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For a public-private partnership to achieve migrant health equality in Morocco

A CROSS-ANALYSIS OF INTEGRATION POLICIES AND MIGRANT PEER
EDUCATOR PROGRAMS

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SIT: MIGRATION AND TRANSNATIONAL IDENTITY
CENTER FOR CROSS CULTURAL LEARNING, RABAT
FALL 2016
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Working definitions

Im/migrant: all people who have come from another country – irregularly or regularly – to live in Morocco, whether temporarily or permanently.

Irregular migrant: those who, whether due to unauthorized entry or unauthorized overstay of an authorized entry, lack legal status in a transit or host country (IOM).

Asylum seeker: those who have applied for refugee status and are awaiting evaluation of their claim by the UNHCR.

Refugee: those 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).

Sub-Saharan: any person originating from a country located South of the Sahara Desert.

Migrant integration: in general, can mean the “process of mutual adaptation between host society and migrant” (IOM); in the context of this paper, the ability of a migrant to equally partake and benefit from the same local system(s) in the same manner as the host country’s citizens.

Peer educator: a member of a given community, in this case the sub-Saharan migrant community, who works with sub-Saharan im/migrants to engage and empower them on a given topic, in the case of this paper health and healthcare.

Sensitization: a rough translation of “*sensibilisation*”, a French term describing a lecture, pamphlet, or information session to raise awareness and knowledge about an issue, such as HIV/AIDS prevention.

Health Center in Morocco: a publically-funded center providing basic health consultations and treatment; persons can only receive services at the health center assigned to their geographic area (split into districts).

Acronyms

ALCS: Association for the Fight Against AIDS (Association de lutte contre le Sida)

Caritas: Catholic relief, development, and social service organization

CNDH: Conseil National des Droits de l’Homme

IOM: International Organization for Migration

MdM: Médecins du Monde

MoH: Ministry of Health (Morocco)

MRE: Ministry of Moroccans Living Abroad and Migration Affairs (Morocco)

NGO: Non-Governmental Organization

OPALS: Pan-African Organization for the Fight Against AIDS (Organisation Panafricaine de lutte contre le Sida)

PE: Peer educator

STI: Sexually transmitted illness

UN: United Nations

UNHCR: United Nations High Commissioner for Refugees

Abstract

Since the Moroccan Ministry in Charge of Moroccans Living Abroad and Migration Affairs (MRE) released its National Strategy on Immigration and Asylum in December 2014, MRE has put forth various policies and action plans to improve migrant integration in Morocco, including the need for their integration into the national healthcare system. Before that, most of the needs of the growing migrant population in Morocco were provided for by civil society and non-governmental organizations, who worked with severely underserved and isolated migrants often fearful and distrusting of the government and authorities. To overcome this resentment, these organizations had to develop community outreach programs to spread out into the community. Four such organizations – Caritas, the Association for the Fight Against AIDS (ALCS), the Pan-African Organization for the Fight Against AIDS (OPALS), and Médecins du Monde – and their community programs were studied as examples of the outreach work developed by civil society in the last two decades or so. Twelve interviews were carried out with (i) migrant peer educators at ALCS and OPALS, (ii) administrators at all four organizations, (iii) officials from the Ministry of Health, the International Organization for Migration (IOM), and the National Center for Human Rights (CNDH), (iv) representatives of the private healthcare sector, and (v) two migrants (to produce their life stories) to gain perspective on the current situation of migrant health in Morocco. The research revealed a disconnect between the policies and action plans set out by Moroccan Ministries and the experiences of migrants on the ground, but also found that several organizations have developed effective peer educator programs to aid in community health engagement and awareness. The recommendation is for a public-private partnership between the Moroccan government and civil society organizations to incorporate the experience gained through the outreach programs (in particular peer educator programs) to improve the implementation of migrant integration into healthcare systems.

Keywords: migrant integration, peer educators, public-private partnership

Introduction

Since the early 2000s, Morocco has transitioned from being primarily a transit country for sub-Saharan migrants on their way to Europe to a country of destination as well, however temporary: “Sub-Saharan migrants generally attempt to cross to Europe illegally but many of them also tend to stay in Morocco to improve their life conditions” (Migration Policy Centre, 2013). A 2012 survey conducted by *Médecins Sans Frontières* (Doctors Without Borders) found that a majority (67%) of immigrants in Morocco have lived in the country for less than one year (Médecins sans Frontières [MSF], 2009). However, more and more migrants have been forced to settle in Morocco because they are denied further entry to European countries or because they have come to Morocco to apply for asylum through the UNHCR, but are stuck in the application or pre-relocation process. Other migrants believe that Morocco could provide them with more economic and social opportunities than their home country. The migrants currently living in Morocco can roughly be divided into four categories: regular migrants, irregular migrants, asylum seekers, and refugees. The Moroccan government has only recently put in place a National Strategy on Immigration and Asylum (2014) and begun the process of implementing migrant integration programs with various priorities and goals. Among these goals is migrant integration into the Moroccan healthcare system, both public and private. In the absence of governmental support for migrant integration in the national healthcare system, nearly all health education, sensitization, and basic care needs of migrants have been filled by non-governmental organizations (NGOs) and civil society groups. These organizations have been funded in large part by the Moroccan government, foreign governments, and international governmental organizations (such as the United Nations and the International Organization for Migration).

Migrants’ needs for healthcare and health education are broad and varied. Migrants need and deserve access to services such as maternal and infant care, STI/HIV testing and

treatment, tuberculosis and other infectious disease treatment, general and family medicine, gynecological care, and chronic disease care. The migrant community is also disconnected and marginalized from general Moroccan society. Migrants lack trust in the host government and its agencies, but also in NGOs. The government has not seen migrant rights and integration as a priority until three years ago, with the release of the CNDH report. Now, the government has plans and actions put in place. And NGOs are still an institution that migrants could perceive have connections with the authorities and have agendas to fulfill in their care for migrants.

More can and must be done to improve the implementation of the government's plans, however. Non-governmental organizations (NGOs) have organized to fulfill nearly all the specific needs of the migrant community and sub-populations, from pregnant women to HIV-positive persons. In addition to having knowledge and experience in direct care provision, NGOs have a 15-year tradition of incorporating peer educators, mediators, and agents in their community outreach techniques. They have improved the trust and confidence that migrants have in them through these peer educators, despite the suspicion and skepticism the majority of migrants have for government institutions and authorities. Since April 2016, the International Organization for Migration has implemented its own peer educator program, in collaboration with the Ministry of Health (MoH), as a component of an inter-regional migrant health project. The government can achieve relationships of trust and respect through mobilizing its own peer educators and community involvement, or substantially supporting existing peer educator programs, as well.

The research questions that this paper will assess, based on the collected data, are: How can the migrant health integration policies and action plans, set forth by the MRE and Ministry of Health in 2014 and further revised in 2016, be implemented and achieved on the ground, taking into account the experiences and programs of seasoned non-governmental organizations? How do four non-governmental and civil society organizations (OPALS,

Caritas, MdM, and ALCS) go about spreading awareness of their health services and health education programs in the sub-Saharan migrant community that they target in the city of Rabat and its outskirts? How were these programs initially organized and put in place? Have these organizations collected best practices from their experiences with peer educator and other outreach programs? What, if any, efforts has the government carried out to date to employ a community approach to increasing accessibility and integration into the healthcare system for migrants? These questions have been approached in the form of a top-down policy analysis of official legislation and relevant literature, in comparison with a bottom-up investigation of work done by civil society and non-governmental organizations in the field of migrant health integration and a collection of lived experiences from sub-Saharan migrants in the Moroccan healthcare context.

This paper will argue that the Moroccan government, in its increasing policy focus on migrant healthcare access and equality, should enter a partnership with non-governmental organizations that have been implementing peer educator programs to increase migrant community outreach for years. This is likely to bolster the government's own developing outreach and peer educator programs, started in 2016. Four distinct but overlapping peer educator programs from four NGOs have been researched, and the differences and best practices between them will be outlined and analyzed.

Literature Review and Framework

Migration in Morocco

Morocco is a country with a relatively long and nuanced history of migration, both emigration and immigration. 60 years ago, Morocco emerged from the existing French and Spanish protectorates. Spain still holds its two coastal enclaves on Morocco's northern coast, Ceuta and Melilla. The Moroccan diaspora expanded in the mid-1960s to early-1970s with the

introduction of large-scale labor migration programs for Moroccans, particularly from the Northern Rif Region and the Middle Atlas region, to various European countries of destination, especially France, Spain, Italy, Belgium, and The Netherlands. The Moroccan government has implemented a long list of policies in support of Moroccans living abroad, including legal and social assistance, economic promotion, and cultural exchange. Three divisions in the Moroccan government are focused on researching, providing aid for, and keeping contact with the Moroccan emigrants: the Ministry in Charge of Moroccans Living Abroad and Migration Affairs (MRE), the Hassan II Foundation for Moroccans Living Abroad, and the King's advisory Council of the Moroccan Community Abroad (CCME).

Sub-Saharan immigration into Morocco has existed for a few decades, but historically migrant movement from countries south of the Sahara was made up of people travelling through Morocco purely in transit on their journey to Europe. The main points of entry into Morocco are along the Algerian and previously Mauritanian borders. Until the 1990s, migration into Europe from Morocco, for both Moroccans and others coming from the greater African continent, was a relatively easy endeavor. Following the establishment of the Schengen Area in 1995, however, immigration and movement into Europe became much more regulated and difficult, leading (since 2001 in particular) to more and more sub-Saharan migrants moving to Morocco permanently or semi-permanently: "Morocco has become a land of asylum and long-term settlement for migrants. It welcomes regular immigrant workers, a relatively large number of foreign students, migrants with an irregular status, 'in transit' often for years, and finally asylum seekers and refugees" (Conseil National des Droits de l'Homme [CNDH], 2013, p. 2). Sub-Saharan migrants settle in Morocco because they are prevented from continuing their desired journey to Europe, are waiting for the right time to make their way to Europe, or increasingly have decided to come to Morocco for perceived increased economic opportunities. In some cases, migrants, particularly members of the LGBTQ community despite laws criminalizing homosexuality, choose to come to Morocco to

apply for asylum through the UNHCR offices in the country. Many migrants are currently in Morocco irregularly (without documentation or papers, due to an unauthorized entry or an overstay of an authorized entry), but many also are in Morocco regularly or became regular during their time in the country. The latter is particularly true since the end of 2013, when the government enacted a regularization program for foreigners living in Morocco illegally. Today, an estimated 86,000 foreigners are living in Morocco: 25,000 to 40,000 are irregular (IOM, personal interview, October 27, 2016), around 14,000 of which are sub-Saharan (CNDH, personal interview, November 23, 2016).

Following the enactment of Law N. 02-03 in November 2003, which criminalized a person's lack of official documentation and sanctioned irregular immigration and emigration more severely (Migration Policy Center, 2013), points of entry (POE) areas experienced migrant rights abuses and health threats. Police beatings, sexual violence, and dangerous living conditions among migrants became prevalent in POE cities such as Tangier, Oujda, and Nador (Chang, 2015, p. 2). According to a 2014 Human Rights Watch report, "these abuses persist despite some improvements in the treatment of migrants since the government announced [the] new migration and asylum policy." In 2013, Morocco signed an agreement with the United Nations High Commissioner for Refugees (UNHCR) delegating the "review and the granting of asylum applications" to the UNHCR (CNDH, 2013, p. 3). The UNHCR received 2,661 applications for asylum from January to September 2015 (UNHCR, 2015, p. 2). Today, approximately 7,000 refugees are living in Morocco (IOM, personal interview, October 27, 2016).

As a part of the European Neighborhood Policy (ENP), Morocco has put in place a policy of control of illegal emigration to Europe by Moroccans and non-Moroccans from within its borders. Effectively, the European Union (EU) has operated through policies to externalize its borders into Morocco (and other countries, such as Turkey) to expand and promote the regulation and prevention of illegal immigration into the European Union by

Moroccan authorities. EU funding has gone to efforts to displace sub-Saharan migrants from border cities, such as Nador and Tangier, to southern cities and regions, in order to discourage migrants from attempting to cross into Europe (Mamed, Médecins du Monde [Mdm], personal interview, December 1, 2016). In June 2013, a joint declaration was signed establishing a mobility partnership between the Kingdom of Morocco and the European Union. Despite these efforts, a significant number of migrants still arrive in Europe via Morocco, particularly through the Spanish enclaves (around 3,000 arrivals from January to September 2016) (UNHCR, 2016).

The issue of migrant rights in Morocco, particularly of sub-Saharan migrants, and human rights abuses against them, was not in public focus until 9 September 2013, when the National Council for Human Rights (CNDH) published the report, “Foreigners and Human Rights in Morocco: for a radically new asylum and migration policy”. Per the report, the border control campaigns brought about in part by the European Union’s policies have “given rise to numerous violations of the human rights of migrants in irregular situations (arrests of refugees, violence and mistreatment, rejections without referral to justice, etc.)” (CNDH, 2013, p. 3). The report further notes that such violations occur in addition to the mistreatments migrants face from human traffickers and others on their journey to Morocco. The report called for public officials and authorities to “act together to develop and implement a genuine public policy that protects human rights, based on international cooperation and integrating civil society.” The report went on to make suggestions for actions on various sub-issues by various actors, including the Moroccan government, the Moroccan parliament, the media, businesses, and trade unions.

The next day, King Mohammed VI called for the Moroccan government to develop a comprehensive policy and an operational action plan on immigration into Morocco. One month later, on October 10, the first ministry of any kind in charge of migration affairs, the MRE, was created. One year later, the MRE wrote and the government adopted the country’s

first National Strategy on Immigration and Asylum on 18 December 2014 (MRE, p. 4). In the process of writing such a National Strategy, the Moroccan government for the first time formally recognized the issue of migrant integration in Moroccan society, migrant rights, and the “perception of immigration as an opportunity and not an economic, cultural, or social threat.”

The King also called for a year-long period of regularization of migrants, particularly women and children, from December 2013 to 2014. Migrants were regularized by providing them with a residency card, valid for one year, dependent on criteria such as how long they have been in Morocco, their gender, and whether they have children (IOM, personal interview, October 27, 2016). The government granted 23,000 migrants residency permits (IOM, oral interview, October 27, 2016). This solution has not been sustainable, however. The government has not arranged for a tracking system to ensure that migrants re-apply for cards once their initial ones expire and keep their contact information and documentation up to date (IOM, personal interview, October 27, 2016). A majority of the regularized migrants now have invalid residency cards because they were not able to or did not know they had to reapply after one year; re-application required showing proof of residence and employment, among other things, which many migrants were not able to provide (Mamed, personal interview, December 1, 2016). Many of the migrants have also left Morocco and moved to Europe, no longer needing the residency permit. In addition, a significant number of those regularized initially were in fact Senegalese and Syrian migrants, the majority of whom have received work permits through government partnerships and refugee status through the UNHCR, respectively. With the introduction of the National Strategy, the Moroccan government shifted from a migration policy oriented towards national security to one with a humanitarian purpose (Mamed, personal interview, December 1, 2016).

The Moroccan Healthcare System: in Theory

The Moroccan healthcare system can be broken into three distinct sectors: public, private, and informal. Following the country's independence from France and Spain in 1956, Morocco slowly began developing its own social systems, including an education system and a healthcare system. In the 1960s and 70s, Moroccans of all social strata began adapting themselves to the services offered by the public health sector (Dr. Hassan, personal interview, November 8, 2016). Without the proper development of regulations and checks and balances, the national health system fell into a period of gradual degradation starting in the 1980s, when limited financial and human resources, combined with poor infrastructure and governance, led the public sector to a near failure (Hassan, personal interview, November 8, 2016). Moroccans, particularly of higher socio-economic levels, and healthcare practitioners began to move again to the quickly growing private health sector. Those who can afford it have almost entirely turned to the private healthcare system, leaving what is left of the public system to the lower social strata.

Public healthcare suffers from being inefficient, lacking good infrastructure, understocked, unregulated, and simply inaccessible for many Moroccans. Reasons for this include distance to healthcare centers, cost, inaccessibility of health insurance programs, and incompatibility of modern medical procedures and treatments with traditional beliefs. A 2011 report from the National Observatory of Human Development in conjunction with the UN Agencies of Morocco claims that the issue of access is first and foremost linked to “geographical access to the desired provider”, particularly in rural areas (Gruenais, p. 28). The average distance to physician consultation office is 13.8 km (8.6 miles) in urban areas, and 38.5 km (23.9 miles) in rural areas. Lack of access or ease of access to healthcare is also related to “lack of money [...] especially for women” and claims that such financial accessibility is “made worse by unofficial payments made to health workers” (Gruenais,

2011, p. 29). Therefore, many lower-class Moroccans have begun to turn to an informal healthcare sector.

The Ministry of Health (previously called the Ministry of Public Health) runs various public health programs and campaigns, including those for dealing with tuberculosis, malaria, and HIV/AIDS. The MoH provides anyone (including migrants since 2014) who tests positive for tuberculosis or malaria a full course of treatment at no cost (IOM, personal interview, December 2, 2016). It also has three social service and general healthcare coverage programs in place to support working Moroccans and documented foreigners, as well as specific programs for the most impoverished and underserved. The Ministry's social protection system consists of the AMO, the basic medical coverage scheme which all Moroccan citizens are required to be members of. Within that, basic medical coverage is divided into the CNSS (La Caisse Nationale de Sécurité Sociale) and CNOPS (Caisse Nationale des Organismes de Prévoyance Sociale), which are primarily available to Moroccan nationals. The CNSS provides healthcare coverage to people who work in the private sector; CNOPS is available to those who work in the public sector (Pagny, personal interview, November 23, 2016). There is no coverage program set up for those who work in the informal economy. Finally, the RAMED (Régime d'Assistance Médicale) program is in place to assist the lowest economic strata. According to the CNDH, the healthcare service programs, and RAMED in particular, should not exclude anybody. Law N. 5500 provides that all people of low economic status may access RAMED (Pagny, personal interview, November 23, 2016). This applies to all Moroccan nationals and, since a 2015 convention between the CNDH and the Ministry of Health, all regular (documented) migrants (Pagny, personal interview, November 23, 2016). The law has not been confirmed to allow irregular migrants to be included.

Migrant Health in Morocco

In 2013, the MRE published a “Practical Guide to facilitate your integration in Morocco,” the first of its kind. It states that “access to healthcare is a guaranteed right in Morocco,” explaining that in 2008, the Ministry of Health (MoH) issued a statement affirming the right to healthcare access to all migrants and since 2011, the Rules of Procedures in Moroccan hospitals require that all foreigners, regardless of status, be admitted and given care equal to that given to Moroccan citizens. However, in a 2011 report by the National Observatory on Human Development (mentioned above), there is no mention of migrant health status or integration. The Ministry began referring to these rights following the publication of the 2014 National Strategy. Similarly, the Ministry of Health’s 2012-2016 Sectorial Strategy on Health does not make a mention of migrant issues (Ministry of Health [MoH], 2012).

