteproject.org/constitution/Morocco_2011.pdf?lang=en).

<sup>31</sup> *Morocco's Constitution of 2011*, 12.

## Moroccan Healthcare Access

What we are discussing here is not only care for people with disabilities in general, but specifically access to healthcare and health supports. UNICEF addresses the right to a good quality of life for children in its report “Promoting the Rights of Children with Disabilities”:

Under article 24 of the CRC, every child has the right to enjoy the highest attainable standard of health and to have access to facilities for rehabilitation and the treatment of illness. Once a child is identified as having an impairment, however, other normative conditions may be overlooked, including basic health care. In countries where access to basic medical services is generally difficult, it is likely to be significantly more difficult for children and adults with disabilities to obtain proper medical treatment.<sup>32</sup>

Healthcare access is problematic not only for the leaps and bounds that need to be taken to improve access, but for the low quality of services provided once a patient arrives to a clinic, hospital, or center, as we shall see in this paper’s Findings to follow. A 2018 comparative study of Morocco and Tunisia contributes three extremely valuable points to the conversation surrounding healthcare access in Morocco:

- 1) First, the overall healthcare capacity is lower in Morocco than in Tunisia... Morocco has 0.9 hospital bed and 0.618 physicians for 1000 inhabitants compared to 2.1 and 1.648 respectively in Tunisia in 2012 and 2014 (World Bank, 2017).
- 2) Second, access in Morocco has been shown to be particularly difficult for the poorest and for rural populations (Semlali, 2010). To date, the new social security system for the most deprived (régime d'assurance-maladie des économiquement fa-ibles (Ramed)) only covers a minority of

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<sup>32</sup> Innocenti Research Center, ed. 2007, 15. Review of *Promoting the Rights of Children with Disabilities*. Florence, Italy: The United Nations Children’s Fund (UNICEF). <https://www.unicef-irc.org/publications/pdf/digest13-disability.pdf>.

potential beneficiaries (Chaouiet al., 2012)...only 30% of the rural population live within 5 km from the closest healthcare facility in Morocco.

3) Finally, evidence shows that persistence of attitudinal barriers towards persons with impairment further limits access as well as impedes the offer of appropriate services (World Health Organization and World Bank, 2011; Parsonset al., 2015; Munthali et al., 2017).

Qualitative interviews demonstrated the persistence of discriminatory attitudes in the health system of Morocco while discrimination was also reported as a widespread social behavior in both countries.<sup>33</sup>

Points one and two demonstrate why improved access is desperately needed in Morocco, particularly the rural areas, and the third point is exactly what this study set out to examine. “Attitudinal barriers” and discrimination are the types of social barriers which impede successful treatment and rehabilitation for those most in need of it.

Similar to the comparison between Tunisia and Morocco, healthcare access is more easily measurable when one has a baseline. As a student from the US with a sister who has special needs, my baseline is accessibility in the United States and specifically the Pacific Northwest. Upper class families with excellent insurance and poverty-level families with state insurance have access to a wide range of care and therapy options. However, middle class families, not granted those options, can afford only subpar care for themselves and/or a child with a disability. But even they have the benefit of research teams from teaching hospitals, such as Oregon Health & Science University (OHSU)<sup>34</sup> where whole teams of specialists troubleshoot health problems

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<sup>33</sup> Trani, Jean-Francois, Parul Bakhshi, Derek Brown, Dominique Lopez, and Fiona Gall. 2018. “Disability as Deprivation of Capabilities: Estimation Using a Large-Scale Survey in Morocco and Tunisia and an Instrumental Variable Approach.” *Social Science & Medicine* 211 (August): 56. <https://doi.org/10.1016/j.socscimed.2018.05.033>.

<sup>34</sup> “About OHSU Health Care | Health Care | OHSU.” n.d. [www.ohsu.edu](http://www.ohsu.edu). Accessed December 11, 2021. <https://www.ohsu.edu/health/about-ohsu-health-care>.

of an individual experiencing disability. For instance, the Down syndrome care team at OHSU includes a neurologist, audiologist, psychologist, as well as physical, occupational and speech therapists. Healthcare Worker #2 from this study's research shared that several of these professions, such as speech therapy and physical therapy, are fairly new to Morocco, so there is a shortage of workers and prices are exorbitant.<sup>35</sup> Research teams at teaching hospitals are not a common occurrence.

