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Refugee and migrant access to health in transit countries

Politics of adaptability, enactment of slow death and inevitability of pain: An ethnography of a poor urban neighbourhood in Rabat (Morocco)

ARMA, The Arab Master's Programme in Democracy and Human Rights

NOURAN EL-HAWARY

REFUGEE AND MIGRANT ACCESS TO HEALTH IN TRANSIT COUNTRIES
POLITICS OF ADAPTABILITY, ENACTMENT OF SLOW DEATH AND INEVITABILITY OF PAIN: AN ETHNOGRAPHY OF A POOR URBAN NEIGHBOURHOOD IN RABAT (MOROCCO)

FOREWORD

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This publication includes the thesis *Refugees and Migrant Access to Health in Transit Countries: Politics of Adaptability, Enactment of Slow Death and Inevitability of Pain: an Ethnography of Poor Urban Neighborhood in Rabat (Morocco)* written by Nouran El-Hawary and supervised by Jeremy Gunn, International University of Rabat (UIR).

The Institute of Political Science of Saint Joseph University does not intend to give any approval or disapproval to the opinions expressed in this thesis. These opinions belong solely to their author.

BIOGRAPHY

Nouran has been working as rights and advocacy officer in several international non-governmental organizations, concerning disability rights; health and wellbeing of different vulnerable groups. Being trained in social anthropology from the American University in Cairo,she has always accompanied her practice in realm of social development. She is interested in investigating the trickle down of health public policies on vulnerable groups accessibility, by leveraging their own experiences with system(s) and actual voices.

ABSTRACT

This thesis project builds on three months of ethnographic and interview research undertaken between February-May 2019 to explore refugee and migrant access to health in one of Rabat's poor neighbourhoods, Youssoufia, which has a high concentration of sub-Saharan African migrants. Morocco's new National Immigration and Asylum Strategy (2014) officially grants them the right to access primary health care (PHC) on an equal basis with Moroccans. This strategy goes hand-in-hand with the Moroccan government's national attempt to extend universal health coverage (UHC) for the poor and less-advantaged classes in order to achieve social equality and health equity through the proliferation of PHC facilities. Focusing on Youssoufia, the field findings suggest that despite the government's numerous reforms, proper implementation of the strategy was hindered by the poor governance and accountability of the health sector, on one hand, and inadequate multi-stakeholders migration management on the other hand. All that combined with poor social determinants of health among refugees and migrants made them depend on medical alternatives presented in self-medication and popular healing practices. This research challenges the predominant proposition assuming migrants and refugees burden national health resources. Rather, it highlights the fact that promoting refugee and migrant access to PHC has been negatively impacted by the dysfunctional national health systems of transit countries in North Africa that have been subject to a massive disadvantage behind the neo-liberal policies imposed by the Structural Adjustments Programmes (SAPs) of the World Bank that have market-based approaches to health care and the social determinants of health.

'نحن بانموتوا بالبحار و انتوا تتداوا ببلاد الناس ...'

'nhna yanmutu bilbihar aw intu titdau biblad al-nas …'

(we die in the sea and you (state leaders) get medicated abroad)[1]

[1] The previous quote wittily projects the contemporary cynical situation of health in several Arab countries that is marked by the avoidance of states leaders and sometimes high officials from using national medical services and going abroad to Europe and the US for any treatment. It reflects a huge distrust in the system as well as inadequacy. It also communicates the reasons why migration to Europe is motivated. The availability of quality basic social services, like health, promise a minimum of decent living conditions that are disregarded in home countries. 'Liberer L'Algérie' YouTube video, 5:08, from a video clip posted by a group of artists to protest against the 5th mandate of the Algerian president Boutafliqa in February 2019, posted by Oussama Zaine (1 March 2019) <www.youtube.com/watch?v=blYMUHRtZ9Y&t=203s> accessed 18 April 2020.

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TABLE OF ABBREVIATIONS

AMO	The Mandatory Health Insurance
AMPF	The Moroccan Association for Family Planning
BHCs	Basic Health Care Centres
BRA	The Office of Refugees and Stateless Persons
CMA	Critical Medical Anthropology
CNDH	The National Council for Human RIghts
EU	European Union
GBV	Gender-based violence
GDP	Gross domestic production
ICESCR	International Convention for Economic, Social and Cultural Rights
ICPI	The Moroccan Central Authority for Corruption Prevention
IDP	Internal displaced persons
IMF	International Monetary Fund
INDH	The National Initiative for Human Development
IOM	International Organization for Migration
MRE	Ministry of Moroccan Living Abroad and Migration Affairs
NCDs	Noncommunicable diseases

NGOs	Non-governmental organizations
PHC	Primary healthcare
PNPM	The National Migrant Protection Platform
PTSD	Post-trumatic stress disorders
RAMED	Medical Assistance Regime
RSD	Refugee Status Determination
SAPs	Structural Adjustment Policies
SDG	Sustainable Development Goals
UHC	Universal Health Coverage
UN	United Nations
UNGA	United Nations General Assembly
UNHCR	United Nations Higher Commission for Refugees
UNICEF	United Nations International Childern's Emergency Fund
WHA	World Health Assembly
WHO	World Health Organization
WWII	World War II

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INTRODUCTION.

1.1 Background

In order to better understand the latest global health trend of mainstreaming[2] refugees and migrants into the national health system that Morocco adopted, I carried out ethnographic research in early 2019 in a community of sub-Saharan African migrants and refugees in Morocco. The migrants and refugees on whom I focused live in the Youssoufia neighbourhood of the capital city of Rabat. Youssoufia is a densely populated, low-income area of the city. My goal was to evaluate the extent to which Morocco has mainstreamed refugees and migrants into its national health system, mainly through accessing primary health care (PHC) facilities, in response to global health standards of universal health coverage (UHC).

Addressing refugee and migrant health needs through contemporary humanitarian interventions proved inadequate, inefficient and unsustainable. Given the constant rise in international migration, global health approaches have moved towards inclusive practices that place PHC as a main gateway to assure equitable access to all, including refugees and migrants. It follows the grand schemes of UHC enshrined in the United Nations (UN) Sustainable Development Goals (SDG)[3] of leaving no one behind. Morocco uniquely adopted a National

[2] It is an approach to be developed and adapted with vertical services and/or mainstreaming being used within general system to meet the needs of migrants and refugees along the different stages of their pathway. See Stephen A Matlin and others, 'Migrants' and refugees' health: towards an agenda of solutions' (2018) 39 Public Health Rev 27 <www.ncbi.nlm.nih.gov/pmc/articles/PMC6182765/> accessed 18 April 2020.

[3] UNGA, 'Transforming our world: The 2030 Agenda for Sustainable Development', UNGA Res 70/01 (25 September 2015).

Immigration and Asylum Strategy[4] in December 2014 which entails migration mainstreaming into national development strategies, including health. In the health section, the objectives include fostering refugee and migrant access to public PHC facilities for better acknowledgment of their right to health which is an essential human right enclosed in article 25 of the Universal Declaration of Human Rights[5] and article 12 of the International Covenant on Economic, Social, and Cultural Rights.[6] PHC is sought as a perfect embodiment of the right to health through enhancing healthcare accessibility and availability for all with no pressure of distance and affordability.

Mainstreaming policy has been strongly advocated – for years – by many health activists, academicians and practitioners concerned with the precarious health situations of refugees and migrants along migratory routes. Yet, this health policy has not been tested enough. Therefore, in this thesis project, I focus on examining refugee and migrant access to health in Morocco through an ethnography in Youssoufia, a popular area highly condensed with sub-Saharan African migrants and refugees. The ethnographic research tried to understand their access to health through the reality of their everyday experience to unpack policy implementation and discursive claims. The research also attempted analysing interactions of the various actors involved, be they service providers (medical staff), state officials or civil society representatives.

In the beginning of my research, I had a hypothesis suggesting that while mainstreaming refugees and migrants into a national health system is ideal in principle, it fails in practice, especially in transit countries where health infrastructure is already poor and flawed where an ordinary citizen also suffers. In other words, promoting refugees and migrants' access to health relies on weakened national system(s) that have been subject to huge disadvantage behind neo-liberal policies imposed by

[4] It represents the first integral policy of migration in Morocco that aims at making the legislative frameworks for migration, asylum and trafficking of persons to Morocco compatible with obligations entailed by international migration law. See IOM-UNDP Joint Global Programme – Mainstreaming Migration into National Development Strategies, 'Country Overview – Morocco' (*Mainstreaming Migration)* <www.mainstreamingmigration.org/country-overview/morocco> accessed 18 April 2020.

[5] Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III) (UDHR).

[6] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR). See also OHCHR and WHO, *The Right to Health Fact Sheet No 31* (June 2008) <www.ohchr.org/Documents/Publications/Factsheet31.pdf> accessed 18 April 2020.

Structural Adjustments Programmes (SAPs) of the World Bank and the International Monetary Fund (IMF). Therefore, adapting a national health system to mainstreaming refugees and migrants falls at odds with internal drawbacks that make accessing health care more apt to an inevitable slow death, in comparison to more severe death surrounding those who fled hardships be it in their countries of origins, in their ways to Morocco (crossing the arid Sahara) or within the amalgam of excursions to the other side of European Mediterranean shores. At the same time, the lack of aid coordination and delivery coherence exacerbate the pain that refugees and migrants endure.

After my field research in Youssoufia, I learnt that migrants and refugees are less likely to access health care facilities in case of illness and that they rely on other alternatives, of self-medication or recipes they brought from West Africa. Despite the PHC availability in Youssoufia, refugee and migrant access was challenged by the poor social health determinants, a lack of awareness of having a right to access free basic health services, administrative hurdles, linguistic barriers (especially among the Anglophone population) and the expensive cost of medicine. The precarious lives these people lead in Morocco, the lack of trust and agency make them suffer from mental health issues of stress, anxiety and depression. Sticking to social circles, ethos and traditions which they interchangeably refer to as 'West African' help them to adapt and survive hardships.

I was interested in Morocco's model in dealing with migration that has been widely praised in different international and regional platforms concerned with migration management, policies and human rights. Morocco is presented as a leading country in North Africa and the Middle East that has passed ground-breaking policies and decisions tackling migration with consideration of human rights measures, adding to a list of a number of achievements to improve the human rights situation in the country. Yet, the implications of this massive move were not adequately documented, especially in regards to how it enhanced the health conditions and access of the populations concerned.

Refugee and migrant access to health cannot be sufficiently understood without an adequate consideration of the national health care system. The broader structure of healthcare in transit countries impact refugee and migrant access to health to a great extent. In the case of Morocco, refugee and migrant access to health overlaps with a long-term process of political reform the government has initiated to enhance the health

sector and make healthcare more equitable to actualise UHC. The Moroccan government intended on achieving UHC through increasing the number of PHCs to enhance health services and health equity that have been undermined by the SAPs implemented in the 1980s.[7] Despite the initial improvements that Morocco was able to reach in enhancing coverage and quality, these reforms lacked adequate governance, community participation and accountability. This is evident in the locale of Youssoufia where people have little opportunity, or none, to plan, design or feedback on health services provided. The nature of planning, in health provision, is still centralised in Morocco, following a top-down approach by the Ministry of Health. The execution or inauguration of health establishments take place under the patronage of the Palace. It does not only overlook people's needs, but it could also undermine sustainability and planning soundness of existing achievements.

The thesis project tries to contribute to the growing scholarship on migrant and refugee health in the Global South, and accounts for the local conditions that structure their access to health, besides the 'daily experiences of exile'.[8] Refugee and migrant health is a particularly problematic aspect of health in contexts of economic inequalities and the state's failure to ensure equitable health access.[9] That gives a space for the emergence of a hostile nationalist discourse towards immigrants that is always supportive of how refugees and migrants burden national health systems, without a consideration of other structural and institutional factors. Instead, the incoherence of coordinating humanitarian aid and the low levels of non-nationals' participation in decision-making processes are highly evident barriers to accessing health for many refugees and migrants.[10] So, global and national health actions targeting the inclusion of migrants and refugees are not properly designed in line with their needs. When health systems fail to deliver, public discourse usually presents migrants and refugees to be pressuring the country's

[7] Hassan Semlali, *The Morocco Country Case Study: Positive Practice Environments* (WHO 2010) 17 <www.who.int/workforcealliance/knowledge/PPEMorocco.pdf> accessed 18 April 2020.

[8] Sarah E Parkinson and Orkidh Behrouzan, 'Negotiating Health and Life: Syrian Refugees and the Politics of Access in Lebanon' [December 2014] SSM 324, 326.

[9] Claire Lougarre, 'Using the Right to Health to Promote Universal Health Coverage: A Better Tool for Protecting Non-nationals' Access to Affordable Health Care' [December 2016] HHRJ <www.hhrjournal.org/2016/12/using-the-right-to-health-to-promote-universal-health-coverage-a-better-tool-for-protecting-non-nationals-access-to-affordable-health-care/> accessed 18 April 2020.

[10] ibid.

scarce resources in order to deflect the responsibility from governments and institutions in charge. While in fact, reforming the health sector has been a challenging issue with a myriad of problems that undermine its quality and accessibility away from refugees and migrants' advent.

There is little literature that addresses refugee and migrant access to public services in transit countries in the Global South that share a similar type of polity. In the Western welfare state, receiving refugees and migrants resembles a controversial issue in the public sphere for pressuring the social services system, funded by the heavy taxes citizens pay.[11] The same rationale cannot be extended to host/transit countries of North Africa that have divergent circumstances and pace of socio-political and economic development. Migrant and refugee issues intersects with the complex realities of those countries that are characterised as either autocracy or incomplete democracy, in peculiar ways. While low-and-middle-income countries have achieved a decline in infectious diseases and child mortality, their national health system fails to contain heart diseases, cancers and other noncommunicable diseases (NCDs) and injuries.[12] The NCDs are generally more expensive to treat and require more health-care infrastructure, such as hospital beds, surgical facilities and more skilled health workers:[13]

> Past studies have found that the majority of death caused by poor-quality healthcare services in low-middle-income nations are linked to cardio-vascular diseases, congenital defects and tuberculosis, the same diseases and conditions that have lower mortality rates in countries with more democratic experiences … democracies are also more likely to increase government spending on health care.[14]

Morocco witnessed an epidemiologic shift with an increasing burden of NCDs which count for approximately 75% of all deaths.[15] This is an essential factor to consider because it reflects governance and management that affect everyday lives of ordinary citizens. In this sense, migrants and refugees cannot be blamed for burdening the national health system.

[11] Sarah S Willen and Jennifer Cook, 'Health-related Deservingness' in Felicity Thomas (ed), *Handbook of Migration and Health* (Edward Elgar Publishing 2016) 96-118.

[12] Thomas J Bollyky, 'Democracy Matters in Global Health' (*Council on Foreign Relations*, 15 March 2019) <www.cfr.org/article/democracy-matters-global-health> accessed 18 April 2020.

[13] ibid.

[14] ibid.

[15] ibid.

Exploring refugee and migrant access interacts with current health management and governance as well as everyday life which can enhance or diminish their accessing of health care services. That was observed through my ethnography in Youssoufia that aimed to examine the impact of mainstreaming policies, within the human-rights based framework of 'access to health,' as an elaborate operationalisation of the fundamental 'right to health' that describes the minimum requirements to be met by member states. Through the stories and experiences of many sub-Saharan Africans I met in Youssoufia, I attempted at elucidating various aspects of health services access, namely: availability, staff interactions, affordability, quality and conditionalities. It also shows how these aspects of health access tend to influence the health and illness of this particular community. The collected data are analysed through the use of grounded theories of medical anthropology that encompassed all issues related to migrant and refugee health, health policies and the impact of neoliberal economic framework on health systems. Furthermore, it interprets the implementation of human rights within broader experiences and practices, of policy design, refugee and migrant life, the current situation of national health and global commitments through an ethnographic approach. Ethnographies shed light on micro-level dynamics that inform macro-understandings of how the texts and tools of human rights work, and are shaped by legal, political and social complexities.[16]

1.2 Research objectives: Was 'mainstreaming refugees and migrants' in public health a valid policy?

This thesis analyses the Moroccan model of mainstreaming refugees and migrants in the public health system through comparing official Moroccan policies to the actual realities lived by a community of sub-Saharan African refugees and migrants residing in the area of Youssoufia. This is conducted against the operational parameters that determine 'access to health care'. Initially, it aims to assess the adaptability of the domestic system to what unfolds from strategies,

[16] Sally E Merry, 'The Potential of Ethnographic Methods for Human Rights Research' in Bard A Andreassen, Hans-Otto Sano and Siobhan Mclnerney-Lankford (eds) *Research Methods in Human Rights: A Handbook* (Edward Elgar Publishing 2017) 141.

policies and laws to align with human rights standards. It also aims to assess global health policies in favour of mainstreaming that is supposed to reduce suffering, pain and vulnerability of refugees and migrants, through a careful contextualisation. So, the entire project is an attempt to contend and critically assess the enacted global health policies, in the core of migration, from the vantage point of its users, in the community of concern.

The objective is to examine all these dynamics and factors on the micro-scale of Youssoufia which is classified as one of the most populous low-middle class neighbourhoods in Rabat, with a considerable number of sub-Saharan African migrants and refugees. But the focus is on access to PHC that is considered a major milestone in consolidating effective and efficient health access to all, including refugees and migrants. My attempt is also directed to not only analysing gaps but also good practices, especially that Morocco might have yielded upon in its efforts towards reforming the health sector. In the end, I intend to provide context-specific recommendations that might be extended into general practices to achieve and accomplish effective and efficient mainstreaming of refugees and migrants, especially in PHC. Lessons learnt for Morocco's experience may be able to provide insights into other cases.

1.3 Research questions

The questions below detail the objectives of the study in greater detail:

1. To what extent is the mainstreaming of refugees and migrants in the Moroccan public health system compatible with the current state of available health-facilities capacity and quality in Youssoufia?
2. Focusing on the administrative sphere of Youssoufia, how was the implementation of mainstreaming refugees and migrants set-up and implemented at the legal, administrative and executive levels? What are the entities that were engaged and responsible for the whole process?
3. How do refugees and migrants gain access to primary health care in Youssoufia, in terms of conditionality, affordability and provided services? Are the services sufficient for their needs?
4. What is the refugee and migrant experience inside the primary health facilities in terms of staff treatment and quality?

1.4 Research motivation and importance

Reading through the literature of migration and refugee studies, health has always been a top issue, given its innate significance. Academic scholarship across disciplines has played a substantial role in shedding light on the urgency of the matter and highlighting discrimination, vulnerability and deprivation. Scholars of medical anthropology and public health engaged in refugee and migrant health extended their works to advocate for the necessity of mainstreaming refugees and migrants within the public health system. The World Health Organization's (WHO) doctrines now promote 'refugee and migrant mainstreaming' within its large scheme of global UHC. Nevertheless, most studies were directed towards pertaining needs like infectious-diseases control, psychiatric support or prevention of sexual and gender-based violence. The bigger picture in assessing the practicality and functionality of such approaches in developing countries that host a high percentage of refugees and migrants is still underrepresented. This study seeks to provide a contribution within the intersection of human rights, medical anthropology, as well as refugee and migration studies. With extending medical anthropology methodological tradition in exploring the different arrays of construction of health and illness, I intend to explore the effect of policies formulated in regards to refugees and migrants, including access to health/PHC, in the context of being hosted by a transit country, located in North Africa. It allows an opportunity to examine the efficacy of national health systems that have endured several reform waves, distinguishably SAPs implemented in the 1980s that enforced expenditure cuts and market-led measures in exchange with loans from the IMF and World Bank. As Johanna Laue avers, 'refugee health is a "magnifier" for more fundamental aspects' that reflects structural violence and inequality in health which arise from 'poor governance, corruption and cultural exclusion' that she describes to be 'health and healthcare that are hidden in the backyard of modern medicine' and how it is insightful to study 'refugees and other vulnerable, marginal groups who occupy the background of our society'.[17] Hence, this project offers a critique over Morocco's attempts

[17] Johanna Laue, 'Refugee Health and Beyond' poster presented in conference at the University of Tromso – the Arctic University of Norway on exploring global health in the Arctic (Tromso 22-23 January 2018).

to count for refugees and migrants, as a continuing endeavour to abide by a human rights doctrine and ever-intensified government-led urban modernisation processes.