In a September 2016 report by the Ministry outlining the status and improvements made in migrant rights and integration since 2013, the Ministry reaffirmed that all persons in Morocco, regardless of citizenship or status, have access to healthcare under the “same conditions” as Moroccan nationals and mentioned specific actions it is taking to achieve that. It goes on to affirm that “immigrants and refugees are also provided services through national health programs free of charge (maternal-child health, malaria, tuberculosis, leishmaniasis, HIV/AIDS, STIs)” (MRE, 2016, p. 47). “These measures testify to the Kingdom's willingness to take migrants into consideration in the national health system. The National Strategy for Immigration and Asylum seeks to strengthen initiatives and actions in the field of prevention and treatment,” asserts the report (MRE, 2016, p. 49).

The adoption of the National Strategy led to various specific actions and programs set out by the Ministry of Health and the MRE, involving the standardization of emergency migrant care; awareness-raising sessions for “immigrants and health professionals on rights to equal healthcare access for all”; medical professionals training on the care of migrants; integration of regular migrants and refugees into the program for medical coverage of the

most underprivileged (RAMED); designation of focal points for information and guidance of immigrants in regional hospitals; integration of immigrants and refugees into special health programs (advocacy, vaccination, screening, mobile care, maternal and child health); and the definition of a reference framework for a more effective intervention of NGOs and associations in the field of immigrant health (regular and irregular). The report produces various results for these actions. For example, the Ministry of Health, in partnership with ALCS, “organized sensitizing sessions that profited 1,268 migrants in 2016”; and separately, “5,419 migrants were tested [for HIV] from April to June 2016” (MRE, 2016, p. 49). IOM has worked with the MoH, MRE, Ministry of the Interior, and the Ministry for Finance for over a year on the upcoming National Strategy on Migrants’ Health, 2017-2021. This Strategy will give every regularized migrant government-funded healthcare coverage, but will only apply to those migrants who received their residency permits during the December 2013 to December 2014 regularization program, many of whom are no longer in the country or valid residence permit holders (Mamed, personal interview, December 1, 2016).

While the affirmation of equal access to equal access to healthcare send an important message in principle, and migrants have confirmed that hospitals do give them care regardless of whether they can produce papers or not, migrants are not given equal quality care as Moroccans. Migrants may be given the simple access to healthcare in terms of having the doors to hospitals and clinics opened, but they continue to face grave barriers to access to full, comprehensive, and quality care.

The second primary goal of the 2014 National Strategy in terms of migrant health is to “coordinate the action of [organizations and] associations in the field of health” (MRE, 2016, p. 49). Action 3.2 of the Strategy involves the “organization of awareness-raising and information sessions for immigrants and health personnel on the right of all migrants to have access to health services (...) and to inform migrants about the possibilities and offers of care available in Moroccan health establishments”.

The International Organization for Migration (IOM) has been active in supporting the government on their management of migrants, with a “focus on health and wellbeing” (IOM, personal interview, October 27, 2016). An IOM project, funded by the Ministry of Foreign Affairs of the Republic of Finland and titled “Promotion of health and well-being of migrants in Morocco, Egypt, Libya, Tunisia, and Yemen,” has been active in reinforcing and building the capacity of such local actors as civil society organizations since May 2015. IOM has worked with organizations through trainings, facility and structural capacity building, and increasing their attention for and work with vulnerable populations within the migrant community. A part of the projects’ framework, IOM put together a group of 21 peer educators in 2016. They also facilitate “regional dialogue in sharing best practices to harmonize” the work done across civil society organizations (IOM, personal interview, October 27, 2016).

The second National Strategy goal is critical in achieving migrant health integration. Considering that migrant integration has only recently become even a concept to consider and strive for in Morocco, despite the multiple and comprehensive plans to improve migrants’ equal access to healthcare, currently most of the burden for community outreach and healthcare provision lies on NGOs and civil society groups, which still remain somewhat more trusted than government ministries and health centers. Prior to the 2014 National Strategy, after all, they were the primary healthcare providers to migrants throughout Morocco. Even though migrants now do have access to all hospitals and health centers regardless of documentation, most are still using organizations as their first points of contact for health information, consultations, and guidance and accompaniment through public hospitals and centers. Organizations, through the umbrella National Platform for Migrant Protection (PNPM) that has existed for a decade but was only formalized in 2015, have coordinated amongst themselves to spread target populations between them. HIV/AIDS-positive migrants seek care at ALCS and OPALS; pregnant women and women with babies six months old and younger are assisted by Médecins du Monde; men and women with

children older than six months attend Caritas. There are some levels of distrust in organizations, particularly ones that have secondary agendas such as the Catholic mission behind Caritas. Organizations will also coordinate to share funding and divide responsibility for complicated cases; a given patient will go to various different organizations for different services, for example (Mamed, personal interview, December 1, 2016).

Civil society groups and NGOs working in migrant communities in Morocco for decades have had to engage in active outreach because of the deeply marginalized and isolated nature of such communities. Certain subsets of the migrant community find themselves marginalized in a more heightened way, and therefore more vulnerable and at-risk. These include the sex worker, LGBT, prisoner, and under-aged migrant populations. Organizations throughout Morocco have found, in roughly the last decade, that one of the best ways to engage in active community outreach is to utilize members of the target communities themselves: meeting migrants where they are rather than expecting them to find their way to a given organization. Organizations select, train, and maintain peer educators who are leaders in their community to routinely go out into the community and inform fellow migrants of their healthcare options and how to access facilities, raise awareness of key health concerns such as HIV/AIDS transmission, and urge them to visit an organization for a consultation or health screening. Both organizations and migrants reap the benefits of such an insider-lead outreach effort. IOM has aided many organizations, most recently ALCS, in capacity building for their existing peer educator programs, and Fondation Orient-Occident in initializing a program on health sensitization and increasing access to healthcare systems (IOM, personal interview, October 27, 2016).

Four Migrant Health Organizations: ALCS, OPALS, Caritas, and Mdm

ALCS is a national organization that works in 18 sections throughout Morocco, and was one of the first Moroccan organizations that began working with migrants on health

issues. The Rabat branch opened in 2005. Its three main goals and approaches are for prevention of the transmission of AIDS particularly in vulnerable populations (LGBT, sex workers, intra-venous drug users, prisoners, migrants, etc.); assisting persons living with HIV/AIDS through medical, psychological, and social aid; and promoting respect for and the rights of people living with HIV/AIDS by fighting marginalizing laws and social stigma. They have employed a community approach to tackle transmission prevention since the 1980s, using members of various vulnerable populations to reach them. ALCS works with the MoH on the National Program for the Fight against Sexually Transmitted Infections and AIDS (STI/AIDS), which aims to sensitize and inform migrants of the transmission and prevention of STIs, including HIV/AIDS. According to the MRE, the program carried out awareness-raising sessions (sensitizing sessions) that 1,268 migrants profited from in 2016, from January to September (2016, p. 49).

OPALS was founded in 1988 and has offices working in various cities throughout Morocco. I have only researched the OPALS branch located in Rabat, and am reporting their services and activities; I understand that other branches follow some different programming. OPALS works almost exclusively in preventing, screening for, and assisting in treating of HIV/AIDS and other STIs. Their main medical activities involve providing HIV/STI tests and condoms; their focus is not to (and they are not financially able to) provide migrants with any other form of contraception, such as the contraceptive pill. They are also capable of providing limited gynecological and dermatological services, and perform consultations for patients to make recommendations or referrals to other organizations for further medical concerns, all with volunteer physician staff. Female physicians are on staff to consult female migrants. Referrals to other organizations are assisted by the organization's peer educators. Much of OPALS' work is limited by their access to funding, particularly the number of awareness-raising sessions they can hold and the funds they can use to reimburse migrants for their

transportation costs to visit the organization. They were previously a partner organization of the Moroccan UNHCR mission (OPALS, personal interview, November 11, 2016).

Caritas Internationalis is an international religious organization, affiliated with the Catholic Church. The organization's broad vision is to "serve anywhere in the world the poor, vulnerable, marginalized and dispossessed. Caritas is inspired by the scriptures of the Social Teaching of the Church and the experience and hopes of people living in poverty" ("Our Vision"). Caritas was recognized in Morocco in 1957, and since has maintained a "modest and discreet" role in "combat[ing] poverty, intolerance and discrimination". Since the mid-1990s, Caritas Morocco has worked on the issue of sub-Saharan migrants living in Morocco, working primarily in Rabat and Casablanca. Caritas provides medical, financial, housing, clothing, and nutrition assistance to migrants; migrant health is their main focus. Much of Caritas' migrant work stems from their two Migrant Welcome Centers, one in Rabat (Takadoum Quarter) and the other in Casablanca, where migrants can get registered for continuous care, interviewed to determine their greatest needs, and referred to various of Caritas' or partner organizations' services.

Médecins du Monde (MdM) began working in Morocco in 2013, following the departure of *Médecins sans Frontières* (MSF, Doctors Without Borders) from the country. MSF closed its operations in Morocco indefinitely in 2012 after publishing a report titled "Violence, Vulnerability and Migration: Trapped at the Gates of Europe", on human rights abuses and sexual violence against migrants in Morocco, and receiving government backlash on it. Officially, their "decision to close the Morocco program was based on the fact that access to healthcare for sub-Saharan migrants has improved, and that local organizations have emerged to help ensure that migrants get the healthcare they need and that their rights are respected" ("Morocco", 2013). Through funding from European Union and Switzerland, MdM is active in Oujda (since 2013) and Rabat (since April 2015). One of their projects, Tamkine, focuses almost entirely on providing medical care, psychological and social

assistance, and guidance through Moroccan healthcare systems to pregnant migrants and female migrants with children under 6 months old (Mamed, personal interview, December 1, 2016). The project was taken over by Mdm from the organization Terre des hommes when it closed operations in 2014.

Peer Education as a Public Health Technique

Peer educator programs in healthcare have existed in contexts beyond Morocco for many years. Healthcare and public health practitioners have realized the importance of social relationships in the promotion and maintenance of health and well-being, and in the treatment of disease (Dennis, 2003, p. 322). Health interventions aimed at altering the social environment surrounding an individual have successfully promoted and expedited recovery from traumatic experiences, such as a migrants' journey through the Sahara desert, and psychological adjustment (making a normal adjustment to a need or stress in the environment), such as having to adjust to a new society with different norms (Cohen, Gottlieb, & Underwood, 2000, p. 3). Similarly, practitioners in various healthcare contexts around the world have shifted their healthcare focus from disease-preventing (treating) to health-promoting. The World Health Organization identified strengthening social relationships as a health promotion strategy (1998). With these two shifts has come the acceptance and growing promotion of the integration of peer relationships and peer support in the provision and advancement of health care and well-being. Such peer relationships are especially useful in aiding individuals with further stresses beyond their health needs, and individuals who must navigate through obstacles and barriers to easy access of healthcare. From an informational support perspective, as is required in the migrant context of Morocco due to unequal access to information about healthcare options, peer educators are especially effective through the means of advice, suggestions, factual input, and feedback (Burlison, Albrecht, & Sarason, 1994).

Methods and Methodology

I have decided to divide this section into three parts: my methods, a narrative reflection on my methodology and research process, and thoughts on my positionality and reflexivity. The reflective narrative is important to give context to the sensitive political nature of research in Morocco into the national healthcare system, and even more heightened into the issue of migrants in Morocco.

Methods

In gathering information about peer educator and general outreach programs, I relied on interviews with two peer educators at OPALS; one peer educator at ALCS that works with the LGBT migrant community; an interview with the two migrant program coordinators at OPALS; the director of the Rabat branch of ALCS; the co-person in charge of health services at the Caritas Migrant Welcome Center in Rabat; and a medical referrer (medical care specialist) at MdM; and the migrant health focal point at IOM. Interviews with peer educators were arranged by my administrative contacts at the respective organizations, and therefore certainly involved self-selection bias (those willing and able to speak with me, and those chosen by administrators to speak with me). All but one interview took place at the organization for which the interviewee worked; I spoke with the Caritas employees at OPALS, because the migrant program coordinator there set up the meeting for me. I was not able to speak with peer educator staff at Caritas, due to their unavailability.

The interviews were both structured and open in nature. The first of my two peer educator interviews, with two educators at OPALS, was more open than the second at ALCS, as I came in with my set questions but was also largely working with what I was being given, as I had no experience speaking to peer educators before. My questions in the second peer educator interview were more specific and pointed, in efforts of being able to create

comparisons, similarities and differences, between the programs and the peer educators' work. This became true for most of my interviews; questions became more informed as I became more informed. Interviews with officials and organization employees were somewhat more open, as I went into each conversation with just a background overview of an organization's services and missions, or a Ministry's policies and programs, but was looking for more specific practices and action plans.

I decided to also employ the life story technique with two or three migrants, to gain perspectives from migrants about their experiences on their migration journey; dealing with health issues (both for them and their children) in Morocco and on their journeys from their countries of origin; their general living conditions and community in Morocco; and their experiences with civil society organizations in accessing health, social, and financial help. In the end, I carried out two such life story interviews, both with female migrants. I met one Congolese migrant through the organization ALECMA; and the other through an open initial contact-making session at OPALS, with migrants gathered at the organization for medical consultations.

I gathered background information and experiences with migration laws in Morocco, the national healthcare system as a whole, migrant integration efforts, and migrant healthcare through interviews with officials at the Ministry of Health, IOM, and CNDH, and through representatives of the private healthcare sector. I contacted Ministry and CNDH officials by walking into the respective institutions and requesting an interview with a relevant employee. The CNDH official was an Ivorian lawyer specializing in foreigner and migration policy law. I arranged my interview at IOM through a previous acquaintance who works at IOM in Austria. I spoke with program officer and the focal point on migration health. Finally, I spoke with Dr. Hassan, a private general physician and the president and founding member of the National Federation of Private Generalist Doctors, through a recommendation from my advisor. I met with him in his practice.

I carried out a total of 14 interviews. All but four interviews took place in French. All of these were carried out through a French-to-English translator, as I do not speak French. I used fellow American students as my translators when interviewing migrants and employees at organizations, and Moroccans when interviewing officials (of the Ministry of Health, the National Center for Human Rights, etc.). Initially, the translators turned out paired in this manner; but as I went on in my research, I began to believe that having a Moroccan translate any interview with a migrant discussing sensitive material about the Moroccan government and systems could lead to difficulties. Migrants may not feel as comfortable speaking around (through) a Moroccan. Indeed, their answers to sensitive questions could even change, whereas with an American translator, that would simply be two Americans in the room rather than one (me). The Moroccans themselves may also feel uncomfortable or shocked hearing how Moroccans were living and being treated in their country, and could even decide not to translate the answers fully for me.

All interviews took place in closed office environments, with me, the interviewee, and my translator (if needed) present. I informed my interlocutors about the goals of the project, that everything they said would be kept anonymous and confidential, asked them if I could record our conversation to aid my note-taking (everyone but the Ministry official said yes; I did not record my interview with the director of ALCS because I did not get the chance to ask), and told them that I could pause the recording at any point if they did not want to be recorded. In addition, I assured my interlocutors that if they said anything they did not want included in my paper, I would not include it. At the end of each interview, I re-confirmed all ethical considerations, and told interviewees how to contact me should they have any questions or want to revise any of what they had said.

In reporting and analyzing my interviews, I have transcribed the ones I was able to record (due to interviewee willingness and my access to a recorder), and used the extensive notes I took during the others. For some of my interviews, I have decided to report the general

meaning of what my interlocutors shared with me, rather than quoting them exactly; this is due to a general uneasiness I felt from my interlocutors at certain points during our conversation, my inability to transcribe exactly what they said due to recording or translation quality, or due to space constraints in the paper. To aid in this and protecting my interlocutors' confidentiality and anonymity, I have given all but one (the CNDH official) a pseudonym.

Reflections on Methodology

My initial research question involved studying informal health and medical care networks formed by Sub-Saharan immigrants in transit in Morocco whose needs are not met by the current Moroccan healthcare system, assuming that such a system must exist. After speaking with a researcher who had done work with female migrants on health and making initial contact with OPALS, I realized that an organized enough system for me to effectively study in a month did not exist; migrants may use elements of an informal economy to attain traditional or counterfeit contraceptives or to get teeth pulled, for example, but in fact many migrants simply sit with their medical conditions until they are able to receive care from an organization's medical services. After hearing this, my research question turned for a short period to looking at chronic illness and disease in migrants, and how migrants are able to employ risk management and deal with these maladies under Moroccan conditions that leave them with unreliable and infrequent access to healthcare. This proved difficult as I tried to find migrants with chronic illnesses to speak to, as all of the migrants I encountered had multiple medical conditions, but none that could be classified as *chronic*, or long-lasting and needing constant care and medication.

I first came into contact with OPALS by simply calling their main number and asking if anyone at the organization spoke English. Tarik, the organization's accountant, was very welcoming and invited me and a fellow researcher to come into the organization right then to

discuss our research and possible collaboration. Tarik gave us a tour of the organization's building: a very clean, white, almost sterile two-story detached building, with offices on the second floor and laboratories, consultation rooms, and a waiting area on the first. He introduced us to anyone we ran into, and was adamant that OPALS would be able to help us with all of our requests, for migrant interviews, contacts, and information about the organization and its programs. We arranged for a meeting later in the week with the migrant program coordinator, Raoul, who detailed to us the various programs they have that are migrant-specific, particularly their sex worker program and their peer educator program. The latter intrigued me, as I thought it was a clever and seemingly effective way to handle outreach issues in a community that is marginalized, isolated, and vulnerable. I later made contact with two other organizations that carry out similar outreach programs: ALCS and Caritas. I contacted ALCS through the health liaison at IOM, and Caritas through the migrant program coordinator at OPALS.

From the discovery of peer educator and outreach efforts at organizations came my final research topic: a comparison of community outreach methods and programs in various non-governmental organizations that work in the field of migrant health. More specifically, peer educator programs that work by using members of the migrant community (migrants themselves) to interact with fellow migrants and inform them about the services that organizations (specific to the one they work for) provide, as well as give them an initial sensitization (*sensibilisation* in French) on issues of sexual health, well-being, and access to medications and services.

In addition to my various interviews with migrant peer educators, I desired to carry out observations of migrants' doctor visits at one of the organizations, during a health awareness training session, or during a peer educator meeting or focus group, but none of these opportunities materialized. This was due to my own time constraints and difficulties in confirming when such an observation would be possible. I felt very uncomfortable asking

most of the migrants I spoke with if I could accompany them to a doctor's appointment, particularly in a public hospital or health center, knowing that my presence in the room would likely make both my migrant interlocutor and the doctor or nurse uneasy and self-conscious. I therefore did not actually ask any migrants if I could observe them in that context, though I did confirm with organization employees that it would be possible and acceptable on their end.