In every culture, impairment sets a person apart so that it is difficult for him or her to be accepted as normal within the community; but disability presents a greater challenge in some cultures than others. This can be due to prejudices or mindsets in various areas. These prejudices change over time with increased knowledge and education. In the United States fifty years ago most children with Down syndrome were institutionalized and not expected to live past the age of twenty, whereas now this disability is better understood, and families strive to keep their child in the home and work toward independence and societal integration. As we have opportunities to show the example of successful persons living with impairment, the mindsets change, and hope grows that a full, meaningful life is possible. To use the social model, "disability" disintegrates although "impairment" remains.

When discussing health care access in general, one viewpoint from the field of sociology is to examine the link between access and "social capital," which was loosely defined by Robert Putnam in 1995 as "features of social organization, such as trust, norms and networks, that can improve the efficiency of society by facilitating coordinated actions."<sup>36</sup> Essentially, relational

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<sup>35</sup> Healthcare Worker #2. 26 November 2021 Interview by Christa Shipman.

<sup>36</sup> Pitkin Derose, Kathryn, and Danielle M. Varda. 2009. "Social Capital and Health Care Access." *Medical Care Research and Review* 66 (3): 272–306. <https://doi.org/10.1177/1077558708330428>.

connections are valuable, and will strongly affect all aspects of life. This is especially pertinent in Morocco, since North Africans are very relational people. The idea of social capital becomes useful to public health researchers for investigating healthcare access because access, in general, is not based on an individual framework, but communities. In other words, health is impacted as much by community support (or lack thereof) as it is by individual choices, if not more so. As an example, in every country around the globe, support groups and networks help parents and families experiencing disability to find encouragement and success. The journal article on social capital points out:

Community organizations can facilitate relationships and trust between health care providers and marginalized communities... Furthermore, when community representatives or organizations...provide community-based services, they can offer protection from potential discrimination and even recourse and accountability for poor treatment.<sup>37</sup>

Although the research in this paper does not operationalize social capital directly, the underlying concept can be found in questions related to support from family and friends, how the community thinks about disability, etc. Interviews and observations with multiple players in the “healthcare and disability” conversation contributed to a well-rounded perspective of the community’s impact on healthcare access.

### **Methods**

My study approach involved face-to-face interviews with people with disabilities and their caregivers, healthcare providers, and social workers/non-profit activists as well as personal observations. Sampling methods were fitted to the Moroccan context, which means mostly carried out face-to-face beginning with a personal or digital introduction. Participants were

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<sup>37</sup> Pitkin, et. al.

invited to take part in the study through contacts mainly at associations. I made a distinct effort to maximize in-person interviews whenever possible; however, in some cases, because of physical distance or scheduling, the participant sent their responses in survey form via email or a Zoom virtual interview was conducted. I chose to perform one-on-one interviews as opposed to focus groups or other methods because it allowed for a deeper level of sharing. My methodological strategy was informed largely by a 2017 research project titled “Cultural barriers to access in healthcare services for people with disability in Iran: a qualitative study.”<sup>38</sup> Impressive in its scope (50 participants were interviewed over the course of a year), the similarity in topic and setting (Iran is also a patriarchal, majority Islamic nation) prompted me to take cues from their tactics, down to using an adapted version of their interview guide (see Appendix).<sup>39</sup>

When beginning each interview, the project was explained carefully, including who would see the final paper and that each person would be kept anonymous (anyone named in this writing is an activist or leader of an NGO who gave permission to be recognized). If the participant gave oral consent, then the interview continued. No individuals denied consent. Participants were also asked if they were fine with the conversation being recorded for the researcher’s personal use in checking notes transcribing later. Interviews took place in Moroccan Arabic with translation, in French with translation assistance if needed, or in English if the participant spoke English. One interview with the leader of an NGO was in Italian with translation—“whatever works, just be flexible” seems to be the theme of fieldwork!

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<sup>38</sup> Soltani, Shahin, Amirhossein Takian, Ali Akbari Sari, Reza Majdzadeh, and Mohammad Kamali. 2017. “Cultural Barriers in Access to Healthcare Services for People with Disability in Iran: A Qualitative Study.” *Medical Journal of the Islamic Republic of Iran* 31 (1): 293–99. <https://doi.org/10.14196/mjiri.31.51>.

