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Politics of Health: the 2013 Integration Policy's Effect on Immigrant Access to Care

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SIT Study Abroad

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ABSTRACT

In September of 2013, King Mohammed VI announced a regularization campaign, implementing a new policy of integration with respect to undocumented immigrants in the country. Deviating from former official discourse, the new measure allowed in principle for—among provision of residence cards and lifted criminalization of undocumented immigrants—greater immigrantaccess to healthcare services. The purpose of the following research was to assess whether the effects of this new provision are being positively felt on the ground in ensuring inclusivity of health services.Individual interviews on personal experiences with the Moroccan healthcare system were held with members of various immigrant subpopulations: refugees, asylum seekers, irregular immigrants, and documented immigrants. Technical and administrative perspectives were also obtained from health professionals as well as NGO officials.The results showed a lack of homogeneity in immigrantengagementwith public healthcare; experiences were dictated by a multitude of individual politics. However, from the qualitative data, it was found that perception of the reality and lack of information placed limits on the recent change's efficacy in improving health access. Confounding factors of typical hospital procedures continue to disproportionately affect immigrants.

INTRODUCTION

Varying Administrative Situations of Inhabitants

Since the 2000s, Morocco has seen increasing emigration, as well as an influx of transit migrants, particularly from sub-Saharan countries (IPPR, 2013).These inhabitants can be roughly categorized into irregular migrants, asylum seekers, refugees, and regular migrants. In this study, the International Organization of Migration's definition will be used to describe irregular migrants—those who, whether due to unauthorized entry or unauthorized overstay of an authorized entry, lack legal status in a transit or host country (IOM, n.d.). The term "refugee" will be defined as according to the UNHCR, asthose who have left their country and are unable to return due to "a well-founded fear of persecution because of their race, religion, nationality, or political opinion or membership of a particular social group"(UNHCR, n.d.). Asylum seekers are likewise those who have applied for refugee status but are awaiting evaluation of their claim (UNHCR, n.d.).Finally, in this study, the term "immigrants," unless otherwise specified, will be

used to include all people—irregular and regular—who have come from another country to live in Morocco, whether temporarily or permanently.

Immigrants in Irregular Administrative Situations in Morocco

Historically, Morocco has often been viewed as a country of transit, an access point for immigration to Europe as a final destination.Indeed, a survey conducted in 2012 showed a majority (67%) of immigrants to have lived in Morocco for less than one year (MSF, 2012).In particular, the border and proximal points to Algeria andSpanish territories—Oujda (bordering Algeria), Nador (bordering Melilla), and Tangier (port city 14km from Spain)—formed important entry and exit points, respectively, to Morocco.In thedecade following the passage of law 02-03 in 2003 criminalizing lack of official documentation, these cities became the sites of health threats—police beatings, sexual violence, and dangerous living conditions as in the Gourougou Forest. Indeed, in 2012,Medecins Sans Frontiers staff recorded physical and sexual violence in 39% of the 5,231 sub-Saharan cases they received (MSF, 2012).

Irregular Immigrants and Access to Health

A 2010 report issued by le groupeantiracisted'accompagnementet de défense des étrangers et migrants (GADEM) demonstrates a continued disregard by the Moroccan government for migrant human rights. GADEM notes a history of discrepancies between the administration's declared and enacted commitments, pointing to the Moroccan state's acting out against its ratification of the International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families, which prohibits collective expulsion (GADEM, 2010). Among the enacted expulsions are those of pregnant women and severely ill, who are abandoned to the Algerian-Moroccan border.

This punitive government attitude towards irregular immigration resulted in an irregular immigrant living conditions characterized by fear of arrest, expulsion, and abuse (MSF, 2012). Apart from the health strains and abuses of difficult irregular travels, the strict governmental attitude also effectively deterred many irregular immigrants from seeking healthcare, for fear of deportation.In 2013, a survey of irregular immigrants by the National AIDS Control Program and the National Institute of Hygiene of the Ministry of Health showed that of immigrants who have received medical care since their arrival, the majority (between 57% and 66%) had operated through an NGO rather than a public health center, private doctor, or pharmacy (Ministry of Health, 2013).

Over the years, several Moroccan and international NGOs located in Rabat have supported the irregular immigrant population in the health sector. Though closed as of March 2014, Caritas, an independent catholic church open to all without means, had established partner hospitals and provided assistance with all aspects of health, as well as with lodging, food, and clothing. Centre Tamkine-Terre des homes, closed at the end of April 2014,worked to the empowerment and support of pregnant women and mothers. Association de LutteContre le Sida (ACLS) and OrganisationPanafricain de LutteContre le Sida (OPALS) work in the fight against AIDS and STDs.

Shifting Access to Health Services

With the increasing politicization and tightening of Morocco-European borders, Morocco has become a destination country, seeing many immigrants remaining in Morocco due to lack of means to pass on to Europe (De Haas, 2007). Confronted with its new position as a residential endpoint of transnational migration and facing pressure following a September 2013 report by the Moroccan National Human Rights Council (CNDH) detailing the situation of migrants and

refugees, the monarchy and Moroccan government were obligated to redefine their attitude towards migrants and refugees, especially those from sub-Saharan Africa.

September of 2013, the King announced a new policy of integration, led by a regularization campaign that would grant residency permits to certain members of the immigrant population (Morocco World News, 2013). Since then, dramatic changes have been under way in all sectors—in education, for example, an ordinance was issued lifting the formal documentation requirement for student enrollment into schools. Since the new policy's implementation, there has been a complete lack of research that has been conducted concerning real changes to health accessibility for immigrants, thus forming the motivation for this study. In the midst of change, this study seeks to assess, in real time, the concrete changes to immigrant accessibility of healthcare and services.

METHODOLOGY

Formative Rationale

Over the course of the study, three main immigrant groups were targeted for discussion: (1) immigrants in irregular situations, (2) asylum seekers, (3) refugees, and (4) documented immigrants (including those with student cards). Individual interviews with the first two groups sought to provide a base for understanding the ability of immigrants to access basic healthcare services. Comparing the experiences of these groups allowed for an understanding of disparities that may exist between those who do and do not receiverecognized status through the UNHCR. As there may also be issues of access to public health in the general Moroccan population, a fifth group of individual interviews were held with Moroccan nationals as a reference for comparison. Finally, a sixth group consisting of officials and health professionals was sought to gain an administrative perspective on shifting policies.