Due to meeting time availability and ease of contact, I carried out most of my background-type interviews with the Ministry of Health, the National Center for Human Rights (CNDH), and a private doctor involved in healthcare politics after I had completed most of my organization-based research. I met with officials at IOM during my preliminary interviews. I made initial contact with the Ministry of Health by walking into the office of the main secretary or receptionist, an official who listened to my interests and needs and directed me to other people to speak with. Though he at first was adamant that I would not be able to speak with anyone officially without previously-attained authorization for research from the Ministry, he did give me the names and locations of three sub-ministries (elsewhere in Rabat) where I could seek to speak with someone. After being passed from office to office for about half an hour, I was able to sit down and speak with an official, the person responsible for migrant integration programs, at the Direction for Epidemiology and the Fight Against Disease (*Direction de l'épidémiologie et de lutte contre les maladies*). She and her colleagues were somewhat uncomfortable with speaking with me as I did not have the official authorization from the Ministry, repeatedly told me that none of what was being said was official, and insisted that I ask very specific questions, rather than broad background question. But I was able to get a lot of information from them.

My contact at the National Center for Human Rights occurred similarly; I spoke to the receptionist about my research needs, she recommended an official and scheduled an appointment for me two weeks later; this appointment then got pushed back another two days

because the official was not informed of my appointment time. Dr. Hassan was very willing to speak with me when I contacted him by phone; our conversation flowed through the topics of concern that he wished to discuss. My interview with the medical care specialist at Médecins du Monde was very last-minute in my research process, but came about after weeks of contacting and trying to receive a specific interview date with the organization. I returned to IOM to speak with the migration health focal point near the end of my writing process to discuss their peer education program, run in collaboration with the Ministry of Health and organizations, which I only found out about as I was writing this paper (following my data gathering period).

As I slowly gained a greater understanding of the extent of policies and action plans that the government and its ministries has put forth, but clearly has not been able to fully actualize, I began to realize the importance of cross-analyzing the policy-level data I had collected with the on-the-ground data from migrants and organizations.

Positionality and Reflexivity in Conducting My Research

Throughout the course of my research, I experienced two kinds of positionality and reflexivity. The first was in talking with migrants, asking them to share their difficult lived experiences, and at times feeling as though I was using their pain for my academic gain. Several migrants I spoke to became visibly emotional and upset during our interview as they recounted their journeys into Morocco, and all I could really do was sit and comfort them with tissues, as I had no experiences to share in order to lighten their load. I thanked all the migrants who spoke with me verbally, and compensated the migrants who had to travel (via bus or taxi) to meet with me. I ended many interviews by saying to my interlocutors that sharing their stories in my academic work would hopefully incite change in their current living conditions; most migrants shared my hopefulness for improvements in the future. One peer educator, however, replied that while he has spoken to various students and researchers

about his living conditions in Morocco, nothing has ever changed. He immediately made me reconsider my assertion to migrants that my work and sharing their stories would have to bring about some amount of change. In reality, I have no idea if it will, as I do not actually have that much power on the issue of migrant integration in Morocco outside of the realm of my paper. He has been told that before by researchers that his life will change, but he is still stuck while they have been able to go on with their lives and move forward – as I will be able to do. His response made me consider the moral issue of researchers, me included, benefitting from migrant's intimate and painful stories academically, while they are left stationary in their social positions and lives despite our conversations.

The second thoughts on my positionality came up during my interviews with Ministry and other officials (CNDH, IOM, the private physician). I realized that I went into many interviews seeking background information for policies and integration systems that I already had formed judgements on. I went into this research process in disdain for the lack of responsibility and action that the government has taken in effectively integrating migrants, not remembering at times that such integration efforts only began three years ago – essentially nothing in the field of policy implementation. Throughout my interviews, I went through periods of being sympathetic and overly critical of the Moroccan government and ministries, in my opinion. I finally realized and decided that in writing my paper I needed to be as objective as possible, while still being critical of the information that has been presented to me.

During the process of scheduling interviews, I was often struck by my contacts' tendencies to schedule meeting times with me very last-minute, as occurred on various occasions. I had also noticed that none of the NGOs I researched used email servers that included the organization's name. As I spoke to many of my contacts about their sometimes difficult relationships with government authorities, in the tense political climate surrounding healthcare and migration, I understood their desire to remain anonymous when it came to

their email correspondence. Or perhaps the organizations simply do not see the need for such a server.

Throughout my work at the organizations with administrators, employees, and peer educators, I entered spaces that people walk into vulnerable, weak and faced with a system that does not favor them and frequently does not or cannot support them. They are spaces where other people work to make a living, and try to do the proverbial good in the process. And I am expecting organization employees and migrants to be comfortable enough with me to open up about their struggles, vulnerabilities, and concerns. At times, I felt I was creating power structures between my interlocutors and myself in the ethnographic process, particularly when they would mention things that have happened to them that are entirely out of touch with the life I live.

I was also aware that I come from a position of not being a migrant in my own country (though living temporarily in Morocco throughout this research period), am fully documented in the country that I live in, and have access to quality care without concerns about finances and access in my country and in Morocco. I have never had to make the tough decision to go to the doctor without knowing if I will be reported for being undocumented, without knowing how I would pay for it, or how well I would be able to communicate with the doctor. I have also never been forced to deal with the pain of an illness or malady without the possibility of seeking medical help for it in my near future. Throughout my interviews, I was finding out new things and hearing about experiences that I do not and will never have a way of fully understanding.

Findings

The Moroccan Healthcare System: in Practice

Government regulation and awareness of the private and public sectors are unequal. Many officials in the Ministry of Health still work under the assumption that most Moroccans

receive their healthcare from the public sector (Hassan, personal interview, November 8, 2016). Therefore, most of the Ministry's research and statistics are done for the public sector, to the exclusion of the private sector. For example, in 2014 the Ministry put together a map of the number of doctors, specialists (cardiologists, radiologists, etc.), hospitals, small health centers, equipment, etc. throughout Morocco – but only did so for the public sector (Hassan, personal interview, November 8, 2016). However, the public sector is not sufficiently regulated at all levels, particularly in terms of geographic differences in access to healthcare services.

The government and its health ministries are aware of the existence of an informal health sector as well as “the dangers encountered by this sector, for example, AIDS transmission during child delivery with untrained midwives.” However, in many cases the government turns a blind eye to it. Dr. Hassan, private general practitioner, noted that the government does not “touch this sector” because of “politics: a lot of people are surviving due to this sector. Thousands of people are working in this sector. [...] If the government wants to stop them, [it] has to give them jobs, and [it] is unable to give jobs to these people, so [it] just lets it go” (Hassan, personal interview, November 8, 2016).

Communication between the public and private sector service providers, among which many patients regularly switch between for different kinds of services and examinations, is also stunted. The Ministry of Health has tried to create a partnership between the public sector (run by the Ministry) and the private health sector, according to Dr. Hassan:

I have wanted before to sign a partnership with the Ministry of Health, to take care of people with Tb, but it doesn't work. Because a partnership needs the two parts to be aware of the situation. They [the public sector] don't communicate enough [with the private sector] through people who work in the public sector. And so when I have somebody here, for example, where I suspect Tb – when I send them to the [public] hospital for an examination, a special kind of examination, he has to come back to me [with the results]. But they [the public hospital] keep it, they keep it. [...] This partnership, if the partnership were well done, it would be a good thing for health in Morocco, because you would have 50 percent of the human resources coming to improve the public sector. And in the town where there is no MRI or no specialist of radiology in the public system, if so the people working at the hospital could send people to the private sector. In a way, privatizing some of the public sector. (Hassan, personal interview, November 8, 2016).

Dr. Hassan goes on to explain that, in his opinion and from his conversations with private sector physicians, “we are ready, the GPs [general practitioners], to do it [deliver services] for the same price that they do it in the hospitals, and the government pays”; as in, to slowly increase government reliance on private providers by funding them, rather than their own hospitals and providers. In addition, Dr. Hassan explained that the entire healthcare system is too focused on sending patients to specialists, rather than having general practitioners (GPs) provide most care for patients:

Because people are used to thinking that specialists are better than generalists, because the stakeholders don't realize that they will have a better system of health if people go first to a generalist and then to a specialist. And because specialists have a strong lobby, because the pharmaceutical industry has a lobby, which helps the specialists (Hassan, personal interview, November 8, 2016).

In advocating for a general practitioner-focused system, the doctor compared the Moroccan system to those in other countries, such as France and Cuba:

The system that gives the best result is the Cuban system. Poor country, embargo for more than 60 years, but they have 30,000 GPs, 30,000 family doctors. And every doctor is in charge of 500 families. [...] They have people taking care of people. There is this human relation between the GP and the family or the patient (Hassan, personal interview, November 8, 2016).

It is critical to acknowledge that while the various social service systems (CNOPS, CNSS, RAMED) are set up, they do not sufficiently support or reach all Moroccan nationals, let alone all migrants and foreigners living in Morocco. As Aminata Pagny, a lawyer specializing in foreigner and migration policy law at the CNDH, explained:

All those who work, should have CNSS. But the Moroccans who work informally, they don't have access to the CNSS, they don't have any coverage. That's why I told you that you must first understand the whole health system, because even the Moroccan people still have issues with their own system [...] [U]nderstand the whole system, and then we can discuss the position of migrants within it (Pagny, personal interview, November 23, 2016).

One must continuously consider the organizational, administrative, geographical, and financial constraints and barriers that Moroccan nationals face in the national healthcare system when discussing the situation of migrant health and migrant integration into the healthcare system.

The Realities of Migrant Health and Well-Being in Morocco: Life Stories

Migrants begin facing health threats, limited access to medical care and medications, and psychological and medical stresses during their journeys from their countries of origin, long before they set foot in Morocco. Many migrants therefore arrive in the country with health conditions caused by their journey. I spoke with Evelin, a Congolese (Democratic Republic of the Congo) migrant who arrived in Morocco in the winter of 2012, and Cynthia, a Senegalese migrant who arrived in March 2016, to gain insight on migrants' experiences with healthcare coverage and medical care access in Morocco and during their migration journeys. Both arrived in Morocco through Oujda on the Algerian border, and both travelled from their respective countries via smugglers (*chequers* in French). Cynthia left Senegal, where she completed a high school education and had a steady job, because a good friend of hers recommended that she migrate to Morocco, because "it's better here." Evelin, on the other hand, left due to a combination of economic and personal issues; she had also been saving money since 1994 with the expectation to migrate, when she left in 2009. She and her family experienced various "aggressions," as she puts it, including two occasions of robbery in her home. She decided to leave following a miscarriage and ending her engagement: "I didn't want to have to count on a man to protect me and provide for me." Both women have experiences with maternity: Evelin has two daughters, one born in Chad and one born in Morocco, both with the same father; Cynthia is currently eight months pregnant after having been sexually assaulted on her first night in Oujda by a man who she asked for help in finding

shelter, and later demanded she pay him for the “help” he had given her. Both have had experiences with the Moroccan healthcare system and with health NGOs.

Cynthia did not receive or seek out any medical care for her first three months living in Morocco, while pregnant: “I didn’t know anybody, I didn’t have any visits because I didn’t have any money.” She discovered the medical services offered by Médecins du Monde (Mdm), a partner of Caritas International active in Morocco, from an acquaintance who volunteers at the organization and works as a street vendor in the Old Medina of Rabat. Mdm has helped her by providing her with pregnancy analyses, sonograms, and medicines relating to her pregnancy. She does not currently know where she will be giving birth: “Mdm says that I will need to pay more to have a baby in the hospital. So, I don’t know because I don’t have the money to pay for a hospital. It’s a problem.” She has also visited OPALS for HIV testing and medical consultations, and attended one lecture on STIs: “they explained how to not become sick.” Mdm recommended she visit Caritas for help in finding housing. When I asked her if she feels she has any kind of a community in Rabat, her response: “I have no one. I stay in my house because after my rape and the violence I am scared” (Cynthia, personal interview, November 8, 2016).

Evelin had a long journey from the Congo until she reached Morocco. Under the guidance of a *chequer*, Evelin travelled from Kinshasa through the Republic of the Congo, and on to Chad, where she remained for several years. In Chad, she contracted tuberculosis and struggled to access proper treatment, started a relationship with a Chadian man, eventually became engaged and twice pregnant. Her partner was abusive, primarily because her first child was a girl, which was not favored by him or his family. When it became known that her second child would also be a girl, Evelin accepted money from her partner to leave the country on her own, with her 1-year-old daughter and three months pregnant. During her weeks-long journey through the Algerian desert to reach Morocco, packed into a 4-person car with 19 other people, Evelin was not able to continue taking hypertension medication she had

been prescribed following her first birth to protect her second child, and experienced severe dehydration and malnutrition. After walking 10 hours across the last stretch of desert, in the winter, with her 14-month-old daughter by her side, she arrived in Oujda with fake papers, and took a train directly to Rabat. She immediately applied for asylum: “they told [me] they wouldn’t be able to give (me) a response until [my] second, unborn child, turned three years old. They gave [me] nothing (...) money, medicine, lodging, nothing.” I asked her if they gave her a reason for this: “it just is that way,” or at least was in 2012 when the Moroccan government and the UNHCR were not working as closely together as they are now.

From 2012 to 2014, Evelin worked in prostitution, as that was her only option to earn steady money. She used condoms with nearly all of her clients, which she obtained from Caritas and ALCS; clients who did not use a condom had to pay three times as much as those who did. ALCS also provided her with the contraceptive pill and “several HIV tests” that always came back negative. She first heard about ALCS through their awareness-raising programs, when she met a representative who was giving a public information session. Evelin and her daughters were given a residency permit by the Moroccan government in 2014, as part of the migrant regularization program ordered by the King. In 2015, she was granted asylum and given refugee status by the UNHCR for herself and her daughters. As a family, the UNHCR provides them with 1200 Moroccan Dirhams (approximately 120 USD); 800 DH for housing and 200 DH for each daughter. The UNHCR also became the organization in charge of all of her and her children’s medical needs. The UNHCR covers any basic medicines they may need, such as topical cream. Anything more expensive, she is expected to pay for. But she has no funds to do so. She is expected to utilize free consultations or general check-ups at UNHCR-affiliated organizations, the public health center in her neighborhood, or at a public hospital. Should she need a specialist, the UNHCR guides her to a private one.

That same year, she became pregnant a third time. Five months into her pregnancy, her partner beat her, and two days later she had another miscarriage. She visited a UNHCR-

approved physician, who confirmed the miscarriage and informed her that she had uterine cysts. However, she was told that her cysts would “have to grow, get bigger, become more of a problem” in order to receive any course of treatment for them, because “at this point they weren’t considered urgent.” Evelin was hospitalized for her miscarriage in a public hospital and remained there for two weeks. During this time, she was not visited once by a representative of the UNHCR, until she was awaiting discharge. Evelin had to entrust her daughters to neighbors to be cared for. I asked her how her experience in the hospital was: “Bad. I would never go back to a public hospital. (...) I went to the hospital, they didn’t even speak French, only Darija [Moroccan Arabic]; my feet and hands were swollen, but no one came to help her; and when they changed the IV, there was blood everywhere. I had a very bad experience there” (Evelin, personal interview, October 26 2016). When she went back to a public health center recently for a check-up on her uterine cysts, she was told that the cysts had grown sufficiently to warrant treatment, and that she also had breast cysts that would need to be analyzed. The public health centers are of better quality than the hospitals, she says, because they are “one-on-one, at the public hospitals you have like 12 people in the same room, it’s especially difficult if you don’t speak the same language. So if you don’t speak Arabic, they won’t even come to you.” Evelin is currently not working due to all of her medical concerns and the time she needs to devote to go to all of her medical appointments.

Daniel and Paola, two peer educators at OPALS, discussed how they speak with female migrants who are the victims of sexual assault in detail with me:

D: A lot of the women who are coming through the forest and Algeria, if you’re coming through that area, there’s a lot of bandits, who will have knives and weapons, and say, like, you guys can all go, but leave the girls, leave the women. And they rape the women. And then by the time the women get to Morocco, those are the women who are really reluctant to get tested, for AIDS.

P: They’re afraid! They’re terrified.

D: Those are some of the hardest women to get in to get tested – many African women – people who have been through a lot of sexual violence. It’s the Algerians!

VA: So what do they do in that situation, to calm them down, tell them it’s better to know, I know you’ve been through a lot...? Does your training cover dealing with women who are the victims of sexual violence?

D (translated): He goes, and he says, we're here to help you. Trying to emphasize that he's there to help, him and the center. And a lot of times the women get really, the victims of sexual assault, get really angry. They say, how do you know? But a lot of times, everyone in the community kind of knows, especially if a woman is pregnant. And he's saying, it's just about really trying to reinforce "I'm here to help you, please, I'm here to help you". But it's hard (Daniel, Paola, personal interview, November 9, 2016).

The Realities of Migrant Health and Well-Being in Morocco: Administrative Barriers

Most everyone I spoke with, doctors, ministry employees, and migrants alike, did confirm that all migrants, regardless of status, are given care in public hospitals and care centers. However, when I pressed about migrants facing discrimination and lower quality care in hospitals than Moroccans, many of my interviewees flipped to assert that most migrants actually receive much of their basic and even specialized care from organizations. Dr. Hassan, the private-sector general practitioner, put it like this:

Dr: Well, what I know about Africans coming from migration, people who have papers, regular migrants, they can go to the hospital, and they have a card and they are taken there.

VA: Yeah, well they're able to go into a hospital, but they face a lot of discrimination in the hospital, for example with language, like not all hospital workers speak French...

Dr. Hassan: What I can tell you is about AIDS, about AIDS, because I work in this field. There are organizations who work with this.

VA: OPALS, ALCS...

Dr. Hassan: OPALS and ALCS, yes. They have everything, they [the migrants] can come there, it's free, the entrance is free, they receive the same care as other Moroccans, there is no discrimination. I worked there for a while.

VA: So, in your opinion, do most migrants rely on organizations like that, rather than public healthcare?

Dr. Hassan: You know, the Moroccan government has problems with the Moroccans, in the field of health. The system doesn't work at all (Hassan, personal interview, November 8, 2016).

Ms. Pagny at CNDH explained that "in Morocco, it's all about the NGOs for migrant healthcare. In terms of human resources, NGOs should have enough employees to help migrants, aid them in dealing with language barriers, accompanying them to hospitals, etc. Every neighborhood there is a [public] health center, but migrants can't profit from these centers, because the people who work there can't verify if they live in that area or not."

Migrants continue to face many barriers to accessing healthcare at all, or accessing care of equal quality as Moroccans (however low the quality they receive may at times be).

According to Ms. Pagny at CNDH, “the main issue for access to healthcare is language. Most migrants speak French, but in hospitals people speak Arabic rather than French. It's difficult for them to explain their conditions through a language that he doesn't understand” (Pagny, personal interview, November 23, 2016). Evelin also confirmed this to me, as during her public hospitalization none of the doctors or nurses spoke any French, and essentially ignored her because she could not speak Darija.