<sup>39</sup> Soltani, et. al, 7/Journal p. 299.m



The goal was to include a wide range of ages and disabilities; this goal was inhibited by early departure from the country when our program decided all students would leave immediately because of an impending border closure due to announcement of the omicron COVID variant. However, the number of contacts made and interviews which did happen is surprising considering the limited time span and other barriers involved (discussed more fully in the Limitations section at the end). One exception to the broad sample set is that no participants were involved who are regularly begging or in situation of homelessness. The rationale for this was two-pronged: 1) to protect the participant: It was desirable to speak with people who have social support from family, friends, etc., because of the sensitive nature of the subject, and 2) to protect the researcher: interviewing someone who is regularly on the streets of Rabat and would afterward interact with her could create awkward and unsafe dynamics. This limitation is regrettable, however, because there is surely a wealth of knowledge to be gained on cultural and social influences to access from persons in such situations. Tables 1 and 2 summarize the study participants.

*Table 1.* Sample set of people with disabilities who were interviewed

Age	19, 42, 59 years old
Gender	3 male, 0 female
Diagnosis of disability	Polio, Down syndrome, visually impaired

*Table 2.* Supporting interviews

Healthcare professionals	physical therapist, speech therapist
NGOs/Associations	1) Organismo di Volontariato per la Cooperazione Internazionale (OVCI) in Rabat & Temara 2) Bouregreg Association in Sale 3) Centre Social Kariat (CSK) in Sale 4) Centre Socio-Educatif des Personnes en Situation d'Handicap in Ait Baha

Data was analyzed using content analysis, i.e. coding and extrapolating themes from surveys or transcripts of interviews. After a careful search, ten main themes emerged, as seen in the descriptive coding chart below.

*Table 3. Descriptive Color Coding for ISP*

Colors applied to words or phrases in interviews transcripts which represent the highlighted description below
1. <b>RAMED insurance not sufficient, services too expensive, poverty</b>
2. <b>Public/private healthcare divide</b>
3. <b>Not able to care for the severely handicapped</b>
4. <b>Family &amp; social support is extremely important</b>
5. <b>Lack of staff, and therapists not appreciated or respected/not paid</b>
6. <b>Lack of understanding of disability</b>
7. <b>Stigma/shame/taboo/fear</b>
8. <b>Work on shifting mindset of parents</b>
9. <b>Medical translation not provided</b>
10. <b>Other:</b> poor behavior of health professionals (x2), poor infrastructure (x4), corrupt associations (x1)

### Findings

The ten descriptive codes are, of course, simplified summaries of the themes which emerged in interviews. While they are not organized in any manner, only as they became clear during data analysis, I will begin with the five related to physical/tangible barriers and finish with five related to unseen/intangible barriers (mindset, stigma, etc).

The first and most frequently called to mind when a conversation begins on “access” is covered in #10 “Other,” as “poor infrastructure.” It is similarly spoken to by #3 “Not able to care for the severely handicapped.” Although lack of infrastructure is not the main focus of this study because it relates more to policy than to societal and cultural barriers, admittedly it is an

important issue. In observations of the Rabat-Sale area and other cities in Northern and Southern Morocco, the physical landscape can be challenging to navigate for any person, let alone someone in a wheelchair, with visual impairment, or trying to overcome behavioral difficulties, to name a few. The downtown area of Rabat is one of the best to navigate, but even then the smooth paving stones become slick in the rain. Old medinas offer their own challenges with bumpy, uneven or potholed areas; and rural villages may be outfitted with no concrete at all but rather dirt roads. Dirt roads aren't a big problem for most of the year, but I imagine when it rains that the story changes. Infrastructural barriers mentioned by study participants included how most buildings do not have ramps or elevators (and schools are no exception), they are not prepared to work with people with severe disabilities (either because of lack of training or lack of facilities such as adapted toilets), and how transportation is costly and difficult (buses used to be free for the disabled in Rabat-Sale but are not anymore).

Secondly, a barrier which came up in all but one of the eight interviews was expense and inadequate health insurance. Like Trani, et. al. discovered in their 2018 comparative survey of Morocco and Tunisia, RAMED, the public health insurance scheme for low-income families, is only available to a minority,<sup>40</sup> and, as my study participants pointed out, it is not specific to the healthcare needs of people with disability because the scheme covers vulnerable populations of all types. Additionally, RAMED does not pay for medicines and some centers are only supposed to accept those who have RAMED, even though there are many others who need help.