Tools Development and Procedure

For each of these populations, semi-structured interviews were conducted in French, the primary language of the immigrants interviewed and second language of the Moroccan nationals. The interviews incorporated a base set of questions concerning health and access to healthcare services (see Appendix A for groups 1-4 and Appendix B for group 5). Questions were drafted to maximize information on where different subsets of the immigrant population received care, why they chose certain locations over others, and what positive changes or remaining challenges characterized their experiences. Questions asked consisted both of short-answer—basic demographic information and history of health questions—as well as open-ended questions targeted towards addressing migrants' perceptions of and experiences with the healthcare system in Morocco.

Due to the potentially sensitive nature of the interviewees' situations, written informed consent was obtained prior to each interview. Respondents were given a summary of the project objectives, procedures, and measures taken to ensure confidentiality of respondents. Study participation was completely voluntary and respondents were clearly informed of their right to decline to respond to any question or withdraw from the study at any point in time. All respondents signed a consent form in the respondents' preferred language—French (see Appendix C). Consent forms wereboth given in written form and orally explained, in the respondents' preferred language. Though interviewees were asked to print their names next to their signature, they were allowed to abstain due to the sensitive nature of their residency in Morocco.

Permission to make notes throughout the interview was obtained prior to beginning. To minimize any discomfort due to the sensitive nature of the questions asked, correspondents were

given the option of moving to a completely private setting. After each interview, notes were transcribed and each respondent assigned a number for anonymity. Short answer responses were recorded and verified in a separate Excel spreadsheet, stored corresponding to the previously assigned respondent number.

Data Collection Locations

Group 1 and 2-respondents were recruited on a voluntary basis through Alecma, an activist organization in Rabat centered on increased respect for the human rights of sub-Saharan immigrants. As Alecma is comprised of and works with members of the irregular immigrant population, its founder was an invaluable point of contact for recruiting subjects. Interviews took place at the organization headquarters in the medina of Takadoum.

Participants for groups 1-4 werefurther recruited on a voluntary basis through La FondationOrient Occident, the social services partner of the UNHCR. Orient Occident, in addition to offering services such as counseling and daycare, targeted towards refugees and asylum seekers, offers various academic and cultural courses of open enrollment. It is consequently a hub of activity and a common retreat for immigrants, in both regular and irregular situations. Resultantly, each day of the week, respondents were gathered by interviewing the organization's attendants throughout their daily activities. This respondent group consequently consisted of immigrants in both regular situations—asylum seekers, refugees, and documented immigrants—and those in irregular. Minors were among the number interviewed because of the value of their personal experiences with health and the independent nature of their lives in Morocco. However, due to minors' particular vulnerability, consent was also obtained through the psychologist at Orient Occident, who worked closely with them. Respondents for groups 5 and 6 were recruited through personal contacts and local universities.

Officials spoken to worked in The Ministry of Health, le Centre de Santé of the Rabat medina, and le Centre HospitalierIbnSina. A personal contact was used to speak with an epidemiologist of the Moroccan Ministry of Health. The worker at le Centre de Santé and the physician at IbnSinawere approached upon initial visit to premises, without prior appointment.

RESULTS

Demographic Information of Immigrants Interviewed

A total of 26 immigrants were interviewed. This group was comprised of 16 irregular immigrants, 3 asylum seekers, 4 refugees, and 3 documented immigrants. The majority of immigrants were originally from Cameroon and Cote d'Ivoire, though other countries of origin represented were Chad, Democratic Republic of the Congo, Guinea, Mauritania, Nigeria, and Senegal (see Figure 1).

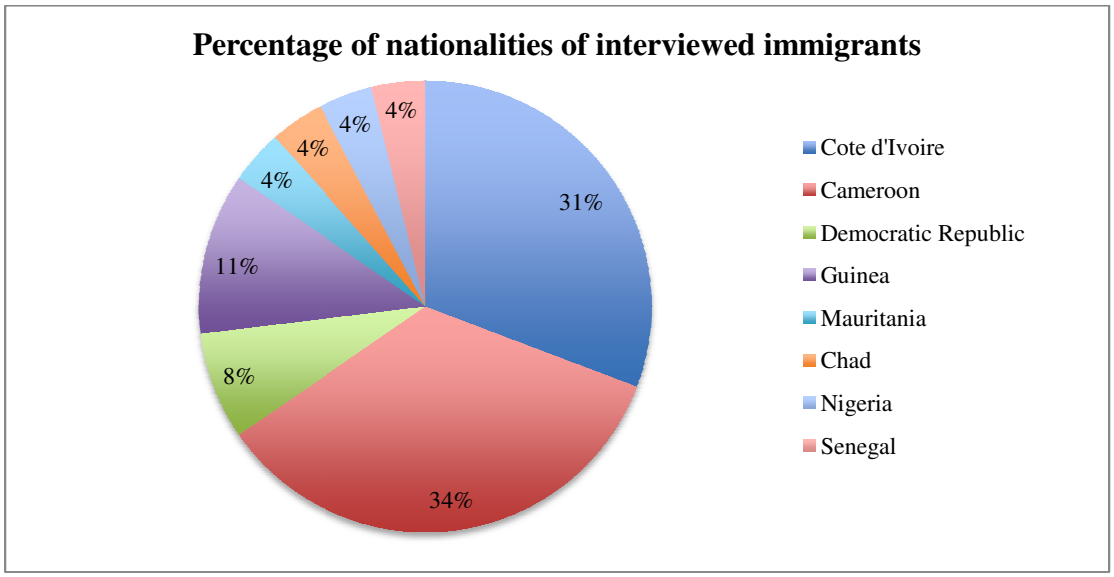

Figure 1. Percentage of nationalities of interviewed immigrants living in Rabat, Morocco.