In terms of healthcare coverage through the Ministry of Health social protection programs, migrants still face an imperfect and unreliable system. Irregular migrants are not given access to any coverage system, including RAMED. And many regular migrants still face issues when seeking to register for RAMED, despite having documentation. Ms. Pagny suggested that much of the issue lies in the authorities that register persons into the program: “the authorities believe that in the law, RAMED is first and foremost only for Moroccans.” Some categories of sub-Saharan migrants, however, do not need to rely on government assistance to attain healthcare. Sub-Saharan students who come to study in Morocco receive a stipend for healthcare, but do not receive any state- or university-provided health insurance or coverage (Pagny, personal interview, November 23, 2016). However, the majority of students are able to use private sector healthcare, because “the majority of the students have enough money to use the private sector.” Therefore, this category of sub-Saharans living in Morocco are not in need of the RAMED program at all.

Migrants also face administrative barriers when dealing with international and national authorities on migration and asylum. Peter, a peer educator who works specifically with the LGBT community, expressed a great deal of irritation with the UNHCR particularly in their lack of support and follow-up with asylum seekers, like him. He told me, bluntly, “the UNHCR should be called the Syrian Help, they don't care about us [sub-Saharan] Africans” (Peter, personal interview, November 18, 2016). In his experience, the employees at the

UNHCR who read over asylum applications and are tasked with keeping asylum seekers informed about the process, are all Moroccan, and are “homophobes, racists.”

I was reminded by Peter that though health is a major concern for migrants, there is a fundamental lack of economic security that can outweigh any health concerns that a migrant has. When I asked him specifically what the main health concerns faced by the LGBT migrant community in Morocco are, he replied: “No, I don’t know. What the main problems are in health? Because the main problem here is the work, housing, nutrition” (Peter, personal interview, November 18, 2016). In effect, when it comes to prioritizing time spent on learning more about your health or getting another HIV test done, versus spending time looking for a job, most migrants will decide to choose the latter. In effect, many migrants partake in risk management in deciding to focus on improving (or attaining) their financial security and living conditions over what in their minds are marginal improvements in health. But for Peter, these two decisions overlapped at ALCS, where he saw the opportunity to have a job (though unpaid) as a peer educator: something that gets him out of the house and allows him to help his community be more aware of their healthcare options.

Mamed from MdM similarly explained that “migrants live day by day” here in Morocco, many without secured housing or income (Mamed, personal interview, December 1, 2016). In his experience, however, the situation for migrants has gotten “so much better” over the last three years since the National Strategy was adopted. He, however, clarified that the report on the 2016 status of the National Strategy is an idyllic picture of the realities migrants continue to face in accessing healthcare: “if you read the 2016 National Strategy [report], you think everything’s great. No, come look at the migrants here, they are not great” (Mamed, personal interview, December 1, 2016).

Caritas is still not fully trusted in the migrant community, in large part because of its ties to the Catholic Church (Peter, personal interview, November 18, 2016). Peter expressed his frustration with Caritas, as he has been denied help from them because of his sexuality

(homosexual) and “visibly feminine” appearance, according to him. Whereas ALCS will help any migrant regardless of sexual orientation:

With Caritas, they don’t help everyone with health. They’re not tolerant, despite being part of the church. (...) You go to Caritas, they have a lot of houses for minors, for women with children, that’s it. For a gay migrant, they don’t help (Peter, personal interview, November 18, 2016).

During an informal observation, when I was attending Catholic mass in Rabat, the presiding priest spoke to the congregation about getting aid from Caritas; he advised parishioners to ask Caritas for food, not medicine or money (financial aid).

In the Absence of Policy: How Civil Society has Tackled Migrant Health in Morocco

Many civil society organizations currently working in migrant healthcare and health education provision were founded to work for underserved Moroccan populations, and saw a great need in the vulnerable migrant population as sub-Saharan and other migrants began entering and remaining in Morocco on a more permanent basis. According to Dr. Usra, director of the Rabat branch of ALCS, most doctors working with the migrant community in the early 2000s held the belief that migrants would simply appear at newly-formed organizations, or organizations with new migrant health provision programs, ready to receive medical care. She found that migrants were, in fact, very afraid to approach any organization for security concerns (Usra, personal interview, December 1, 2016). Their skepticism was due to their similar suspicion for the Moroccan authorities, their increased marginalization and isolation prior to the existence of any migrant integration rhetoric in Morocco, and that migrants at the time had generally only planned on remaining in Morocco very temporarily on their way to Europe, and therefore had suddenly become longer-term residents in Morocco. She began going from house to house in migrant-populated communities, informing families of the work and services ALCS could provide for them. She witnessed first-hand the unhygienic conditions migrants were forced to live in, and in most cases was the first doctor a

given migrant had ever seen since they arrived in Morocco. Slowly, the migrant community as a whole became more aware and trusting of civil society organizations, though some skepticism still exists. Community outreach still remains very difficult and largely reliant on word of mouth passage of good and bad experiences at organizations from migrant to migrant.

From this door-to-door community approach came about ALCS's peer educator program, with the aim of using members of their given target populations to reach people within them. Further organizations focusing on different aspects of migrant health, as well as other healthcare aid, similarly began to realize the need for the inclusion of migrants in their programming, outreach, and staff. Most organizations (certainly the four I researched) have migrants on staff who organize not only the organization's community outreach programs, but also the migrant health and health education programs.

Though many organizations rely on financial support from the Ministry of Health and other Ministries, many expressed to me their frequent frustrations in dealing with government authorities. *Médecins sans Frontières* (Doctors Without Borders) closed its operations in Morocco indefinitely after publishing its 2012, following repeated disagreements with the Moroccan government (Mamed, personal interview, December 1, 2016). At ALCS, they explained that the various ministries have contradictions and paradoxes within and between them, making it very time consuming to deal with them. IOM relayed similar thoughts, saying that inter-ministerial coordination is difficult. Organizations have had to fight with the Ministry of Health to uphold healthcare rights for migrants over the years, using the argument that epidemics within migrant communities must be controlled to protect the general Moroccan public; the argument of upholding international human rights treaties and declarations did not work as well (Usra, personal interview, November 7, 2016).

The Four Peer Educator Programs: Similarities and Differences

All four organizations employ specific and clear community outreach actions, and all involve members of the migrant community to do so. However, each program has its own specificities and methods. Some of the starkest differences between programs are whether or not peer educators are paid; what peer educators spend most of their time doing and where they do it; and what they are encouraged and trained to share with migrant contacts they make.

The ALCS peer educator program came to fruition mostly due to Dr. Usra's migrant home visits. As she visited people frequently, she began to see potential in a few migrants, particularly students, who could work as peer educators. These peer educators then helped shape the organization's STI testing and other migrant health programs. ALCS focuses its peer educators in HIV/AIDS prevention in two key "bridge populations": sex workers and intravenous drug users. It has recently also hired a PE for the LGBT migrant population (Peter). The criteria they use to select a peer educator include: that they are part of the target community; are willing to work as a volunteer; are willing and ready to engage in the fight against HIV/AIDS; are leaders and respected members of their community; and are committed to respecting the rights and confidentiality of people living with HIV/AIDS. Peter reported that he was not given any specific training for his position, though he was told about the job's specifications by the migrant who had previously worked in his capacity.

The PE program at OPALS arose from their "needs in the field", as a solution to having to work with each persons' specific needs within the migrant population. The organization receives funding from the Global Fund to Fight AIDS, Tuberculosis, and Malaria for the program. Peer educators are selected based on their "loyalty" to the organization: essentially, how visible and present they make themselves at OPALS over a period of time. They are trained extensively in "how to approach people" on the street with information about

HIV/AIDS transmission and the services OPALS can provide migrants (Daniel, Paola, personal interview, November 9, 2016). The number of PEs varies, though it usually stays at around 5 persons. The program only works in the Hay Nahda quarter of Rabat and in the sister city of Salé. They are assigned to geographic regions to take care of based on where they themselves live, which they are expected to be very well connected to and knowledgeable about. OPALS uses people who already are in positions of community leadership and connectivity, and cultivates those connections to lead to community awareness about sexual health and the organization itself.

Caritas employs migrant staff members, who they call mediators, to work at the organization's Migrant Welcome Center. Caritas runs one such center in Rabat and one in Casablanca. The staff members go out into the community on a regular basis to hold awareness-raising sessions in different settings, all with the aim of informing migrants of the care networks that are available to them through Caritas and encouraging migrants to visit their Welcome Center for specific guidance. When going into the community, mediators also work to identify vulnerable and unreached migrant populations, such as sick migrants not receiving any medical care. Once a week, a group of mediators will go on a kind of field mission to a newer migrant-populated area or specific houses where many migrants live to inform them of Caritas' services. Mediators are selected through a general outreach and hiring process, and Caritas aims to have a staff with diverse nationalities and spoken languages. Mediators are supposed to know the migrant community(ies) and be aware of the needs and vulnerabilities facing migrants within them.

Peer educators at MDM, actually called Community Relayers (*relais* in French) are volunteers chosen to inform their community of fellow nationals (whether Cameroonians, Guineans, Congolese, etc.) on the services that the organization provides for pregnant female migrants. Relayers speak to members of the community in homes, businesses, and at aid organizations and encourage them to refer any pregnant women or recent mothers they know

to MdM for help. There are currently 4 relayers working in Rabat (and 4 in Oujda), each in charge of at least two nationality groups. Relayers are overseen by specific staff member focal points, also migrants, who are in paid positions. They are trained in how to approach a migrant, especially a pregnant migrant, and delicately get as much background information as they can, so as to fully understand the migrants' situation in pregnancy (who the father is, if he is present, if the woman has been seen by a doctor while pregnant, etc.). They are also given a comprehensive overview of the Moroccan healthcare system, and taught how to explain it to migrants. The main concern for relayers at MdM currently is that, without certification or a way of proving their authority in a public hospital setting, they are regularly prevented from accompanying migrants into their doctor's visits and testing appointments.

MdM is currently working with all other organizations to regularize the peer educator programs of all organizations, calling them all "health mediators" (*mediateur santé*), and finding a way of getting PEs certification, identification, and authorization to enter hospitals and health centers with migrants as secondary health professionals.

How the four organizations select their peer educators varies in some ways and does not in others. Both at OPALS and ALCS, PEs are chosen because of their knowledge of, experience with, and commitment to their organization. At Caritas, mediators are chosen through a hiring process. ALCS PEs are chosen because they are connected to a specific subset population within the greater migrant community, mostly in the sex worker, LGBT, female, and intravenous drug user populations. OPALS, MdM, and Caritas educators are simply required to be well connected in any migrant community, generally based on their neighborhood and friend circles. Finally, PE positions at Caritas and OPALS are paid positions, while at ALCS and MdM educators work on an entirely volunteer basis (though at MdM there are overseeing peer educator coordinators who are paid).

Being a peer educator at ALCS, MdM, and Caritas is a full-time job, though PEs at ALCS and MdM are there fully on a volunteer basis and therefore can work on a more

flexible schedule; PEs do most of their work at their respective organizations, with some time spent out in the community. Peter reported that most of the migrants who came into ALCS to speak with him had heard about the organization by word of mouth; Peter also instigates his friends and peers to share information about the organization with further friends, in a form of snowballing. Peer educators at OPALS and Mdm carry out the vast majority of their work outside of the organization, on the streets of their neighborhood and in migrants' homes. The peer educators at OPALS and ALCS reported that they speak with between 10 to 15 people each week in their educating capacity; mediators at Caritas generally speak to more through the Welcome Center. Daniel (OPALS) said he "goes out" into his community three times a week, on average.

Both ALCS and OPALS PEs reported that there is a lot of turnover amongst educators, as migrants tend to move around Morocco frequently or decide to take up other employment opportunities. To combat this, ALCS has a target to train 10 new migrant peers each year. In comparison, OPALS generally aims to have 5 peer educators, though this number can also vary due to turnover. Mdm's 4 current PEs have been in their positions for a minimum of 8 months and up to 2 years, indicating for them to stay longer. Caritas did not provide me with a number of mediators on staff.

Peer educators at OPALS (such as Paola and Daniel) are encouraged to speak with their contacts about the specifics of HIV/AIDS transmission, including lifestyle and hygiene choices, and using a condom. Paola put it this way: "the more information we give them, the more likely they are to come in to get tested" (Daniel, Paola, personal interview, November 9, 2016). Meanwhile, peer educators at ALCS, Mdm, and Caritas primarily determine what need a given migrant has that their organization can help them with, and direct them to the services that they can provide. Mdm additionally motivates PEs to contact community members outside their target population of pregnant women, by incentivizing them to refer any pregnant women they know to the organization. All peer educators are also informed of and

told to refer migrants to the services that other organizations can provide that theirs cannot, and are encouraged to speak from their personal experience seeking services at organizations with their contacts.

All four organizations keep the information of beneficiaries of their peer educator programs completely anonymous and confidential. OPALS has developed a tracking system using a code involving a random number and an indicator for their age and gender. Program coordinators track the work of peer educators through these codes, by seeing how many of each PE's contacts actually come into the organization for an HIV test or a consultation. PEs are also tracked based on how many condoms they give out in the community, which is recorded by how many times they have to return to the center to pick up more condoms.

Government Catch-Up: Involvement of the MoH in IOM Peer Educator Program

The purpose of IOM's 2015-2017 project titled "Promotion of health and well-being of migrants in Morocco, Egypt, Libya, Tunisia, and Yemen" in Morocco is to support the government in implementing their national integration policy, and therefore must involve government ministries in its activities. As part of the framework of the project, IOM has selected and trained a group of 21 peer educators in Rabat (10), Oujda (10), and Tangier (1) (IOM, personal interview, December 2, 2016). The program is run in collaboration with the Ministry of Health, migrant health organizations, and the migrant community. PEs were selected from a list of migrant community leaders recommended to IOM by various organizations (both NGOs that work with migrants and migrant-run NGOs), including ALCS, OPALS, MDM, and Caritas. A priority was given to migrants who are respected in their community and able to effectively communicate with peers to improve behaviors and spread awareness amongst their target population. The ultimate goal was to put together a diverse group covering an even mix of nationalities, men and women, and migrants who speak French and English (one or the other). IOM shares MDM's desire to find a way to give its peer

educators certifications in order to fortify their authority in hospitals, but sees no way to do so given its status as an international organization that is not fundamentally connected to the Moroccan government and its institutions.

The migrant health focal point at IOM implementing the peer educator program previously worked in training mediators at Caritas. He therefore used his experience and best practices from his previous work when developing the training and structure of the IOM program (IOM, personal interview, December 2, 2016). He did not, however, consult other NGOs with PE programs for their advice and suggestions during development. The peer educator training, which occurred in April 2016 and lasted three days, involved sessions developed and run by representatives from migrant NGOs and the Ministry of Health. Organizations trained the PEs in the migrant health issues they focus on (for example, ALCS trained them on HIV/AIDS issues), while the Ministry of Health trained the group on containing the spread of tuberculosis among migrants. Further topics covered: migration as a phenomenon, migration in the context of Morocco, how the Moroccan healthcare system functions, the main health and psycho-social issues faced by the migrant community, which organization offers which medical services, and information about select illnesses and diseases.

Migrants sensitized by educators have the opportunity to provide feedback and evaluations to the IOM coordinators. PEs are also encouraged to notify IOM of any questions they were asked by migrants for which they did not have an answer, and must regularly submit reports on the amount of people they sensitize. Reinforcement and capacity building trainings for the PEs in each city are already scheduled throughout December 2016, and will also be led by NGO and Ministry representatives. They will provide educators with more information on the migrant health system and health issues based on their feedback on needed topics, as well as holding sessions for PEs to recount experiences and questions from the

field, discuss the most vulnerable populations they encountered, and how to increase the reach of the migrant information network.

IOM was not immediately able to give me specific statistics and records on the number of people the peer educator program reached. The 2013-2016 National Strategy report claims that, in fulfilling Action 3.2, IOM's multi-regional project formed a group of 27 peer educators were mobilized "to encourage migrants to seek medical and hospital care", inform them of the "rights they may enjoy in medical and hospital care" and orient them "towards the appropriate medical units [in hospitals] according to their needs" (MRE, 2016, p. 50). The report announces that 359 migrants "were sensitized and informed on a specific topic by a peer educator" (MRE, 2016, p. 50).

Analysis and Discussion

The 2014 National Strategy for migration policy reform provided for access of migrants to the national healthcare system of Morocco. The reason for the creation of this integration-focused policy was the shifting of the Moroccan government's approach to migration from one oriented toward security to one seeking to be humanitarian in nature. Morocco's concepts of humanitarianism in the face of increased immigration, particularly of sub-Saharanans, are based on the National Center for Human Rights' ideals for migrant rights, outlined in their September 2013 report for "radical reform". The immediate impetus for the implementation of Morocco's migration policies, both its initial security-based approach and now its humanitarian approach, lies in the European Union's policy of border externalization into Morocco. The push for migrant integration into Moroccan systems in effect allows and incentivizes sub-Saharan migrants to remain in Morocco without the need (or motivation) to continue migrating to Europe. The cross-analysis of policy and migrant reality presented here has presented the case of migrant integration into the Moroccan national healthcare system.

Still, the humanitarian policy has not reached through into migrants' daily interactions with governmental agencies and even NGOs. Migrants do not feel that the Moroccan government has their best intentions in mind as they implement their integration policies, or that Moroccan society is willing to fully accept and integrate them either. Peter's distrust and skepticism in the Moroccan government and the UNHCR displays how migrants who are marginalized also feel undervalued and unsupported. The Moroccan UNHCR employees whose job it is to be asylum seeker advocates and guiders (no matter their country of origin, reasons for application, race, religion, or sexual orientation) have denied him (in his opinion) access to information and services due to his race and sexual. Even migrants who have not explicitly come in contact with authorities feel a sense of distrust and disrespect by the government. In order to fulfill the stated humanitarian commitment on migration, the government of Morocco would need to achieve a fundamental shift in how it and its actions are perceived in migrant communities, from within a migrants' home to the waiting room of a public health center.

Peer educators in Morocco, as they currently exist at NGOs and at IOM, have various purposes and capacities in reaching a given target migrant community: they assist migrants in navigating the national healthcare system; assist migrants with communication issues within the system and with healthcare providers; inform migrants of available services at organizations; sensitize migrants with information about common migrant health concerns; and are equipped with common experiences and understanding, leading to their ability to form trust-based relationships with migrants. A migrant peer educators' inherent ability to relate with migrants and meet them where they are at in their healthcare needs is invaluable, as outlined in the experiences and efficacy of the PE programs outlined in this paper.

The Moroccan government and NGOs both have positive additions and drawbacks when facing to the issue of migrant integration in the national healthcare system. Government policy allows migrants basic access to all public healthcare systems, and organizations

generally hold the trust of migrants that they have their best interests in mind and will offer any service to them without discrimination. On the other hand, government actors lack a broad reach within migrant communities to inform them about the healthcare system and suffer from general migrant distrust in their motivations and willingness to integrate them; NGOs face issues of funding and capacity to provide varied and comprehensive services, and lack the authority to fully assist migrants through the inner workings of the public healthcare system. Should the Ministry of Health coordinate their own peer educator program, mobilized by government officials, it would face the same obstacles and advantages. See Appendix A for a table outlining the differences in fulfilling peer educator roles for (possible and existing) programs sponsored by government ministries, faith-based organizations that may not be fully accepting of all demographics of migrants (Caritas), and other NGOs (ALCS, OPALS, and MdM). If the government were to join forces with the civil society sector, they would together be able to attain better quality of care, reach within communities, and trust amongst the migrant population. These outcomes would reach the very population that the 2014 National Strategy aims for.