1.5 Conceptual frameworks

The research project is envisaged in relation to two chief conceptual underpinnings that are debated and subject to several developments, in the realms of academia and human rights practice. These conceptual frameworks are the definitions of the differences between a refugee and a migrant, and the relevance of health access to human rights. The differentiation between a migrant and a refugee is getting blurred due to the constant legal and political contentions. Understanding the stakes at the conceptualisation of these categories lays in the crux of the thesis project. The fluid nature of immigration and increasing displacement, witnessed over previous decades, had greater implications on clear-cut definitions, and in turn developing sound and responsive health interventions.

1.5.1 Refugees and/or migrants

My research proposal was initially about 'refugee access to health,' based on the context from which I came.[18] In Morocco, I was forced to broaden my research focus to be on refugee and migrant access to health because the complex reality entangles those two non-mutually exclusive categories. The separation or merging of those generic categories is debatable and concern other issues of institutional injustice, inconsistent policies and lack of systematic human rights protection. Being a migrant or a refugee has been further complicated with the 'migration crisis' in 2015. In my field work, the informants were predominantly migrants, among whom some strongly believe that they qualify as refugees in their assessment. Refugee legal status has more advantages and access to protection and support than the category of a migrant. Yet, the applied criteria that determines who is a migrant and who is a refugee are

[18] In my job as communication and advocacy officer for Medecins du Monde, I worked in Egypt since January 2018 with refugee communities coming from 12 different countries.

not objective enough and highly politicised, especially with the 2015 'migration crisis'. The controversy of being a migrant or a refugee poses a fundamental challenge.

Prior to the 'migration crisis' that touches the nerve of European politics and publics, since the explosion of Syrian refugee crisis, the terms 'refugees' and 'migrants' were rarely combined in literature or policy rhetoric. From this historic moment onwards, 'refugees and migrants' have become a novel combination, addressing new situations of massive displacement and wide xenophobic reactions. In the past, refugees and migrants were treated separately. In particular, each term reflects certain modes of management mandated by international organisations and international legal frameworks. In principle, a refugee is seen as more worthy of support and protection than a migrant who voluntarily left his/her country. A 'refugee' as a concept was demarcated from migration to evoke enforced displacement due to wars, conflicts or disasters. Typically, a refugee is referred to in international law as 'a person who is outside his or her country of origin and who cannot return due a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion'.[19] However, such a distinction – supported by the Refugee Convention 1951 – is rendered irrelevant for two major reasons.

Firstly, addressing refugees and migrants at the same time acknowledges the greater phenomena of irregularity that disturbs nation-state order(s) and borders. Refugees and migrants negate 'citizenship' and evoke peculiarity.[20] Refugees and migrants are governed by distinct and particular policies that affected their lives, identities and self-perceptions. In this context refugees and migrants' access to social services are usually questioned from the basis of 'deservingness' as non-nationals.[21] They are usually perceived as burdens on national resources. This leads to the second reason why refugee and migrant are often used interchangeably. Endorsed polices and actions are driven

[19] Convention Relating to the Status of Refugees (adopted 28 July 1951, entered into force 22 April 1954) 189 UNTS 137 (The Refugee Convention).

[20] Barbara Harrel-Bond and Efithia Voutria, 'Anthropology and the Study of Refugee' [August 1992] Anthropology Today 6, 7.

[21] Sarah Willen, Jessica Mulligan and Heide Castaneda, 'Take a Stand Commentary: How Can Medical Anthropologists Contribute to Contemporary Conversations on "Illegal"Im/migration and Health' [September 2011] Medical Anthropology Quarterly 331.

by real life complexities and theoretical definitions are not enough to capture the conditions of disadvantage and the state of peculiarity that both are subject to.

However, as Hassouri explains, the distinction between a refugee and a migrant has a significant implication. Registered refugees:

> obtain residency and work authorization in Morocco. Some may be eligible to resettlement from Morocco to third countries. Migrants on the other hand are not owed these protections and although regularized migrants are able to obtain work authorization, they are not eligible for other forms of assistance provided to refugees by the [UN High Commissioner for Refugees] UNHCR and its implementing partner and other [non-governmental organisations] NGOs.[22]

Qualification conditions that the UNHCR still apply overlook the fact that most migration coming from non-conflict countries is not from choice, but from equally dreadful situations that could be similar to conflict and war situation in terms of survival. All that is exacerbated in Morocco with the tightening of security around European borders. Regional instruments also provide protection to forced migrants, such as the Organization of African Unity Convention which has an extended refugee definition that takes into consideration migration caused by 'events seriously disturbing public order'.[23] This is contrary to the narrow scope of the Refugee Convention that leads to many injustices and arbitrary qualifications and disqualifications of who is refugee and who is not.[24]

I insist on using the terms 'refugee' and 'migrant' throughout the research project. Not only do they both endure similar conditions of uprootedness and vulnerability as non-citizens, but there is a growing conceptual awareness and a momentum on including them both policy wise. The shift is clearly marked by the New York Declaration for Refugees and Migrants, released on 19 September 2016, during the UN General Assembly (GA) that convened a high level Summit for Refugees and Migrants to address 'large movements of refugees and

[22] Parastou Hassouri, 'Refugees or Migrants? Difficulties of West Africans in Morocco' (*Middle East Research and Information Project,* 12 September 2017) <https://merip.org/2017/09/refugees-or-migrants/> accessed 13 March 2019.
[23] ibid.
[24] ibid.

migrants'.[25] All the 193 member states of the UN unanimously adopted the declaration that paved the road towards a solid Global Compact for refugees and migrants that was put in effect in December 2018. The quality change lays in the global commitment to address the situation faced by refugees and migrants including but not limited to racism, xenophobia and human-tracking.[26] In other words, I follow the new terminological and epistemological approach for these interlocked human phenomena. It is a way to fully address such structural inherited flaws of the Refugee Convention. The reality is more complex than these frameworks could help to resolve. Even so, the European Union (EU) is stuck with this deep problematic and tumultuous contestation among its members. Europe is in a dilemma in how to react to preserving its borders, and abiding by the international law, at the same time. In June 2018, the European Council president Donald Tusk raised a proposal of creating 'Regional Disembarkation Platforms' outside the EU, where differentiation could be made between 'refugee' in need of protection and 'economic migrant' who would potentially face return to their country of origins.[27] All these propositions expose a moral impasse of existential fears at stake.

According to the official statistics of the UNHCR office in Morocco released in February 2019, the total registered number of refugees and asylum-seekers is 7,775. Only 5,940 of this number are refugees coming from 38 countries and 60% are Syrians.[28] This is very few in comparison to thousands of sub-Saharan Africans living and entering the country every day. The latest estimation of sub-Saharan Africans living in Moroccan territory carried out in 2008 refers to around 15,000.[29]

[25] UNGA, New York Declaration for Refugees and Migrants (A/RES/71/1 3 October 2016).
[26] ibid.
[27] David M Herszenhorn and Jacopo Barigazzi, 'EU leaders consider centers outside bloc to process refugees' (*Politico*, 19 June 2018) <www.politico.eu/article/regional-disembarkation-platforms-eu-leaders-consider-camps-outside-bloc-to-process-refugees/> accessed 18 April 2020.
[28] UNHCR, 'Morocco Factsheet' (February 2019) <http://reporting.unhcr.org/morocco> accessed 29 March 2019.
[29] Ines Kegygnoert, Abdessamad Dialmy and Altay Manco, 'Sexual Violence and sub-Saharan Migrant in Morocco: A Community Based Participatory Assessment Using Respondent Driven Sampling' [May 2014] Global Health Journal 10-32.

1.5.2 Access to health

Access to health is primarily a human rights issue. Article 12 of the ICESCR states 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[30] General Comment no 14 gives further elaboration of how this right could be attained by member states.[31] It includes substantive content and monitoring requirements for the attainment of the right to health. It does not only assert what constitutes timely and appropriate heath care but also determinates of health. 'Access to health' is an operationalised term of basic human right to health, entailing the minimum measurable criteria that must be met by member states. Access to health is also inclusive to the term 'vulnerability' that indicates the requirements of extra protection measures to assure right to health. Migrants and refugees fall under this rubric of vulnerability. Depending on a human rights perspective to assess health-related issues gives a better understanding of state obligations. Besides, it allows an understanding of the factors that shape policy design, implementation and evaluation in meeting these obligations.[32] In order to assess refugees and migrants' access to health, it requires an examination of adaptation measures done to the domestic legal, executive and administrative systems that are applied to comply with the obligations enclosed in international human rights conventions and tools. Here, human rights are tested to answers the questions of: 'does the realization of rights relevant to health also lead to better health outcomes? In this case, not only does the extent to which a government has fulfilled its health-related human rights obligations matter[33] Human rights frameworks also focus on assessing 'national-accountability mechanisms' that handle migrants and refugees as service-users who could give feedback on the efficacy of the provided health services. In turn, health providers and health policy-makers are held accountable to their communities.[34]

Refugee and migrant access to health is included in the global health initiative to achieve UHC that aims to strengthen health systems and

[30] ICESCR (n 6).

[31] General Comment no. 14, The right to the highest attainable standard of health (11 August 2000) E/C 12/2000/4 <http://docstore.ohchr.org/> accessed 29 May 2020

[32] Bard A Andreassen, Hans-Otto Sano and Siobhan Mclnerney-Lankford, *Research Methods in Human Rights: A Handbook* (Edward Elgar Publishing 2017).

[33] ibid 410.

[34] Sandy Smith-Nonini, 'Conceiving the Health Commons: Operationalizing a "Right" to Heath' [2006] Social Analysis 233, 240.

improve health equity and access to all.[35] UHC is 'the third global health transition' subsequent to the first wave of public health (promoting hygiene and sanitation) and the second wave of combating communicable diseases.[36] UHC is inserted as one of key targets of the UN SDGs. 'UHC implies all persons in a country including refugees, asylum seekers, and undocumented and documented migrants should be provided with health entitlement for affordable and necessary health care.'[37] UHC grants non-nationals affordable health systems. UHC could be realised through establishing PHC.

In 1978, the concept of PHC service was adopted during the Alma Ata Declaration[38], co-organised by WHO and UNICEF (the UN Childrens' Fund), with the attendance of 134 countries as a key to the attainment of health for all, through the delivery of basic health care services, with a particular focus on the poor.[39] The PHC services include vaccination, maternal-child care, family planning, endemic and epidemic disease control, first aid and referral systems for complex cases to secondary and tertiary health care level. So, PHC resembles the first point of contact that individuals have with health care. However, the implementation of PHC was affected by the constraints imposed on public health behind the SAPs that are addressed in the subsequent section. Here, the dilemma of the service standardisation arose between those who support selective PHC to meeting acute priorities within the reality of resources constraints, in opposition to 'comprehensive PHC'.[40] The ideal actualisation of PHC has been affected by this systematic privatisation of medical-care that has led to the weakening of public health systems. The year 1987 witnessed the launching of the Bamako Initiative by WHO and UNICEF in the city of Bamako, Mali. The initiative was a response to the problems facing the financing of PHC in sub-Saharan Africa attributed to the economic crisis and negative effects of the SAPs on health. So the initiative laid out a new vision and approach for how primary health care should be sustained by generating funds via drugs sales and self-financing mechanisms that

[35] Audrey R Chapman, 'The Contribution of Human Rights to Universal Health Coverage' [2016] Health and Human Rights Journals 1-5.
[36] ibid.
[37] ibid.
[38] International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978
[39] Chapman (n 35) 4.
[40] James Pfeiffer and Rachel Chapman, 'Anthropological Perspectives on Structural Adjustment and Public Health' [June 2010] Annual Review of Anthropology 149.

are defined and implemented at the district level.[41] However, these decentralisation attempts, seeking community-led development – at the heart of neo-liberal adjustments – did not result in tangible outcomes. Ellen E Foley points out – through her ethnography in Senegal after the adaptation of the Bamako Initiative – that the discourse promoted by officials to the community-led development from the perspective of state-citizen partnership is a way to deflect health costs to poor communities.[42] PHC is now sought to be, in the global health domain, a main efficient and effective gateway for mainstreaming refugees and migrants into national health systems that parallels the national attempt to enhance health coverage and insurance to include all.

In September 2018, Morocco joined the Global Compact for Universal Health Coverage 2030.[43] As of 2011, Morocco has 2,626 Basic Health Care Centres (BHCs); 1,731 of them are in rural areas. They provide curative and preventive activities. In urban areas, 100% of the population live less than five kilometres from a providing health care facility that is only enjoyed by 30% of the rural population.[44] Morocco invested in BHCs to face difficulties in accessing care for the poorest and rural populations, in particular chronic illnesses, per the Ministry of Health statement in 2007.[45] The number of BHC facilities increased by 63% between 1990 (1,653), and 2011 (2,689) with an enhanced availability assessed by the ratio of facility to inhabitants. In 1990, a BHC covered a population of 14,600 and now each one serves around 12,000 inhabitants.[46] Despite the findings that indicate substantial achievements in enhancing access to health and health care, there were challenges by their unfair distribution between regions and across classes. 'Average access to health care and services, as well as health outcomes have improved that last decades. However socio-economic inequalities and health inequity are persistent.'[47]

[41] UNICEF, Bamako Initiative (1987) <www.unicef.org/sowc08/docs/sowc08_panel_2_5.pdf> accessed 18 April 2020.

[42] Ellen E Foley, 'Neoliberal Reform and Health Dilemmas: Social Hierarchy and Therapeutic Decision Making in Senegal' [2008] Medical Anthropology Quarterly 259.

[43] Xinhuanet, 'Morocco Joins Global Compact for Universal Health Coverage' (*Xinhua*, 6 September 2018) <www.xinhuanet.com/english/2018-09/06/c_137447792.htm> accessed 18 April 2020.

[44] Semlali (n 7) 17.

[45] ibid.

[46] Waim Boutayeb and others, 'Action on Social Determinants and Interventions in Primary Health to Improve Mother and Child Health and Health Equity in Morocco' [February 2018] International Journal Equity Health 15.

[47] ibid.

1.6 Literature review

The literature review focuses on relevant works in respect to the domain of refugee and migrant health within the field of medical anthropology and other disciplines. The field of medical anthropology represents a core constituent of this thesis that follows an ethnographic methodology that is originally an anthropological fundamental. Both theoretical and empirical propositions of this thesis seek to be grounded within the general practice of anthropology and more specifically the sub-field of medical anthropology. Anthropology is not confined to the classical study of exotic communities' lives, cultures and behaviours, but it has expanded to capture the multiple implications of urban transformation, policies and transnationalism on people's everyday lives, new forms of socialites and belonging. This methodological flexibility permits its practitioners to cooperate and engage with wide range of phenomena. Medical anthropology is specifically concerned with how the praxis of health and sickness are shaped, experienced and understood at the interplay of global, historical and political factors. It has been expanded to explore intersection of people's everyday lives, health systems and growing inequalities worldwide.[48] The themes of medical anthropology vary from this and focus on 'doctor-patient relationship', cultural diversity, etc. The theme that is of great importance to this research project is the study of the development of health care and medical treatment in the social system. Given the fact that illness and health are informed by the socio-political and economic realities, ethnography attempts to explore these different dynamics and how they impact people everyday life and world views.[49]

1.6.1 Refugee and migrant health

Within the interdisciplinary studies of migrants and refugees, scholars, analysts and experts paid attention to the discrepancies between policy formation and implementation. While a variety of international instruments assert the right to health, in practice migrants, refugees and asylum-seekers often fall victims of incoherence and miscoordination

[48] Robert Pool and Wenzel Geissler, *Medical Anthropology* (Open UP 2005).
[49] ibid.

of service providers and humanitarian relief programmes at national and regional levels.[50] Medical anthropologists have worked intensively on the phenomenon of refugee and migrant health and well-being, highlighting their increased vulnerability to illness, injury and violence. They focused on how the fact of 'illegality' exposes them to considerable health risk. Migrants and refugees were framed as a threat as 'others' who should be excluded and not given entitlements to national resources or assistance. Most of these works had an activist stand against the denial of emergency care in life-or-death situations for refugees and migrants. And they explicitly called and advocated for improving the accessibility, affordability and adequacy of healthcare for those populations on an equal basis with other citizens, based on human rights and the right to health.

In other words, such a terrain of scholarship has triggered the debate of whether unauthorised immigrants should be entitled to exactly the same forms of health care benefits as citizens or not. That call has become nowadays the 'mainstreaming policy of migrants and refugees' in public healthcare, indoctrinated in the UHC of the WHO. It became an official global health approach, after the year 2014-2015 that witnessed the highest wave of displacement since World War II (WWII). It was the first time that the UNGA, in September 2016, hosted a high-level summit to address large movements of refugees and migrants. The major conclusion of this summit was that the challenge of migrants and refugees cannot be viewed as a short-term problem that can be solved exclusively by means of exceptional or emergency responses. Hence, the necessity was directed toward finding a solution that recognises refugees, migrants and asylum seekers as 'part of the society and that make them structural rather than "external" in health system', as well as other basic social services.[51] Prior to this juncture of history, many EU member states restricted entitlements of undocumented migrants' to health to discourage the entry of new ones. The 69th World Health Assembly (WHA), in May 2016, emphasised refugee and migrant access to quality health and essential health services to reduce health inequities. Here, the WHO supports developing health policies that would include migrants and refugees within health services

[50] Matlin (n 2) 30.
[51] ibid.

provision among host communities, as stated in the WHA resolution no 70.15 on 'promoting the Health of Refugees and Migrants', endorsed at the 70th WHA. Similarly, the development-led approach to forced displacement adopted by the European Commission, in April 2016, focuses on engaging host governments at the national and local level towards the gradual socio-economic inclusion of refugees and internal displaced persons (IDP) through helping them to access basic social services, including health.

Yet, implementation remains a challenge. Kathryn Goldade discovers in her ethnographic research on Nicaraguan migrant access to healthcare in Costa Rica that undocumented migrants are denied medical services from the state health system that has been renowned for universal access.[52] 'Migrants were portrayed as morally inferior and excessively demanding on the system,' and 'blamed for health system declines that should be attributed to cutbacks imposed under SAPs,' she avers.[53] Her work remarkably lays in the area she denotes, 'access (to) state-provided services within south-to-south migrant circuit'.[54] That is contrary to a long-standing tradition in medical anthropology endeavours motivated by the 'south-to-north migrant circuit'. This larger context of south-to-south is particularly underpinned by modes of globalisation or 'denationalisation economies' that gives rise to a new wave of critical medical anthropology. [55]

Public health studies concerned with refugee and migrant health focus on a number of challenges that reduce their access to health and exacerbate their sickness and pain. These challenges are related to legal status, entitlement, poor communication and poor health systems. At the same time, accessing health is affected by low paid jobs.[56] Discrimination, social exclusion, language barriers, poor policy coordination, and financial and administrative hurdles are other recurrent barriers. One of the neglected aspects of refugee and migrant health is mental health and psychosocial services, as migrants and refugees are usually identified

[52] Kathryn Goldade, '"Health is Hard here" or "Health for All"?: The Politics of Blame, Gender, and Heath Care for Undocumented Nicaraguan Migrants in Costa Rica' [Dec 2009] Medical Anthropology Quarterly 483 <www.jstor.org/stable/40541934> accessed 18 April 2020.

[53] ibid.

[54] ibid.

[55] ibid 487.

[56] Seth M Holmes, 'The Clinical Gaze in the Practice of Migrant Health: Migrants in the United States' [September 2012] Social Science and Medicine 873, 875.

as being at risk of mental disorders like anxiety, depression and post-traumatic stress disorders (PTSD).[57] In addition, health professionals' lack of cultural sensitivity when dealing with refugees and migrants has been considered a crucial challenge. Therefore, one of the highly recommended solution for countries to respond to the complex health needs of heterogenous refugee and migrant groups is to follow a double-twin track approach. This approach requires special support services that cater to the pertaining needs of refugees and migrants that might include a specific reception for comprehensive medical assessment, besides the mainstream health services that should be accessible to all.

Public health studies indicate the need to address the social determinants of health that make refugees and migrants more vulnerable to illness and pain, such as poor housing conditions, malnutrition, lack of access to clean water, etc.[58] The WHO-Europe policy paper on refugee and migrant health emphasised the need to strengthen public health and health systems in the long-term.[59] In turn, the views started to concentrate on the potential role of PHC in mitigating the barriers and inequities refugees and migrants face in accessing high quality health care.[60] However, the ability of PHC to meet the needs of vulnerable and marginalised migrants depends on national healthcare policies and systems.