The total demographic breakdown of interviewees is displayed in Table 1. By nature of the sub-Saharan immigrants who worked with Alecma and the chance of who was available and willing to speak at la Fondation, only 5 of the 26 respondents were female. Resultantly, the data will not be disaggregated by gender throughout the remainder of the paper.

	Irregular Immigrants		Asylum Seekers		Refugees		Documented	
	N = 16		N = 4		N = 3		N = 3	
	n	%	n	%	n	%	n	%
Country								
Cote d'Ivoire	2	12.5	4	100	2	67.7	0	0
Cameroon	9	56.3	0	0	0	0	0	0
Democratic Republic of the Congo	2	12.5	0	0	0	0	0	0
Guinea	2	12.5	0	0	0	0	1	33.3
Other	1	6.25	0	0	1	33.3	2	67.7
Age								
15-19	6	37.5	1	25.0	1	25.0	0	0
20-24	2	12.5	0	0	2	50.0	0	0
25-29	5	31.3	3	75.0	0	0	1	50.0
30+	3	18.8	0	0	1	25.0	1	50.0
Sex								
M	13	81.3	4	100.	2	67.7	2	67.7
F	3	18.8	0	0	1	33.3	1	33.3
Length of Stay								
<1 yr	5	31.25	1	25.0	1	33.3	1	33.3
1	1	6.25	2	50.0	0	0	0	0
2	4	25.0	1	25.0	1	33.3	1	33.3
3	4	25.0	0	0	0	0	0	0
4	1	6.25	0	0	0	0	0	0
5+	1	6.25	0	0	1	33.3	1	33.3

Table 1. Demographic information—country, age, sex, and length of stay—of interviewed immigrant living in Rabat, Morocco, broken down be immigrant type. N stands for the total number of interviewees of each immigrant type. n stands for the number of respondents answering fulfilling the given criteria.

Where Immigrants seek healthcare

When asked where interviewees sought medical care, results, summarized in table 2, showed the plurality of irregular immigrants to seek aid from NGOs, which pharmacies being the second most frequent destination. The majority of asylum seekers, too, sought aid primarily from NGOs. Refugees, however, were found to equally seek aid from NGOs and public hospitals/health centers. Documented immigrants were found to seek medical care from public hospitals/health centers, clinics, and pharmacies. The majority of immigrants indicated seeking the services of the organization Caritas at least once since their arrival in Morocco, and two of the female respondents had sought le Centre Tamkine. When asked where they would go with both organizations now closed, most responded that they did not know, using the word "serious" to describe the situation. Several responded that they would have go to the pharmacies now, and it would be necessary to pay their own medications.

	Irregular Immigrants		Asylum Seekers		Refugees		Documented	
	N = 16		N = 4		N = 3		N = 3	
	n	%	n	%	n	%	n	%
Where respondent has sought medical care*								
Public hospital/ health center	1	6.25	2	50.0	3	100.	2	67.7
Private clinic/doctor	1	6.25	0	0	0	0	1	33.3
Pharmacy	3	18.8	0	0	0	0	1	33.3
NGO	7	43.8	4	100.	3	100.	0	0
Traditional	1	6.25	0	0	1	33.3	0	0
Hasn't been sick	7	43.8	1	25.0	0	0	0	0
Aid from public hospital/health center								
Solicited	3	-	1	-	2	-	2	-
Received	3	100.	0	0	2	100.	2	100.

*May have multiple responses

Table 2. Where interviewed immigrants in Rabat, Morocco have sought medical care in the past. Responses are broken down by immigrant type. N stands for the total number of interviewees of each immigrant type. n stands for the number of respondents answering fulfilling the given criteria.Because multiple responses were allowed, percentages for the first question were taken as a percentage of the number of interviewees. Percentages for aid received from public hospital/health center were calculated as a percentage of the number who had solicited aid from that institution.

When asked whether they had ever solicited and received care from public hospitals/health centers in particular, most immigrants said that they do not have access to these institutions. In one testimony, a Senegalese male said, “I don’t go to the hospital because I know if I were to go there, there would be a lot of drama. People would stare and follow me with their eyes.” Another testimony, indicated hesitation due to a fear “that when I ask for help they will give me a hard time and ask me why I came without any papers.”

Current State of Immigrant Health

Living Conditions

Each interview started off by obtaining a self-description of the living situation in Morocco for the migrant, from the questions of: (1) how the immigrants found living in Morocco and (2) whether they could describe their living conditions. All but the two documented immigrants immediately identified two defining aspects of life here: the lack of employment and the prevalence of racism. Three others pointed to the difficulty of obtaining proper nutrition. In every interview with irregular immigrants, asylum seekers, and refugees—regardless of nationality—widespread racism and discrimination based on color of skin were among the first things noted, concomitant with mentions of violent acts of aggression by Moroccans.

In the 26 immigrant interviews, 12 further referenced difficulties in lodging as defining living conditions. Bad lodgment was referenced in the context of crowdedness, lack of clean drinking water, lack of security, anddiscrimnatory prices—over three times as high as a Moroccan would pay. Irregular immigrants spoke of secure housing as being conditional upon untenable prices; even refugees noted that with the UNHCR stipend given for lodging, one was obligated to buy housing in a less secure area.

Common Maladies

Several immigrants noted being sick more frequently here than in their home countries. Implicated were the colder weather and accumulation of stresses. Most common maladies reported were fatigue and migraines. Four immigrants independently stated that when they are at home, they tend to worry and reflect too much, creating a lot of stress and anxiety. One irregular immigrant went so far as to say that all irregular immigrants here had psychological health disorders, due to the difficulty of their experiences—according to her, some just denied it.

Irregular Immigrant Experiences Seeking Healthcare

Of the immigrants interviewed, two documented immigrants, one asylum seeker, two refugees, and three irregular immigrants interviewed had solicited aid from a public hospital in the past. While those with documentation had only minor complaints with their hospital experiences, there was no apparent, homogenous opinion among the refugees, asylum seekers, and irregular immigrants, nor were there clear differences in care received by the different groups of immigrants. Individual politics were found to define immigrants' experiences with health.