Healthcare Worker #1, a physiotherapist, stated that “The care of a disabled person is random. The state fails to reimburse all their medical or paramedical care. As for insurance, it only covers

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<sup>40</sup> Trani, Jean-Francois, Parul Bakhshi, Derek Brown, Dominique Lopez, and Fiona Gall. 2018. “Disability as Deprivation of Capabilities: Estimation Using a Large-Scale Survey in Morocco and Tunisia and an Instrumental Variable Approach.” *Social Science & Medicine* 211 (August): 56. <https://doi.org/10.1016/j.socscimed.2018.05.033>.

70% of these costs, with an annual ceiling.”<sup>41</sup> Health insurance for someone with a government job is better. But, without health coverage, out-of-pocket care is virtually impossible for the working class. For example, the cost of one session of physical therapy is 300 dirham (about \$32 USD), which in the Moroccan economy means ongoing care is too expensive even for wealthier families.<sup>42</sup> We can assume this refers to public care, because Healthcare worker #2, an “orthophonist” (speech therapist) stated that a private therapy session can cost exorbitant sums of up to 3,000 or 4,000 dirhams per visit.<sup>43</sup> When one considers, too, that apart from healthcare, the norm is that parents must pay for a personal aide to assist their child in school, extra costs keep adding up. Thus, poverty and financial accessibility is a big issue, tied in with the need for improved social assistance.

Thirdly, as we continue with tangible barriers, two themes are closely knit together: the more relevant one is #2 “Public/private healthcare divide,” and in its shadow comes #9 “Medical translation not provided.” Overall, private care was spoken of highly and public care not favorably. The reason translation is nested into the public/private divide is because I was informed that private hospitals are more likely to make an effort to speak the language the patient understands or to provide a translator, although the usual method for this was cited as finding a family member or staff member nearby who speaks the language and can help out.<sup>44</sup> More grievous than lack of translation was the difference in quality of care provided at public vs. private institutions. To contrast ability to speak to a practitioner in private: In a private hospital or clinic – yes, they provide a private room (but these clinics are expensive!); in a public facility

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<sup>41</sup> Healthcare Worker #1. Survey response 23 November 2021 by Christa Shipman.

<sup>42</sup> Braghini, Alessandra. 24 November 2021 Interview by Christa Shipman

<sup>43</sup> Healthcare Worker #2. 26 November 2021 Interview by Christa Shipman.

<sup>44</sup> Participant #2. Interview 26 November 2021 by Christa Shipman.

– No, they don't respect privacy. There are big rooms with many people (BUT it's free). And to contrast whether treatment is discussed fully: "They do better at explaining everything to parents in private hospitals. They don't do well in public hospitals. 'If you want great treatment you have to pay!'"<sup>45</sup> This last sentiment, sadly, can be said of many healthcare facilities globally (although this does not excuse it). Lastly, behavior of doctors, nurses, and other providers was said to be greatly improved in private facilities, i.e., less talking in loud voices or rude bedside manner. If public facilities are free but patients will not attend them because of past negative experiences, this is a significant barrier to care, because they may not be able to afford private services.

To wrap up the tangible barriers to healthcare access, there should be mention given to the lack of qualified, trained staff available to care for the needs of children and adults with handicaps, as well as the lack of respect for those who are currently working (#5 in the coding chart). Among NGOs the cry for "help! more staff!" came through loud and clear. But more disturbing than this was the fact that COVID has been a difficult season and one of the ways it affected healthcare is that therapists working for the state have not been paid for almost a year and half. A frustrated provider said it this way:

"We are competent professionals, but we're not taken care of in basic things like salaries. How can we work for 12-16 months and be recognized as professionals, yet not be respected when it comes to being paid? How can the treatment of people with disabilities and recognition of professionals evolve if they are not respected on the basic terms?"

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<sup>45</sup> Participant #2. Interview 26 November 2021 by Christa Shipman.

The budget allocated for the handicapped should be *sacred*. It's not even about the money itself, but our dignity. We are doing everything we can and we're not recognized."<sup>46</sup>