1.6.2 Medical anthropology and undoing of inequalities

Medical anthropologists have a long tradition in tracking health inequities by unpacking the impact of the SAPs on public health.[61] The SAPs consist of economic policy reforms towards neoliberalism, imposed on developing countries. The advent of SAPs – in the 1980s – has caused drastic political, economic and social changes in favour of realising 'free markets, privatization, small government and economic deregulation that have been operationalized at country level through

[57] Omar Martinez, 'Evaluating the Impact of Immigration Policies on Health Status Among Undocumented Immigrants: A Systematic Review' [June 2015] Immigrant Minority Health 947, 949.

[58] Matlin (n 2) 32.

[59] ibid.

[60] Catherine Agnes O'Donnell and others, 'Reducing the health care burden for marginalised migrants: The potential role for primary health care in Europe' (May 2016) 120 Health Policy 495, 497.

[61] Pfeiffer and Chapman (n 40) 149.

concerted,formulaic and strategically harmonized action by IMF and World Bank'.[62] SAPs were enacted to help these countries to restructure their crippled economies with loans that require a reduction in public expenses, including diminishing salaries, cutting public sector budgets, removing subsides, the devaluation of local currency, privatising state-owned entities and services, and tax reduction on exports. In this context, anthropologists have been interested in exploring the impact of SAPs on national economies and public health in which their field endeavours have transcended 'a new intensity of immiseration produced by adjustment programs'.[63] All of these changes undermined national health systems' equity and quality, especially PHC. In 1987, the World Bank released a report that provides an applicable instrument for privatisation of health services through user fees, private insurance, engaging NGOs and the private sector, and decentralisation.[64] These factors have triggered a rise to a new school of thought and practice within medical anthropology, known as Critical Medical Anthropology (CMA) concerned with studying the different implications of policies and state interventions on public health. This school adherents are keen to bring 'political economic, post-structuralist and critical theory approaches to health and society':

> CMA insists on locating socio-cultural and health phenomenon in the context of political, economic and social forces that shape and constrain individual agency, often drawing on Marxian political economy of Foucauldian notions of biopower and biopolitics. The structural violence analytic, popular among CMA adherents, offers an alternative lens to reinterpret disease and morality among the poor as a form of violence that derives from structured inequality.[65]

Thus, this thesis aligns with this tradition to provide an assessment of refugee/migrant mainstreaming policy, inseparable from explaining the national health system that was subject to systematic neo-liberal reforms for decades. The global health policy formation has not been considerable enough to this reality of national health systems of transit countries located in the Global South that host around 90% of the

[62] Pfeiffer and Chapman (n 40) 149.
[63] ibid 151.
[64] World Bank, *Financing Health Services in Developing Countries: An Agenda for Reform* (A World Bank Policy Study 1987).
[65] Pfeiffer and Chapman (n 40) 153.

displaced populations. Instead, the national health systems are not discursively problematised in terms of efficiency and effectiveness, as issues of scarcity and capacity-burdening occupy the core rationale of the issue.

Most importantly, some anthropological works embarked on showing the negative impact of SAPs on public health embodied in weak infrastructure and poor quality that are directly experienced in longer waiting times, misdiagnosis, lack of appropriate treatment and the implementation of global health policies programmes. Ida Susser argues in her work how addressing gender inequality and the AIDS epidemic were affected by years of SAPs that shrunk essential health services, due to the rise of neoliberal agenda of privatisation and commercialisation, which has hardened access to health services for women and the less-privileged.[66] This case suggests how global health funds and programmes 'collided directly with structural adjustment polices on the ground,'[67] in what they described as 'dilapidated and under-resourced health systems'.[68] Consequently, SAPs undermine the 'effective response in spite of the new resources made available'.[69] Audrey R Chapman argues that the right to health has been challenged by the dominance of neo-liberal economic policies that favour the wealthy and powerful, while leaving the disadvantaged to suffer and die.[70] By the same token, other pertaining health issues are attributed to SAPs that caused poverty, lack of income and food insecurity. This shows what Chapman explains as 'normative dissonance' between neo-liberal measures and human rights-based approaches:

> A human rights approach rests on a conception of health and health care as social or public goods of special importance that are designed to benefit the whole population. In contrast, neoliberalism tends to promote the view of health care as commodity whose price, availability and distribution like other consumer good, should be left to the market place.[71]

[66] Jenevieve Mannell, review of *AIDS, Sex and Culture: Global Politics and Survival in Southern Africa,* by Ida Susser [1 September 2011] Global Public Health 681, 682.
[67] Pfeiffer and Chapman (n 40) 155.
[68] ibid.
[69] ibid.
[70] Audrey R Chapman, *Global Health, Human Rights and the Challenge of Neo-liberal Policies* (CUP 2016) 40.
[71] ibid 85.

All these propositions are strongly present in the case under study. Chapters 2 and 3 try to situate migration policy and health integration within macro-politics and tendencies towards development and health, with a focus on the locale of Youssoufia. According to the WHO country collaboration report of Morocco in 2010, poverty and social inequalities have always been pertinent characteristics of Moroccan society, but they have been significantly exacerbated with the application of SAPs, since the 1980s.[72] Poor management of public health facilities makes them unable to compete with private hospitals.[73] Poor management is also present in the lack of coordination with BHCs, poor quality of reception and cure. The financing of the health care system in Morocco shows a global expenditure of 4.3 billion USD at end of 2008, precisely 5.6% of the GDP, which is extremely lower than the global threshold of 15%; even 'compared to other countries at a similar level of development, there is a sizeable gap'.[74] The medical personnel have been badly affected by the application of SAPs, as the reduction of public spending on health sector depreciated the quality of facilities – and in turn – the work environment. That forced health professionals to migrate to find better conditions. The lack of sufficient well-trained medical staff represents a complication in the national health delivery system that the Moroccan government constantly tries to solve.[75] According to the statistics of the Ministry of Health from 2007, 45% of doctors nationwide work in the private sector. A phenomenon of 'moon-lighting' has emerged among public health staff who work in private clinics, although it is not allowed. Figures indicate that they are around 50%.[76] By the end of the second millennium, only 15% of the Moroccan population enjoyed national health insurance coverage, while 33% of the population was unable to afford necessary medical care. Out-of-pocket represented 60% of the total health expenditure.[77]

Criticising the impact of SAPs implementation on the public health sector in many of the Global South countries sheds a light on the necessity for incorporating a careful consideration of the national

[72] Semlali (n 7) 10.
[73] ibid 20.
[74] ibid 22.
[75] ibid 26.
[76] ibid 31.
[77] Boutayeb and others (n 46) 19.

health systems at place, while designing, applying and monitoring a refugee and migrant mainstreaming health policy. This factual flimsy status of the health care infrastructure – in transit countries – represents a fundamental challenge for enhancing refugee and migrant access to health. Thus, having a robust national health system is indispensable and it cannot be replaced by the 'patchwork of NGOs, charities, missions and private providers'.[78]

1.7 Methodology

The research project relies on ethnographic methodology, in order to better understand how refugees and migrants could access healthcare in Morocco, after the launching of the National Strategy for Immigration and Asylum in 2013. The ethnographic fieldwork mainly focuses on the poor urban neighbourhood of Youssoufia, in Rabat. Youssoufia resembles a micro-political space that is meant to examine the conjuncture of different policies on migration, healthcare and urbanisation that tacitly shape the daily lives of refugees and migrants in this area. Within the contours of Youssoufia, I investigated the parameters that determine 'access to health,' namely availability, accessibility, quality and accountability. Ethnography allows the examination of the actual implementation of refugee and migrant right to health through their actual lived realities and experiences within a specific commune.

The duration of the fieldwork – upon which the thesis is based on – is a three-month period, from February to May 2019. The month of February was consumed in looking for a particular site to start my field work. Meanwhile, I was able to conduct interviews with national authorities and civil society representatives working in the field of immigration. Then in March, I invested efforts and time in building rapport with the target populations and host community at large, in Youssoufia. During the entire indicated period, I kept writing an attentive reflexive field journal that includes detailed observations and

[78] James Pfeiffer and Mark Nichter, 'What Can Critical Medical Anthropology Contribute to Global Health? A Health Systems Perspective' (2008) 22(4) Medical Anthropology Quarterly 410, 411 <www.jstore.org/stable/25487843> accessed 18 April 2020.

interviews. I was able to collect a number of individual stories of migrants living in Youssoufia, each with different background, present and future aspirations. I interviewed those who only consented to talk and after I explained my research purpose through a snowballing technique. For ethical considerations, I have given them different names to protect their identities.

The interviews were conducted in the 'history of life-story' style that is an ethnographic method to explore how people denote and label their own experiences of health and illnesses through deployment of personal narrative. The interview questions were semi-structured and open-ended to help in probing all relevant details from the informants. I mapped public health services, with a focus on PHC centres, and I was not able to interview the doctors, nurses or receptionists working inside, until I handed a special request to the Ministry of Health Directorate in Rabat. The request was obtained by the second week of April. The questions directed to refugees and migrants investigated their health situations: what do they usually suffer from? What are their health needs? What do they do when they feel sick? How are they treated by the health care system? What are the barriers and obstacles they might face? I was equally interested in also counting care-seeking pathways that refugees and migrants might pursue when access to health care services is blocked.[79] It tends to show how policy works and how people negotiate pertinent gaps in the system. Medical anthropologists have long focused on describing the community-level ramification to the wide range of public health policies, including the diminishment caused to the public health sector by liberal economies and the privatisation process. In this context, ethnographies are deployed to deconstruct official discourses and knowledge structures that perpetuate inequalities, showing gaps that policy-making circles usually overlook. In fact, public policies 'are often made on the basis of personal or institutional ideology, abstracted data and conventional wisdom or bias'.[80] Thus, 'community-based and health system-based ethnographies of health care and health services can act as power antidotes or correctives to this conventional wisdom and can help shift how we might evaluate the effectiveness of competing strategies'.[81]

[79] Pfeiffer and Nichter (n 78).
[80] ibid 413.
[81] ibid.

The refugees and migrants I interviewed were sub-Saharan Africans; from Ghana, Nigeria, Guinea, Sierra Leone, Cote d'Ivoire, Senegal, Cameroon and Mali. Concentrating on a specific locality allowed the observation of community dynamics and other social determinants of health that have an effect on health access. Talking to Moroccans illuminated other factors related to the general situation of health access, or precisely the nature of barriers that one might face in obtaining healthcare. Comparing and contrasting different experiences allow the research to answer the question of whether the barriers are related to factors commonly known[82] or new factors are less presented? (with a focus on the renovation of health facilities). It was essential to solicit their experience and the memory of Youssoufia from long-term residents of Morocco, and compare it with those of refugees and migrants.

The first aimless visits to the neighbourhood enabled me to initiate spontaneous talks with local Moroccans and migrants/refugees who are either shop-owners, street venders, shoe-repairers, side flâneries or consumers. Cultivating a rapport within the first few casual visits had been crucial for trust-building and knowing the nature of area and people. Reviewing the content of local and international newspapers related to the area, gentrification, health in Morocco and migration is indispensable. It assisted in unpacking the discursive systems (re)shaping this area, the public sentiment towards migration and refugees, and the current health-care situation. However, depending solely on the refugee and migrant narrative is not sufficient to build a critical assessment to their access to health. It must be complemented by the views and experiences of health-care providers.[83] My field work precisely tried to 'critically examine the complex processes through which national as well as local policies are created, implemented, interpreted, subverted and transformed through everyday social interactions, in the clinics, social offices, work places, household where such policies come to

[82] Barriers to accessing health could be for reasons related but not limited to: 1) high cost, 2) language, 3) cultural differences, 4) discrimination, 5) administrative hurdles, 6) inability to affiliate with local financing schemes, 7) adverse living conditions or/and 8) lack of information on health entitlement. Those factors are commonly cited in works concerned with refugees and migrants' health as well as in international reporting that I was able to observe the applicability of some of them in my conversations with some informants but their multitude differs and needs a triangulation among other informants and other actors.

[83] I had two appointments with two major health facilities in Youssoufia; 1) Youssoufia Medical Centre/PHC and 2) The Pan-Africanist Centre against HIV.

life'.[84] Therefore, I conducted semi-structured interviews with relevant stakeholders and experts in the fields of migration and public health. It helped in understanding the details pertaining at establishing health access to refugees and migrants, the existing level of coordination among the entities in charge, and the types of operational challenges. I was able to interview the National Council for Human Rights (CNDH) focal person in charge of migration folder, International Organization for Migration (IOM) and Gadam.

Questions to the PHC staff:

- What are the different health services available at the centre? What are the working hours?
- What are the conditions for refugees and migrants to access the PHCs? What are the services refugees and migrants are eligible to access? Or are they entitled to all services?
- How is the flow and traffic on PHC centres by the sub-Saharan African refugees and migrants? How frequently do they visit the PHC centres? What are the demographic characteristics of the patients (in terms of gender, age, nationality, etc)? What are the common health conditions they suffer from? What are the prevalent health needs for these categories?
- What are the barriers or the challenges that you think refugees and migrants might face in getting the health care they need? What are the barriers or the challenges that you (as staff) might face or have faced in dealing with them?
- What are the things or stuff you could recommend to enhance the service quality and access of health to refugees and migrants?

[84] Willen, Mulligan and Castaneda (n 21) 335.

Questions for each of the following categories		
Public authorities:	International organisations:	NGOs:
1. What are the entities most relevant mandate in relation to refugees and migrants' health? What are the national policies, strategies and laws that include the refugees and migrants' right to health? 2. What is the general assessment for refugees and migrants' health in Morocco? What are the issues? in case it exists, what are the major causes (lack of institutional response, national coordination, etc)? 3. What are the methods and mechanisms followed to tackle and address health issues of migrants and refugees? 4. What are the future plans for further enhancing the situation? 5. Is there any sort of representation of those refugees and migrants groups residing in Morocco that could be consulted and have their say in relation to the different stages of conceptualisation, acting or raising recommendations? And if not how do you assure their satisfaction and needs are well-accounted for in these different efforts?	1.What is the department/ division responsible for refugees and migrants' health? 2.What are the major activities conducted, where, duration and the targeted beneficiaries? Along with elaborating these different aspects, what are the approaches followed? 3.What are the major characteristics of the targeted populations (in terms of nationality, sex, age etc)? What are the major problems and issues they face? What are the most common health needs they have (among which age and sex groups)? 4.How are these issues and needs accommodated in collaboration with other actors? 5.What are the issues you might face in the implementation that hinder the intended objectives? 6.How do you measure the satisfaction of targeted beneficiaries and the consistency of intended interventions in line with their needs? 7.How is sustainability assured?	1.What are the projects designed to cater to the health of refugees and migrants? How are they funded? 2.What are the major activities conducted, where, duration and the targeted beneficiaries? Along with elaborating these different aspects, what are the approaches followed? 3.What are the major characteristics of the targeted populations (in terms of nationality, sex, age etc)? What are the major problems and issues they face? What are the most common health needs they have (among which age and sex groups)? 4.How are these issues and needs accommodated in collaboration with other actors? 5.What are the issues you might face in the implementation that hinder the intended objectives? 6.How do you assure the satisfaction of targeted beneficiaries and the consistency of intended interventions in line with their needs? 7.How is sustainability assured?

1.8 Limitations of the fieldwork

It is important to mention research limitations to better situate the results that the research has been able to offer. In this section, I detail the internal and external limitations, pertaining at my very subjectivity of it, as from the very visible side as an Egyptian English-speaking master's degree/exchange student, and the invisible side of being a former development practitioner who previously interacted with migrants and refugees but in Egyptian contexts. Counting for such limitations would help in reading and understanding motives but also the capacity that this research project has been based upon. Counting for the visible side first, being Egyptian with a familiar Arab profile in which I could be confused to be Moroccan gave me a greater advantage. Moroccans, in particular, have affinity towards Egypt and Egyptians thanks to the Egyptian soft powers that are engraved in the minds and hearts of majority of Moroccans if not all because of the epic proliferation and passionate consumption of cinema and pop-culture in the greater entity of the Arab World. Sub-Saharan Africans also relate to Egypt as a leading African country in soccer and with high anticipation to the African Cup of Nations that will be held in Egypt in June 2019. It is an external circumstance that has smoothed my encounters with people and informants in a noticeable way. That being said, people's fair knowledge of the Egyptian dialect eased the factual linguistic barriers I faced as an English-speaking person in a Francophone country. Above all, *Darija* (the Moroccan dialect) is equally foreign to my ears and not easy to comprehend. A few classes at university helped me to dismantle the logic of *Darija* and understand key utterances. Being an Arab exchange student is not a usual thing to be seen where the norm is Westerners. There are no tangible implications of this fact in how it altered behaviours, but it still counts as a factor not necessarily a limitation to consider. Yet, I vividly recall a statement made by the head of the Moroccan Center of Arab-language Teaching and Exchange Programs, advising me when setting up my field work, 'Arabs don't like each other'. In a broader sense, I was warned not to reveal my real identity as a master's student working on her thesis that the fieldwork I was planning is part of. His assertion came in a form of speaking about Morocco's level of tolerance and democracy that he emphasised to be existing to a certain extent, but it is still a way far from being initially democratic, despite the mainstream media highlights of the improved

human rights situation that Morocco witnesses, in comparison to the rest of the Middle East and North Africa region. Other external limitations are to do with the inscribed nature of the site of my fieldwork at the area of Youssoufia that is known as a condensed unsafe slum area. During my first excursions, I was warned not to get my cellar phone out of my bag, as it might get stolen so easily.

Given the intrinsic nature that the modern categorisation of 'refugee' or 'migrant' denotes of help-worthiness, people tend to hold great expectations that I would offer them something; money or assistance. That posed a challenge of explaining my purpose or convincing them to talk and open up. It was a sensitive matter of explaining my objective which is collecting their stories and obtaining their trust. Because of my work with refugee communities in Cairo as a NGO worker, I was aware of the high possibility of encountering what I would like to call the 'politics of miserability' that people internalise. Because of the global refugee discourse and praxis a reciprocal process of self-helplessness has got shaped in relation to the complex dynamics of aid flow and disbursement.

Another limitation I faced is the reluctance of some NGOs to be interviewed in respect of their work in relation to the focus of this study. Caritas was one of these NGOs that I failed to include in my fieldwork, despite my several attempts to reach out to them. Their latest reply was that they fear I would twist their statements in the research content. Nevertheless, this in itself a strong indication of the politics of some NGOs that is primarily motivated by funds-hunting, instead of building an institutional and social capacity around the cause they proclaim they serve. Including the perspective of Caritas on the subject matter of this study was of high importance, because it has been one of the first NGOs supporting migrants in Morocco, decades before the National Strategy on Immigration and Asylum. Caritas runs a social centre and a clinic that are still operating, and they are located five minutes' walk from Youssoufia. In reversing this limitation, I depended on the political science department of UIR (Universite Internationale de Rabat) connections to put me in contact with relevant actors.

However, the most dangerous limitations one could have are those emanating from inside, the stands that one has cultivated through former situations and events. My in-depth interviewing of different refugee/migrant communities in Cairo and my knowledge and witness of the viciousness of the health care system or lack of a system all together

reside in my sub-consciousness, like a 'ghost'. Heath Cabot highlights this form of unintended bias or prejudice ethnographers have, in constructing alternative representational tactics of refugees' voices that end up 'haunted by various ghosts: traces of silenced subjects who index both limits and possibilities of representations'.[85] Resemblances between Egypt and Morocco exist, but each has different circumstances and implications. That is an aspect that my field notes and reflections could help to dissolve.

1.9 Thesis overview

In chapter two, I lay out a detailed description of the field site – Youssoufia – and the social world of my informants, along with the first of my thesis arguments that suggests the situational and structural circumstance influencing migrants health, apart from the clinical sphere of the PHC centre. Instead, the chapter tries to provide a nuanced account of the daily details of their lives to better understand the differential circumstances surrounding their health and well-being.

Chapter three explains the macro-policy context and involved actors related to the process of refugee and migrant mainstreaming in the Moroccan national health system. Screening of global and national policy-formation, besides the power relations among main actors, underpin several pertinent circumstances of the national health systems' adaptability to accommodate refugee and migrant health needs and access, upon mainstreaming implementation.