Irregular Immigrants and Asylum Seekers

Of the irregular immigrants, 3 of 16 had solicited aid from a public hospital in the past. All three were received, though with widely varying levels of satisfaction. One 29-year old Camerounese woman reported complete satisfaction with her experience, saying "each time, I was received. I was treated well and I have no reproaches."Though she did encounter a few problems in receiving the birth certificate, the hospital worked with her patiently throughout the process.

Yet, another Camerouneseirregular immigrantin the same age range—31 years old—had a completely different set of experiences. When asked broadly to describe her experiences with health in Morocco, she immediately commented on bad conditions, particularly for women,due to issues of sexual harassment. Her first experience with the hospital here was when she was giving birth. She was not allowed to keep copies of her results, screenings, and diagnostics. Furthermore, she was told she would have to receive an operation or risk dying in five days' time. She had worked as a doctor in Cameroun and saw this to be a lie, refusing the operation and interpreting it as a ploy for money. After giving birth, she was not allowed to leave with the birth certificate without a passport; another women eventually put forward her passport so that she would be released from the hospital. Her second encounter with the Moroccan health system, Tamkine advised her to solicit a referral from a centre de santé. She was completely refused by the center. She stated that if it had not been for the fact that a woman from Tamkine had eventually accompanied her, she would never have received care.

Only one of the four asylum seekers interviewed had ever sought aid from a public hospital, and he was refused. Another asylum seeker spoke of consistent use of a dispensaire, without ever having been asked for documentation or otherwise having encountered problems.

Refugees

Two of the total three refugees interviewed had solicited aid from a public hospital in the past. Although recognizing their technical access to healthcare services, and the privilege of the refugee cards in granting them free access to services, both of the refugees voiced perceptions of discrimination. One refugee remarked that though he was not obligated to pay due to his possession of a UNHCR card, the problem was that the hospitals didn't attend to him. Since his arrival here, he had been looking for a skin specialist. However, when he tried to schedule an

appointment, he was told he would be called back. Now, a year has passed without a call. Furthermore, he said that whenever he is given medication, it is not the medication that he needs and is often the cheap medication costing no more than 20DH that he receives. On several occasions, the medication does not serve the intentions they were meant to serve—medicine for headaches given for symptoms of the body. He believes all would be different if he were either Moroccan or Senegalese.

The other refugee from Cote d'Ivoire, a 40-year old female, remarked that as a refugee, she could go to the hospitals and receive care without paying. However, the problem was that they did not pay much attention to immigrants. In her testimony, the procedure for receiving a consultation was conveyed in Arabic, and no one would explain to her in French. She said she watched and waited as Moroccans went through their consultations without receiving one herself. It came to be that she needed accompaniment by a UNHCR member, which was, of course, difficult because of their limited availability.

Documented Immigrants

Neither of the two documented immigrants interviewed had experienced difficulties in receiving entry or services. One, a Guinean immigrant who had been received his formal documentation through a religious organization, remarked that hospitals here were not always worth the time and process of receiving a consultation card. In general, his complaint was that they were not well attended because the sheer number of patients and the incompetency of specific professionals.

Perceptions of the Moroccan Healthcare system—quality and accessibility

Immigrant perception of qualityand access to national healthcare

Immigrants who had not yet themselves experienced the healthcare system gave overwhelmingly positive accounts of healthcare. A 23 year-old Guinean echoed the viewpoints of several other migrants in saying "the Moroccan healthcare system here is good—the medicines and doctors are both of good quality. The only problem is that it is sometimes a little expensive." Four immigrants, none of whom had yet sought care from a public healthcare institution in Morocco, noted that what distinguished the Moroccan healthcare system from their home countries' was that it was first concerned with treatment and then with payment. One speaker noted, "If, after treatment, you are not able to pay, they help you work out a solution." Simultaneously, however, the majority of immigrants—both those who had and hadn't yet visited any public hospitals or health centers—pointed to racism as existing in the hospitals. The most common dialogue heard was "in the hospitals, the doctors don't attend to us blacks. Moroccans, they don't like the color of our skin."

Moroccan resident perception of the national healthcare system

Moroccan nationals and documented immigrants expressed a viewpoint differing widely from that of Moroccan nationals. When asked generally to describe the Moroccan national healthcare system, perceptions were attune to negative aspects of quality of care and the dichotomy between private and public healthcare. Of the eight Moroccan nationals interviewed, three had started outright by saying that the Moroccan health system was not very good. Reasons given were the existence of a high discrepancy of service between the rich and the poor and a high patientto doctor physician/nurse ratio. In fact, six of the interviews immediately pointed to long wait times, sometimes of 8 or 10 hours, when broadly asked how they would describe the Moroccan health system. Five of the Moroccan nationals indicated seeking private clinical care rather than going through the public institutions. Each interviewee indicated the linkage between

quality of care and whether the patient chose a public or private option. The private option was preferred not necessarily because the doctors were more competent or the medicines different but the attention more directed.

Another Moroccan resident detailed his experience receiving two incorrect diagnoses and medications, before finally being correctly diagnosed with appendicitis. In his analysis of the situation, the doctors were too overwhelmed to properly attend to his illness. He thereafter switched to seeking care from private clinics. One woman, in her early thirties, complained of physicians' impatience, especially in relation to her experience giving birth. In her account, she switched to the private sector after feeling she wasn't being treated in a dignified manner. "It's a choice," she said, "and personally, I prefer to pay more for a private doctor to feel I am being treated well and as an individual."

Perceptions of differences in quality of and access to care

Nearly two-thirds of all refugees, asylum seekers, and refugees indicated believing there were generally differences in care between them and Moroccan nationals. Both of the two documented immigrants interviewed indicated believing there was no difference of care between them and Moroccan nationals. Opinions ranged, however, on the issue of whether or not there were differences in care among immigrants of different nationalities. Of the 26 immigrants, 13 perceived no differences among the immigrants, 8 perceived preferences for specific nationalities, and 5 indicated not knowing (see figure 2).