Transitioning into intangible barriers, the first one to address is #4, the importance of family and social support. This is vital for the success of each one of us, and particularly for a child or adult who must overcome the daily challenges of physical or mental impairment. One NGO interviewed, Centre Social Kariat, stressed that they focus on helping children leave their homes to do activities out in the community "because they can't without someone to help."<sup>47</sup> The mental, emotional, physical and financial stress of caring for a child with disability can be a heavy burden, a burden which most often falls to the mother. When asked if they had good social and familial support, responses by participants were varied, from "Yes," to "Yes, but it's not automatic," and "It depends." One participant asserted proudly that he is autonomous, which is a big deal, "so important!"<sup>48</sup> Healthcare Worker #1 pointed out that poor insurance makes it even more necessary for a person with a disability to be able to depend on their family and community. She gave a positive view of Moroccan society's response to this need: "In Morocco, our culture obliges us to help each other; for example, the physiotherapist can volunteer, the pharmacist can sell medicines on credit, the doctors can treat us at a lower cost. Fortunately, we are in a country where the charity and solidarity of citizens count enormously, thanks in part to the religion."<sup>49</sup>

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<sup>46</sup> Healthcare Worker #2. 26 November 2021 Interview by Christa Shipman.

<sup>47</sup> Healthcare Worker #1. Survey response 23 November 2021 to Christa Shipman.

<sup>48</sup> Participant #1. 24 November 2021 Interview by Christa Shipman.

<sup>49</sup> NGO Centre Social Kariat (CSK). 6 December 2021 Phone Interview by Christa Shipman.

The second intangible barrier is #6, “lack of understanding of disability.” Associations included in their goals “the desire to address a lack of understanding on how much a child or adult with disabilities can learn or behaviorally and physically improve with the right treatment/teaching.”<sup>50</sup> One participant, who is the mother of a child with a disability, shared her personal story of how she had studied her son’s specific impairment in secondary school, unknowing that it was helping her prepare in advance. She commented on the fact that not all mothers can educate themselves on their child’s situation.<sup>51</sup> When impairments are not understood, they cannot be addressed properly. A sense of fatalism and hopelessness may inhibit steps toward improved wellness and integration.

This leads us to the next code of barriers discovered in this study: #7, “stigma, shame, taboo, or fear.” The overall theme of coding related to this color was that society has a negative, stigmatized view of disability. Doctors will tell parents “He’s normal” about their child and not explain the diagnosis well,<sup>52</sup> something which contributes to fear because of the knowledge gap. Participant #3, in his own words, said, “We label people with impairments, stigmatized labeling. There are negative perceptions.”<sup>53</sup> Other difficulties mentioned were lack of respect for and acceptance of the disabled, doctors afraid to treat patients thinking they might damage the situation further, taboo because of a feeling of shame for having a child with a disability (and subsequent hiding away of children from the public), having pity on a person instead of considering their capacity, and negative interactions with nature especially animals. This last point came out of a conversation on therapy horseback riding implemented by one of the

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<sup>50</sup> NGO #2. 2 December 2021 Survey Response to Christa Shipman

<sup>51</sup> Participant #2. Interview 26 November 2021 by Christa Shipman.

<sup>52</sup> Participant #2. Interview 26 November 2021 by Christa Shipman.

<sup>53</sup> Participant #3. Phone Interview 7 December 2021 by Christa Shipman.

centers.<sup>54</sup> The leader stressed that the program promotes coordination, posture, and respect for animals instead of fear. I reflected on how the fear of animals aspect comes into play specifically with dogs; the older generation in North Africa has a low regard for dogs, sometimes exacerbated by the belief that they may have evil spirits. This is changing with the younger generations who are influenced by social media. This same organization, founded 35 years ago, had positive words to say about how the “ashamed of myself/my child” mentality has been improving. They recounted, “35 years ago it was way worse. Being born handicapped was like a curse, like being born with -5 points. For example, a child would be left in a corner at a restaurant, not sitting at the table with the family, because they are ashamed of him. Children with disabilities would also be used to beg.”<sup>55</sup>

With all this talk of negative perceptions, you can imagine that excitement is stirring to work on shifting the mindset (#8). This conversation revolves around deconstructing the narrative that a child with a disability is a burden. After undoing the idea that an impairment is a problem/disease and a weight on the family, healthy foundations which legitimize the person’s innate worth and capacity to contribute can be built in its place. The fatalism referred to earlier sometimes shows up in the belief “It’s all according to God’s will, so there is nothing I can do about it.” This interesting interpretation of destiny, although legitimate in certain situations, is a huge hurdle for those facing incapacitating struggles. Why accept brokenness passively? Some innate parts of who we are do not need to be fought against, yes—for example, autism gives a person unique abilities and strengths, almost “superpowers” if you will, just as much as it gives problems of a sensory, communication or behavioral nature. However, a friend of mine in the US

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<sup>54</sup> NGO Centre Social Kariat (CSK). 6 December 2021 Phone Interview by Christa Shipman.