In chapter four, I elaborate the various elements determine refugee and migrant access to health in Youssoufia BHC. Based on the various experiences and stories narrated by my sub-Saharan Africans informants, as well as the conducted interviews with other stakeholders – the BHC staff – I build the second of my arguments on how migrants depend on alternative medicine as a way to negotiate sense of identity and avoid possible hassle in seeking healthcare.

The fifth and final chapter recaps major conclusions that are extended into policy recommendations and potential future academic research.

[85] Heath Cabot, "'Refugee Voices": Tragedy, Ghosts and the Anthropology of Not Knowing' (2016) 45(6) Journal of Contemporary Ethnography 645 <https://doi.org/10.1177/0891241615625567>.

2.

INSIDE YOUSSOUFIA

2.1 Introduction

This chapter provides a contextualisation to the time and place of my ethnographic field site, and brings a textual description of the lives and social worlds of my informants in Youssoufia, relying on the anthropological tradition of 'thick description'. I try by that to follow the premise Sarah Parkinson and Orkidh Behrouzan render in studying Syrian refugee health access in Lebanon that emphasises the importance of exploring other factors 'surrounding the clinical encounter'.[86] Hence, the everyday lives and experiences of migrants and refugees interact with health procedures in a way that could 'prevent and/or disincentivize refugees' accessing healthcare services'. In the case of Youssoufia, the lack of protection, lack of jobs, poor housing conditions, scarcity of nutrient food and exploitation that sub-Saharan African migrants experience prevent them from prioritising their health and wellbeing. They also refrain from accessing health facilities due to their cultural beliefs in the supremacy of the West African lifestyle as a social marker between themselves and the other. However, the poor health determinants that refugees and migrants endure make them more vulnerable to illness; both physical and mental.

[86] Sarah E Parkinson and Orkidh Behrouzan, 'Negotiating Health and Life: Syrian Refugees and the Politics of Access in Lebanon' [December 2014] SSM 324, 325.

2.2 Geographies

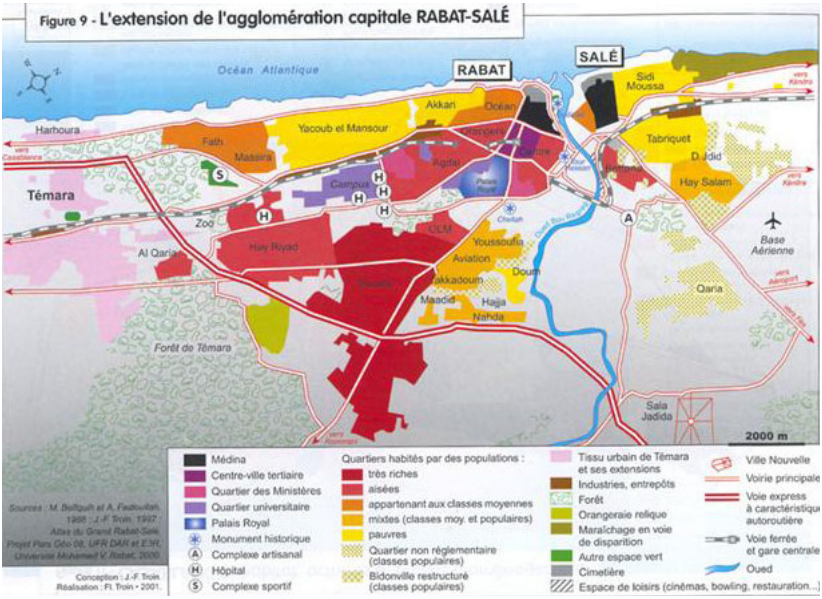

Figure 1: Map of Rabat- 2003[87]

Youssoufia is in the East-South part of contemporary Rabat. Rabatis refer to Youssoufia as *hi sh'bi* (a popular neighbourhood).[88] Youssoufia is located next to the neighbourhood of Takadoum that is also known for a high concentration of sub-Saharan Africans. Takadoum is only a ten minute walk from the Mini-Park at the forehead of the old market of Youssoufia (aka *Marché Grande*). Both Youssoufia and Takadoum have notorious reputations of being dangerous places with a high prevalence of criminality. The news published around 2008 revealed that the area witnessed an unprecedent prevalence of drug dealing that exacerbated

[87] Urban Slums Reports: the case of Rabat – Sale, Morocco, 'Expansion of the City Rabat-Sale' (2003).

[88] 'Rabat Treasures: a Tour in Youssoufia Neighborhood', YouTube video, 15:56, from a performance televised by Tele Maroc (10 November 2017) <www.youtube.com/watch?v=yqmqvfquIVQ> accessed 18 April 2020.

with the high level of illiteracy, unemployment and police absence.[89] All of which I can relate to through my first-hand experience and observations in the neighbourhood and most importantly from people voluntarily warning me, with no prior acquaintance, of never getting my 'mobile out of my bag' or to ' pay attention to your bag,' '*haramyh beaucoup*' (thieves are a lot). *Hashish* (the local substance of cannabis) is openly smoked and shared. My sub-Saharan African informants repeatedly reflected on drug abuse among Moroccans and how it impacts their mental soundness. Most of them recalled incidents of violence or fear of being potentially subject to physical violence, especially if they are well-dressed. Therefore, they try to keep a low-profile.

Youssoufia was not part of the formal urban plan of the city in the past, but it had been created out of a spontaneous squatting of internal immigrant waves coming from the southern parts of the kingdom during the time of the French mandate. Two tales are circulated behind the original reason of this sudden internal immigration. The first suggests that they came to flee famine and drought, while the other is that they came to back the anti-colonial national movement.[90] Youssoufia was named after Moulay Youssef, the grandfather of King Mohamed V. An informal clustered settlement resembled a worrying issue for the city rulers who attempted to get rid or reduce the image of informality of the cottages people built and dwelled. In 1962, King Hassan II initiated a process to address 'inappropriate housing,' and to combat *safih* (tinplate) houses. That can be present today in the texture of Youssoufia between the finely sequenced housing blocks, and the overtly dense and narrow lanes of Dawar el-Roum; the mushroom houses that one of the Moroccan news outlet describes to be similar to Latin America's slums.[91] Youssoufia is considered one of the mixed and less exclusive areas in Rabat, in terms of class and population composition (see figure 2). It is noteworthy that the tramway that started operating in 2011 is not extended to Youssoufia. Wondering about this fact with one Moroccan resident, he answered, 'why would they? We are perceived as a popular quartier; a source of problems'.

[89] Mostafa el-Hajri, 'Youssoufia Qala'at el-Igram el-Hasyina in Rabat' (Youssoufia is the fortified citadel of criminality in Rabat) (*Maghress*, December 2008) <www.maghress.com/almassae/16950> accessed 18 April 2020.

[90] 'Rabat Treasures: a Tour in Youssoufia Neighborhood' (n 88).

[91] El-Hajri (n 89).

Youssoufia resembles a thriving place for the poor and migrants, especially from sub-Saharan Africa. The rentals are relatively affordable; an apartment costs 2,000 Moroccan Dirham (approximately 200$) and could cost half that in Dawar el-Roum (100$ or less). These houses are not regulated by formal registered contracts and are not subject to state tax. It is where most sub-Saharan Africans live. They usually share flats and even rooms. An entire family of a couple and new-born child could fit with all their belongings in one room. The same goes for single young men in which three or four could share a tiny room. The bathrooms are narrow and the kitchens are barely equipped. Some of these houses are mouldering and have health risks. In the house where a Nigerian family lives, the ceiling leaks water when it rains. The places are hardly ventilated or exposed to sunlight. Another family did not have a fridge.

Figure 2: Dawar el-Doum – Youssoufia

The houses I visited branch out of the wide avenue of Koundafa that extends across Youssoufia from the Mini-Park plaza to the end of the *marche grande* (see figure 3). I carried out most of the fieldwork excursions in this space where my interactions and existence can be accepted or justified at best. Koundafa street has most of the shops, besides venders who sell all sorts of goods. The *marche* is an interesting space of daily interactions between the migrants and the host community members. The sub-Saharan Africans, however, are defined and distinguished with their dark skin colour. Blackness has different social and cultural implications within the migrant communities, among the Moroccans and to the urban character of the city.

Figure 3: Koundafa Avenue – Youssoufia

2.3 Socialities

The dark skin of sub-Saharan Africans adds to their visibility within the urban physiognomy and texture of Youssoufia and in the city as a whole. Getting in a taxi from the city centre to Youssoufia, the driver expressed how bad the increasing presence of sub-Saharan Africans in Morocco is in a disapproving tone, saying 'they outnumber Moroccans now. They have surged the rental prices and living costs'. The sub-Saharan Africans belong to 37 countries. In Youssoufia, I crossed people coming from Guinea, Liberia, Sierra Leone, Congo, Mali, Ghana, Nigeria, Senegal and Ivory Coast. They form different communities mediated by language, nationality and religion. English-speaking people from Ghana and Nigeria are less likely to have contact with French-speaking nationalities who are the overwhelming majority. But those who are capable of speaking Arabic, whether due to their prior Islamic education in their home of origins, or from many years of living in Morocco, are more likely to blend like the cases of Dialo (from Guinea) and Zoubair (from Ghana). However, the NGO worker who is a migrant himself asserts, 'migrant communities are organised by nationality. People get closer to their origins. It is easier to blend. Also communication and trust are more instant'.[92]

[92] Interview with an NGO worker (Rabat, Morocco 14 February 2019).

Figure 4: Lane 33 – Youssoufia marche

Religion is a subtle element with no trace of any tension on the surface. It is another identity component that my informants talked about in referring to the space their community assume or in their way to verify my presence. I was directly asked about my religion, whether I am a Muslim or not? Similarly, Christian informants expressed, without me asking, how Muslims outnumber Christians and how Christians are denied the right to build worship houses and secretively turn private houses into churches. One of the Ghanaian informants, Zoubair, started his talk with me about the scarcity of Muslims in the area. Yet, blackness provides a wider reference for fraternity among them, for good and bad. It can also be a driving element for solidarity, in case of deliberate discrimination practiced by Moroccan nationals. Normally, someone could introduce me to another person saying my 'brother,' or 'sister', not of the same mother or father but belonging to the same village, region, country, language,[93] religion or shared blackness.

Blackness is both a source of potential disadvantage and a driving force for solidarity and unity. Moroccans call black/dark skinned people in two ways; first is *'izi* which means negro. Or they call them *mon amie* (my friend) that actually drifted from the literal meaning to be associated with blackness in the everyday imagination and habitual vernacular

[93] Fula is a spoken language across 20 countries from Guinea to Cameroon, Sudan and Senegal.

of many Moroccans who do not necessarily know French. Although Morocco is classified as Francophone country, unequal access to quality education French-schooling remained a monopoly of the well-off classes, especially with the Arabisation of public schooling in the 1980s. Dr Mehdi Alioua, a sociology professor in UIR, clarified that *mon amie* (my friend) has its origins in the linguistics structure and logic of local colloquial dialect, in which Moroccans in intense situation or moments of tension can call each other as *ya sahibi* (my friend in Arabic) to set a personal space.[94] This personal space is between two binaries of rivalry and fraternity that Moroccans deliberately use in the case of no prior acquaintance. Rather than that Moroccans also call each other *khuia* (my brother). In return, using *mon amie* (my friend) by Moroccans is embedded in the local language to refer to sub-Saharan Africans, but also to mark a social acceptance that is far enough from discrimination and not close to the degree of intimacy like being a Moroccan.

Blackness reinforces a state of 'otherness' that indicates a sort of hierarchy of the inherent inferiority that comes in the public imagination with the colour black. Gaia Giuliani analyses the semiotics of the contemporary discourse in the Mediterranean to reflect associations to 'the historical reasons, power relations, colonial archives and memories that continue post-colonial conditions'.[95] Here, the Mediterranean gatekeeping does not convey a certain regulatory mode, based on international law and domestic jurisdiction, but what Giuliani underlines as a 'space of governmentality,' meaning that the Mediterranean is defined by a number of institutional and non-institutional actors to manage and control the bodies and borders. The Mediterranean turns into a 'stage' where boundaries are performed that exert symbolic and material registers. Thus, there are:

> the bodies of migrants, the risky bodies and bodies at risk as, identified based on security system and made operational or enhanced within the 'frame' of the War on Terror, as well as the memories of colonial and post-colonial violence.[96]

[94] Interview with Mehdi Alioua, Sociology Professor, Faculty of Social Sciences, International University of Rabat UIR (Rabat, Morocco 9 May 2019).

[95] Gaia Giuliani, 'Afterward: The Mediterranean As a Stage: Borders, Memories, Bodies' in Gabriele Proglio (ed), *Decolonising the Mediterranean: European Colonial Heritages in North Africa and the Middle East* (Cambridge Scholars Publishing 2016) 92, 93 <http://hdl.handle.net/10316/34189> accessed 18 April 2020.

[96] ibid.

Explaining the intractable issue of discrimination black migrants face in Morocco is complex because it reflects a process of furthering otherness by Africans (from the North) to their fellow Africans (from sub-Sahara), based on different skin colour, perpetuating the same colonial legacy.

Discrimination and racism are experienced on a daily basis by almost all the sub-Saharan informants I met in Youssoufia, despite the legal and policy promotion of migrants rights since 2013. This banal form of discrimination based on race and colour intensified a sense of community among the sub-Saharan Africans and surged a distrust in the entire system of Morocco, and in turn, they try to minimise their interaction as much as possible to avoid potential harm. Zoubair, the Ghanaian man who has been living in Morocco for 25 years, acknowledges the protection and human rights they (sub-Saharan Africans) started to enjoy after the National Strategy of Immigration and Asylum, but it did not erase negative attitudes towards them from the rest of society. He explains:

> No one likes black man, every black man is having a problem, he has no respect even if he is a president. This colour [pointing to his own skin] is not liked. So, we take care of ourselves. They perceive a black man as a slave. They do not respect it; Europeans, Asians, Arabs.

This general sentiment was reaffirmed with the treatment of Syrian refugees by Moroccans that is noticed to be less aggressive and much more tolerating to their existence. This was explicitly expressed by Moroccan passers-by in the *marché* who would warn me from them (my migrant informants), saying 'they are so stiff'.

2.4 Past(s) and current(s)

This part summarises the profiles of the interviewees, charting the overarching commonalities and differences that could better explain their existence and relations. I conducted my interviews with sub-Saharan African migrants living in Youssoufia with no systematic plan. I depended on interviewing those I met through a network of people and who accepted to talk to me. The informants were predominantly illegal migrants, except for one person who filed a refugee application with the UNHCR, Sow, who had entered Morocco from Algeria. Before

living in Algeria for a year, Sow lived in Mali for a couple of years, after moving from Guinea where he fled a civil war in his home country Sierra Leone at the age of 12. He lost his family and got one of his legs permanently injured. Only two cases I met had the *carte de sejour* (residency card)[97] with the regularisation processes that accompanied the National Strategy of Immigration and Asylum. The first case was Zoubir, a Ghanaian who had been living in Morocco since 1994 and was married to a Moroccan. The second case was the Nigerian family who had completed 12 years in Morocco. The rest had entered the country very recently, from five months to two years ago. There are those who entered by land through the help of smugglers, or actually the abuse of smugglers, trekking the Sahara and crossing borders of several countries to enter Morocco. There are also those who reached Morocco by plane, as some West African nationalities who do not have to obtain a visa to enter Morocco like Senegal and Mali. Most of my informants were young males in their 20s and 30s. There were also three young women who came on their own. All those who I interviewed were both French and English speakers.

There are those who came to Morocco with an explicit intention to illegally reach Europe. And those are – in fact – the majority. My question of 'why he/she came to Morocco?' did not resonate as a viable question that needs an answer as it is pretty well known for everybody. This question made me looks ridiculous and silly, because the answer mostly goes without saying: it is 'to cross to Europe'. This journey is full of risks and it requires careful organisation and long arrangements. It is a journey that becomes more impossible with the high restrictions of EU borders. The journey to Morocco itself costs already a fortune. So, they are forced to stay in Morocco to financially prepare themselves to be able to pay the smugglers to either cross by sea or sneak to the Spanish enclaves of Ceuta and Melilla, in the right timing. Bright is a 32-year-old Ghanaian who illegally sneaked into Morocco in November 2018, trekking across five countries; Togo, Benin, Niger, Mali and Algeria. He was robbed in a taxi and he lost his belongings, including his passport. 'We are studying the weather (waiting for the summer sea tides) and work to have around 2,000 euros to go to Europe,' he explains.[98] When

[97] The *carte de sejour* includes a work permit and offers access to primary and secondary, but not to public health insurance.

[98] Interview, 7 March 2019.

I asked what he would do without a passport, especially as he has no other legal documents, Bright was unexpectedly unworried. On the contrary, he finds it an additional advantage that will help him during the crossing attempt with the Spanish guards, and it is better to pretend that he knows nothing.

Bright is not an exceptional case. Immigration to Europe is a shared individual dream of self-actualisation, of sweet life and better opportunities that are lacking in their home countries. 'Our countries are rich, but our leaders are bad,' Bright added. Zoubir blames the smuggling networks that sell a misperception and a false promise for many like Bright in Ghana and other countries for the constant surge in the numbers of illegal immigrants. Smugglers, according to Zoubir, tell poor people, 'if they reach Morocco [it] means they are in Europe'. Zoubir feels sorry and outraged over people who have been deceived and are left to suffer; what they find in the end is a bitter reality of Morocco where they have nothing to eat or no place to sleep. 'Morocco is no sweet' he concluded his statement.[99] Zoubir also attributes this constant increase of individuals coming from West Africa to Morocco to the human trafficking rings that exploit young minor girls in prostitution that is extended to Europe. Happy, the Nigerian lady, was brought to Morocco with the help of a Nigerian man 12 years ago in order to depart to Europe, but she must have worked as a prostitute so she refused and was left in Morocco. So, those people with the intention to cross the sea wait until the summer when the sea level descends; or they go to Nador city, ten kilometres from southern Melilla, where they camp in the bush waiting to sneak past the ten feet long cement blocks. Thus, Youssoufia becomes a transit itself for these constantly mobile populations inside Moroccan territories.

Nonetheless, Morocco could initially present a final destination for a few. Aliou, a 29-year-old Senegalese man, left his work as a car mechanic to find a better life in Morocco in December 2018. For five months, Aliou has been searching for a job without any result. Employers ask him for a residence card, while he needs a job contract to issue a residence card. Sohali is a 32-year-old Senegalese lady who entered Morocco at the same time as Aliou with the hope to find a good job in Morocco which she failed to achieve. Isa from Mali came to Morocco

[99] Interview, 25 March 2019.

to complete his studies in computer science and he has a side job in a store in the Youssoufia *marché*. The third category of my informants is made up of those who have failed to make it to Europe and found themselves stuck and settling in Morocco like Dialo, Zoubir and the Nigerian couple (Happy and Mathew). All of them have families and kids that they do not want to risk on a perilous unguaranteed journey. Line Richter talks about this situation and describes it as 'life in exile on the edge of Europe'.[100] Richter remarks on the extended liminality of Malians in transit countries of North Africa as a 'limbo' that has three major features, all of which apply to the cases of my informants. The immigration is motivated by 'the lack of opportunity for social mobility'.[101] Yet, the transit countries where those Malians stay have the same social and political structures of their home countries that 'are quite discernible'.[102] In addition, they endure what Richter states are 'dramatic ruptures with humanity'. All these factors together create a state of 'limbo' or diminished chances.

Figure 5: Dailo's work place

[100] Line Richter, 'On the Edge of Existence: Malian Migrants in Maghreb' (2016) 8 Culture Unbound; Journal of Current Cultural Research 75 <www.cultureunbound.ep.liu.se/v8/a07/cu16v8a07.pdf> accessed 18 April 2020.
[101] ibid 76.
[102] ibid.