Positionality

Although I went into my interviews and observations with an understanding of my position of privilege, the analysis of my findings has ended up being framed by my positionality as well. I was quick to judge the integration efforts of the government as ‘not enough’, without context for migrant realities, and in large part tied to the interests of Europe rather than Morocco’s own citizens and residents. While the government can certainly continue to improve their understanding of migrants’ needs on the ground, and its own citizens needs in the healthcare sector, I came to realize that their efforts appear well-intentioned and are still relatively new and in development. In addition, I generally

took everything that I was told against the government and in praise of NGOs as truth, in part due to my outsider status in the context of migration and healthcare in Morocco and due to my tendency to believe in the proverbial good of any humanitarian aid organization.

Recommendations

The ultimate recommendation to MRE, as well as the MoH, is to create a partnership with civil society organizations that work in migrant communities throughout Morocco as it continues to implement its migrant integration policies first outlined and enacted in 2014. In looking at the data collected from actors in the civil society, governmental, and international institutions, various recommendations for government actions can be made. Ministries should increase funding to organizations to bolster their peer education programs, which do and can further increase migrant awareness of their options for healthcare access through public programs; involve NGOs and their existing peer educators as they develop community outreach frameworks, including considering starting their own independent peer educator program; continue their collaboration with IOM for their peer educator program introduced in 2016, which is the first instance of government collaboration in such a program; and continue developing policy to give migrants further access to public healthcare coverage programs (RAMED, CNSS, CNOPS, etc.). I recommend that the National Strategy on Migrants' Health for 2017-2021 should apply to all migrants currently living in Morocco with some form of documentation (and eventually irregular migrants as well), rather than only those who were regularized during the December 2013 to December 2014 regularization campaign.

I also encourage the government of Morocco to consider developing a reformed path to regularization for migrants, particularly those who have arrived in the country after the

2013-2014 regularization program. Migrants need a consistent and systematic way to attain regular status and documentation, under certain conditions.

Limitations

There were several factors that significantly limited the extent and depth of the research presented in this paper. Most notable are the time constraints of only having four weeks to carry out research and write a paper; a language barrier with most of my interlocutors and sources, and therefore having to use French-English translators in most interviews; and administrative issues when carrying out research in Morocco, such as facing difficulties contacting possible sources. I would have liked to hear some of the statements I learned toward the end of my research, especially that of the representative of Médecins du Monde and the National Platform for the Protection of Migrants (PNPM). The issues of migration and healthcare are extremely political and tense in the Moroccan context, as evidenced by my difficulties in getting official statements from the Ministry of Health.

There are some additional questions I wish I had asked, as I realized after listening to the recordings of my interviews. I would have liked to ask peer educators more about their relationships and position within the migrant community and for more specific examples from their interactions with migrants in their PE capacity. Further, given what I learned from Peter (ALCS) about his treatment at Caritas due to his sexual orientation, I would have liked to ask Caritas about their opinion on this issue, and similarly religious concerns, such as giving migrants contraception. Finally, I would have liked to ask officials at the Ministry of Health about their opinion of implementing a peer educator program of its own. Given a longer research period, I would have liked to obtain official research certifications from the Ministry as well, in order to be able to speak with officials more openly.

Further Research

The research presented on migrant integration in the Moroccan healthcare system, and migrant health in Morocco in general, is not and was not set out as a comprehensive analysis of the issue. Independent research on the status of integration and migrants' health conditions must be carried out continuously and in other contexts. Similar research must be done on peer educator programs in other cities and migrant communities throughout Morocco, for example in Marrakech, Casablanca, and Tangier. Other existing community outreach efforts should also be investigated, such as the efficacy of activities at the Caritas Migrant Welcome Centers.

On an administrative level, once the Ministry of Health's upcoming National Strategy on Migrants' Health (2017-2021) is released and implementation begins, independent research must be done on the impact and efficacy of the Strategy's framework and action plan components. An examination of the collaboration between IOM and the MoH in their recent peer educator program and other migrant health improvement efforts should also be carried out, in coordination with both actors.

All related research should engage all of the actors involved, government ministries, civil society organizations, and the migrant community, and all results should be shared with them. There is a need for increased dialogue and sharing of best practices between all three actors as well; such exchange can be facilitated by international organizations or non-governmental institutions with influence, such as the CNDH.

Conclusion

According to Aminata Pagny at CNDH, the issue of migrant integration in Morocco is "all about access to the healthcare sector, that's the major problem left to deal with" (personal interview, November 23, 2016). The Moroccan Ministries of Health and Migration Affairs

have done an extensive job in drafting and considering policies and action plans needed to integrate migrants, especially the highly marginalized sub-Saharan migrant population, into the national healthcare system. Now what needs to be done is to actualize the implementation of these policies fully. While the Ministry of Health's awareness-raising sessions and collaboration with IOM on a new peer educator program are showing positive results, demonstrated in the MRE 2016 status report, many of the government's integration efforts are not yet being felt on the ground in the deeply isolated migrant communities.

The Ministry's efforts are overshadowed by the history of organizations effectively providing migrant healthcare and health education using a community-based approach. Both actors have different things to contribute to the issue of migrant integration: the government provides authority for migrants to access the national healthcare system but faces shortcomings in the level of trust and reach they have within the migrant community; NGOs are much more trusted and understood, but lacks capacity to fulfill all migrant health needs and license to fully walk migrants through the healthcare system. By sharing resources and positions in providing migrant healthcare, both will be able to improve and accelerate integration and quality of care. This paper has studied migrant communities in Rabat, the capital of the country and the center of all policy making. There are many other geographical areas with large concentrations of majority sub-Saharan migrants that face even greater access and coverage issues, such as Oujda, Marrakech, and Tangier.

While the government must put more efforts and energy into fortifying the national healthcare system as a whole so that it can reach all Moroccan nationals, it must also continue building its foundations of a migrant healthcare system and network. Without a solid healthcare system foundation, migrants will not be given equal weight when considering healthcare access and quality. By forming a public-private partnership between the Ministries and the Moroccan civil society and non-governmental organizations that have been working in and developing migrant healthcare systems for decades, policy implementation can take a

position from inside the community to affect it. One of the most effective ways of taking such a community-based approach are peer educator programs, which should be supplemented with funding and training, and promoted throughout Moroccan healthcare systems.

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** Indicates that the name of interviewee has been changed to maintain anonymity and confidentiality*

Appendices

Appendix A

Table demonstrating different fulfillment of PE roles and responsibilities sponsored by three actors: government ministries, faith-based organizations, and other NGOs

Peer Educator's roles	Moroccan Government & Ministries	Faith-based NGOs (Caritas)	Other NGOs (ALCS, OPALS, MmM)
Navigating migrants through the healthcare system	√√	√	√
Credibility and authority within the healthcare system	√		
Helping migrants with communication issues	√	√√	√√
Common experience and understanding		√	√
Informing migrants of services available in national healthcare system	√√	√	√
Informing migrants of available services at NGOs	√	√√	√√
Forming trust-based relationships with migrants		√ (varies)	√
Providing migrants with information about common health concerns	√	√√	√√

√: able to fulfill role

√√: able to fulfill and have inside knowledge on role

Classifications and roles are tentative and based on what was heard from interlocutors involved in research; further research needs to be carried out to sharpen the criteria for the classifications.

Appendix B

Guiding questions in different interview formats

Ask participant if they are comfortable with me recording the interview (sound only): we do not have to record it if they are uncomfortable with it, and if they agree to have it recorded, I can pause the recording at any point they want and restart it or not.

Clarify to each participant before beginning the interview that they do not need to answer any question that makes them uncomfortable or stressed, we will simply skip over it and move onto the next question, no questions asked. Tell each participant that we can stop or pause the interview at any point: if they need a break, they can take it and we can continue our interview after they have recovered.

Migrant Interviews

Background questions

1. What is your nationality? Or, where did you come to Morocco from?
2. How long have you been living in Morocco? In Rabat?
3. Why did you decide to come to Morocco?
4. How is your life currently in Morocco? Do you have a job, stable shelter, consistent access to food and supplies?
5. What is your family status? Are you married? Do you have children?
6. What is your legal status in Morocco? Do you have a resident permit? If yes, when did you attain the permit?

Relationship with NGO, How they heard of NGO, Whether they are satisfied with services

1. Why did you first come to (name of the NGO)?
2. How did you first hear about (name of NGO)? Who did you hear about it from? What is your relationship with that person? What did you hear about (name of NGO) before coming here for your first visit?
3. (If the person who recommended them was a peer educator): How did the peer educator convince you to come to (name of NGO)?
4. Did you decide to come to (name of NGO) directly after hearing about it, or did you research the NGO at all before coming for your first visit?
5. Why did you come to (name of NGO) today?
6. When you first came to (name of NGO), what was the reason for your visit?
7. What services have you used at (name of NGO)?
8. Have you developed relationships with the employees of (name of NGO) or with other migrants who come here for services?

NGO Administrator Interviews

1. Please describe your role at (name of NGO), and how long you have worked here.

2. Please describe the general goals and projects of (name of NGO).
3. Please describe the average migrant who benefits from (name of NGO)'s services?
4. How are you involved with community outreach (or the peer educator program, if there is one)?
5. How is the community outreach program or strategy of (name of NGO) organized? When did (any specific programs they have) start being put in place? Have you seen the impact of your community outreach efforts?
6. Do you keep statistics on your community outreach programs? If yes, could you describe the trends you have seen?

Peer Educator Interviews

1. How did you first come into contact with (name of NGO), and for what reason did you first come to the NGO?
2. How did the NGO help you (i.e. find out how they became a loyal and consistent patients at the NGO)? How often did you benefit from services provided by (name of NGO)? What services did you most benefit from/wat services did you get the most out of/what services did you use the most?
3. How did (name of NGO) recruit you to be a peer educator? Did you say yes immediately, or did you take time to think about it?
4. What training did you receive as a peer educator? What instructions were you given? Were you given a specific region or category of migrant to focus on (e.g. going to female migrants' homes, going to schools, working in Sale, working with young migrants, etc.)?
5. How do you get out in the migrant community for your job as a peer educator?
6. What exactly does your job as a peer educator entail? How often do you work as a peer educator (number of hours or days a week)?

Appendix C
Transcriptions of cited interviews

Interview with Aminata Pagny, lawyer specializing in foreigner and migration policy law
11/23/16

Interviewee: Aminata Pagny
Interviewer: Victoria

Translated from French to English

Victoria: I am a student, I speak a little French.

Aminata: Yeah, I speak very little English, little Arabic.

Victoria: I am a student in Rabat for four months, I'm studying migration into Morocco and from Morocco to Europe. I am writing a research project, about sub-Saharan migration into Morocco and migrant integration in the Moroccan healthcare system. Specifically, I am studying how NGOs do outreach in the migrant community. I want to speak with you because I want to know more about integration of migrants in the healthcare system in Morocco.

Aminata: Specifically, integration of migrants in the healthcare systems.

Victoria: What projects CNDH works with migrants in the healthcare, reports CNDH writes, etc.

Aminata: Are you speaking of integration of sub-Saharan migrants, or a specific category of migrants?

Victoria: Just sub-Saharan migrants.

Aminata: If you are doing a research project, you have to specify. Not all migrants are sub-Saharan and not all sub-Saharan are migrants. You are talking about the integration of sub-Saharan migrants specifically in the health system.

Victoria: Right, migrants from other countries into Morocco, specifically the new 2013 migration law.

Aminata: OK, why specifically sub-Saharan migrants?

Victoria: Because, I am interested in how a migrant group that is not the normal in Morocco, that is generally marginalized, discriminated against in the Moroccan context, neglected, and I've realized that many migrants rely on NGOs to provide healthcare.

Aminata: I understand. You believe that sub-Saharan migrants are the most marginalized, and they rely on NGOs. I can discuss. When you say so many migrants, it's relative to what study you are basing your conclusion on, to say "so many migrants". I would say, yes sub-Saharan are the most marginalized, and they are a large portion of the migrant population. There are a lot of nationalities within sub-Saharan. How many of each depends. There are 86,000 migrants in Morocco: 40,000 are French; 30,000 Spanish; Sub-Saharan make up 7 to 10 nationalities and there are 14,000. When you say many, it's because they are visible? Because

they are black? I mean compared to Chinese migrants, there are a lot. So to give you the right information, because there's so much media attention to this issue, I want clarification. And for sub-Saharanans, there are also groups. There are students who are marginalized, but they for example don't need the help from NGOs. We have to be precise when talking about sub-Saharanans, what category we are speaking about. But I will postulate that in Morocco, there's a stereotype that all sub-Saharanans are not legal, that they come to Morocco by night on migration routes, they live in forests. We have to focus on a specific category, focalize. Now we can talk about migrant integration into the healthcare system, your interests. I just propose you my questions, for your research you should have a focus.

Well I have worked with a lot of Francophone migrants, that's one group of migrants. And migrants who have lived in Morocco for many years. Not migrants who just want to go to Europe

Those who are transit migrants, how many years have they lived here?

From one up, five, seven years.

Well the question is the role of CNDH in this?

Yes, what is the opinion of CNDH about migrant integration from governmental, non-governmental, social levels? In the public and private healthcare systems.

Aminata: First, we have to talk about the Moroccan health system. Insurance is split in certain categories. For example, those who are receive monthly financial assistance from CNOPS (for people who work in public and private sector), those who are in the CNSS health insurance if they work in the private sector. Foreigners only have those two options for health insurance and care, if they work in the private or public sector. Then there is AMO, Assurance de Maladie Obligatoire (Obligatory Disease Insurance), which works in two aspects: RAMED, for those who are of low economic status and are given access to the healthcare system. CNDH works with all these systems to ensure that everyone is given the right to healthcare, without distinction for nationality, race, sex, religion. So there are regular foreigners who access healthcare through CNSS, CNOPS, or RAMED given their economic and job category. In Morocco, there is a principle of financial assistance and access to healthcare for each social category. It's a system that shouldn't exclude anybody, and should affect every social category. Law N. 5500 ensures that people of low economy status can profit from RAMED. In the law, we have no laws that limit anyone from accessing RAMED (but only those who are documented), if you read it word by word, no body is allowed to be excluded from the program. If we're talking in theory, yes, nobody is allowed to be excluded. But administratively, there are always problems with irregular migrants who don't have documentation. Always the problem of documentation. But the law has not been confirmed for irregular (illegal) migrants. The authorities believe that in the law, RAMED is first and foremost only for Moroccans. It's not only about the law, but also about the funding for this program. There are no obstacles for migrants to also partake in RAMED. But there are always financial issues. The government has to solve the financial issue first, and then can give RAMED to all migrants. That's for the most marginalized.

In practice, now, not all categories of migrants have the right to partake in RAMED. You already know the history of migrants in Morocco. The CNDH in 2013 asked the government in a report to find a solution to the human rights issues for migrants. Because of the CNDH report and the suggested changes to the law, the government did a great job in changing the

law and assuring migrants all needed rights to have access to healthcare. CNDH does work especially in migrants' rights. The government made the decision to have the regularization program, to ensure access to healthcare for all migrants, regardless of documentation, and to access to education. Today, from the administrative side of the National Strategy, there is a cooperation between the Ministry of Health, Ministry of the Interior, and the CNDH. We had a conference in 2015, and the product of the convention was the government's allowance for migrants to access RAMED. Now, in practice we have a law that ensures this, so that migrants can profit from the RAMED program. And the regularization program was not for all foreigners, not all migrants, it was for the most capable cases, so that they can get work. Then those who get work can get health coverage through the CNSS, so then they don't need RAMED. The RAMED is just for those who can't get any other service, for those who can't work, who aren't capable. The CNDH's position is that RAMED should be available to all migrants who are of low economic status, in precarious social status. Moroccans and migrants should have the same rights. All those who work, should have CNSS. Even the Moroccans who work informally, they don't have access to the CNSS, they don't have any coverage. That's why I told you that you must talk first about the whole health system, because even the Moroccan people still have issues with their own system. It's not about just public or private systems, it's about the person and the case, every participant in a program. This is why we have to understand first the whole system, and then we can give the position of migrants within it.

Sub-Saharan students who come to Morocco, their stipend assistance is the only source for their healthcare. They don't have any health insurance or coverage. The majority of students are able to use the private sector healthcare, because the majority of the students have enough money to use the private sector, so this category of sub-Saharans don't need RAMED at all. In general, RAMED does not function very well for migrants. That's the story for RAMED.

But the other systems have been neglected. The government spent so much energy developing RAMED, they didn't work as hard on CNOPS and CNSS. Things are different across geographical regions, between cities. There is a big difference between the situation nowadays and what was happening in 2013 for migrants. Nowadays, migrants have their own houses, they can own a car, a business. Now, it's all about the access to the health sector, that's the major problem left to deal with. The main issue for access to healthcare is language. Most migrants speak French, but in hospitals people speak Arabic rather than French. It's difficult for them to explain their conditions through a language that he doesn't understand. The system is still not functioning well. In the US, the health system goes in levels. Here in Morocco, it's all about the NGOs for migrant healthcare. In terms of human resources, NGOs should have enough employees to help migrants, aid them in dealing with language barriers, accompanying them to hospitals, etc. Every neighborhood there is a health center, but migrants can't profit from these centers, because the people who work there can't verify if they live in that area or not. Health centers work by district.

Dr. Hassan Interview

11/8/2016

Interviewee: Dr. Hassan, general practitioner

Interviewer: Victoria

Translator (when needed): Sanae Chemlali

(previously: Dr. Hassan explains that there are three healthcare systems functioning in Morocco – the private, public, and informal.)

Victoria: Could you tell me anything you know about the informal system, I've heard a lot about the public and private.

Dr. Hassan: Well, we have a public system and a private system, I'm working in the private system. But we have an informal system, sector. The informal, they are working, they are not doctors. You have –

Sanae: They don't have experience, maybe they never went to school.

Dr. Hassan: No, no school. You know, for example, in the Souq (market), you have these people – dentists, dentist, they are not dentists.

Victoria: They just pull out teeth.

Dr.: We have this problem with people who use scarification, they are not doctors. We have people who do dermatology, they are not doctors. You have people who help with pregnancy, abortion, too – they are not doctors. You have these people who, their writings, they say “your husband will love you once you give him this –“, this exists. And a large part of this population goes to these people.

Victoria: Moroccan or migrant population?

Dr.: Of course, Moroccans. I don't know about migrants. But anyway, migrants are coming from African countries, and this kind of stuff is usual in African countries. I lived in Senegal and Cote d'Ivoire, and they use all this in Africa. They go to these street doctors. Well, what I know about Africans coming from migration, people who have papers, regular migrants, they can go to the hospital, and they have a card and they are taken there.