<sup>55</sup> NGO Centre Social Kariat (CSK). 6 December 2021 Phone Interview by Christa Shipman.



faces a comparative hurdle with mental illness and responses from acquaintances in her Christian faith community: the thinking is frequently either shame-based, that she simply needs to be more spiritual, or that nothing is wrong, all that is needed is to accept God's will for her life in this matter. This response is not only unhelpful, but painful to her. Personally, I do not believe in a God who desires to inflict pain, but rather to heal.

The final point related to intangible barriers has to do with the quality of services provided, not at health care facilities, but at associations. Since the launch of The National Initiative for Human Development in 2005, thousands of dirhams have been provided to open and run centers serving populations with disabilities. However, an anonymous participant pointed out that a significant issue arose, that of corruption. Centers were operating poorly because the money made its way into the pockets of the leaders. This resulted in more stringent regulations related to founding and running centers, and the shutting down of many of them. Although frustrating and disappointing, the participant who mentioned this reflected that perhaps it is better to have a few good, effective associations than numerous ineffective ones.

Observations also contributed to the full picture of life for people with disabilities in Morocco. My first observation experience came unexpectedly. While on a class excursion to the south, a group of young politicians and community leaders hosted us in their Amazigh village of Ait Baha, in the Atlas mountains. When I asked one of them where she works, I was surprised to hear that she was a social worker who teaches children with disabilities! She and a few friends made time for me to visit her school that afternoon, "Centre Socio-Educatif des Personnes en Situation d'Handicap in Ait Baha." I was surprised at the size and completeness of services offered there—multiple classrooms, physiotherapy room, dining/socialization area, and parent counseling room. The center provides transportation for all the children, including those in

wheelchairs, and they are the only center like this in the region. Funding comes from national initiatives as well as non-governmental organizations. I realized that the work of the school is incredible not only from the view of an educator, but because they are providing health and wellness services which would be completely inaccessible otherwise. Even deeper than that, by investing in the lives of these children parents begin to see the innate worth and potential of their child, truly an invaluable contribution.

My second observation experience came during a day at a project run by the Italian NGO called OVCI. We visited a school in Temara which allows them to use rooms for therapy programs, and I had the opportunity to observe two sessions. With an autistic girl, age 8, I noticed the great love and compassion shown to her as the teacher worked on memory, numbers & colors. Recognizing my positionality as an observer, I made sure to place myself behind/off to the side of the child and therapist so as not to interrupt the session. With another young boy, I saw the differences in how the Italian volunteer interacted with him versus the Moroccan teacher. The Italian “psychomotor therapist” interacted with the boy in a more child-led instead of teacher-led way; she tried to catch the child’s attention or interest and motivate him to get involved. In contrast, the Moroccan therapist was very hands-on. She took a stricter approach, seeming to follow a more authoritarian structure. For example, she said “shuma!” to correct him and get his focus back on track. They also had great use of the sensory ball! My conclusion from this observation experience is that cultural differences affect the style of therapy practiced. As is true of different cultures, one style is not better, it is simply different. They both have their strengths and weaknesses.

Another huge privilege was meeting the physical therapist who participated in this study at her workplace, so I could see an outpatient clinic in Morocco firsthand, including treatment

rooms, changing rooms, a pool for aquatic therapy, and reception and offices on the inside, as well as the entrance area with steps and a wheelchair ramp on the outside. Observing a medical clinic helped me have a more complete perspective of my topic.

As the course of the research went on, I found myself noticing persons with disabilities in a way I hadn't before. Walking around Rabat, I observed deaf people signing to each other, physically impaired people begging in busy areas, and girls with Down syndrome walking holding the arm of their mothers. Curiously, I started to imagine life in their shoes, something which stretched me to grow in compassion. There was an openness and community acceptance present, a feeling that the city is welcoming for all; on the downside, an attitude of pity still presides, as seen in how profitable begging is for those with a physical handicap.