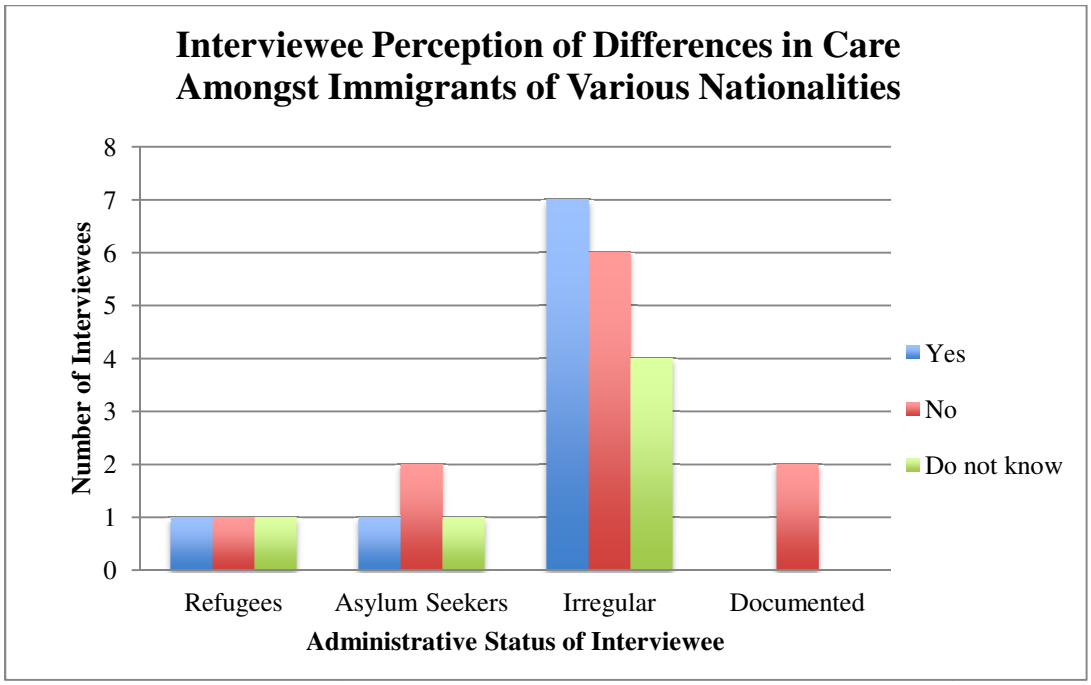

Figure 2. Perception of interviewees of the existence of differences in care amongst immigrants of vaious nationalities: number of interviewees vs. administrative status of interviewee.

Of those who perceived differences among the nationalities, 6 indicated preference for Senegalese and 2 for Syrians.

In three of eight conversations with Moroccan nationals, receiving an appointment at a public hospital was associated with having a contact/personally knowing someone within the hospital. When asked if they perceived differences of care between Moroccan residents and immigrants, all eight indicated there was no difference. One Moroccan national said that as long as the immigrant was allowed to receive care, there was no difference in quality. Two others stated that as long as the patient can pay, quality of and access to care is universal.

Perceptions of changes to immigrant access to health in recent years

Change as perceived by the interviewed immigrants

Of the 26 immigrants interviewed, four did not know if there had been any tangible changes to the healthcare system in the past few years and 11 noted that there had been none.

The two documented immigrants justified this by saying there had never been egregious problems with immigrant access to health. The majority of the other respondents made comments centered on a theme of the healthcare system always having been marked by racism and discrimination. Nine noted improvements in the healthcare system. Of these nine, two marked an increased use of and accessibility to ambulatory care. Five noted an increased ability to circulate the streets in the past year, with lower antagonism by the police and risk of deportation. Four of these five directly referenced the King's new policy of integration. Of the remaining two immigrants, one, directly referencing the King's integration program, stated that before the recent changes, medical service to undocumented immigrants was explicitly forbidden, whereas now, it was no longer criminalized. In her account, immigrants previously had to seek aid from private clinics so as to bypass the documentation requirements. However, now, especially at the primary care level, access had been improved. The final respondent spoke to generally increased availability of medicines and rises in physician availability.

Change as perceived by officials and health professionals

At a centrede santé in the medina of Rabat, one long-time reception center worker indicated perceiving no changes in healthcare over the past few years.According to the worker, immigrants without any papers or documentation have always been typically treated as travelers and may receive one treatment without formal proof of residency. However, beyond the first treatment, it is necessary to have proof of residency, for which anything from a carte de séjour to an electricity bill is acceptable. The worker explained that conditionalityof care on residency has always been based on the very structured nature of the healthcare system—each centre de santé serves only its neighborhood of location and receives only a pre-determined amount of supplies, such as medicines and vaccines, each year.

In an interview with a Malian doctor at le Centre HospitalierIbnSina, immigrants have always had a formal level of access to health. However, with the recent regularization campaign and shift of government attitude towards immigrants, he has seen an increased number of immigrant patients—due not to changes specific to accessibility of care but due to increased liberty to circulate the streets. According to the physician, the changes of the past year eliminated immigrants' fear of leaving the house, which is clearly a prerequisite to receiving care. Now, with this shift against immigrant criminalization, more immigrants are able to seek healthcare. In his remarks, access to care is conditional not upon race or immigration status but level of urgency and ability to pay. In urgent cases, treatment is always given first, before documentation and payment are requested. For cases of admission, a form of identification is required, not with the intent of exclusion but for reasons of practicality and security; formal identification is needed to ensure that a patient who has come to the hospital is indeed the person who has previously scheduled a consultation for which the patient claims to be here. In admission, avalid and regularizedidentification is necessary for security, to ensure that a patient is indeed here to receive care and not for any other reasons—such as of criminality.

Likewise, according to an interview with an epidemiologist from the Ministry of Health, immigrant access to healthcare has been established since the 1980s. In her words, immigrants have always been able to access care through NGOs. Because immigrant healthcare access has always been available, she has remarked no changes to healthcare access over the years. In her words, the question of whether healthcare access has changed is the wrong question to ask. The question should be whether there have been changes in efforts to increase immigrant education of how the healthcare system works—an understanding of why certain policies, such as conditionality of healthcare on documentation, is not a mechanism of exclusion but one of

practicality for both security and efficient materials distribution. “I continue to believe that perceived discrimination in the healthcare system is really just an immigrant lack of understanding of how the system works,” she says.