Victoria: Yeah, well they're able to go into a hospital, but they face a lot of discrimination in the hospital, for example with language, like not all hospital workers speak French...

Dr.: What I can tell you is about AIDS, about AIDS, because I work in this field. There are organizations who work with this.

Victoria: OPALS, ALCS...

Dr.: OPALS and ALCS, yes. They have everything, they can come there, it's free, the entrance is free, they receive the same care as other Moroccans, there is no discrimination. I worked there for a while.

Victoria: So, in your opinion, do most migrants rely on organizations like that, rather than public healthcare?

Dr.: You know, the Moroccan government has problems with the Moroccans, in the field of health. The system doesn't work at all. They're wasting money in this public system. The government is putting a lot of money in the public system, which doesn't work at all. For example, doctors in the public system work half a day, maximum. And, for example, you go to the big hospitals, and rooms for surgery work only in the morning, why don't they use them in the afternoon and in the night? In Canada, they use them during the night.

Victoria: 24/7.

Dr.: 24/7, here they work for six or seven hours. It's a waste. And you go to certain services in the university hospitals, you will find for example 25 dermatologists, and everyone goes to operate once a week, or twice a month. It's a waste of human resources.

Victoria: Right, so you have a system, with lots of people working in it, but they don't work enough.

Dr.: If you go to the small hospitals in the districts, the doctor comes in at 9 o'clock and he leaves at 11, he goes to pray and doesn't come back to his work. It's a waste.

Victoria: Are they still paid for a full day?

Dr.: Yeah, they're paid for a full day, yeah!

Victoria: So there's no, you don't clock in?

Dr.: No, they don't check.

Victoria: They don't check.

Dr.: Nobody checks and nobody wants to check.

Victoria: Because that would be, realizing that the system doesn't work.

Dr.: Yes. They are buying, for example in Rabat, you have, in a circle of two km wide you have 11 units of MRI, Magnetic scanners, in this area.

Victoria: Where is that?

Dr.: Just in Rabat, in cities. But you don't have this is –

Victoria: In rural areas?

Dr.: Not even, in big towns. For example, Sefrou is a province, you have 350,000 inhabitants, you don't have any. But you have 11 here. Concentration. You have a big concentration of materials, doctors, and stuff. But in Casablanca, Tangier, not towns. There is no regulation.

Victoria: No control.

Dr.: No, no control.

Victoria: Should the Ministry of Health be the ones who are regulating, but they're not?

Dr.: Listen, I'll read you the conclusions of this study: "In Morocco, if people of different social strata that adapted themselves in the 1960s and 1970s to the services offered by the public health sector, the gradual degradation experienced by this main part of the national health system over the years, led people in the early 1980s to move to the expanding private health sector, all but those less fortunate. Indeed, limited financial and human resources, combined with poor infrastructure and governance, led the public sector to a near failure. Today, this sector is deserted by a more demanding population that turns to a more efficient private health sector, but unfortunately, poor people cannot afford to do so". Ok? "The informal sector supports the health problems of a large part of an excluded population, for various reasons, such as low socio-economics and cultural levels, distance to healthcare centers, or traditional beliefs". Some people still go to the informal sector. "Health authorities are aware of the dangers encountered by this sector, for example, AIDS transmission during child delivery with untrained midwives, etc. But the authorities remain static in regulating this informal and empirical sector." Ok? Nobody wants to touch this sector.

Victoria: The public?

Dr.: The informal.

Victoria: Because, why?

Dr.: Politics.

Victoria: Politics, because it would be...?

Dr.: A lot of people are surviving, due to this sector. Thousands of people are working in this sector. Just like people you see on the street, selling things.

Victoria: Yeah, no one touches that. Because it supports them and the government doesn't have to do anything for it.

Dr.: Well, because if the government wants to stop them, he has to give them jobs, and he is unable to give jobs to these people, so he just lets it go.

(interruption in recording, conversation moves to talking about ministries and governmental view of the healthcare system)

Dr.: Because they still have this reflex, because in the past we had the Ministry of Public Health, but it's not of public health anymore, now it's Ministry of Health. But the people working in this department still think, public. Understand what I mean? When they want, for example, they made sanitarian cards (carte sanitaire).

Victoria: For patients?

Dr.: No, for human resources. To know where is the cardiologist, where is the X-Ray. They did it only in the public sector.

Sanae: A kind of, identification card?

Dr.: No, it's not a card. A map, to map out where everyone is. In Fes, we have a certain number of cardiologists, how many hospitals, how many small health centers, etc. etc. They did it for the population.

Victoria: When was that?

Dr.: Couple of years ago, two, three years ago. It was done two years ago. But they haven't done it yet for the private sector. And at the same time, they're claiming that the Ministry is taking care of the problems of the two sectors, you know. And at same time, the Ministry of Health is asking our sector for a partnership. I have wanted before to sign a partnership with the Ministry of Health, to take care of people with Tb, but it doesn't work. Because a partnership needs the two parts to be aware of the situation. They (the public sector) don't communicate enough (with the private sector) through people who work in the public sector. And so when I have somebody here, for example, where I suspect Tb – when I send them to the (public) hospital for an examination, a special kind of examination, he has to come back to me (with the results). But they keep it, they keep it.

Victoria: He has to come back to you, to tell you?

Dr.: With the results. And then I will explain to him that, I can take care of him here for his TB. He asks how, for example, here in Morocco, the government gives the medicine for TB, nobody pays for TB medication in Morocco. Because controlling TB is very important. We have 30,000 new cases per year, so it's very important. So, we had this – this partnership was signed by the government, with the Ministry of Public Health, if somebody comes here for any reason, I suspect TB, I send them – not everywhere, in places where we have lots of TB, Tangier, Fes, the area of Kenitra, Souk El Arbaa. For example in Souk El Arbaa, five doctors agreed to be in this experience, ok? And in a couple of months, they suspected TB in 20 patients, they sent them to the center where they give diagnosis. The answer was, negative, negative, negative. They weren't satisfied. They went and sent them to a private laboratory. And they have 25% positive.

Victoria: So the public system just got it wrong?

Dr.: Because, the problem in TB in Morocco is biological dominance, it doesn't work. Because people working in this unity (diagnostic center) don't want to work in this unity any more. There are no incentives. The guy says, I am working here, makes maybe 3,000 dirhams a month, and asks why should I stay here? I prefer to work in another service, because here we have the risk of contamination, there are no intense incentives. So most of the guys don't want to work in this unity (partnership). They prefer to work in a medical department. The second reasons is this unities are very old. These unities are infested with bacteria.

In Tangier, they have another problem. As soon as they suspect TB, they send you to the hospital for the examination. And when the technician in charge of the examination wants to send him back to his doctor, the physician who goes with him, the specialist, says "why are you sending him to his doctor, he has TB? I am the one who takes care of TB, not the GP". Because the Ministry didn't communicate and didn't explain to this guy that we came to help them, they need help because they have a lot of problems. To help them. In this unity (diagnostic center), taking care of TB, there is a lot of discrimination and segregation. Here in my waiting room, no one knows if you have TB. I've had some cases here, you know, I have

2 or 3 cases here, people of high level, and they have TB. In Rabat, we don't have this partnership (with public diagnostic centers), I send them to the hospital. The only one, Moulay Youssef, oldest hospital taking care of TB in Morocco. Moulay Youssef is for TB, and they took care of him. Then the guy came back, first I sent him for the diagnostic examination, using phlegm. That's where you look if the person has TB, but it's not enough. If he (the patient) is rich enough, he would go to a special laboratory with a special examiner, which is a little bit expensive. He had the money to do it, and it was positive. He had TB, and they took care of him. And when he came back a few months later, I asked him how it was, and he said it was good but there was only one problem. HE said every day when he got to the treatment, he said "I had to go home, change my clothes, get a change of clothes, change his coat, get a casket (hat) and get glasses, because I don't want anybody to recognize me", because in this place he might see one of the workers working in his society. There's a lot of stigma and stigmatization. The facilities are stigmatizing, having TB is stigmatizing. Having to go for treatment is very embarrassing. In the private sector, nobody knows where you are going, you could come here for many reasons, you know. This partnership, if the partnership were well done, it would be a good thing for health in Morocco, because you would have 50 percent of the human resources coming to improve the public sector. And in the town where there is no MRI or no specialist of radiology in the public system, if so the people working at the hospital could send people to the private sector. In a way, privatizing some of the public sector.

The people with RAMEL (healthcare for the most impoverished), they often go to hospitals where they are only walls, they are nothing. They have no echography, no equipment. I propose that they send them, they let them go wherever they want, they can go to the private sector. And the government will pay the private sector the same price that they are paying the hospital. We are ready, the GPs, to do it for the same price that they do it in the hospitals, and the government pays. When we say same price, some people think that it's 60 dirhams, in fact in the hospital it's more, it costs more to take care of people than in the private sector. When you take care of an emergency in the hospital, it costs 10 times what it does in the private sector. If it costs 10 times, it cannot, it costs 100 times. It takes time to have an appointment at the hospitals.

Sanae: Maybe 2 or 3 months.

Victoria: Long wait times.

Dr.: It's also more complicated. And once you are in the hospital, there are lots of people taking care of you, so it takes, it's more expensive to take care of people in bigger unities than in small, in small doctor's offices.

Victoria: Yeah, like private.

Dr.: Yeah, for example, somebody comes right now, he has stomach pains, I examine, I talk with him, I do an echography, I say ok you have appendicitis. It takes 15 minutes.

Victoria: But at the hospital you wait and wait and wait.

Dr.: It can take hours. In a private clinic, I can call them up, and within one hour he is operated. In the public sector, it will take one week and in the meantime, he's developed a gastrointestinal complication.

Victoria: He could die.

Dr.: And then it takes even more money to take care of him, too. Even here, you know with an urgent case, we do the tests, and within 15 minutes we have the result. I send him to a private laboratory for the testing and they (do tests) and tell him he has appendicitis.

Victoria: Why do you think that there is still this culture of patients going to specialists instead of general practitioners? Is it because of corruption with the specialists?

Dr.: No, no, no. Because people are used to thinking that specialists are better than generalists, because the stakeholders don't realize that they will have a better system of health if people go first to a generalist and then to a specialist. And because specialists have a strong lobby, because the pharmaceutical industry has a lobby, which helps the specialists.

Victoria: A lobby with the government? With people?

Dr.: No, with specialists.

Victoria: Oh, the pharmaceuticals do.

Dr.: Because when you go to a specialist and when you go to a GP, the prescription is different. We're trying to give generics and to give the minimum needed. But when you look for the same problem, prescription of the specialist, it's heavy. You are prescribed the newest medicine, the most expensive. Because the money then goes to a company in the US, in Australia, it needs to go to a laboratory to pay for it.

Sanae: And maybe it's not the right diagnosis, maybe if I have a headache it's because my eyes have something or in my ear, and he gives me something specific to headache.

Dr.: They immediately classify the condition. The French are doing the best, they're best in the world. The American system is in 30th place. Canada and America are close. Why? Not because the doctors are better, because in France they have a dispositive, their organization is better. They are very good organizers in the French system. But the system that gives the best result is the Cuban system. Poor country, embargo for more than 60 years, but they have 30,000 GPs, 30,000 family doctors. And every doctor is in charge of 500 families. And the Cuban system is the first system who could stop the transmission of AIDS from mother to the baby, just with cleaning. There are 11 million inhabitants and have 30,000 GPs, that's huge, a huge number of GPs. Every GP is in charge of 500 families, so he knows all the problems. You know, a small village, he knows everyone, all their problems. He's giving better care.

Victoria: Right, there's a focus on general practitioners.

Dr.: Cuba is the best example. They don't have the best scanner, they don't have scanning, they don't have –

Victoria: They don't have the most up-to-date medication...

Dr.: But, they have people taking care of people. There is this human relation between the GP and the family or the patient. The relation is very important. Now here, like in America, if you go to a specialist, he doesn't even shake your hand.

Victoria: No, yeah. They're the most dry people, and they're only with you for three minutes.

Dr.: Five minutes, ten minutes. But when you got to a GP, the contact is better.

Victoria: Yeah, especially if you've known him, you see him over and over again every year.

Dr.: Well here, I used to have somebody to work, when I would travel. But since a couple of year ago, I just close. Not close, if my patients came and they didn't find me, they'd leave. Because over years, we developed a friendly relation, they come because it's me. It's the same everywhere else. But a specialist, you see a specialist once in your life. But if you have a family doctor, you're going to see them for you, your husband, the kids, the family. You will come with your husband and children many times in the year. So you develop a relationship. Well, what else?

Victoria: That was a lot. We're going to talk to someone about the RAMED.

Dr.: I think RAMED is open to immigrants? For those who have card, that are regular. And it's without charge. But for hospitalization, it's not. We need help on this from other countries, it's like for climate change.

Victoria: Yeah, what did you do at COP 22 (UN Climate Change conference).

Dr.: I was there, I was there yesterday.

Victoria: You had said, yeah.

Dr.: For COY, the youth conference.

(Sanae and Dr. Hassan speak)

Dr.: So, Morocco is a highway from Africa to Europe.

Victoria: Well, it's changing, but yeah it is a transit country.

Dr.: So these countries have to help us, because the weight is too big for us. We can't take care of our own population, the European Union has to help us, for healthcare.

Victoria: She (Ministry of Health employee) had mentioned that the EU was helping with that program.

Dr.: With AIDS?

Victoria: Also the studies on migrants and the epidemiology of migrants in Morocco, she said the EU is going to help with that.

Dr.: Well, that's not on the ground.

Victoria: But you have to know what's happening, you have to know the problems so that you can be effective on the ground, right?

Dr.: Yeah, of course. But I can tell you that since I am working with NGOs and I am working with the Ministry of Health, more than 20 years, I go to all the meetings. They're doing a lot of studies and studies and studies in every field, with no action. Because it's easy to do studies, you're paid to do studies, you travel. But when you want to put it in action, it's different.

Victoria: Yeah, it takes planning.

Dr.: There is an Arabic expression which is, ink on paper.

Victoria: It's the exact same thing in English, yeah.

Dr.: They are spending lots of money on studies, lots of money.

Victoria: Right, but no actual legislation.

Dr.: I was in a study with USAID about group – group practices?

Victoria: Yeah, we call it physician's practice.

Dr.: You have 11 or 12 physicians in the same practice, we want to deliver this here. And we've started a study, and what I want to do, they gave me a full box – they've done 100 studies about the same subject, but we didn't achieve the work on the ground.

Victoria: Nothing was done.

Dr.: Combining specialists and generalists together, in a group.

Victoria: Do all doctors have their own singular office in Morocco?

Dr.: Everyone has single offices.

Victoria: Just them.

Dr.: Once I had a visit from the Vice President of the American Association of Physicians, with an economist. And I told them to visit some practices, and we went to a practice of radiology, it was in 2001. And he asked the radiologist, how many radiologists are here? He said, I'm the only one. The economist said, so you're working for the bank. In America, you can't have one radiologists, you have to have 10 radiologists.

Victoria: You can't take that many patients if you only have one.

Dr.: Right, because there's innovation in the technology and if you have to change all the stuff you have, you have to go to the bank again and take lots of credits, because the material is very expensive. But if you are 10, it's easier to change every 2 or 3 years, to buy brand new.

Victoria: It's like insurance.

Dr.: Yeah, you can share the charge, security, people working with you, rent of the place... And I'm looking for people to share with me here, for more than 20 years, nobody wants.

Victoria: Nobody wants to?

Dr.: Because in the mentality of Morocco, everyone wants to have his own practice, his own car, his own house.

Victoria: That's making it.

Dr.: It's a mentality, it's cultural.

Victoria: Even though it's such a welcoming society, that's...

Dr.: It's difficult, even in a building, this notion of co-property is very difficult in Morocco. We have problems, people – it's difficult to live with people in the same building. Because people want their own house.

Sanae: Yeah, it's all about the culture. All Moroccans are used to having their own house, where there is the grandma, the grandfather, all the family in just one house. But the way you share a residence with a lot of people, it's not a regular idea in Morocco.

Dr.: For example, here, you have this barrier, the barrier to the exterior, we wanted to have an electric one, there's more than one person in the building to share the cost. 75 percent don't want, though they use this place. It's difficult to share.

Victoria: Collaboration, there's no collaboration.

Dr.: Collaboration. Everybody is selfish, because as she said, people are used to living in big families. Now, people live in nuclear families.

Victoria: Interesting.

Dr.: All good (c'est bon)?

Victoria: C'est bon. Yeah, I just wanted to get a general outlook on the Moroccan healthcare system as a whole, so thank you.

Dr.: Yeah, you should, talk about the public, the private, and the informal. And then how if Moroccans aren't getting helped, migrants won't either. If there is nothing in place for Moroccans, there will be nothing for the migrant?

Victoria: Well, but that's the thing, is that Moroccans are treated badly, but then migrants are treated 10 times worse. Because they're not given access, and they're discriminated against.

Dr.: No, no, they don't get treated better in the hospital, no.

Victoria: Yeah, I've hear from many migrants that it's – people don't speak French, for example, and the migrants are relying on people speaking French so that they can get in, that's why they decided to come through Morocco, because you can speak French here and they already speak French, and people in the public hospitals don't speak French, they only speak Darija. And, so they can't even communicate.

Dr.: Many migrants speak Darija now.

Victoria: Well, yeah, but when they first come I mean, in their first few months here, they just can't. And yeah, I mean they should learn Darija as fast as they can, but they speak French, and French is an unofficial language of Morocco.

Dr.: Yeah, in Europe it's different. When you have migrants coming to Italia, Italia is different than Morocco, it's the EU, and they have people who take care of them. Well, look what happened in France a couple weeks ago, in Calais, it was a jungle for two or three years because the government didn't take care of them, they're in a situation worse than what they left. And France is a big country, and now they were supposed to take care of people, but in fact they separate them to different regions. And some people welcome them, some people say "no, we don't want them in our district".

Victoria: Right, we don't want them here, they'll steal, they're bad. It's the same in the U.S. Donald Trump says the same thing. Today's the day!

(conversation turns onto U.S. election before ending)

Interview with Peter

11/18/14

Interviewee: Peter, ALCS peer educator

Interviewer: Victoria

Translator: Hannah Rose

Notes: Peter called black migrants “black” (plural and singular), even though he speaks French and no English

Victoria: For starters, how long has he been in Morocco?

Peter (Hannah): He left there when he was 4 months old.

Victoria: Why did his parents come to Morocco?

Peter (Hannah): No, no. His parents didn't move here, he moved here out of choice for reasons of human rights. He left Cameroon because of human rights abuses against LGBT, and left for public security, personal security reasons. He wanted to be somewhere where he would be more accepted.

Victoria: Ok, so not when he was 4 months old? Can you just double check.

Hannah: How many years have you been here?

Peter (Hannah): Seven years. He lived in Cameroon for 2 years, and then he moved to Cote d'Ivoire for five years, and now he's been here for seven years.