### **Conclusion**

This paper set out to examine how social and cultural factors influence access to healthcare for people with disabilities in Morocco. The explorative journey of academic study and cross-cultural field research resulted in the confirmation of my hypothesis that people with disabilities struggle to obtain needed healthcare because of inhibitive mindsets, perceptions, and beliefs. It was found, firstly, that both tangible and intangible barriers exist. Just as current researchers are attempting to find a healthy integration of what "disability" means, healthcare access is a multi-faceted subject which must be addressed in more than one way. For example, a better health insurance or social scheme would assist immensely in removing financial barriers, but what about stigma and lack of respect, or the need for societal integration? There is much work to be done. My hope is that this small project contributes to the conversation surrounding disability, healthcare access, and needed human rights developments, and that it can be a motivator for continuing activism and support of disability rights. Globally and locally, mindset

shifts can happen, shifts which will radically improve the experience of our friends, neighbors, and family members living with an impairment.

### **Limitations of the Study**

It can be openly admitted that this study encountered multiple limitations.

One shortcoming was the language barrier and difficulty finding translation. For two of the interviews there was little to no translation, but I was understanding the French being spoken quite well and the colleagues translating for me verified that my notes were correct. However, I could easily have misunderstood or misinterpreted information from these interviews. Other feedback came in French and was translated using Google translate, or was received as responses written in English, the second or third language of the speaker.

My various identities impacted fieldwork in unique ways as well. As an American, English-speaking student, I was cautious of a power differential affecting matters. For this reason, I relied on Moroccan contacts to invite participants, which slowed down my ability to make contacts and set appointments. When I did come for interviews, the cultural and linguistic barriers could be frustrating for both parties. In my first interview, a participant informed me that I should speak French or Arabic and that if he came to the US, people would not understand him in Arabic, he would have to learn English. This was humbling, and I felt ashamed to have mentioned I studied Arabic in our program, because it seemed I didn't have much to show for it; a shortcoming is these negative emotions could have colored the interview experience and imperceptibly affected data. It was important in every fieldwork encounter to carefully explain my identity: that I am an undergraduate student, not representing any organization, there to listen and learn from them, and conducting research for a school project.

Lastly, my personal interests (prior work volunteering with disabled populations, as the sibling of a special needs child, and as a future physical therapist) have surely given me a biased view on the subject area. Perhaps I overestimated the relevance of the topic, unconsciously limited inclusion of health professionals from mainstream medicine, or even allowed the story of myself and my sister to emotionally sway participants. In each situation I was aware of this last point, and I took care to never use it for manipulation.

### **Recommendations for Further Study**

An area for further research studies to explore is that of inadequate infrastructure. This is a topic which came up but could not be addressed fully in this project. Another relevant topic is inclusive education, both the strengths and weaknesses which currently exist and how access to education can be improved for the disabled in Morocco. In addition, because this study was so limited in scope, a more in-depth study of social and cultural influences would be beneficial.

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## Appendix

### Questionnaire/interview guide utilized

#### **TOPIC: Disability and Healthcare Access in Morocco: Social & Cultural Influences**

(Introduction: Who I am, getting to know them, about the study, verbal consent, time it will take)

#### **ISP Interview Guide for Participants with Disabilities**

1. Your age
2. Your disability
3. What healthcare needs specific to your disability do you have?
4. Is access to healthcare a problem for you? If yes, please describe how.
5. Do you/people with disability have all the support that you/they need from family and friends?
6. Does the community think negatively about someone who has a disability?
7. In a clinic are you/people with disability able to talk to the doctors or nurses in private?
8. Do doctors & nurses (health workers) speak languages you/people with disability prefer?
9. Do health workers treat you/people with disability with respect?
10. Do health workers discuss treatment fully with you/ people with disability?

#### **Interview Guide for Healthcare Workers**

1. In your opinion, are societal & cultural problems effective to decrease access to health care for people with disability? How?
2. Are conditions in your facility suitable to serve clients with varying types of disabilities?
3. How does health policy (insurance, etc.) influence care of people with disability?
4. How do you think culture & society affect access to healthcare for those with disabilities?
5. Is there any further issue you would like to add?

#### **Above questions adapted from:**

Soltani, S., Takian, A., Sari, A. A., Majdzadeh, R., & Kamali, M. (2017). Cultural barriers in access to healthcare services for people with disability in Iran: A qualitative study. *Medical Journal of the Islamic Republic of Iran*, 31(1), 293–299. <https://doi.org/10.14196/mjiri.31.51>

#### **Questions for Social workers/NGOs/Activists:**

1. What needs does your center meet that would go unmet if your center/NGO wasn't working in this area?
2. Are there any cultural or social mindsets/perceptions/beliefs that make it difficult for people with disabilities to do well in Morocco? If so, what?
3. What is one of the biggest challenges your center/NGO faces currently?
4. What else would help those you serve be successful?