Perceptions of UNHCR cards and cartes de sejours

Of the immigrants interviewed, not one had yet received a residency card. While the majority agreed that residency cards would inevitably aid in accessibility to services, the majority of respondents used words such as “complicated,” “long,” and “impossible” to describe the process of its acquisition.Five respondents specifically stated that there were too many specific criteria that they could not fill. “Even if I had already been here for five years and met the other criteria,” says one, “there is still no guarantee that I would be able to receive my residency card. There is a committee who makes the final decision, and a number of arbitrary factors are involved in the outcome of this committee.”The three interviewees who did not believe the residency card were useful at all pointed to several different factors: (1) the perceived lack of Moroccans’ respect for these cards, (2) the widespread lack of employment, which invalidated one of the main advantages the residency cards—legally searching for employment, and (3) the personal lack of desire to remain in Morocco.In the words of a Senegalese immigrant,“they *say* they are changing. But we have a saying in my home country: even if you throw a rock into the water, it will never become a fish.”

About half of respondents believe UNHCR cards were useful, in finding jobs and receiving both free lodging and healthcare services. However, the process was referred to as being impossible, especially for those who had to work and did not have the means to pay for transportation to the UNCHR headquarters. One irregular immigrant offered another reason offered for the inutility of applying for a refugee card; according to him, the UNHCR believed

those who lied and did not give cards to those who told the truth. Additionally, he indicated a lack of a culture of respect for the UNHCR cards.

DISCUSSION

How perception can define the reality

Though long wait times in public health centers/hospitals were immediately identified by six of the eight Moroccan residents interviewed as characteristic of healthcare in Morocco, long wait time was referenced by the irregular immigrants as an example of disparate treatment. This suggests that viewed from a framework of daily discrimination in Morocco, felt in the streets and in their disparate lodging situations, the widespread realities of and challenges to the healthcare system in Morocco—felt by Moroccan citizens themselves—are often perceived as targeted behavior to bar healthcare access to the immigrants. This idea is reinforced by interviewees' dialogue surrounding employment. While four of the immigrants pointed to the nationwide shortage of work as the source of their employment troubles, over half of the irregular immigrants, asylum seekers, and refugees used a specific dialogue of "Moroccans won't give us jobs," though it was found upon further inquiry that there were no job openings in question that they were actively being refused.

Despite the fact that three of the four irregular immigrants and asylum seekers (seven out of eight of all immigrants) who sought aid were received by the public health centers, the primary dialogue of the other irregular immigrants and asylum seekers who had not previously sought aid was of sub-Saharans not having access to these institutions. The notable aspect of respondents' answers was how even though only two of these respondents had ever personally tried to solicit the care of state institutions, their discourse showed a deep conviction in their perception of exclusion. This semblance of discrimination, whether real or perceived, inherently

challenges immigrants' reception of healthcare; irregular immigrants and asylum seekers who had never personally engaged with public health centers were discouraged from furtherseeking out these institutions, unwilling to subject themselves to what they believed would be further stigma.

The immigrants' preconception of the Moroccan healthcare system as being a good healthcare system served to aggravate the perception of discrimination in care. The positive remarks of countless immigrants in describing the national healthcare system suggests the construction of a stark contrast between expectation and reality, one that later adds to a conception of discrimination of care. Further exacerbating the perception is that one third of the immigrants believe differences in care exist amongst immigrants of various nationalities. The concept of a preference towards Senegalese and/or Syrians was voiced by 9 of 26 respondents (6 answered "don't know" and 11 with "no"). This perception of internal inequalities among the immigrant populations reinforces irregular immigrants' conceptions of a system of operation fraught with injustices. Similarly, the perceived inequalities in the UNHCR card distributions also reaffirmed immigrants' wariness of the institution. These different factors eventually coalesce to prime immigrants to projecting their lived experiences with discrimination outside of the hospital onto their experiences inside of the hospital. This perception of inequality, built by discriminations of the day-to-day, threaten the degree to which integration policy changes to health can be felt on the ground.

Lack of information

In the Ministry of Health official's opinion, lack of immigrant information and understanding of the rationales for population-wide policies is one of the biggest inhibitors to health access. Indeed, the results showed dramatically varying levels of understanding of the

primary care system amongst the immigrants. Alongside an almost complete reliance on Caritas and pharmacies for care, the 18th interview conducted was the first in which the words "dispensaire" or "centre de santé" had been raised on the immigrant's own accord. When subsequent immigrants were asked about their experiences with these health centers, responses were of puzzlement and unfamiliarity.

However, the MoHofficial's explanation of immigrant unfamiliarity with the healthcare system does not fully account for the dialogue concerning immigrants' lack of healthcare access—the theme of confused objectiveswas apparent in the immigrants' interviews surrounding the utilities and inutilities of residence cards. Words like "arbitrary" and "contradictory" were used to describe the government's policies. What these words signify is that in this period of nationwide transition,irregular immigrants are constantly put in a position ofnegotiating the line of inclusion and exclusion. While this policy of integration has been championed and widely publicized by the administration, only 800 residency cards have been distributed in total; the remaining majority of immigrants are still caught in the space between verbal recognition and official conferral of rights, a confusing dialectic of the official discourse on rights and those actually experienced. While some reservations in seeking care may be due to a lack of understanding of the system, a crucial aspect of lack of accessis the immigrants' lack of understanding of just where they fit into the national, legal construct.

Theoretical vs. experienced rights

While comments from the Souissi physician, centre de santé worker, and the Ministry of Health official (former practicing physician) all pointed to a history of technically permissible immigrant access to health, qualitative data suggests that the experience of this right in practice was limited before the regularization/integration campaign. As demonstrated in the physician's

comments on the King's recent integration policy's effects—detailing the recent rise in sub-Saharan patients due to decreased fear associated with circulating the streets to seek health services—as well as in the immigrants' testimonies of recently decreased fear associated with circulating the streets, the 2013policy seems to have indirectly had positive effects on immigrant access to health.