Victoria: Has he always been in Rabat?

Peter (Hannah): When I got here, I was first in Marrakech. Then I came to Rabat, and now I'm staying here definitively.

Victoria: When did he first hear about ALCS, and why did he first come here?

Peter (Hannah): He was in contact with UNHCR, and they gave him a reference.

Victoria: And why did he come here at first, for an HIV test, for medicine, for?

Peter: The first time, I came for health. But then I wanted to come here to learn about the organization and get a sense of the community.

Victoria: And so what did he find in the community? Or, what kind of a community did he find?

Peter (Hannah): In the migrant community in general, there are a lot of problems. And there's even more problems in the LGBT migrant community. Amongst LGBTQ Africans, there's a niche population. This is a safe space. A lot of migrants come here because, this place is a safe space for migrants who are LGBTQ – sub-Saharan migrants. It's hard to establish a community and find other LGBT Africans here. But there are a lot of programs and there is a community, but when you arrive you don't see it. People try to get to Europe, and think you'll

be able to find jobs in Morocco, housing, you'll feel safe. But it's not like that. And with health, too. ALCS helps with providing medications and basics, but not everything.

Victoria: When was he, how did he get involved with ALCS so much that they chose for him to be a peer educator? Or how did ALCS ask him to become a peer educator?

Peter (Hannah): I don't work here. If you're black here, there is no work. It's very difficult for black people to get jobs here, they aren't given jobs at all. All I could do when I first got here was stay at home, do nothing. So my job isn't – it's a job, but it's not paid. I give advice to LGBTQ blacks, help them out, help them get situated in housing. My work here consists of sensitizing black migrants, with LGBTQ. I sensitize them in issues of HIV, screening, work with sexual violence. Sexual violence in our community.

Hannah: And you're not paid?

Peter: No, I'm not.

Victoria: What, how does he sustain himself if he's not paid?

Peter (Hannah): Well, it's so hard for blacks to get jobs here. I'm not going to lie, I am a prostitute.

Victoria: When did ALCS ask him to start working, or did he offer to work for ALCS? When did he start working with ALCS?

Peter (Hannah): It's my second month.

Victoria: Did they ask him to work, or did he offer?

Peter (Hannah): I asked to work.

Victoria: How open were they to him starting to work, how quickly did it happen?

Peter (Hannah): It was immediate. When I asked, they asked if I was qualified to work, to do this work. And they asked to know if I was connected with my community.

Victoria: What does he spend most of his time doing, does he do a lot of sensitizing (sensibilisation) here, or does he go to people's homes, or – where does he do most of the sensitizing?

Peter (Hannah): During the week, I work here in the office mostly.

Victoria: So how does he get people to come here? Migrants to come here?

Peter (Hannah): I tell them about AIDS, STIs, and screening/testing services we have here. And I just know a lot of people, they voluntarily want to do screenings. Within people in the community, it's really difficult – I knew of people in the community, because the community is really small and tight, so I bring them here, and then they know of people who would also know people.

Victoria: Interesting, like snowballing. How did he find out most of the information that he shares? Did he find out most of the stuff about HIV, AIDS, here at ALCS, or did he know it before?

Peter (Hannah): He already knew it. He knew the information because he knows what they're going through.

Victoria: Next question is, did ALCS give him any training in reaching the migrant community?

Peter (Hannah): Yes, briefly. There was someone working here before me, but the UNHCR moved him to the US. He gave me the information before he left.

Victoria: Was he told mostly biological information about STIs, or was he told about talking to people?

Peter (Hannah): They told me about sexual health, issues with migrants here. We don't work with psychology, social issues, situating them in Moroccan culture, anything like that.

Victoria: What does he usually say to someone when they come here for the sensitization? Like what information does he go through in the sensitization?

Peter (Hannah): His job is just to inform them of the services that ALCS offers, they do offer some social services, but mostly focusing on health. He basically guides them to the other services.

Victoria: Does he do anything, like provide condoms, anything like that?

Peter (Hannah): Yes, I give them condoms, pamphlets, information.

Victoria: Does he track people, when they come, how many times they come to ALCS, anything like that, is there a system for that?

Peter (Hannah): All of my work is anonymous and confidential, I don't know their names. It's anonymous and discrete.

Victoria: How do people usually react, what are their thoughts after he tells them about their services? Is it usually very excited and energetic to come back, or are they kind of eh (indifferent)?

Peter (Hannah): Most of them scared, but grateful for the information.

Victoria: Can he explain, kind of, what he tells a person in order to make them feel more comfortable, in order to reassure them that getting an HIV test is a good idea?

Peter (Hannah): It's a long-term process with each person. I tell them if the test is negative, great, it's negative. I'll give them condoms to prevent transmission. If it's positive, it's not the end of the world. We will take charge of everything they need and we will give them an orientation to Caritas. For pregnant women especially.

Hannah: You do great work here, it's incredible.

Victoria: Does he follow up with people to see if they come in for a test, or does he follow up with people who are positive? Does he follow along with people to see that they get the services they need?

Peter (Hannah): He can't do that, that's not a part of his job. It's up to them, they get a test, it's up to them to follow up on it.

Victoria: But does he see people over and over again for different services, or for more information, not related to an HIV test?

Hannah: I think he does, I'm sure he does, but he can't contact them. So it's just about when they come in.

Victoria: Has he noticed any changes in the LGBT population, since he started working here, how informed they are, whether information is passing in between people, stuff like that?

Peter (Hannah): Yes, I've seen changes. Institutional changes, no. With UNHCR, I don't know exactly what work they do. There aren't huge changes in the social status of LGBT people. I've been here (ALCS) for three months, and still can't get a real job. This is my experience, not everyone has this experience, but overall, there hasn't been that big of a change, they don't care. It's still really difficult for LGBT people and LGBT migrants here.

Victoria: Does he think that, despite the social status issue or problem, has there been a change in how LGBTQ people deal with their health, and how informed they are about health issues relating to their lives and lifestyles?

Peter (Hannah): There has been, the association has done great work to give more information to people, to make getting sexual health tests and your health checked something people should want, so yes. And over time, people have gotten better.

Victoria: Really, ok. What has been the most difficult thing for him to get into the LGBTQ community here.

Hannah: Well, he's a part of it.

Victoria: Right, but what has been hardest for him to talk to them about health? Not on a personal level.

Peter (Hannah): Sexuality, it's entirely a Muslim country. It's not even on the radar here, it's illegal to be gay, so it's really difficult for people to come to terms with sexuality.

Victoria: Are most of the people he speaks to, do they know that they are LGBTQ identity, or are they questioning and they come here in that way?

Peter (Hannah): No, most of the people will hide it, because it's not something you can outwardly present about yourself, especially here. If you see someone, you know when

they're gay, but you're not going to say something about it, because it can damage their safety.

Victoria: Does he deal at all with, do you know how to say risky behaviors? When someone is hiding their identity, but still having sexual activity?

Hannah: Yeah, he deals with that all the time. Most people who come in are hiding their identity, and having sex.

Victoria: Does he work with men and women, or mostly gay men?

Peter (Hannah): I work with men and women, gay and lesbian.

Victoria: Is it mostly one or the other?

Peter (Hannah): There's more men than women. Women, in majority, can easily be with men, but for men it's much harder. They can be lesbian, and hide it, and marry a man. With men, it's hard for them to be with women.

Victoria: Does he deal with bisexual or transgender people?

Peter (Hannah): Yes. I don't know any transgender migrants here. For my four years in Rabat, I've never seen them. In Cameroon, I'd noticed people though.

Victoria: Does he personally feel more safe here than he did in Cameroon, in terms of his identity, or does he feel that people think the same way?

Peter (Hannah): In Cameroon, it's super dangerous. In Cote d'Ivoire, it's ok. Because in Cote d'Ivoire, homosexuality isn't illegal, there's no real law, it's just how it is. Here, it's dangerous (because it's illegal).

Victoria: Ok, and in Cote d'Ivoire, it's just neutral. What are the biggest health issues that he has faced in Morocco, personally?

Peter (Hannah): In my experience, it's just the difficulty in getting jobs as a black person. For blacks, for everyone, the stigmatization and discrimination here is so hard. For the LGBT community, it's selfish. Being gay you can hide, being black is very visible. Most Moroccans discriminate against Africans, they look at the color of our skin and say no.

Victoria: It's double.

Hannah: It's crazy.

Victoria: Does he find, does he feel less danger, I guess is the word he said, in the black community, even if they're not gay? Like in the non-LGBT black community, or does only feel safe and accepted in the black LGBT community?

Peter (Hannah): It's really difficult for him in the black community, because he's kind of feminine, so he's not accepted. And others who are hyper feminine are very much not accepted at all.

Victoria: What would he say are the main health issues faced by the LGBT migrant community in Morocco?

Peter (Hannah): No, I don't know. What the main problems are in health? Because the main problem here is the work, housing, nutrition. With health, UNHCR does a lot. Caritas is another, Accion Urgence. Access to healthcare is hard, for all migrants. Our representatives, it's not their job, but it's part of their responsibility to provide healthcare for migrants. It's (healthcare) not even for charge (it's free). There is some healthcare that we have to pay for, but organizations, like ALCS, give these services for free. They don't take charge of housing, food, clothing. Those are the main problems here. ALCS only pays for testing, nothing else. I am a prostitute for money, I need money, it's not for pleasure. Not all black people do this, just some are prostitutes for money. Other people are beggars, but getting a job is extremely hard.

Victoria: Where does he live?

Peter (Hannah): I live in Hay Nahda, in Takadoum.

Victoria: That's an area with a lot of migrants.

Peter (Hannah): Yes. I live in a house, and there are five people living in my room.

Victoria: So that's where he lives? Wow. It's a house?

Peter (Hannah): In the house, there are three rooms. And in my room, we're five. Some rooms have three, four, it's not constant.

Victoria: Five men? Or...?

Peter (Hannah): It's everybody.

Victoria: And children?

Peter (Hannah): Yeah, there are.

Victoria: Does he, so since he said that health is not as difficult of an issue, does he or ALCS have other associations that they recommend people go to for housing, social issues, employment, stuff like that?

Peter (Hannah): There are, *but* – they only assist straight people. And they don't do their job well. Caritas is a religious NGO, Catholic, it's part of the church. And when I arrive at Caritas, I say (feminine) hello, they say Oh! They don't help me.

Victoria: And Caritas is the organization that has the most services, finances.

Peter (Hannah): Right, I know. But when they know I am LGBT, they don't work with me. But ALCS, and many others, they don't have money, don't have finances. They only have little money to help with food, anything other than health. But with Caritas, they don't help everyone with health. They're not tolerant, despite being part of the church. (...) You go to Caritas, they have a lot of houses for minors, for women with children, that's it. For a gay migrant, oof, they don't help.

Victoria: Do you go to church?

Peter (Hannah): Yes, I'm faithful.

Victoria: You're Catholic?

Peter (Hannah): I'm protestant, evangelical protestant.

Victoria: Which church?

Peter (Hannah): The Evangelical church, the one neat the train station.

Victoria: Yes, I know it.

Peter (Hannah): Near the museum...

Victoria: Yeah, I know. They have a migrant health program!

Peter (Hannah): Well, I don't know.

Victoria: I think they do.

Peter (Hannah): I don't know, the church, I don't know. I know they have a program that helps student migrants.

Victoria: Is there any organization that does work with social issues, not just health, for LGBT? Caritas is not, but is there any organization that is willing to work with LGBT on social issues and housing?

Peter (Hannah): This is it. And we don't have money. There's another one that gives drugs, but it's for Moroccans.

Hannah: Wait, I know it.

Peter (Hannah): For LGBT... It exists, but I don't know what they're doing, I don't know what they're doing. They give medications for diseases, they do tests, (*moutoure*), (...). Here, we don't have the means.

Victoria: Do you know OPALS?

Peter (Hannah): No.

Victoria: Jumping back to ALCS, how many people does he usually speak to in a week?

Peter (Hannah): Well, I'll check in on a lot people. It depends. Sometimes 10 people, sometimes 15. It depends on if I'm here, if I have to be at home, what it's like that week.

Victoria: And he did say that most of the people come here by word of mouth? Can we just reaffirm that?

Peter (Hannah): Yeah, mostly word of mouth for sensitization. UNHCR sends us a lot, Caritas does too. But word of mouth, too.

Victoria: Caritas?

Peter (Hannah): Yeah, they'll send them here.

Victoria: Oh, so they're not just like we won't help you, they're just like, go there because we don't help LGBT, Ok. God, Caritas! Has he found a community in Morocco that he feels supports him?

Peter (Hannah): That's the only community I have. What other community could I have?

Victoria: And it's a good community for him.

Hannah: Yeah.

Victoria: Does he plan on staying in Morocco for the rest of his life?

Peter (Hannah): No. But it's really difficult to leave. It's up to UNHCR when, where I'll get to leave. I want a real social life, here I don't have any social life; I am anti-social here.

Victoria: Are you of refugee status?

Peter (Hannah): No, I've applied.

Victoria: When did you apply?

Peter (Hannah): I sent in my application, since August, yes.

Victoria: Has he heard anything back from the UNHCR since then?

Peter (Hannah): No, nothing. When you go to UNHCR, it's Moroccans working there, they are rude, they don't even let you in. I don't understand how they're homophobic, racists that work there. I don't understand why those are the people who are supposed to help me. When I call them, they never respond, I haven't talked to them since August. The majority of the media and the rest of the world think that the refugee crisis is just, exclusively, Syrians. They prefer helping Syrians because they are Arab and Muslim, like Moroccans. The UNHCR should be called the "Syrian help", they don't care about us Africans. They should help all the refugees, not only Syrians. We are also refugees. This problem isn't only in Morocco, it's all over the Maghreb (Northern Africa).

Victoria: Are the people who work at the UNHCR who he's saying are homophobic and racists, are they Moroccans or Europeans?

Peter (Hannah): Moroccan. They're homophobic, hyper racist. For Syrians, it's so much easier...

Victoria: They're Muslim, not black, and there's a war there, so they're all ok...

Peter (Hannah): I first came across the UNHCR on the internet. I expected that they would truly help me, but I found out it's all publicity. They don't actually help.

It's not a choice for me to prostitute myself, it's not my choice, I have to put food on the table. So when he does do his job, he demands that they give him the money first, no matter what, because he's risking himself, so...

Victoria: Are the clients that he works with mostly Moroccans or other Africans?

Peter (Hannah): Yes, most Moroccan, but I don't always have sex with them. I perform sexual acts. And sometimes they are so aggressive, it's painful. But I can't complain to them.

Victoria: But only with men?

Peter (Hannah): Yes, that's what I know.

Victoria: Has he thought at all about how to get to Europe on his own?

Peter (Hannah): I was in France for a month in 2014, when I worked for an organization in Cote d'Ivoire. I was there for a month. I regret that I didn't stay in France, I really regret it. I thought I would be able to come to Morocco and leave to France. But I am stuck here in Morocco, without the residency card or a work contract, or a bank account. You need a visa, and I can't get one. The UNHCR's work is required, they need to use their money, it's not a charity. It works well in other countries, I don't understand why it's so different here in Morocco.

Victoria: Tell him that, hopefully, if he's comfortable, me sharing his story will inform people about the issues, hopefully.

Peter (Hannah): It's not a problem. I really want to share my story to make migrants' lives better and to change things. People say that, this isn't the first time I've been interviewed, and people say that, but nothing's happened.

Victoria: Right, no I'm not saying... I just hope that, sharing, no matter how many times, however times it has to be shared, sharing it will have to at least change peoples' thought process, not necessarily policy. Thank you so much. Is he planning on working for ALCS for a long time?

Peter (Hannah): It's good here, I like it. I like working here.

Victoria: Does he feel satisfied, or gratified in working here?

Peter (Hannah): Yes, I love it, I get satisfaction from it, that's why I don't mind working here for no pay.

Victoria: I'm sure people are grateful that he does work here. What you're doing is incredible, thank you, nice to meet you.

OPALS Peer Educators Interview

11/9/2016

Interviewees: Daniel and Paola

Interviewer: Victoria

Translator: Maddy Murphy

Victoria: Ok, first question is – when did each of them, we can start with Paola, when did she arrive in Morocco, where did she come from, and how long has she been in Rabat?

Paola (Maddy): I arrived on December 8, 2012.

Victoria: Almost four years.

Paola (Maddy): She came after the Couit d’Etat in Cote d’Ivoire. It was really difficult, there wasn’t a lot of work or security in the country. Her friend told her – her sister’s in Europe – and she wanted to go to Europe as well, so a friend told her that this is an easier way to get to Europe, but that hasn’t proved true. She came in a plane, but it’s not possible to get a visa, so now – here we are.

Daniel (Maddy): I am Congolese, I got here in 1998. He left because of the economic crisis that followed the coup d’etat. After the Coup there were all these economic problems, so he fled.

Victoria: When did they get to Rabat, or Sale?

Daniel (Maddy): I came through Algeria, I got to Rabat in 2000.

Maddy: (to Paola, in French) Did you get here directly?

Paola: Yes, directly here.

Victoria: When did they first hear about OPALS, and how did they hear first about OPALS?

Daniel (Maddy): I hear from an intervener at OPALS, he told me about OPALS. Pasteur told me about it, and brought him to OPALS. He works here.

Victoria: What year?

Daniel (Maddy): Eight years ago.

Victoria: Why did he come here at first, was it for testing...?

Daniel (Maddy): I first went to Caritas first, but Pasteur told me to come for AIDS testing.

Victoria: When was he asked to become a peer educator?

Daniel (Maddy): Pretty soon after. I participated in events, I came here a lot.

Maddy (in French): Yes, but when did you become a peer educator?

Daniel: (...)

Maddy: Are you one of the first peer educators:

Daniel: No, there's been a lot, but there is a lot of turnover and change. I'm just one now.

Maddy: He's been a peer educator for three years, but he just started off coming here every day and got really close with the other people on the staff, and developed relationships.

Victoria: Every day?

Maddy: Not every day, but he said, for most of the activities, he just became very present.

Victoria: Then the same questions to Paola, when did she first come to OPALS, why, when did she become a peer educator?

Paola: It's been 2 years since I've been a peer educator. She was invited by a peer educator originally, and then they asked her to become a peer educator two years ago.

Victoria: How were they asked to become peer educators, who came up to them, how did they ask them?

Maddy (in French): How is it that you became peer educators? Did someone ask you to become educators?

Paola and Daniel: Yes.

Maddy: Someone on staff approaches them directly, and there's a lot of turnover, so there's always new people who come in, it's rolling.

Victoria: But there's always five peer educators?

Daniel: No, not always. There's normally 10, it depends.

Victoria: How much longer do they plan on being peer educators?

Paola, Daniel: I don't know.

Victoria: What training did they get, and how long was the training to become a peer educator?

Daniel: The training was good, they informed us how to speak to people, how to approach people; I didn't know how to do that before. They told us how to apply, how to put on condoms.

Victoria: And how to teach people to put on condoms?