What Richter was able to observe applies to migrants living in Youssoufia where conditions do not allow them to make a breakthrough in what they dreamed they would achieve when they came to Morocco. They face double the challenge; a challenge for being illegal migrants added to the challenge of the dwindling domestic situation in Youssoufia and Morocco, in which unemployment is an omnipresent reality. All of my informants have no fixed jobs. Some work in the market in shoe-repairing, like Dailo, Zoubir and Watara (a 27-year-old young man from the Ivory Coast who has been in Morocco for a year entering from Mauritania, in the hope of becoming a footballer in one of Europe's soccer clubs). It is pretty striking to observe that the shoe-repairing business is only handled by sub-Saharan Africans in the *marché*. Others work selling fruits and vegetables like Bright and Reindolf (a 28-year-old Ghanaian who has lived in Morocco for a year and half) who sell oranges and peas. Seila, a 24-year-old Guinean came to Morocco four years ago, sells food on the sidewalk. Sohali and Olivier (who is from the Ivory Coast. He is 27 and usually sets next to Watara, in the *marché*, sharing the same passion of having a professional career in football in Europe) sell several sorts of spices and other food items that are brought from West Africa.

Sometimes, they could take temporary unskilled jobs in construction like Watara and Olivier. Laurence is a Cameroonian who works as a truck driver. The Nigerian couple depend on begging to support themselves and their six children. Mathew, the husband, is a volunteering pastor in his congregation, and he seeks a job that suite his education credentials and his non-proficiency in the French language. Street-begging is pervasive, especially in public squares. According to Happy, begging is a more respectful source of income than engaging in 'dangerous illegal businesses,' or prostitution. Fatema, the 19-year-old Guinean girl is engaged in prostitution to support herself and her new-born baby that she delivered in February 2019, after being raped by a Moroccan man when she first arrived Morocco.

It is noteworthy that the tedious living conditions and difficulties experienced in Morocco by the majority of West Africans, combined with limited protection under the UNHCR, do not halt, prevent or urge them to go back to their home countries. Immigration could arguably be considered a cultural engine in West African societies that keeps on driving millions of people to risk themselves, their assets and bodies in a process that has few chances to end up in what they want. Sometimes,

people justify their presence in Morocco to the highly turbulent social and political situation in several West African countries that dis-motivate many like Happy to go back to Nigeria, finding Morocco to be a peaceful safe country. Seila, however, justifies her existence in Morocco, 'I want to live the best life. Life is better here'. It could be observed that coming to Morocco is a way for almost all of them to get self-actualised that is socially pressured and shaped. They described their unfixed jobs as 'troubleshooting,' meaning temporal small works in between until they find the proper job they are looking for. Oliver and Watara added, 'everything is not okay in our lives. Our life is a struggle. Leaving your country and preparing another life, with no guarantees, is a struggle. But, we believe in God, we know he will help us. We have faith'. When I asked about 'faith' and how it exists, despite the existential difficulties and increasing impossibilities in crossing to Europe. Isa replied:

> people have a lot of imagination and dreams, they pray for God, in West Africa to help them achieve what they want. They do not know if they will win or lose. A person has no choice but hard work, and to put in your mind that everything will be okay. They actually prepare themselves for two options. Because you will go back and find people surpassed you, those who got married, had children and you are still a foreigner.

Aliou holds the same philosophy of life, adding 'I am the elder of my family and they need me'.

2.5 Neighbourhood in (re)making

The local *marché* – the main space of social interactions – is paralleled by another novel market that the government tries to establish as a replacement to the old spontaneous people-led socio-economic space. However, the new market has failed to assume primacy over the original one that is more convenient and convivial. Urban gentrifications witnessed in the space of Youssoufia are arguably motivated towards establishing the authority of the state and not for empowering people and erasing social marginality. The ongoing renovations in the area, under the banner of the National Initiative for Human Development targeting the less-privileged and slum areas in Rabat, is a part of wider neoliberal policies urged by a securitisation strategy. Koenoraad Bogaert makes a compelling argument about how such state strategies targeting

slum areas reflect different phases of neoliberalism in Morocco.[103] These phases have a dialectic relation between 'rollout' and 'rollback'. The rollout of neoliberal policies in the 1980s caused wide social disturbance and riots led in most of the cases by the people living in slums (informal urban areas) because of the negative consequences of market liberalisation; the shrinking of public sector and the privatisation of major public assets.[104] These incidents urged the government to change its urban techniques to manage the slum areas that are characterised to be a 'rollback' to 'compensate for the negative social outcomes of structural adjustment'.[105]

Due to the fact that state policies towards informal came as a reaction to the urban violence of 1981, and the 2003 suicide bombings in Casablanca, Bogaert contends, 'Morocco's recent political transformation cannot be understood in terms provided by the mainstream narrative linking economic liberalization to democratization'.[106] But it reflects a mode of upgraded authoritarianism that is configurated at an urban level. Neoliberal policies are imprinted on the urban planning in which capitalist strategies determine how the city should be shaped at the expense of the intrinsic right of citizens to the city. This is very evident in Morocco's state-led programme of *the Villes sans Bidonvilles* (Cities without Slims) (VSBP) which targets the issues of urban poverty, housing and marginality. Such attempts strengthened the state interventionist polices again, after experiencing the limits of neo-liberal measures imposed in the 1980s. The state interest was targeted more towards the 'control of the physical environment' that led to a sort of 'objectification of the slum population', and 'to securitize the city through strategic and political motivated planning and administration'.[107]

The different development projects that the Moroccan government implements are not directed towards promoting the principles of citizenship, but they are intended to control the social spheres of the urban poor conglomerations. Bogaert avers a distinction must be made between 'sovereign city planning' and a 'city of security'. The former concept underpins a group of techniques that the state deploys in the

[103] Koenoraad Bogaert, 'The Problem of Slums: Shifting Methods of Neoliberal Urban Government in Morocco' [June 2019] The Hague Institute of Social Sciences 709.
[104] ibid 711.
[105] ibid
[106] ibid 712.
[107] ibid 714.

space-making of the city to promote 'monumental state architecture' that incites 'loyalty to a sovereign'. The later notion describes a contrast situation in which urban planning techniques are 'concerned with the biopolitical management of the urban population'. And Rabat definitely falls under the category of 'city of security', in which all state projects are directed towards calming the poor and not engaging them in making their own space of what they collectively see and have of needs. This point is particularly elaborated in relation to health facilities implemented in Youssoufia, further described in chapter 4.

In Rabat at large, it could be observed that the spatial disparities that the neoliberal orientation of the Moroccan government have produced intensify a societal violence towards Youssoufia and its people as a slum/popular area. Bogaert distinguishes two urban processes taking place in regards to addressing slums by the Moroccan government. The first process is basically the state interventionist approach to control and assure the fluidity of urban circulation, visibility and integration. This process is intertwined by a parallel process of 'large scale "neo-Haussmanian" projects' to embody the power of the state and the monarchy, like the case of the Grand Mosque of King Hassan II (being the second largest mosque in the world). Another example is Royal Avenue; a spectacular urban project which targets the attraction of tourism and foreign investment, following market measures. This project was executed on the ruins of the relocation of several families living almost ten kilometres from the centre. The new developmental projects Bogaert analyses in Casablanca are replicated in Rabat.

2.6 Conclusion

Access to health cannot be comprehended without an understanding to the social milieu of the people concerned. Incorporating this dimension is significant as migrants and refugees do not live in isolation from the societal and institutional factors shaping their host communities. In Youssoufia migrants came with great expectations that were harshly hit by the social realities of being illegal migrants caught in another form of poverty that they have been trying to escape. This tension is also caused by the long-term modes of developments led by the state that reveal on an orientation towards neoliberalism with adoption of global market measures, undermining real human-led development based on the pertaining needs of communities.

3.

THE OUTER WORLD OF YOUSSOUFIA

3.1 Introduction

The presence of the sub-Saharan Africans in Morocco, in search for a better life through the illegal migration to Europe, parallels a Moroccan deeply rooted socio-cultural tendency of emigration to Europe as an escape from diminished employment and persisting poverty. The geographical location of Morocco on the Mediterranean in the closest spot to the Spanish coasts, eight miles away, and the existence of two Spanish enclaves – Ceuta and Melilla – shifted the identity of Morocco in the geopolitical scene into a country of immigration for the last couple of decades. Immigration – the hot issue of the moment – has become heavily inscribed in the current Morocco's foreign policy and political character. The way in which immigration is discussed and manifested – worldwide – cause several transformations around which social relations and personal views are configured in Youssoufia. The endorsement of the National Strategy for Immigration and Asylum represents one of these transformations.

A general description of how immigration in Morocco became a top public issue is indispensable. This also must be complemented with a policy overview on how integration of migrants and refugees into the Moroccan national health system took place, besides a stakeholders analysis at both the national and community level to count for the different interrelated factors that impact the adaptability of the human rights perspective in the protection of refugee and migrant access to health. The contextual analysis could highlight how immigration became a source of capital for Morocco to either promote its image projection as human-rights guarding country – in a dwindling region that fell into intractable civil war, or regressed into authoritarianism

after experiencing the widely popular protests of the Arab Spring – or to manoeuvre for interests and space in the new geopolitical order.

3.2 Migration and Morocco: Culture, politics and momentum

The time in which this study was intended and conducted – in the academic year of 2018-2019 – was marked by an immense interest and outpouring momentum of the refugee/migrant theme whether in circles of academia,[108] art spaces, social initiatives, public debates, regional summits, film festivals or cultural activities. In Morocco, migration is a pivotal constituent of mainstream culture, state politics and society. Morocco is itself 'considered a "sending" or "emigration" country' with a global Moroccan diaspora of 4 million.[109] Then in the mid-2000s, Morocco became a 'transit' country that migrants cross to reach Europe, mostly through the Spanish enclaves of Ceuta and Melilla or by sea-crossing.[110] So Morocco is a migratory road. It is a dangerous journey that has ended thousands of lives. Those illegal migrants usually endured precarious living conditions, lacked any sort of protection, faced aggressive police crackdowns, inhumane detention and unlawful deportation on the Algerian borders. This was the situation prior to 2013, when the Moroccan government decided to develop a specific strategy that deals with immigration and regularises the situation of those illegal migrants living on Moroccan soil.

'Experts highlight Morocco's success story in the migration policy field in Rabat'

This is the headline of a news piece on the 11th edition of the World Policy Conference held in October 2018, in Rabat. The event was attended by Saadeddine Othmani, the Moroccan Prime Minister,

[108] Two conferences were held in UIR during the duration of my stay. One was on 'Migration' and the other one was entitled 'Africa (s) en Movement' (February 2019) which focused on migration, mobility, cosmopolitanism and cultures. See <https://movida.hypotheses.org/4196> accessed 18 April 2020.

[109] Parastou Hassouri, 'Refugees or Migrants? Difficulties of West Africans in Morocco' (Middle East Research and Information Project, 12 September 2017) <https://merip.org/2017/09/refugees-or-migrants/> accessed 13 March 2019..

[110] ibid.

who gave a speech on the efforts exerted towards the full integration of migrants, stating that 'during the monthly public policy session in the Parliament, Morocco has not become a transit point to Europe only, it has rather became a safe haven for settling down from Africa, due to social and economic factors'.[111] In addition, he emphasised how these changes are part of the inclusive transformation of the kingdom towards its international human rights obligations. The prime minister also highlighted the empowerment of those populations of concern through enabling them to access public services such as education and health, on an equal basis with Moroccans. He asserted the importance of coordination among public entities, civil society and international organisations, besides amending the legal and organisational frameworks related to illegal migration.

It was not the first international forum of this kind to be convened in Morocco. Hosting several high-level conferences and global events affirmed and promoted the image and standing of Morocco as a human rights holder. Morocco utilises immigration to enhance its diplomacy. Morocco was able to rebuild its broken ties with the African Union over the dispute over the Western Sahara self-determination cause. The Ministerial Conference for the African Agenda on Migration was held in Rabat, in January 2018, in preparation for the African Union Summit, in Addis Ababa, Ethiopia. The endorsement of hosting the Global Compact for Safe, Orderly and Regular Migration in December 2018, in Marrakech, was the most significant occasion. In all these high-profile occasions, Morocco is framed as the best exemplar in handling and dealing with uncontrolled illegal migration. The Moroccan government does not hesitate to proclaim credit and ownership on 'exceptionally un-wavered efforts' exerted to preserve the human dignity and rights, amid controversial stands towards migration and refugees worldwide. The strategy endow Morocco with prominence, in comparison to its neighbouring countries and the rise of the extreme right-wing in Europe that assumed popular support based on the plague representation of migration.

Morocco's exceptionalism should not be taken for granted. A critical reading of the wider contexts in which migration is constructed and

[111] 'Experts Highlight Morocco's Success Story in Immigration Policy Field' (*Maghress*, 1 November 2018) <www.maghress.com/bayanealyaoume/118731> accessed 18 April 2020.

reconstructed is required. The immigration policy of Morocco has been mostly shaped by EU interest that shifted drastically after 2015, after the eruption of what is named the 'refugee crisis'. The division of EU vision over the ideal solution of the 'refugee crisis' without breaching international law increased the importance of cooperation with Morocco where they can apply something similar to the original idea of 'regional disembarkation platforms'. Such a solution looks for outsourcing the problem. Stranded opinions inside the EU led to a greater policy disarray that overlooked human rights measures like the case in the EU-Turkey deal, search and rescue operations, the Dublin regulations (on asylum), Frontix and the Libyan coast guards (to prevent departure from Libya).[112] Countries along the Mediterranean on the other side of Europe resembled a viable solution, namely Morocco and Egypt to construct an immigration deterrence, framed within human rights standards.[113]

Addressing immigration by the Moroccan state exceeds the initial urgency of human rights. Immigration became one of Morocco's foreign diplomacy tools to forge its national income resources. Gerasimos Tsourapas reveals migration deals became an 'economic rent' with peculiar politics that could be similar to rentier states, but it has serious implication on human rights status. 'Governments (of Global South) are beginning to employ refugees in their foreign policy agenda, particularly [because of] their negotiations with industrialized state of the global north.'[114] The language has altered from 'shared responsibility' and 'human rights' into a new discourse of 'economic opportunities, refugees' self-reliance and their integration into host countries' development plans'.[115] Host countries deploy exaggerated narratives on challenges they face to attract external funds. 'The narrative of imminent state collapse are also aimed at lending urgency to host states' international appeals for economic aid.'[116] The political

[112] David M Herszenhorn and Jacopo Barigazzi, 'EU leaders consider centers outside bloc to process refugees' (Politico, 19 June 2018) <www.politico.eu/article/regional-disembarkation-platforms-eu-leaders-consider-camps-outside-bloc-to-process-refugees/> accessed 18 April 2020..

[113] ibid.

[114] Gerasimos Tsourapas, 'How Migration Deals Lead to Refugee Commodification' (*Refugee Deeply*, 13 February 2019) <www.newsdeeply.com/refugees/community/2019/02/13/how-migration-deals-lead-to-refugee-commodification> accessed 18 April 2020.

[115] ibid.

[116] ibid.

manipulation and abuse of immigration control and management created what Tsourapas calls 'coercive migration policy'.[117] In February 2017, hundreds of sub-Saharan African migrants were able to sneak to Ceuta through Morocco that was observed as an intended act through which the Moroccan authorities wanted to practice some pressure on Brussels in relation to the court sentence over the fisheries deal between EU and Morocco for the Polisario.[118] In 2018, Morocco received $275 million from the EU to stem migration through promoting inclusive economic growth and basic services.[119]

The picture described above on the overall context of higher politics around immigration takes on a curious twist in Youssoufia that can be concluded in two main points. First, the advent of those migrants, either in a search for better life opportunities or forcibly fleeing hard situations, resonate with many young people in Youssoufia who dream of moving to Europe. Sharing the same life vision creates an empathy that reduces extreme migrant-host community tension. 'I am Moroccan and a migrant in my own country,'[120] that was a first reaction of Radwan, a 26-year-old unemployed man who only finished his high-school education, when he knew I was conducting research on refugees and migrants. He continued, 'the only and the most popular dream is going to Europe for money, work, decent life, and beautiful women. It is to see life'. Radwan is one among plenty who share the same philosophy and are waiting for the right moment. The second point is related to the collective awareness of Morocco's duty to take care of migrants because of the aid it receives in this respect. So, any right Morocco gives to migrants and refugees is not perceived as a transgression on Moroccans' share in the country. Both facts ease the pre-assumed social tension and neutralise the presence of migrant class. Samir, the spices shop-owner in Youssoufia, comments while talking with some sub-Saharan Africans selling fruits in the stall facing his store, 'Morocco receives a lot money for hosting those people'.[121]

[117] Tsourapas (n 114).

[118] Bou'lam Ghbashy, 'Haal Tastkgdaam al-Rabat waraqaat el-Muhajerrin al-Afarcaa lildaghat 'ala Broukseil' (*France 24*, 22 February 2017) <www.france24.com/ar/20170222> accessed 18 April 2020.

[119] MEMO Middle East Monitor, 'Morocco Receives $275 m from EU to Stem Migration' (*Middle East Monitor*, 17 September 2018) <www.middleeastmonitor.com/20180917-morocco-receives-275m-from-eu-to-stem-migration/> accessed 18 April 2020.

[120] Interview, 1 April 2019.

[121] Interview, 15 February 2019.

3.3 Policy analysis

The breakthrough Morocco achieved with the development of the National Strategy on Immigration and Asylum in 2014 adds to a long trajectory of improving human rights record since the 1990s.[122] The strategy resembles a significant process of state establishment building in terms of constitutionalism and institutionalism. It also shows the prominence of Morocco over the international community that has since passed a novel international charter on the issue in 2016, seeking to ever integrate the world management of migration. All these changes streamed the necessity of explicit recognition of transit countries, located in Global South like the case of Morocco to be supported in the mission of hosting those displaced populations. However, despite the high promises that the strategy gave rise to, it failed to be fully implemented due to centralisation and lack of effective and efficient coordination between state actors and with other stakeholders.

The strategy came as a response to a report presented by the CNDH on situations of foreigners that raised a number of recommendations that included the necessity of having an integral strategy assuring human rights measures and protection of this vulnerable population. The CNDH enjoys institutional autonomy per constitutional mandate, since the amendments of 2011.[123] Based on the CNDH report, King Mohamed VI ordered the establishment of a new Ministry of Moroccans Living Abroad and Migrant Affairs that would be in charge of developing a national migration policy. A 'regularisation' process to fix the situation of illegal migrants was carried out in two inconsecutive periods of 2014 and 2016, by the newly formed ministry in collaboration with the Ministry of Interior. The first round accepted 24,500 applicants out of 28,000, and in the second, 21,000 persons were granted legal status from 25,600 applications. According to one of the NGO workers – working on advocating migrants rights – women and

[122] Marina Ottaway and Meredith Riley, 'Morocco: From Top-down Reform to Democratic Transition?' (Carnegie Endowment for International Peace September 2006).

[123] The rise of the Arab Spring motivated King Mohamed VI to undertake number of reforms to contain the social movement started in Morocco, known as 'February 20th,' that was inspired by what took place on the streets of Tunisia and Egypt. On the top, the constitutional reforms in 2011 established a greater potential for human rights; legally, institutionally and administratively. The new constitution includes 60 articles that are directly related to human rights and freedoms.

children were exempted from providing required documents. Women were seen as more vulnerable and worthy of extra assistance.[124] The fundamental issue with the 'regularisation' is that it is short-term, and not a permanent mechanism. The regularisation commission resumed on 4 December 2018, after 20 months of suspension. Similarly, the strategy that provides the governmental entities and other stakeholders with guidelines to address migrants and refugees issues, has no estimate of numbers of migrants, disaggregated by different determinants of their demographic composition, such as nationality, age, gender, etc.

The strategy has unfolded two tangible benefits. The first is the regularisation.

> It is a big trauma to live without (legal) papers. The regularization was a good move that eased life for migrants and allowed them to lead a normal life, open bank account, obtain housing, schooling. Before, they used to be subject to deportation to Algeria in desert where is nothing. It was an issue, people were not even able to get their shoes.[125]

Thus, the strategy represents a remarkable move by the Moroccan government in having a positive impact in the lives of refugees and migrants. Second, after the strategy migrants have the right to establish their own associations. I was able to meet a representative from a federation of twelve migrants NGOs, named *Le Plate-forme des Association Communates Subsahariene Organizations du Maroc* (ASCOM), founded in 2016. This could give more voice to migrants. ASCOM conducted the situational analysis which demonstrates that health, education and justice are priority areas for full integration of refugees and migrants. The reality of migrants after the strategy is different from official enacted laws and decrees, and they usually need NGOs' interference to obtain health services, according to the report.