This points to the idea that while the caveats to immigrant perceptions of marginalization in health—mentioned in the previoustwo sub-sections—must be taken into consideration, the frequency with which individual challenges arise on the ground cannot be overlooked. For example, while both officials and immigrants agreed upon urgent care as being an increasingly applied and developed universal right, individual situational contexts continue to define immigrant experiences. One irregular immigrant detailed the impossibility of receiving ambulatory care due to distance from Centre Ville—urgent care, and hospitalization services as a whole, remain largely centralized to the main city area. Another, an asylum seeker, told a story of his experiences with the individual politics of ambulatory care: he had a friend who suffered an asthma attack, and when he called Action Urgence, he was asked if the case could wait until morning, because he lived far from Centre Ville—even though ambulatory care is obligated to remain an always-operational service. Though Action Urgence eventually came, he said it was with an air of ill will and with comments from the paramedics to move closer to Centre Ville.

From among the other examples addressed in the results, despite having a refugee card, language barriers and an inability to explain procedures in French still prevented one immigrant from receiving access. For another refugee, it was the failure of a specialist to follow up on a scheduled consultation. A violent theft by three Moroccans prevented another irregular immigrant from being able to present necessary identification upon attempted admission to the

hospital. These examples come to show that despite a longstanding theory of open access to health,individualized politics conditioned by personality and context more often than not come into play.It becomes difficult to comprehend rights when those experienced are in direct contradiction to what the understood formal rights are.

The Remaining Financial Challenge to Access

While health access is not formally and directly forbidden to irregular immigrants, procedures have still been found to indirectly bar irregular immigrants from receiving health services. For admissions into the hospital, though the procedure is the same for all patients and is not meant to be discriminatory, the security requisite for legal identification at the reception desk effectively blocks irregular immigrants from access to the hospital in a capacity separate from urgent care. Regardless of intent to discriminate or intent to protect, the end result is still the marginalization of those without residency cards. But even more than that, all officials agreed that health access is conditional only upon ability to pay. However, ability to pay is the one greatest barrier remaining for immigrants. Indeed, when asked what they would do once Caritas left, the majority of interviewees said they did not know because now they would be obliged to pay; the link between Caritas and immigrant healthcare access had always actually been one of financial capacity and healthcare access. Two groups of subsidized payment exist in Morocco, neither of which irregular immigrants who have not yet obtained residency cards are eligible for: (1) insurance, given through formal employment and (2) RAMED, a system of need-based insurance available only to Moroccans. In sum, to say that irregular immigrants have had post-September2013 increased access to health is true only of a very small portion of the population—that which had the means of payment to begin with but not the security.

CONCLUSION

The situation of immigrant access to health still remains incredibly heterogeneous. While the present King and new migration policy are recognized by a number of immigrants as having led to positive changes in access to health, especially with respect to emergency care and freedom to circulate, there is a limit to the level of concrete change that this verbal measure of integration can bring about. Especially subjected to a harsh context of racism in the everyday outside of the hospital, immigrants project and continue to perceive injustices inside public health centers that discourage their attendance. While it was found that immigrants are not explicitly excluded from health care and services, a multitude of individual politics continue to impede the ability of immigrants to access healthcare. Finally, changes in health access resulting from the new integration policy exist but will remain minimal until financial integration of sub-Saharan immigrants into a system of need-based insurance takes place.

Study Limitations

The first area in which the study could be improved is in increasing the sample size of the population of study. Due to the limited number of research subjects, it is possible that final conjectures drawn were based off of a non-representative study population.Furthermore, the study used a potentially non-randomized and narrowly ranged method of recruiting research subjects. Because only two spheres of recruitment were used, respondents attracted could have been homogeneous in a way that was not representative of the entire immigrant population. La Fondation Orient Occident, for example, is a common ground for those taking courses and is open within a specific window of time during the week. As such, attendance and resultant possibility of inclusion in the study is conditional upon several factors: (1) proximity of residence to the foundation or the means for transportation to the foundation, (2) availability

during the typical 10am – 4pm data collection periods at the foundation, thus excluding working groups and (3) willingness to participate in the study.

Similarly, immigrants living in Takadoum were recruited through a single point of contact. As head of an activist's organization, pushing for increased sub-Saharan immigrant rights, this point of contact represents a potential conflict of interest that could have skewed the type of information being collected. In both Takadoum and at the Foundation, a limited number of female respondents were contacted, by chance and nature of respondent-recruitment. The study did not actively recruit for parity between sexes of the subjects, which

There were several limitations in the actual execution of the interviews. First and foremost was the language barrier. While the interviewer's French was proficient, it was not completely fluent, so there was the risk of loss of key words. Furthermore, as note taking discomforted some interviewees, several of the interviews were conducted and then only afterwards reconstructed and recorded from memory. With such methodology was an associated risk of lost or warped information. Furthermore, without a verbatim transcript of the interviews, no word analyses could be conducted. Finally, several of the interviews were not conducted in one-on-one settings. In the first round of interviews in Takadoum, six interviewees were convened in one room, due to lack of space to separate a waiting area. As a result, there were some questions on which a peer interrupted the interviewee in question, risking the integrity of each person's individual ideas being expressed.

In a general retrospective view of the study, several questions that could have provided a more comprehensive view of the respondents' thoughts were missing from the study. To begin with, interviews should have asked for a self-assessment of interviewee health, to better determine the current state of and threats to immigrant health. Furthermore, the immigrants who

did not specifically reference dispensaires and centres de santés as options for receiving care, it should have been asked why they chose not to utilize them. This would have provided a more comprehensive picture of the interviewee's level understanding of the health care system in Morocco, as well as their motivations and experiences with different portions of the health structure.

Future Investigation

Future investigation could benefit from a study on changes to immigrant health established by the integration policy, as measured over a longer period of time; at the present time, it has not yet been even a full year since the policy change. Furthermore, in future investigation, diversification of interview population could better be obtained by recruiting participants with a greater range of organizations, including Association de LutteContre le Sida (ACLS), OrganisationPanafricain de LutteContre le Sida (OPALS), and Action Urgence. Alternatively, a respondent-driven sampling method could be used. This involves the random selection of study "seeds,"after which each seed is asked to further recruit a given number of people in their social networks. This would better ensure a representative population sample, especially in regards to a vulnerable population such as this one.