The strategy preceded the New York Declaration for Refugees and Migrants that was urged by the so-called 'migration crisis'.[126] The declaration was a concrete step towards a unified universal vision and measure of the necessity of mainstreaming refugees and migrants into national development schemes that would assure protection and inclusion for one of the most vulnerable groups. The declaration

[124] Interview, 14 February 2019.
[125] ibid.
[126] UNGA, New York Declaration for Refugees and Migrants (A/RES/71/1 3 October 2016).

recognises the need for a proper response to what has been observed as unprecedented displacement. The declaration established a number of rules, like the necessity of supporting the countries receiving refugees and migrants. Consequently, the Leaders Summit of 47 states, on the next day, agreed to increase humanitarian aid and expand access to a 'third country solution'[127] that Morocco can be categorised under. So now, the global tendency favours mainstreaming of refugees and migrants to be effective migration management.[128] Based on the declaration two grand action-plans were designed: the Global Compact on Refugees;[129] and the Global Compact for Safe, Orderly and Regular Migration[130] that came out after two years of consultations, in 2018. Although both are not legally binding, they provide a comprehensive framework to deal with migration. Health is included in section 2.3 in the Global Compact on Refugees[131] and in action (e) of objective 15[132] of the Global Compact for Safe, Orderly and Regular Migration, in line with the Sustainable Development Goals Agenda. Both action plans match the WHO Thirteenth General Program of Work (2019-2023), including the achievement of UHC for refugees and migrants. The first priority in the WHO Country Cooperation Strategic Agenda (2017-2021) focuses on moving towards UHC, including two relevant goals:[133]

> 1.2. support a reform of person-centered primary health care, anchored in family medicine, with the involvement of the community
>
> 1.5. Supporting efforts to strengthen the provision of services dedicated to the management of people with specific needs, especially migrants populations and with disabilities and elderly

[127] UNHCR, '*The New York Declaration: Answers to Frequently Asked Questions*' (2016) <www.unhcr.org/584689257.pdf> accessed 9 March 2019.

[128] ibid.

[129] UNHCR, 'Global Compact on Refugees' (26 June 2018).

[130] Global Compact for Migration, 'Global Compact for Safe, Orderly and Regular Migration' (11 July 2018).

[131] The specific section on health came in two points; 'to expand and enhance the quality of national health systems to facilitate access by refugees and host communities' and to 'build and equip health facilities or strengthen services'.

[132] Objective no 15 states 'provide access to basic services for migrants', including six points. The fifth point is the one on health, precisely mentioning 'incorporate the health needs of migrants in national and local health care policies and plans, such as strengthening capacities for service provision, facilitating affordable and non-discriminatory access,, reducing communication barriers, and training health care providers on culturally-sensitive service delivery, in order to promote physical and mental health of migrants and communication overall, including by taking into consideration relevant recommendations from the WHO Framework of Priorities and Guiding Principles and to Promote the Health of Refugees and Migrants' (Global Contact for Safe, Orderly and Regular Migration n 123 23).

[133] WHO, 'Country Cooperation Strategy at a Glance' (WHO Morocco 2018).

Implementation remains a challenge; and it would include variations in methods and results. The Global Compact on Migration caused lots of tension and polarisation between member states. It was also criticised for being too broad and ambitious, with no specific deadline to help states to commit. It is primarily up to the national governments of states and multilateral institutions involved.[134] Arguably, the implementation of the compact objectives entail political, technical and financial challenges, especially in regard to objective 15 related to providing access to basic services to migrants. It is critical to the wellbeing of migrants, but at the same time it is 'controversial where citizen struggle to obtain such services'.[135] Therefore, migration experts perceive the flexibility of the compact as a positive element in balancing between human rights of migrants and the state's prerogative role in designing its own migration policy based on empirical evidence, priorities, capabilities and resources.[136] The executive office responsible for refugees in Morocco is the *Bureau des Refugees et Aptrides* (The Office of Refugees and Stateless Persons) (BRA). Yet, the actual adoption of a domestic asylum law and procedures is still pending and the UNHCR, thus, still handle RSD (Refugee Status Determination) interviews to assess the asylum seekers' applications until it could be put in action. Furthermore, in October 2015, the Ministry of Health, the Ministry of Moroccans Living Aboard and Migration Affairs, the Ministry of Interior and the Ministry of Economy and Finance endorsed a partnership agreement over providing the basic medical coverage scheme for women refugees and migrants.

Providing free access for migrants to PHC incrementally started in 2003, in which they were permitted to receive free preventive and curative services delivered under a communicable diseases control programme.[137] In 2005, a law was endorsed to accept all migrants in emergency cases regardless of legal status. Then in 2008 expanding free access to all health services provided by the network of PHC facilities

[134] Kathleen Newland, 'Global Governance of International Migration 2.0: What Lies Ahead?' (February 2019) 8 Migration Policy Institute <www.migrationpolicy.org/research/governance-international-migration> accessed 18 April 2020.

[135] ibid.

[136] ibid.

[137] Interview with IOM – Morocco interview, IOM country office (Rabat, Morocco 3 April 2019).

started.[138] In 2013, mainstreaming gave greater granters in the new National Strategy for Migration and Asylum.[139] Recently, the public authorities in charge or migration along with IOM and other relevant stakeholders embarked on developing a National Strategic Plan on the Health of Migrants (2017-2021). This plan is driven by the National Strategy for Immigration and Asylum. At the same time, it goes hand in hand with the national goal of implementing UHC for all, including refugees and migrants. It entails the inclusion in the health services coverage plan for the most deprived or the creation of a specific health insurance scheme.[140]

Implementing efficient mainstreaming is subject to number of factors, namely the situation of the national health care system in general, the national approach towards refugees and migrants, and the level of collaboration and coordination among major stakeholders. In the case of Morocco, massive efforts are exerted towards aligning with global human rights and development agendas and standards which makes it a relatively 'impressive model' comparable to the rest of countries in the same region or in the categorisation of low- and middle-income countries. Yet, what is ideally enclosed in papers differs from reality and that needs to be explained.

3.4 Actors mapping

Actors mapping analyses the existing dynamics and power relations among major stakeholders responsible for managing and deciding refugee and migrant access to health. Such an analysis is instrumental in eliciting challenges pertain at coordinating health access for refugee and migrant communities in Youssoufia. Relevant actors can be grouped under one of the three general categories; public authorities, international organisations and NGOs. The mapping is done on a national level that is very applicable to Youssoufia, since it is located in Rabat. Conversely, the official recognition of immigration issue by the government is

[138] WHO, 'Situation analysis and practices in addressing the health needs of refugees and migrants: Examples of public health interventions and practices' (WHO Eastern Mediterranean Region 2018) <www.who.int/migrants/publications/situation-analysis-reports/en/> accessed 31 March 2019.
[139] ibid.
[140] ibid.

a recent development that resulted from a persistent civil society movement capitalised around the severe mistreatment and inhumane conditions that only those who are lucky could survive. Nevertheless, civil society mobilisation and current developments overlook the necessity of including a genuine representation and participation of migrant populations in all different policies, programmes and projects that target them to be part of conceptualisation, implementation, monitoring and evaluation. The heterogeneity of migrants living in Morocco could be a challenge to have a representation that could voice their needs and allow them to have responsive actions.

Figure 6: Stakeholders related to refugees and migrants access to health

On a national level, the CNDH (National Council of Human Rights) is chiefly responsible for monitoring the human rights situation and violations thereof to provide recommendations and consultations over the follow-up of the National Immigration and Asylum Strategy of Morocco. It presents a third eye over the government and executive authorities performance, assisted by several monitoring chapters located nationwide. Above all, the CNDH enjoys constitutional autonomy, since 2011, which grants a degree of check and balance. With the official presentation of the joint situational analysis report on the acute living

conditions and multi-faceted challenges refugees and migrates face in Morocco, in September 2013 in collaboration with IOM, a new Ministry in charge of Moroccans Living Abroad and Migration Affairs (MRE) was commanded to be created a month later. The ministry is responsible for mainstreaming refugees and migrants into the national health system.

The official entities enlisted above are relatively new, in comparison to other civil society organisations and NGOs that have been operating in the field for a long time. They were solely responsible for migrant protection and human rights monitoring, besides several advocacy activities in order to advance migrant rights in the government's agenda. A momentum was built after the massacre events of 2004/2005 in Melilla that led to the death of around 500 people, while thousands more drowned in the Mediterranean. At this point, organisations and people working in the field of immigration felt the urge to call for migrant rights through an organised agenda and unified goals. According to my interviewees' reflections on these landmark events, a dialogue started to be well-established between associations, based on no external funds, but self-support that complied the government to listen and react. All these efforts then resulted in the collaboration of the CNDH to get involved in the issue that became a priority in the national human rights agenda to combat losing lives.

However, the space enjoyed by the civil society organisations is limited. The representatives I was able to talk with affirmed that they are not powerful enough to compel the government to (re)act until there is a political will to do so. The National Migrant Protection Platform (PNPM)[141] is a coordination mechanism and an example of the ceiling to civil society organisation operations:

> The PNPM had some impact, but it is not a prime driver of decision-making. In the end it is government that decides. In our organization, we monitor, report and denounce. That is the case most of the time. We work and know that we will not necessarily change something.[142]

[141] The National Migrant Protection Platform (PNPM) is an advocacy platform formed in 2009. The PNPM is currently composed of 13 members working for the promotion and protection of the rights of migrants in Morocco. Advocacy and field organisations, the PNPM members have a long experience on the migratory theme and, by their diversity, have developed an expertise on various subjects concerning the situation and the rights of the migrant population in Morocco. Through its actions, the PNPM seeks to stimulate a dynamic of social change favourable to the rights of migrants. See <www.pnpm.ma/> accessed 18 April 2020.

[142] Interview, 14 February 2019.

One of the interviewees pointed the fact that the Ministry of Interior does not provide the precise number of refugees and migrants, creating a state of ambiguity and giving the impression that they are a lot. 'Given also the pressure practiced on Morocco by the EU – since 2015 – to establish a disembarking center like the case of Turkey has altered the state attitude towards securitization that has a backlash on human rights,' the same interviewee adds. 'So, in this context, we try to play our role by working in accordance [with] human rights frameworks to act as an alarm in case of violations, providing information, describing issues and drawing recommendations to improve the status quo'. The reality is:

> the state gives some space but then it tightens it up, there is an invisible ceiling that everybody knows. But Morocco works on building the constituents of state institutions that could be evident in the CNDH performance. The CNDH took our stand in constructing and working seriously developing a specific strategy on immigration.[143]

The problematic nature of the Moroccan healthcare system hinders the optimal advocacy for migrant health. The problems are not exclusive to migrants, but they are shared by the Moroccans but with a different multitude. According to a community-based organisation representative it is a dilemma that surrounds their efforts and ability to mobilise towards a full recognition of migrant right to health and health access. He added:

> even if the Moroccan state receives money to enhance the living conditions of migrants, it is reluctant how to spend it in a way would not provoke the rest of populations' grievances, in case they feel that migrants and refugees are leading better life and getting more opportunities.[144]

Caritas and UNHCR are the most repeatedly mentioned organisations by migrants I met in Youssoufia. Unfortunately, it was difficult for me to interview them. Caritas is one of the oldest organisations started working on supporting migrants in the fields of education and health. Caritas has a social centre and a clinic that is located in Taqadoum, around five minutes-walk from Youssoufia. UNHCR is concerned with refugees and asylum-seekers. These two organisations are referred to be both

[143] Interview, 14 February 2019 (n 142).
[144] Interview, 15 February 2019.

primarily responsible for supporting them, and at the same time not sufficiently attending their needs but rather that they exacerbate their bad conditions due to administrative hurdles and delays. In this context, urgent health cases are less likely to be handled on time, increasing the severity of pain and the probability of death. Fatema narrates she was raped, and she reported the case to Caritas where they wrote her case, but she did not receive any immediate assistance:

> Caritas helped me with nothing … Look to the baby she is so tiny, I have nothing to eat, has no clothes, I do not work. Caritas is wasting our time for nothing because each time people will tell them go there and here … Caritas is no good.[145]

Zoubir says:

> If I am sick, I will not go to Caritas and collect the medicine for free, they will be tossing you (telling you go and come) and sickness has no joke, so you go and come before you see a doctor for several rounds.[146]

The same was told about UNHCR. Obtaining a refugee or asylum status takes a long process of applying, scrutinisation and receiving the final reply. Sow explains, 'I went to UNHCR and wrote my story in a form. They did not give me a status and they tell me each time tomorrow and they did not let me inside just outside the fences'.[147]

IOM-Morocco has a specific programme on migrant health, in which the health promotion component is implemented with close collaboration with the government to enhance the mainstreaming of migration to the national healthcare. In an interview with health component heads, it was affirmed that health is a cross-cutting theme in other themes of counter-trafficking, gender based violence (GBV) and labour migration. In comparison with other transit countries, 'Morocco has a comparative advantage for being a migrants-friendly country'.[148] This is evidenced by the Ministry of Health's Strategic Plan on Health and Migration that is a part of a broader National Health Strategy. It is not issued yet. IOM works on migrant health through partnerships with NGOs – like *Association Morocaine de Planification Famile* (AMPF)

[145] Interview, 7 March 2019.
[146] Interview, 22 March 2019.
[147] Interview, 5 March 2019.
[148] Interview, 3 April 2019.

– that provide direct assistance to secondary and tertiary health care and tries to guide beneficiaries to PHC facilities. Since migrant health and wellbeing cannot be guaranteed by enhancing health access alone IOM tries to address social determinants of health, 'through promoting access to jobs, food, drugs and sanitisation'. The main barrier remains securing funds. The UNHCR in Morocco publicised information about the fiscal deficiency of 87%. It hinders the sustainability and consistency of interventions. 'So, we have criteria to select the most eligible for assistance,' IOM representatives justified. Another barrier they mentioned is reaching out to the population of concern:

> some have no information. And some know and come at our doors asking for help. They are not hegemonic and thus uneasy to reach out … Gaps reside in determinants of health either be it in protection, safe house/shelters, GBV, or/and housing that is a big challenge.[149]

Promoting migrant and refugee access to health is subject to the governmentality and politics of civil society organisations that are primarily determined by availability of funds and not necessarily the cause they were established to serve. This fact can make organisations keener to promote a marketable self-image that enables them to attract funds and proclaim credit. Thus, NGOs, especially those with more expertise, are less likely to collaborate, share and democratise the operational field to be more inclusive and accountable, especially to their consistencies. An international consultant on migration based in Morocco reflects on this competition that strongly presents in the PNPM management. To an equal degree, organisations are – sometimes – not transparent in sharing the results of their activities because they either fear accountability, or they have an unrightful claim on the target beneficiaries who they talk and deal with them as possession and not individuals with full potentials. So, they would be calling them 'our migrants' which indicates a lack of ownership.

[149] Interview, 3 April 2019 (n 148)

3.5 Conclusion

Having a specific national strategy to the issue of immigration is a significant step that is needed for other assistive factors for desired outcomes. A national strategy should have an enabling environment for civic participation which is capable of influencing the decision-making process. The institutionalisation of genuine civic participation is not possible without access to and existence of accurate public information. Secondly, there must be representation of migrants and refugees in policy dialogue to have a voice in matters that touch them.

4.

REFUGEE AND MIGRANT ACCESS TO HEALTH IN YOUSSOUFIA

4.1 Introduction

The fieldwork encounters, interviews and secondary sources suggest refugees and migrants' access to health in Youssoufia – and the city of Rabat in general – has been noticeably enhanced due to the increased availability of health facilities that were part of the state-led urban gentrification to less-privileged communes, under the umbrella programme of the National Initiative for Human Development. Also, the National Strategy for Immigration and Asylum sensitised public health facilities on refugee and migrant rights and entitlements. Through the narrative of personal experiences of migrants I met in the sphere of Youssoufia, I have found out they are less likely to use medical facilities in a case of illness. That affirms what Marta Crivos argues about how the narrative about the self and others is not just a strategy to communicate medical customs, but 'it enabled me to focus on the sequence of decisions and actions oriented to the resolution of the illness as a practical problem, looking at the procedural and dynamic aspects more than to the systematic aspects of traditional medical knowledge'. [150]

At the same time, the avoidance of sub-Saharan Africans to accessing healthcare can be attributed to institutional and operational gaps and reasons, but it takes on a quintessential cultural expression. It rather comes as Crivos refers to as a 'practical dynamic' to avoid all the hassle that they might face in accessing professional medical care. Or it entails a copying mechanism that people deploy, given their unawareness of their

[150] Marta Crivos, 'Narrative and Experience: Illness in the context of an Ethnographic Interview' (2002) 29(2) The Oral History Review 13-15 <www.jstor.org/stable/3675615> accessed 18 April 2020.

right in accessing proximate free of charge BHCs, regardless their legal status. It reflects how lack of jobs, poor living and housing conditions, discrimination and an inability to move forward can lead them to depend on self-medication and alternative medicine of substances brought from their home of origins which they call West Africa. These substances are used in cooking and medicine for different purposes. Investing, believing and habitual consumption of their West African recipes constitute what Marybeth Macphee distinguishes as 'an underlying cultural pattern of interiority,' in her study about medical pluralism in Morocco practiced by Saharan housewives who draw on 'oral tradition, personal experience and common sense in their efforts to prevent, diagnose and treat illnesses in the household, before paying a professional healer'.[151] This pattern of 'interiority' allows sub-Saharan Africans to retain some sort of the trust they lost, as they try to go on in their lives and/or assimilate in their new socio-cultural environment. Conversely, the West African lifestyle provides a 'moral and cosmological context for everyday life rather than a cultural trait or explanatory model'.[152]

In this chapter, I try to detail refugee and migrant access to health in Youssoufia, in relation to the major performance criteria of availability, accessibility, quality and accountability. It is indispensable to review the overall situation of the Moroccan healthcare system in the first sector in order to fully explore health access for refugees and migrants. In the 2000s, many reforms took place to enhance health access for Moroccans, to overcome a number of serious setbacks in the health sector, after implementing the SAPs in the 1980s. The enacted reforms aimed at enhancing healthcare availability by expanding BHCs and establishing obligatory health insurance financial schemes. Despite the tangible improvements that have been documented, in terms of health indicators, inadequate health sector governance and lack of community participation would undermine the significance and sustainability of these improvements. Youssoufia enjoys several health facilities that are fully operative, with a few number of others under construction or about to be inaugurated, but they are provided as a gift from the king, not as a right. Besides patronage, the reforms followed a top-down approach with no equal consideration for solid governance and community-participation.

[151] Marybeth Macphee, 'Medicine for the Heart: The Embodiment of Faith in Morocco' [June 2003] Medical Anthropology 53, 54.
[152] ibid.

The absence of the latter is particularly reflected in people's intrinsic collective feeling of poverty, despite the drastic ostensible developments of the area. Talking to the Moroccan residents of Youssoufia about health services, they do not express extreme dissatisfaction, not clear satisfaction. But they share the same idea that it should be better.

4.2 Availability

4.2.1 The current Moroccan health system

> Morocco knows two health care systems: private and governmental, the first of which is only accessible by money and the second is often associated with decreased quality of care which may also apply to the private sector[153]

This quote almost describes the ubiquitous reality of healthcare in many countries of the Global South that is divided between decaying public health services and private health facilities that are affordable to few where also quality cannot be granted. The quoted article that was written in 2008 describes the present situation of health in Morocco to be 'everything but humane and accessible healthcare system. Patients of governmental hospitals are required to pay for equipment such as sterile syringes or bandages'.[154] Patients also suffer from a delay in diagnosis that impacts the survival status. The article states that the eight million poor who come under the health insurance are not capable of covering the medical costs. Out-of-pocket health expenditure reached 88.3% (percentage of private expenditure on health between 2009 and 2013).[155] Since 2005, the government started implementing new healthcare financing schemes to assure the health coverage.

Prior to the episode of reforms started in the mid-1990s by the Moroccan government, health sector was identified with critical lackings and as being the most corrupt sector in Morocco.[156] The directed reforms attempted at achieving health services quality and equity through expanding PHC,

[153] Charifa Zemoouri, 'Examples of Morocco's Continually Failing Health Care System' (*Morocco World News*, 2008) <www.moroccoworldnews.com/2018/03/241860/morocco-continually-failing-health-care-system/> accessed 18 April 2020.

[154] ibid.

[155] Jennifer Prah Ruger and Daniel Kress, 'Health Financing and Insurance Reform in Morocco' [July 2010] Health Affairs 1009.

[156] ibid.

health insurance coverage and supporting private medical enterprises. Noticeably, all enacted reforms have adopted the language and the normativity of global health and international development initiatives, doctrines and conventions. However, the returns of such initiative have been modest – in my assessment – due to the lack of equal consideration to establishing the principles of good governance that could grant check-and-balances, citizen participation and social accountability. Community oversight and participation, and user-accountability are crucial elements to assure ownership and sustainability of such reforms.

The health sector has endured long-term neglect and a number of serious issues that undermined its quality, due to budget-cuts imposed by implementing the SAPs. The problems include outdated equipment, limited number of services provided and a scarcity of doctors (estimated to be less than 1,000 doctors for the entire population). The underfunded health sector suffered from staff shortages, because of the inability to recruit enough medical and administrative staff.[157] The disparity between rural and urban areas increased, having a concentration of secondary and tertiary health facilities in Rabat and Casablanca. The lack of qualified medical and support staff contributed to the dwindling of quality and disparities of health coverage, particularly in rural areas. Morocco is listed one of 53 countries with a critical shortage of health workers, because the poor management of hospitals have led to an exodus of health care personnel.[158] Economic inaccessibility to medicine has increased.[159] Morocco is also among the five lowest-ranking countries in the adult health and expenditure component of the Human Development Index among the 22 countries of the East Mediterranean region division of the WHO.[160] The annual public funding to health sector does not exceed 6% of the GDP. As a result, Morocco faces a huge challenge in delivering services to secure good health for all citizens.[161]

[157] Oxford Business Group, 'Developments and Challenges in Morocco's Push Towards Universal Health Coverage' (*Oxford Business Group*, 2018) <https://oxfordbusinessgroup.com/overview/increasing-coverage-developments-and-persisting-challenges-push-towards-universal-health-0> accessed 18 April 2020.

[158] Hady Fink and Karen Hassman, 'Practice Insight: Addressing Corruption Through Sector-Approaches: Exploring Lessons from the Moroccan Anti- corruption Strategy' [May 2013] CHR Michelsen Institute 1, 10.

[159] ibid.

[160] Khaled Tinasti, 'Morocco's Policy Choices to Achieve Universal Health Coverage' [25 May 2015] Pan-African Medical Journal 21, 22.

[161] ibid 24.

In 1995, hospital and institutional reforms started to took place, followed by regionalisation[162] in 1996 then decentralisation[163] efforts in 1997. 2002 witnessed the introduction of several reforms of financing health care. In 2010, the Moroccan Central Authority for Corruption Prevention (ICPI) identified the health sector as a priority, part of its sector-based work approach, in fighting the severe problem of corruption in Morocco.[164] The ICPI conducted a 'situational study' to assess the width and breadth of corruption residing in the health sector of Morocco. The study showed corruption manifested in three forms; 1) bribing the medical staff to receive public services without being entitled; 2) under the table payments for the provision of health services or management of public goods; and 3) exchange of services based on favouritism. The study was followed by prioritisation and drafting of an anti-corruption strategy for the health sector. Despite the fact that this move was extremely revolutionary and daring in reforming one of the most important sector of public services, the centralisation of power and lack of governance did not allow for effective and efficient implementation of this strategy aimed at combating corruption.

Currently, approximately two-thirds of the population have medical coverage by one of two state-financed schemes; the Mandatory Health Insurance (AMO); and Medical Assistance Regime (RAMED). AMO has been implemented since 2005 and covers about 34% of the population. It is a mandatory public health care scheme for employees in the formal public and private sectors. In 2012, the government introduced *Regime d' Assistance Medicale* (RAMED), a non-contributory basic health assurance to cover the informal sector that is around 30% of the population, under a major condition of proving impoverishment. A certificate *d'indigence* (of poverty) must be obtained to have free access to public health facilities. With the advent of the Arab Spring

[162] Regionalisation aims to set up strong, democratically elected regional institutions that enjoys a degree of fiscal autonomy in order to ensure sustainable development. The health system is expected to benefit from this regionalisation order which will improve financing and management of health resources, health access and service delivery. Regionalisation presents a level of state action in national strategies implementation and reforms with intersectional collaboration to allow the accountability of external services and local communities. Regularisation has been put in place for regularisation and redistribution of resources based on negotiations and partnerships with public sector, private sector, civil society (WHO 2010).

[163] The decentralisation of Moroccan administration divided the country – by law 47-69 – into 16 economic regions, 45 provinces, 26 prefectures and 1,547 communes (WHO 2010).

[164] ibid.

uprisings in 2011, significant governmental and institutional reforms were implemented, including the Constitution (2011) that emphasises the equal access of citizens to healthcare, basic medical coverage, solidarity, health equality and equal distribution of health resources. The enlisted health insurances cover the secondary and tertiary healthcare. Access to PHC is free of charge for all, including refugees and migrants (even those without legal status). For those illegal migrants, the problem lays in referral to specialised medical services, because they are excluded from any sort of health insurance coverage. They could be assisted by Caritas. Migrants with legal residence documents in Morocco are entitled to RAMED, if they are not formally employed.

Promoting health access to basic care and health coverage are combined with other initiatives directed towards improving the social determinants of health and poverty reduction. A series of reforms started with a charter on education in 2000, a reflection to evaluate 50 years of human development in Morocco in 2003, the Equity and Reconciliation Commission and the Moroccan Family Code (Moudawana) in 2004, and the National Initiative for Human Development (INDH) in 2005. Most of the health restructurings in Youssoufia come under the banner of INDH. The initiative was conceptualised to combat poverty in rural areas, social exclusion in urban areas and vulnerability.[165] The INDH found support[166] from international cooperation including the World Bank who support 'the government in improving inclusiveness, accountability and transparency of decision-making and implementation processes at the local level in order to enhance the use of social and economic infrastructure and services by poor and vulnerable groups'.[167]

The operations review of the INDH – in 2014 – shows that the programme objective has a high relevance in helping the government to accelerate its poverty reduction efforts, based on a bottom-up approach. It entails a mode of a socio-economic development informed by citizens participation in local governance, partnerships, sustainability and results-

[165] Waim Boutayeb and others, 'Action on Social Determinants and Interventions in Primary Health to Improve Mother and Child Health and Health Equity in Morocco' [February 2018] International Journal Equity Health 15. 19.

[166] The initiative is financed by 60% from central government, 20% from local government and the remaining 20% from external donors.

[167] World Bank, 'National Initiative for Human Development (INDH)' (2014) <http://projects.worldbank.org/P100026/national-initiative-human-development-support-project-indh?lang=en&tab=documents&subTab=projectDocuments> accessed 18 April 2020.

driven goals.[168] However, the review points out that design was modest, as it was driven towards achieving outputs and not outcomes.[169] The projects in the programme achieved more than the set indicators set for civil society participation that consists of elected representatives, women, youth and the poor in governance structures. Yet, the report indicates the quality of representation did not unfold on solid social movement-building. The poor, women and youths who participated did not have 'voice in the deliberations'. There is absence of indicators that could confirm their actual influence on the proceedings. 'While most of the projects are high impact and poverty-reducing, in only some cases are the participatory development plans genuinely phased investment programs built on a truly participatory process, validated and owned by poor people and poor communities.'[170] In addition, the review reveals that accountability measures like grievances mechanisms were not formally set up all across the programme. The review, thus, concludes, 'improvements in transparency and accountability remain to be made'. That gap is actually attributed to weakness in the design and the implementation of monitoring and evaluation which overlooked accountability and transparency measures. Therefore, the review denotes this gap as a significant risk to development outcomes, stating an unfinished agenda in key areas of participation and implementation, ownership, planning, monitoring and evaluation, and exchanging information.

These challenges signify the efforts that the government must exert in light of being itself accustomed to centralised decision-making. The review's assessment of programme supervision highlights it was challenging because of the programme size and the introduction of concepts that were totally new and unfamiliar to the authorities such as inclusiveness, transparency and accountability, with a tight preparation phase. That also accumulated with the lack of specialists in the 'Participatory Community-driven Development Process' among the supervision team. Ironically, the INDH National Coordinating Unit responsible for implementation did not have a decision-making authority. Even if the government has a strong ownership and a dedicated performance, it is not close to satisfactory with the absence of the second part of the equation; the rights-holder.

[168] IEG ICR Review, Report Number ICRR14356 <http://documents.worldbank.org/curated/en/817541475092702301/pdf/000180307-20141120030237.pdf> accessed 18 April 2020.
[169] ibid.
[170] ibid.

In this regard, the review lucidly states that 'there is no mechanism for beneficiaries to report systematically on implementation, usage and satisfaction'.

RAMED resembles another example of a great visionary national programme that suffers from the pitfalls of poor governance. The implementation was subject to several complications. The public hospitals are not well-equipped. Referrals to secondary and tertiary health systems take time and it might cause a delay that could force people to access private health facilities as the only available option. The medical care is not free because the patients bear the costs of transportation and medicine. Institutionally, financing was contested among three different national institutions that threatens having a viable sustainable mechanism of RAMED. This goes back to the prolonged gradualness of implementation. RAMED was conceptualised in the late 1990s and got implemented in 2012, more than a decade in between. That makes RAMED less relevant to the context of endorsement back then. Experts conclude that RAMED is a part of a flawed system. Policy analysis of RAMED underlines that the process lacked well-structured learning and lack of knowledge management. It also notices that some decisions and actions had a very long duration like the pilot experiment, 'it is not sufficient, other conditions like resources or political willingness determine the results of the policy'.[171] 'There may be some progress but the process of health policy design in Morocco remains characterized by verticality in the decision-making imposed by the rules of hierarchy.'[172]

These structural and institutional setbacks in healthcare management are lived and experienced by citizens and health providers alike. In mid-April 2019, my Moroccan/Spanish-citizenship holder friend fainted during her visit to Marrakech. It took an hour for the ambulance to arrive and lift her to the nearest public hospital. She felt she was about to die, suffocated by the oxygen mask improperly placed on her face. Her body was in complete fever and she could not feel her arms and legs that were numb. The hospital staff did not carry out a thorough examination. They, instead, prescribed her some painkillers without a precise diagnosis of what happened to her. She was forced to go to a private clinic to know

[171] E Akhnif, J Macq and B Meessen, 'The Place of Learning in a Universal Health Coverage Health Policy Process: the Case of the RAMED Policy in Morocco' [2019] Health Research Policy and Systems.

[172] ibid.

the leading cause of these symptoms and paid around 150 euros. The end of the same month witnessed a group resignation of 300 doctors working for the public health sector in the region of Tangier (in Northern Morocco) and 123 doctors in the Beni Mellal region (the central Morocco). The doctors listed their names in a common resignation form which they stated was a reaction and a disapproval of the 'catastrophic and off-putting conditions that affect the public health sector,' and how the work conditions do not meet the minimum appropriate standards, restricting them from fully carrying out their duties. 'They added that the services do not live up to the expectations of Moroccan citizens and that they can no longer be blamed for the "failure" of those in charge to guarantee citizens' rights to healthcare under the Constitution.'[173] All these ongoing recent incidents reaffirm that one of the major challenges in the Moroccan health sector that remains unaddressed is governance, in which the Ministry of Health is the singular decision-making body. This deprives communities from the right to take part in programme design, implementation and monitoring.

Morocco is recently moving towards opening the healthcare market for private and foreign investors. In February 2015, a new legal framework was passed to liberalise the ownership of private clinics by non-medical professionals. The increase of healthcare expenditure increased to 7.7% over the last four years, in which the majority of expenditures went to private sector. Health is under-documented when comes to sub-Saharan immigrants.

4.2.2 The health landscape in Youssoufia

The areas of Youssoufia have four BHCs. The BHC is referred to in local language as either *markaz sihi* (medical centre) or *mustawsaf* (clinic). Each must serve a definite constituency, based on the administrative blueprint of the city. Therefore, each user must show his or her identification card that includes an accommodation address to access the facility. All services and medicines are free of charge for all, even undocumented migrants. The BHC includes several services such as reproductive health, paediatrics, women's health, tuberculosis, dentistry and general medicine,

[173] Mohamed A Benabou, '123 Moroccan Public Sector Doctors Resign En Masse' (*Morocco World News*, 26 April 2019) <www.moroccoworldnews.com/2019/04/271574/123-moroccan-public-sector-doctors-resign-en-masse/> accessed 18 April 2020.

vaccination as well as a pharmacy. They provide drugs for five chronic diseases, including hypertension and diabetes, for free. The BHCs were originally three, in addition to *sahat el-shabab* (a youth space) that was established in 2004 to have a youth-friendly medical facility for young people who might shy from accessing health care and talking about their health problems.[174]

When I started my field work, construction of two more health facilities was taking place. One of them is located at the forehead of the *marché*, overlooking the central plaza of the *Mini-park*, named *Centre Medical de Proximite Fondation Mohammed V Pour La Solidarite* (the Proximate Medical Centre of Mohamed V Foundation for Solidarity) that was inaugurated by his highness King Mohamed VI on 11 May 2019 (during Ramadan) (see figures 7 and 8). The establishment is referred to as a solidarity project that the king commanded in March 2017 to promote access to health as one of the citizenship pillars. The king also stated, on this occasion, the importance of enhancing the health sector through providing quality and proximate services in order to reduce the overcrowding at general hospitals and to overcome delays in medical care. The centre operates 24/7 for enhanced availability of emergency interventions, besides general and specialised medicine. The centre lays between primary and secondary health care.[175] What is striking is the perplexity between charity-driven and national programme implementation. The naming of the facility as 'proximate' reflects something particular about the Moroccan politics. Why it is named 'proximate'? What does it imply and convey in the public perception of the Youssoufia commune? Why is the new establishment presented by the Mohamed V Foundation for Solidarity and not under the infrastructure scheme of the Ministry of Health that is said to be its partner? What is the political symbolism and power that this label holds? In my conversation with a couple of political science professors in UIR; one of them presumes that it is a part of calming or shutting up the masses; there are sports and social initiatives that are established with the same style, for proximity. The other professor suggests that it is credit-claiming by the palace.

[174] Assahraa, *'Awl Mu'asasa mn Nu'aha fil Maghreb Tu'naa Bisihat el-Shabab el-Nafsiya wel 'Udouyia'* (The first institution of its kind that is concerned with the psychological and physical health) (*Assahraa*, 13 June 2013) <https://assahraa.ma/journal/2013/165461> accessed 18 April 2020.

[175] Ihata, 'The King Inaugurates a Medical Centre for Proximity in Rabat' (*Ihata*, 11 May 2019) <http://ihata.ma/?p=188466> accessed 18 April 2020.

However, the rhetoric unfolds on a patronising tone, as well as implicit social stigmatisation to Youssoufia, as a poor needy neighbourhood. This could be linked to anthropologists' suggestions that health is not about availability of healthcare, but it must be operationalised as a right and healthcare must be seen as 'common' for the public good, where health providers are accountable for their communities.[176]

Figure 7: Minipark at the entrance of Youssoufia

Figure 8: The Proximate Medical Centre of Mohamed V Foundation for Solidarity – Youssoufia

[176] Sandy Smith-Nonini, 'Conceiving the Health Commons: Operationalizing a "Right" to Heath' [2006] Social Analysis 233, 238.

The previous critique should not, however, undermine the efforts the Moroccan government have been exerting to reform the health sector and to meet the acute needs, in compliance with human rights and global health initiatives, directed to the less privileged populations and areas like Youssoufia. Obtaining my research approval to enter BHCs in Youssoufia from the Ministry of Health Directorate of Rabat gave me an exposure to the system, allowing to see and feel how it works. The materiality of BHC matters. Entering the BHC of Youssoufia that is close to the *marché* and the major one I focused on, one could observe the operationality of the acceptably standardised health facility, despite the fact that it is located in a poor neighbourhood. The space has a nice architecture and is well-maintained, surrounded by a well-trimmed garden. The reception is organised through a security lady who verifies users' addresses to assure they are located in the constituency that the centre is designed to serve. This condition is meant to assure the equal distribution of patients on the total three BHCs in the neighbourhood, to balance and avoid overcrowding in one BHC over the others. A banner facing the entrance says *al-khadamat el-mouqadama fil markaz maganyia* (the provided services in the Centre are for free) (see figure 9). Another big frame explains the population size, human resources and a diseases prevalence overview (it is in French) (see figure 10). And a third vertical banner visually explain the spatial division of the centre with the name of different departments (see figure 11). The place is fairly clean, taken care of and maintained (see figure 12). The staff are respectful to the dress code/uniform. The offices are set in the same way. The overall performance shows the respect of professional conduct (see figure 13). The health-awareness posters about different and diverse health issues from anti-smoking to good nutrition tips, holding logos of different entities with the logo of the kingdom and the Ministry of Health along other international organisations and entities cover the walls all around. Even obtaining a research permit was indicative of having a respected organisational and communication flow in place, going through several bureaucratic procedures that are meant for the correctness of the process, and not a collective punishment from a system in decay.

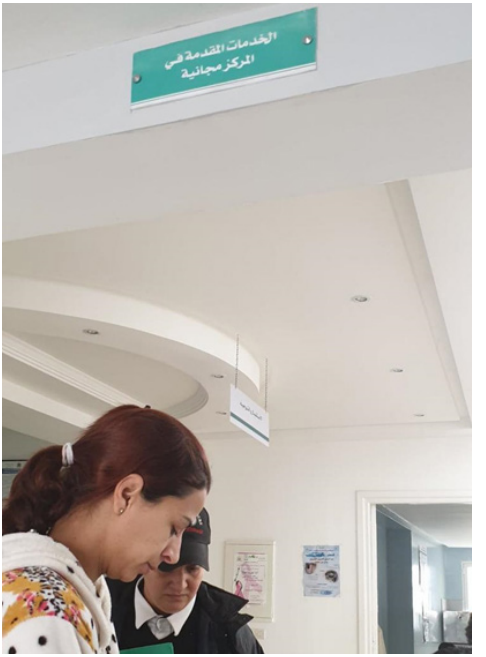

Figure 9: The entrance of the BHC

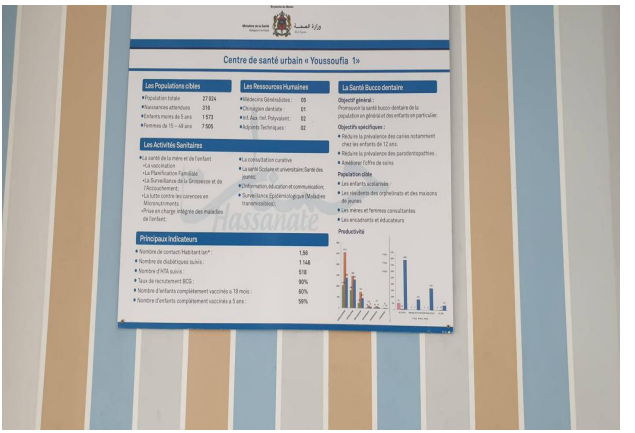

Figure 10: BHC illustrative

Figure 11: BHC visual map

Figure 12: Youssoufia BHC

Figure 13: Youssoufia BHC internal space

All the details I narrated and described are strong indicators of the system's orientation and work culture. I was able to observe all these material and immaterial details that impact a person's experience of the service, because of my experience with health in Egypt – in professional and personal contexts – it was the closest point of reference that unintentionally accompanied my reflections that I do not have enough space to elaborate in the scope of this thesis. If we would compare Morocco to other neighbouring countries, it could be asserted that

the health sector has suffered from decades of neglect as previously mentioned, but the only difference is the fact that Morocco is moving ahead because of the existence of a strong political will for making reforms and improving the situation. While the attention is always focused on the outputs as discussed earlier, the quality of the processes is overlooked. The quality refers to the components of governance and accountability that enable people to shape the services provided in accordance with their needs.