Apart from extending this research longitudinally, future investigation should seek to encompass a greater female respondent population, as well as expanded work with refugees, asylum seekers, and documented immigrants—for a more reliable comparison of the four groups and their health experiences in light of the new integration policy. The inclusion of a greater interview set from anglophone countries would also be a useful analytical tool for factors involved with changes to health access. Additionally, expanding

the geographic scope of the study's purpose could provide valuable cross-city information on services available and different organizations of access between centers.

Given the number of interviewees who indicated psychological stress and excessive reflection in their comments on conditions of life, a possible future investigation should examine the new integration policy's effects through the specific lens of mental health access, for which there is not yet any research. Furthermore, in light of the integral role the organizations Caritas and Tamkine have aided immigrants of this study in receiving healthcare access, an investigation should be conducted into how immigrant health access is continuing to be provided, if at all, in the absence of these two NGOs.

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APPENDIX A: INTERVIEW QUESTIONS—ALL IMMIGRANTS

Les informations démographiques

1. De quel pays êtes-vous venu ?
2. Depuis combien de temps restez-vous ici au Maroc ?
3. Quel âge avez-vous maintenant ?
4. Par le passé, est-ce que vous avez fait une demande à l'UNHCR pour obtenir le statut de réfugié ?

Les renseignements généraux

5. Comment vous trouvez le Maroc ?
6. Pourriez-vous décrire vos conditions de vie ?

Les renseignements à propos de la santé

7. Comment décrivez-vous le système de santé national du Maroc ?
8. Avez-vous remarqué des changements du système de santé national pendant les années dernières ? Si c'est le cas, quelles sortes des changements?
9. Comment décrivez-vous votre santé depuis votre arrivée au Maroc ?
    a. Est-ce que vous prenez des médicaments maintenant ? Si oui, d'où viennent vos médicaments ?
10. Depuis votre arrivée, avez-vous sollicité des soins médicaux (y des diagnostics ou des consultations) ?
11. Depuis votre arrivée, avez-vous reçu des soins médicaux (y des diagnostics ou des consultations) ?
    a. Si oui, où êtes-vous allés pour ses conseils médicaux ? Est-ce que vous avez jamais sollicités l'aide des institutions de l'État—come les hôpitaux publics ?
    b. Pourriez-vous décrire ces expériences ?
    c. Sinon, où iriez-vous si vous aviez besoin des conseils médicaux ?
12. En générale, pensez-vous que votre expérience avec le système de la santé aurait été/serait différent si vous seriez marocaines ?
13. Pensez-vous qu'il y aurait des différences de l'accès à la santé entre les nationalités différents des immigrés ?
14. À votre avis, est-ce que ces cartes de séjour amènent aux changements des soins médicaux pour les immigrés ? Pourquoi oui ou non?

APPENDIX B: INTERVIEW QUESTIONS—MOROCCAN RESIDENTS

1. Comment décrivez-vous le système de santé national du Maroc ?
2. Avez-vous remarqué des changements du système de santé national pendant les années dernières ? Si c'est le cas, quelles sortes des changements?
3. Comment décrivez-vous votre santé depuis votre arrivée au Maroc ?
    a. Est-ce que vous prenez des médicaments maintenant ? Si oui, d'où viennent vos médicaments ?
4. Par la passé, avez-vous sollicité des soins médicaux (y des diagnostics ou des consultations) ?
5. Pourriez-vous décrire vos expériences avec ?
    a. Sinon, où iriez-vous si vous aviez besoin des conseils médicaux ?
6. En générale, pensez-vous que votre expérience avec le système de la santé aurait été/serait différent si vous ne seriez pas marocaines ?
7. Pensez-vous qu'il y aurait des différences de l'accès à la santé entre les nationalités différents des immigrés ?

APPENDIX C: INTERVIEWSUBJECT CONSENT FORM

FORMULAIRE DE CONSENTEMENT

LA PARTICIPATION AUX RECHERCHES D'ÉLÈVE AMY CHANG

Instructions: Avant de participer, merci de lire attentivement ce formulaire de consentement. On doit rendre cette forme pour que vos remarques soient incluses dans cette investigation. Tous renseignements seront gardé confidentiel, et point de noms seront utilisés.

Titre de la Recherche : Évaluation des Politiques de Santé et l'Access des Immigrés aux Soins

1. Le but de la recherche est d'examiner comment la politique de l'administration se traduit par une amélioration réelle de la santé du public. On vous contacte pour connaitre vos expériences et vos opinions à propos du système de santé nationale au Maroc.

2. La participation comprend les éléments suivants :
   - Une interview – Pendant une conversation qui durera vers une heure, on vous posera quelques questions à propos de vos expériences avec la provision des soins de santé au Maroc. Des questions pourraient être posés à propos de l'immigration en particulier.
   - On vous demandera de répondre honnêtement.
3. Des avantages qui peut résulter de la participation :
   - Vous aurez l'occasion de parler de vos expériences personnelles.
   - Vous contribuerez à la compréhension de l'état en cours du système national de santé au Maroc, particulièrement pour les gens vulnérable.
4. Merci de noter que votre participation est entièrement volontaire. À tout moment, vous pouvez choisir de ne pas répondre à une question. En outre, à tout moment, si vous sentez de ne pas pouvoir participer à ces recherches, vous pouvez vous retirer.
5. Encore une fois, cette étude sera anonyme et confidentiel; cela signifie qu'on ne révélera pas votre identité ou vos caractéristiques d'identification. Cette étude sera réalisée et présentée seulement dans un contexte scolaire—un groupe des collègues et des professeurs. À la demande, vous pouvez avoir accès au document final.
6. Si vous avez desquestionsou des soucis à propos des recherches-ci, vous pouvez me contacter par email: amy.chang@yale.edu, outéléphone:843-532-0494.

J'avais lu ce formulaire de consentement et j'avais eu l'occasion de poser des questions. Par le présent document, je permets l'utilisation de ce que j'ai dit dans le projet d'Évaluation des Politiques de Santé et l'Access des Immigrés aux Soins.

Signature **Date**

_____ _____