The case of Venezuela is the best exemplar in this respect. The Venezuelan health sector approach to PHC, *Mission Barrio Adentro,* was celebrated as exceptional in the Global South that rejected the SAPs. The Venezuelan PHC approach adopted a comprehensive version, with massive public investments. The Venezuelan model was highly praised, 'Alma Ata is alive and well in Venezuela'.[177] The ascending of Hugo Chavez into power was marked by huge spending on basic social services to appeal to the general masses of underprivileged, as Venezuela has the highest oil reserves. The quality and availability of social services, particularly healthcare, did not continue long though, once the oil prices started to drop worldwide, in 2013. It negatively impacted health system and infrastructure. The expansion of social services by Chavez was not paralleled with an equal respect to state institutionalism and constitutionalism. Now, the Venezuelan health system is experiencing a humanitarian crisis, the reappearance of endemic diseases, a medicine shortage and the collapse of hundreds of hospitals and clinics.[178] The delivery and availability of care is limited and inadequate due to lack of funds, as 'populist measures, mismanagement, pillaging, corruption, lack of forethought and expertise have brought the country into severe economic collapse and political turmoil'.[179]

In January 2016, a news article was published covering a strike people held in Youssoufia over shutting the Youssoufia Medical Centre for four years since launching the renovation process. People complained because it forced them to access the overcrowded University Hospital which was tiring for them. They also complained of the prolonged wait

[177] Carlos H Alvarado and others, 'Social Change and Health Policy in Venezuela' (March 2008) 3(2) Social Medicine 95, 98 <www.socialmedicine.info/index.php/socialmedicine/article/view/229> accessed 18 April 2020.

[178] Sunil Daryanani, 'When Populism Takes over the Delivery of Health Care: Venezuela' [November 2017] ecancermedicalscience.

[179] ibid.

for the BHC to resume. The BHC did not seem under construction, but it had turned into an abandoned dumpster. This incident shows how benign political will for reform could be a victim of lack of governance and poor accountability.[180]

4.3 Accessibility

In 2013, the new Ministry of Foreigners and Moroccans Living Abroad released a Practical Guide to Facilitate Integration in Morocco confirming refugee and migrant access to healthcare. That was preceded by several actions of emergency standardisation to be inclusive of migrant care and awareness-raising sessions for immigrants and health professionals on the right to equal healthcare for all. The right of refugees and migrants is not a contested or denied matter by the different personnel working for the Ministry of Health whom I met. They rather showed enough knowledge and awareness. Dr Rahmani, the head of PHC sector in the MoH Directorate of Rabat, mentioned in a brief meeting that a high percentage of sub-Saharan Africans access the PHCs in the popular neighbourhoods of Youssoufia, Takadoum and Yacob el-Mansour. He added that they provide more services than Caritas which is only concerned with refugees:

> We receive refugees and migrants and deal with them like Moroccans, especially mothers. We do not ask the husband's name at birth. In the past it used to be a big problem. Now we give them a birth certificate. At referrals, there is a problem for the illegal migrants because they have to pay service fees, as they have no health insurance … The health insurance is mandatory on all formal employers (in public and private sector), and a part of money is deducted from the salaries to cover the medical insurance. And we have RAMED for the poor, all that in case of referral from primary health care to secondary or tertiary levels of health.

[180] Al-Akhbar, 'Halting the Renovation of Youssoufia Health Centre Deprives Thousands of Citizens from Medical Services in Rabat' (*Al-Akhbar*, 21 January 2019) <www.alakhbar.press.ma/%D8%AA%D9%88%D9%82%D9%81-%D8%A5%D8%B5%D9%84%D8%A7%D8%AD-%D9%85%D8%B3%D8%AA%D9%88%D8%B5%D9%81-%D8%A7%D9%84%D9%8A%D9%88%D8%B3%D9%81%D9%8A%D8%A9-%D9%8A%D8%AD%D8%B1%D9%85-%D8%A2%D9%84%D8%A7%D9%81-%D8%A7-19105.html> accessed 18 April 2020.

The same principles on and awareness of refugees and migrants' right to primary care are confirmed by the heads, doctors and chief nurses of the two BHC facilities I focused on, but it did not guarantee a high turnout of refugees and migrants. In Youssoufia BHC the turnout is notably low. The Youth Space has relatively a higher turnout, composing almost a quarter of overall patients awaiting. The general practitioner Dr Aziz states, 'we receive all categories of people and do not discriminate between Moroccans and non-Moroccans, in enjoying all provided services of check-ups, consultation and treatments'. The doctor can check more than a patient at the same time. Despite the high numbers of clients, turns are organised in order, with no preference of Moroccan over a foreigner. Unfortunately, it was difficult for me to easily understand the ongoing verbal interactions in the BHC space, because of my lack of French and weak account of *Darija*. Surely, all these conversations, and even patients whispering in the waiting room, would have opened more insights into refugees and migrants' experience with the medical service; what were the ladies were saying when the two black men came in? Why did a black patient looked upset coming out from the doctor's room? Why did the doctor thanked him in a firm tone? All these are rich situations that would have told more. The doctors seemed so professional with several large data-entry records on the desk, working in a multi-tasking manner of checking, receiving medical checks, talking and recording with several persons in the room, back-to-back.

No enough awareness about available health services exists among refugees and migrants. In addition, administrative hurdles and lack of money demotivate refugees and migrants from accessing health services. On my way to Youssoufia (for fieldwork), I met Fatema, by coincidence, carrying her baby girl near the taxi station; she asked me money for transportation to go to the nearest University Hospital, *el-Swisi*, to vaccinate her daughter. She did not know that she could have vaccinated her in the BHC two minutes-walk from her home. Even though migrants have access to all hospital and health centres regardless of their legal status, they still go to NGOs like Caritas. Dr Azizi, the general practitioner, revealed that they have a high turnout due to the coordination between the centre and other NGOs like Caritas and AMFP that refer the patients to them. Happy says that she would never go to Caritas, each time she goes for medical consultation, she was scheduled a far appointment. And each time she needs a medicine, they

will not withdraw it, as it exceeds the financial limit. She prefers the BHC over the Caritas clinic, but she rarely goes because of the linguistic barrier.

The BHC staff averred that the major challenges they face with sub-Saharan migrants are the communication barrier with the Anglophone group, unclarity of their accommodation address and their resistance to family planning means. Happy is a mother of six children and despite their poor living conditions and dependence on begging as a resource of income, they kept on getting pregnant, without careful minding. When I confronted her with this puzzlement, her reply was that she wanted to have family planning advice after the fourth child, but she did not find any available back then, they depend on condoms, and she did not know what had failed and made her pregnant with twins.

In most of the cases I met, I found migrants depending on self-medication when they do not feel okay. They either go to pharmacies and describe their case, or rely on the different substances and spices they bring from West Africa. So, it is rare to find them going to regular spice shops in the *marché*, or it is never possible to find a Moroccan paying for the same food items and spices labelled West African. It signifies a demarcation between two distinctive lifestyles. Bright and Amin expressed how they do not trust health facilities because they find Moroccans themselves to look unhealthy, and they complained about the quality of water, food and eating habits, in comparison to what they have in Ghana where food is fresh, nutritious, organic and has no refined sugar. Most of my informants, males and females alike, perceive their health to be their valuable assets that they are keen to preserve attributing to their well-bringing in their home countries. Bright reflects:

> The water is never good. The food is full of chemicals. Moroccan food contains a lot of sugar. They drink a lot of tea. We have herbs that help us in getting better and fresh food. When I am sick I go to pharmacy … Moroccan women are overweight because they do not work.

He kept on mentioning how sugar is bad for health, that they rarely use sugar like here and how too much sugar accumulate fats around the waist and it does not help in having sex.[181]

[181] Interview, 7 March 2019.

Holding on to a West African tradition in perceiving health and wellbeing is indirectly linked to the estrangement and disappointment that migrants might experience in Morocco. For Amin:

> these people (Moroccans) have different mindset, their own way of living and they deal differently with migrants, like renting homes, they gave us higher prices. They open up for people (foreigners), but do not treat you well. We learnt how to cope and adapt. They are poor, have no money, no food, no job. The general health of Moroccans is bad. People have a problem of consuming too much sugar. When I feel sick or not okay, I seek a West African treatment, I do not believe in their treatment, when I see how Moroccans look.[182]

Asking Oliver and Watara what the different food spices on the street stalls were, in the presence of Zoubair who came to purchase some, he started to explained, 'this is West-African Maggie's,[183] we bring it from Western Africa. It makes food so delicious'. Pointing into an off-white soft substance, Zoubair explained 'this one a pregnant woman dissolves it in water and becomes like milk it is a bit salty and not sweet'. Then, Isa remarked saying:

> our power is in trees … If a married man has a problem with his woman, cannot satisfy her, here, they (Moroccans) will tell you go to health centre. In our village (in West Africa) they will give you leaves from the forest. This is the power of black people.[184]

In my visit to Dailo's home, he gave a medicine to his toddler daughter that he bought on his own without a doctor's prescription and consultation because money scarcity prevented him from seeking proper health care from professional paediatricians and at the same time he does not know that he can use the BHC next door that has child health services and free vaccinations.

On a regular visit to Youssoufia, on 20 March 2019, people were still troubled by the news of the death of a young sub-Saharan African man a couple of days earlier. No one had the exact information of how, where and when it had happened. Ricky and Bright speculated that he might

[182] Interview, 18 March 2019.

[183] It is an artificial food flavour produced by multi-national food company, Knorr. This company also produces customised flavours to cater to specific cultural tastes, as part of its marketing strategy to expand market share.

[184] Interview, 5 April 2019.

have passed away from the low quality food that migrants and refugees sometimes resort to like buying the chicken skin legs and all parts that no one would buy in normal living circumstances. The low food quality that people are forced to consume contains hormones, chemicals and dirt. I tracked the news and went to the place where he used to live, in lane 33, branched out from the major sidewalk of the *marché*. The person who passed away was Guinean, named Gaby, had no family and lived with a number of other fellows, coming from the same country. He was 26 years old. The lane has a sharp cliff downward that only a healthy able-bodied person could walk. His place of accommodation was an extremely small room shared with three others consisting of their belongings, a kitchen and one bed. The bathroom is separate and seems to be shared between different rooms. His roommate for almost a year narrated:

> he was in Nador, and came back sick. Each time he goes to Nador he tries to pass. But this time he was in a bad health condition because he sleeps at the bush. He went to Caritas but they did not offer him any help, they offered him food that equates 100 dirham. He had severe pain in his stomach/abdominal … An ambulance came, when he was already dead. A representative from the embassy of Guinea came with the police that asked people to move to investigate the case and his hospital record. And we did not hear back from them … Morocco is not good for black people.

This case raises an instant question of what could have been done to prevent his death? Ricky responded, 'prevention is difficult for blacks because you won't be able to prevent them from going to Nador, because of the lack of jobs'. Tika added:

> if someone is sick and could go to Caritas, in the first time a person goes and also depends on his age, they provide food (equivalent to 100 dirhams) and blankets. This assistance is not permanent but for couple of months until they manage.

The imperative question, here, is what if the sick person cannot move? What would be the case?

Mental health is significantly missed and extremely needed. Similar to Gaby, I met a guy around the same age who was present at the gatherings of Ghanaians but who does not greet back or speak. I was told by others that he is 'mentally sick', since he came from Tangier (Northern Morocco, where crossing operations to Europe take place, and a highly

securitised place where the existence of blacks is suspected). He does not talk at all. Zoubir commented:

> He has mental disturb because of frustration, we are looking for this frustration, hassling for this. The root cause is back in Africa those who sell illusion to people and creating migrants. they collect money from them to entering Morocco, so entering Europe.

Fatema is still traumatised by her experience, and breaks into heavy crying when she talks about it. Happy feels so tired and exhausted, psychologically. The BHCs do not have mental health services. Only the Youth Space does, but it has no banner that clearly shows the availability of services the facility provides like Youssoufia BHC does.

4.4 Quality and accountability

For quality, it is hard to determine and assess, especially through my interlocutors' narratives that are highly subjective and mixed with their broader experiences of distrust and societal discrimination. It is very hard and sensitive also to ask the BHC staff. The PNPM reports many challenges remain to be overcome.[185] Most of the health centres face a shortage of human resources, equipment and medicines. Requiring a proof of address for foreign patients prevents migrants from accessing health centres. Migrants often do not have documents proving their address and their name because they usually reside in rooms in names of other migrants, or they only passing by the city. This requires the intervention of NGOs working with migrants to facilitate exchange and guarantee access to care. The other monitored challenge is the insufficiency of drug supply. Most centres frequented by the migrant population do not have drugs for the number of foreign patients they receive. When Happy goes to the centre, she gets the medical consultation for free, but she has to buy the prescribed medicine from outside. The report of the PNPM elaborates that the allocation of health centres is calculated according to the population living in the district without taking into account all the foreign inhabitants, especially if they

[185] PNPM, 'Les capacités des centres de Santé au Maroc: accès gratuit pour les migrants, mais…,' (*PNPM*, July 2018) <www.pnpm.ma/2018/07/18/les-capacites-des-centres-de-sante-au-maroc-acces-gratuit-pour-les-migrants-mais/> accessed 18 April 2020.

do not have a residence permit. It leads to a high rate of prescriptions that remain the responsibility of patients, like the case of Happy.

The reported deficiency of medical staff in health centres of the neighbourhoods with high concentrations of migrants in their population negatively affects the quality of care. In this context, medical staff are overworked and pressured, so they do not have enough time to examine the patients. The consultations are, in turn, brief. Although this issue also affects the Moroccan population, the impact of this setback is more visible in the case of migrants who are more vulnerable. Other challenges exist in the non-compliance with the principle of free pregnancy. For delivery operations for Dialo's wife and Fatema, in *Swisi* hospital, they had to pay fees of 1,000 Moroccan dirhams (equals around 100 $). Fatema did not receive a birth certificate for her daughter because she did not have the money to pay for it. The report adds that the medico-social care of women and child victims of violence is still very marginal and is probably attributed to a lack of human resources and lack of training to available staff on the well-reception of foreigners. Hence, the PNPM raises a recommendation for authorities to accept the derogation of address proof requirement, given the high mobility of majority of them and the fact that landlords refuse to provide proof of address. The second recommendation states the necessity of having a constantly updated estimation of the migrants population per locale, through the verification of three sources of ministry of interior, municipalities and NGOs.

4.5 Conclusion

Studying migrant and refugee health must pay considerable attention to the external social dynamics of the clinic, and the ways people develop in case the official health access is blocked. The West African migrants pride in their cultural and material medical heritage should not be essentialised as a mere cultural trait but it should be assessed in broader social structures that permit for the revival of such traditions. At the same time, migrant and refugee health touches the core of the quality of governance of the national health systems. Such systems have a peculiar development state in the countries of the Global South that were subject to several modes of colonialism, post-independence modernisation and neoliberalism.

5.

RECOMMENDATIONS AND FURTHER RESEARCH

The research focused on the shift taking place within global health approaches to the growing phenomenon of immigration and massive displacement by asserting the necessity of integrating refugees and migrants within national health systems along different points of their migratory routes, rather than dealing with their health needs through a temporal humanitarian response that is incapable of accommodating the ever-growing health needs. Instead, migrant and refugee health is enclosed in the global health initiative of UHC that is one of the UN SDGs targets, to leave no one behind.

World migration policies started engaging and prioritising the so-called 'third countries' for all those transit countries that are theoretically situated in between the two points; that of origin (where a refugee or a migrant comes from) and the final destination (where they actually aspire to go, either in Europe or US). Focusing on engaging third countries in the scope of new global immigration management policies came in response to the explosion of the so-called 'migration crisis' in Europe in 2015 that marks the highest human displacement after WWII. It promotes what international actors now refer to as 'responsibility sharing'. Consequently, third countries are provided with international cooperation aid to help retaining immigration flows through integration or mainstreaming of migrants and refugees in basic social services, including health, on an equal footing with country nationals to activate fundamental human rights to health. This paradigm shift underscores an unprecedent policy coherence in global migration health management to the 'deservingness' of refugees and migrants that has been advocated for several years.

Despite this global approach to migrant health which is principally sound, the implementation remains problematic because it depends

on the domestic context of public healthcare in a given country. The third countries that are characterised as low-middle-incomed usually have intractable institutional problems in delivering available affordable quality healthcare for all. Public hospitals are not viable options for people to seek when they are sick; they are extremely bad to the extent that no sane person would access them even if he/she has no choice but private healthcare is unaffordable for many. This contemporary reality of healthcare is attributed to the restricted measures of the SAPs that World Bank and IMF imposed on 'under-developed countries' to fix their economies. However, these conditions led to a noticeable economic growth in most cases, but they undermined social equality and equity, leading to increased impoverishment and deprivation of basic social services like health. Thus, the poor health infrastructure hinders proper adaptability of mainstreaming refugees and migrants in transit countries in the Global South. Refugees and migrants get trapped in a situation where they have to accept the service or leave it. In both cases, they undergo a differing physical pain.

In order to contend with the global health approach of mainstreaming refugees and migrants into national health system – especially in the PHC to enhance their health access, and thus their right to equitable quality health care – I focused my research on the case of Morocco. The Moroccan government has crossed a significant milestone in the migration issue that became the world's top concern. Morocco endorsed the National Strategy of Immigration and Asylum that aims at integrating refugees and migrants in basic social services, including health. I methodologically depended on conducting an ethnography to one of Rabat's poor urban neighbourhood known with a high concentration of several migrant communities, coming from different countries of West Africa. Doing so permitted me to challenge the general claims that speak very highly of both mainstreaming refugees and migrants in primary public health care and Morocco's approach towards immigration that complies with a human rights framework. The novel world migration management tendency development in 2016, on the echo of the 2015 'migration crisis' in Europe, is keen to involve transit/third countries in sharing the 'burden of illegal migration' with no comprehensive attention to the structural and governance issues pertain in delivering quality healthcare. Thus, migrant and refugee misery is hit by the harsh reality of the healthcare systems in these countries that went through the harsh measures of the SAP in the 1980s.

In Morocco, several efforts have been directed towards several purposes, namely poverty reduction, enhancing the human rights situation and constructing an integral migration policy. The politics of these reforms has been however subject to the deep long term impact of the SAPs and the struggle to fully democratise the country through inclusiveness and community-participation. So, all reforms are still directed by the government with no intervention from the people. The same applies to refugees and migrants who neither have a chance to feedback on the services they use, nor a strong representation to influence policy dialogue of relevance to meet their pertaining needs. But avoidance of BHC facilities by migrants in Youssoufia is related to their cultural cultivation of their West African traditions in health and lifestyle that they associate with to subvert general sentiment and collective experience of despair, disappointment, distrust and discrimination. Hence, migration health should be attentive to other factors that could exist outside the sphere of the clinics, but the broader social milieu that migrants and refugees live in.

Therefore, I recommend the consolidation of the principles of 'accountability' by citizens and migrants alike in mainstreaming PHC to be inclusive to all. Accountability underlines 'key role that citizen voice plays in the definition and imple-mentation of social policy, and in making decisionmakers accountable for their decisionsand actions'.[186] Accountability seeks to enhance the effective delivery of social services, and makes the policy design more equitable and inclusive. The participation should, however, be based on plural voices and not limited to advisory only, but they should participate in planning social policies, monitoring of the implementation and evaluating the outputs and outcomes.

In order to have a social accountability mechanism in place, a number of factors must be met. First, people must know about their right to participate, and have the capacities to practice this right. Then, the accountability mechanism should be set in a way that is easy for people to participate with no high cost. It is better to organise consultations by zones to bring it closer to communities. Another factor is to ensure that people (the service users) have a stronger role of voicing their needs and

[186] Daniel Cotlear, *A New Social Contract for Peru: An Agenda for Improving Education, Health Care, and the Social Safety Net* (A World Bank Country Study, January 2006) 245.

feedback in the monitoring system of social policy and service delivery, through two ways. The first way is through using surveys and/or focus-group discussions to gather the user perspective on the implementation. The other way is to include citizen voices as performance indicators in any social policy. The sort of accountability through direct feedback on social policies and services is referred to as 'client power' that involves beneficiaries. Hence, if there is an efficient delivery system like that which the Moroccan government works towards but without or with little accountability, it could negatively impact the legitimacy of public institutions and create political unrest.

Migration health in transit third countries cannot be studied as inseparable from the overall situation of national health systems. So next, further research endeavours should consider this fact and we need to utilise migration as a vantage point for unpacking construction, politics and cultures of formal bureaucracies in the Global South that underpin the different modes of colonialism, post-independence and neoliberalism.

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Riviera San Nicolò, 26
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