Daniel and Paola: Yes, how to teach other people.

Daniel (Maddy): In the Congo, he had no idea about it, condoms, he didn't know what they are.

Victoria: So he never used condoms in Congo?

Daniel: No.

Paola: I did, I knew what they were and used them.

Daniel: I knew what they were, but I didn't know officially how to use them, how to use them correctly or what they were used for. They also taught us about how you can get AIDS in general.

Victoria: Do they think that most people they speak with have seen or used a condom before, or when they get in Morocco, that's the first time?

Daniel (Maddy): Most people don't know about condoms. Most people know that AIDS exists, but they don't know the correct information about all this stuff, if they know any information at all.

Victoria: Does Paola think that, maybe women know about condoms than men, or is it either way?

Paola (Maddy): Both know, both of them know. But when she goes out, she feels that women ask more questions and want to know more than men do.

Victoria: Do they both speak to men and women equally, or one more than the other?

Maddy: They both talk to both.

Daniel: But not to minors, only to adults.

Victoria: So when they first approach someone, do they ask their age if they look like they might be a minor?

Paola: Yes.

Daniel: We have to ask, we have to make a code, their date of birth is on that.

Victoria: In the training, where they taught how to, or were they taught to approach women and men differently?

Daniel: Yes, that's right. The approach is really important, how do you explain it, there are differences.

Maddy: What is the difference with men and women, in your experience?

Paola (Maddy): She has a lot of difficulty talking to men, because she'll give them condoms and they'll be like, I don't have a girlfriend, who do you want me to use this with? So she enjoys working with women more.

Daniel: Since I am a man, when I go up to a woman I have to be careful to emphasize, this [condom] is for your health. A lot of the women want female contraceptives (birth control),

but they don't have the resources for that. And because a lot don't trust the men or think that the men will use them (condoms), so they wish that they could have something in their own hands.

Victoria: What do they speak to people about more, is it more about, they should come to OPALS for the HIV test or is it more about the condoms and AIDS, stuff like this.

Paola: Both, the more information we give them, the more likely they are to come in to get tested. So both are important, but they I think focus on...

Daniel: It's hard, but when they approach people, they say, listen, even if you have – if you test positive, if you come in here to get treatment, there's a possibility, you could live to be 80 years old, you could keep going, you can still have a life and live with this. But if you don't get tested, and you have it and it's not treated, that's when it's not going to go well for you. So don't be afraid to take charge of it.

Victoria: Can they just describe an average interaction that they would have with someone, like how they would go up to them, how they would display their information?

Daniel: Well I start by introducing myself, that's always good. Hello, hello, how are you, my name is Daniel, I'm Congolese, all of that. I say hi to people from all different nationalities. Then I present myself – I walk at an association. What is OPALS, I explain to them, their services, they work on sexually transmitted disease and AIDS. I ask how their family is, how their baby is, if it's a couple and I know that I ask how they are, how they're doing. I talk with them first. This is the organization I work for, it's about health. Then I educate them on sexual health, and eventually I present them with preservatives (condoms). The condoms are the key to your health – do you know what these are? Are you using them? So you have to – especially the first time talking to someone – you have to ease your way in with small talk, see if they have children, because then if they have children it's easier to be like, so have you had sex? Ease the way into it.

Victoria (to Paola): Is her experience at all different?

Paola: Well my training is the same. The introduction, everything is the same. And if they don't want it, you just can't – you can't force it. If they don't want to hear it, you can't force it.

Victoria: You just walk away.

Paola: If from the beginning, you say hello, and someone doesn't want to listen to you, then they won't want to listen to you. It's not conducive.

Victoria: Do they ever see someone in the street that they've seen before, and go up to them and check up on them, like ask – oh we spoke about this, did you go to OPALS?

Daniel and Paola: Yes, yes.

Daniel: We are supposed to follow up with people, as much as possible. You also have to be careful about things like razors and needles, a lot of times it's five people in one house, and they might think – they don't have a lot of resources, of I'll just use his razor. It's things like that where people don't realize, because they associate AIDS as a sexual disease, there's other

ways that you can get it. Even if someone has gotten tested once, he says, you need to come back, during a period of three months, because that's the only way you can know. You can get contaminated using a razor, there's other – you need to, just in your day-to-day life, you're at risk. You need to be coming back (to OPALS).

Victoria: How do they usually go up to people, is it usually on the street, do they go to a house where a lot of migrants are living, what is the situation that they're in when they talk to people?

Daniel: At the home. We know the neighborhoods where migrants live, everything is done in houses inside closed doors.

Paola: But also in the street.

Victoria: Do they usually talk to people one-on-one, or in groups, in couple?

Paola: It's easier in a group.

Daniel: Yeah, it's a lot easier in a group.

Victoria: Do they just, kind of, give information and ask for questions, or do they do any kind of follow-up, do they go "what do you know about AIDS?", or do they just go ahead and tell them, this is what you need to know? Is it just information, or is it interactive?

Daniel: Most of the time they try to go in and say, do you have questions for me? And to ask questions in the same manner that they were posed.

Victoria: Interesting.

Daniel: You can't just go and give a lecture, and then pack up and leave. It needs to be about what they want to know.

Victoria: Have they, like gathered up any tricks? –

Daniel (interjecting): One time, he went with a big truck load of people to (OPALS) to get tested, and he convinced this older guy to come, like please please, just come, it'll only take five minutes. And with everyone else, it only took five minutes, but this man, it took a full 10 minutes for him to get the response, and after 5 minutes the man was just so angry, saying "you said it would only take 5". If people have like hatred in them, or some anxiety in them, then they're not easy to work with. It's little things like that that will push them over the edge. That's why you have to approach it from the most positive way as possible. 'It's only going to take 5 minutes, and if you have it, it's better to be treated.' He was very sensitive, mad.

A lot of the women who are coming through the forest and Algeria, if you're coming through that area, there's a lot of bandits, who will have knives and weapons, and say, like, you guys can all go, but leave the girls, leave the women. And they rape the women. And then by the time the women get to Morocco, those are the women who are really reluctant to get tested, for AIDS.

Paola: They're afraid! They're terrified.

Daniel: Those are some of the hardest women to get in to get tested – many African women - people who have been through a lot of sexual violence. It's the Algerians!

Paola: The Algerians.

Victoria: So what do they do in that situation, to calm them down, tell them it's better to know, I know you've been through a lot...? Does your training cover dealing with women who are the victims of sexual violence?

(interruption)

Daniel: He goes, and he says, we're here to help you. Trying to emphasize that he's there to help, him and the center. And a lot of times the women get really, the victims of sexual assault, get really angry. They say, how do you know? But a lot of times, everyone in the community kind of knows, especially if a woman is pregnant. And he's saying, it's just about really trying to reinforce "I'm here to help you, please, I'm here to help you". But it's hard.

Victoria: I'm sure. Do they ever follow up, like are they told to follow up with people who have been tested, and it turns out they are positive?

Daniel: No, it's anonymous, who it is, who's positive.

Paola: Yeah, it's completely anonymous. There's a code that keeps it anonymous, it indicates age and gender. But it's completely anonymous.

Victoria: How many times do they come to OPALS for training, or to pick up more condoms, or to talk to someone, or to bring reports, or anything like that.

Daniel and Paola: Every month.

Daniel: Two times a month. All the people are asking for condoms, so I have to come back a lot.

Paola: I come here every week.

Victoria: Do they kind of give everyone ten condoms, or do people ask for more? Like how many condoms do they usually give out?

Daniel and Paola: 20, to anyone who asks.

Victoria: And do people usually ask them for them, or do they push it on them?

Paola: Yes. Sometimes I propose them to people, but most of the time people are asking for them. Some of them ask for 40, and I give 40 to them.

Victoria: How many people do they usually speak to in a given week?

Daniel: It depends, a lot.

Paola: It depends.

Victoria: So like 20?

Daniel: A lot. A lot of people. In a week, I usually go out three times to talk to people. So maybe 15, maybe 10, maybe 7 people at a time, it just depends.

Victoria: How exactly do they explain to someone how to use a condom? Do they take it out and show it to them, or do they show it to them abstractly?

Paola: No, no. I explain, I tell them.

Daniel: I explain. Well with guys, I show it to them.

Paola: Here, at OPALS (during health education programs), they'll show migrants with a condom how to use them, in a more formal setting.

Victoria: How much time a week, or in a month, do they spend writing their report for OPALS?

Paola: Every month.

Daniel: An hour, an hour and a half.

Victoria: How do people usually react when you show them how to use a condom? Is it a laughing thing, is it an interested thing, is it a nervous thing?

Daniel: Interested, no (laughs), interested.

Paola: They don't know how to do it, so they're very attentive, they're very interested.

Daniel: Especially if they're here (at OPALS), it's very informative, very interested.

Victoria: Here, with a doctor. How many times do they – have they gotten little trainings since the first trainings?

Paola: Yes, we've had others. We have small ones, too, always.

Daniel: People get recycled through so much that we just kind of constantly get trainings. There's doctors that come (to OPALS) a lot to teach us things.

Victoria: And Pasteur (migrant program coordinator at OPALS)?

Paola: Yes, Pasteur.

Victoria: How were they assigned to the region that they take care of?

Daniel: No, it's where we live.

Victoria: Your region?

Paola: Yes.

Victoria: Do they know everyone in the community?

Paola: No, of course not.

Daniel: You can't know everyone because there's a lot, but we're working with our own communities.

Victoria: And, how is the relationship between the peer educators? Are you friends?

Daniel: Yes!

Paola: We're all friends.

Victoria: Are they happy with their job? Why do they want to keep doing it?

Paola: I'm very satisfied. The only thing is, I'm not really allowed to move, which is frustrating. I can't move out of Rabat, I can't move to Sale.

Victoria: Would she like to live in Sale?

Paola: Yes.

Victoria: But they're happy, and they want to keep doing it as long as they will?

Daniel: For right now, for me, it's good.

Paola: Yeah, for right now. Everything's good. It's not very stressful, it's ok.

Victoria: Are they planning on staying in Morocco?

Paola: No, hopefully to Europe. Maybe back to Cote d'Ivoire.

Daniel: For me, if I can find happiness here, I'll stay here. In Europe, people are suffering. It's good here, it's worth it to stay here. The way into Europe is so dangerous, it's not good.

Victoria: Do they have a lot of friends in Morocco, do they have a good community?

Paola: Moroccan friends?

Victoria: No, or sub-Saharan.

Paola: Yes, I do.

Life Story of Cynthia

11/5/16, OPALS

Interviewee: Cynthia

Interviewers: Victoria and Alex Brantl

Translated from French to English

Cynthia: My name is Cynthia and I am Senegalese.

Alex: Is it possible for you to tell us your story, like the reason that you left Senegal, and the voyage, and life here in Rabat, if you want?

Cynthia: Ok. I was in Senegal, I completed my studies through high school. After I stopped to help my family who is poor. So I worked as a cleaning lady to help my sister and my brother to pay. **After that I did something religious.** That's five years of information. I found work, I worked well. Now there was a friend that told me I should travel – that it's better here.

Alex translates.

Cynthia: So after that I saved a little bit of money to go to Libya.

Alex translates.

Cynthia: So to go to Libya, I would need to cross through Europe, and it was difficult there, so I knew a girl that was here in Morocco.

Alex translates.

Cynthia: This girl talked with me on the phone often. She said you should come, life in Morocco is good to come here, it's easy, etc. etc. etc. So after I decided to come to Morocco through Libya.

Alex translates.

Cynthia: So when I arrived, when I took the route through Libya to Morocco, I arrived in Oujda and when I arrived in Oujda I had no more money so I telephoned my friend. Nothing. I telephoned and my friend wasn't there.

Alex translates.

Cynthia: So I saw a black, an African person like me. I had no housing, I had no money for a hotel. I explained my problem to him. I had come from Libya like this. I needed to have an Arab girl help me but I had no one. "Could you help me figure out how to spend the night and after I will try to figure out what to do." He said it wasn't a problem. I could spend the night with him, he said he had a lot of people in his house, a lot of men, a lot of women. But that night he abused me and I became pregnant.

Alex: In Oujda?

Cynthia: Yes. In Oujda?

Alex: By the friend?

Cynthia: No not a friend, just an African.

Alex translates.

Alex: When did this happen?

Cynthia: This was March 20th (2016). Just when I arrived in Oujda.

Alex: So did you stay in Oujda for some months?

Cynthia: No, I spent that night in Oujda and he abused me and he was violent to me. After he demanded that I pay him a lot because I was going to see my friend here in Rabat.

Alex: You went with your friend (to Rabat)?

Cynthia: Yes. So when I arrived in Rabat with my friend. I didn't have a telephone, I didn't know any Arabs, there were a lot of Africans here who helped me. There are 9 boys in my room.

Alex: There are just men in your room?

Cynthia: No it is a big room so we divide it.

Alex translates it.

Alex: In Oujda you stayed at a hotel or at a church? (In hindsight this was a question I already knew the answer to).

Cynthia: No, when I arrived in Oujda I had no money. The money was finished. I explained to him my problem. That was the night that he abused me.

Alex: Now, in Rabat, do you work.

Cynthia: No.

Alex: Do you go to the doctor here for the pregnancy?

Cynthia: Yes. Medecins du Monde.

Alex: How do you know about MDM?

Cynthia: It was a girl who volunteers, I saw her. She explained to me about the people that they help. Because I had been living here for three months, I didn't know anybody, I didn't have an visits because I didn't have any money. After I explained to her, she said to go to MDM.

Alex: She came to you house?

Cynthia: She does the little commerce in the medina.

Alex: Does MDM help a lot?

Cynthia: For help with the **analysis and _____graphies** (medical things that I don't know).

Victoria: Do they help with medicine?

Cynthia: Yes, Medicine for the pregnancy.

Alex: And Opals, how did you learn about Opals?

Cynthia: It was a girl who shared the information about OPALS with me. Because after I helped the problem... I didn't have anywhere to live.. the girl said come to OPALS to get the test. So I took the test two times here. After the test I had a consultation here.

Alex: So this girl came to you house?

Cynthia: We share the same "foyer" (I don't know what this is) in a house with a lot of women.

Alex: Do you have a community here in Rabat, with the other migrants, friends?

Cynthia: I have no one because I stay in my house because after the violence I am scared.

Alex: Do you still talk with your family in Senegal?

Cynthia: Oui. (She's very upset at this point.)

Alex: Do you know if the baby is a girl or boy?

Cynthia: Girl.

Alex: A question on the trip from Libya to Morocco: Did you travel in a car?

Cynthia: In a car with other migrants from Congo, Niger, Cameroon. It was hard.

Alex: Do you know where other people that you traveled with are?

Cynthia: We all separated in Oujda.

Alex: Do you want to stay in Morocco or leave.

Cynthia: Leave.

Alex: For Europe?

Cynthia: I would like to work to help my family in Europe.

Alex: Are there other female migrants who are in the same situation with a pregnancy during the voyage?

Cynthia: I have never seen them but I have heard about them.

Alex: For my project, I want to study family planning, like contraception, but if the question is too intimate, don't respond. Before your pregnancy did you use contraception like a condoms or oral pills?

Cynthia: In Senegal I took the pill. But it wasn't to prevent pregnancy, it was because I had an irregular period. It wouldn't come all the time. Because I wouldn't get a period for two months. So it was prescribed to me for irregularity.

Alex: Same for me! So for the voyage, no pill?

Cynthia: No.

Victoria: In Rabat?

Cynthia: No.

Alex: Are there organizations that have helped you financially or socially?

Cynthia: It was Caritas that helped me find my house. They said they would give me money for three months but they only did for one month. And now I can't pay because I don't work.

Alex: How did you learn about Caritas?

Cynthia: MDM recommended that I go to Caritas because I was having problems with housing and MDM doesn't help with that so they told me to go to Caritas.

Alex: What are the nationalities of the people you live with?

Cynthia: There are Camerouns in one room and others in the other room.

Alex: Do you think the reason that it is difficult for you to find work is because you are pregnant?

Cynthia: Yes maybe.

Alex: Do you know where you are going to give birth? In a hospital?

Cynthia: MDM says that I will need to pay more to have a baby in the hospital. So I don't know because I don't have the money to pay for a hospital. It's a problem.

Alex: And MDM said that you need to pay?

Cynthia: Yes.

Alex: When are you due?

Cynthia: The next month – December.

Alex: Do you already know the name?

Cynthia: I will give her the same of my mother, Monica.

Alex: Have you had a relation with a man here in Rabat?

Cynthia: No. Because they know that I am pregnant.

Alex: What would you like to do for work?

Cynthia: Anything that I can find, cleaning, commerce, anything.

Cynthia asks us about family planning in the U.S.

Alex: in Senegal is there education for family planning?

Cynthia: Yes there is a service that raises awareness about it.

Alex: Have you thought about going to one of those lectures that raise awareness in Rabat?

Cynthia: Yes, with ALCS. They called me to come to the lecture and I came.

Alex: What did they talk about at the lecture.

Cynthia: A lot of things, about sexual illness.

Victoria: And contraception?

Cynthia: Yes, and they explain how to not become sick.

(End of interview)

Life Story of Evelin

10/26/16, CCCL

Interviewee: Evelin

Interviewers: Victoria Anders and Alex Brantl

Translator: Zerlina Bartholomew

Alex & Victoria: Can she tell us about why she left her country, her journey coming to Morocco, where she stopped and lived, and her life since arriving in Morocco, etc.? Like the story she told us at Orient Occident.

Evelin (Zerlina): She left the country primarily because of aggression (...) and she's from Congo, Kinshasa. She is the oldest of 5, the only girl with four brothers. And she worked in the Congo, she was a commercant - meaning, merchant. She sold goods, like balls, things that came from Europe. In 2008, there were two thieves that came to the house, they ransacked everything, but they didn't kill anyone. But the door was opened and it was at night. It happened twice, sorry, there weren't two thieves, it was two separate instances, the second was in 2009. She was also engaged. During the engagement period, she became pregnant before getting married. It wasn't a problem, though. There was an issue with the pregnancy, he, and there were also issues with her relationship with her fiancé, apparently he became jealous. And at 6 months, she has a miscarriage and she lost the child, and because they weren't technically married, she decided to end the engagement. After she ended the engagement, she started to save money so that she could leave the country. And so I asked her, why did she decide to leave, she said it was because of like aggressions, talking about the two instances where her house was robbed, she lost her child, and then also she didn't want to have to count on a man to protect her and provide for her. She said, from Kinshasa, she went to Brazzaville, and from Brazzaville she went to Chad. And in Chad she contracted tuberculosis. The conditions in Chad were really bad, and coupled with her own kind of personal issues that were reasons why she left, and she's saying a lot of it had to do with stress, and also with the environment of Chad. She said it's kind of a really desolate place, it's not clean, there's a lot of trash and waste in the street, so that's why she think she contracted TB.

Victoria: Where did she live in Chad?

Evelin (Z): In the capital, in Chad.

Victoria: In a home, or?

Evelin (Z): Let me back up, because there were a lot of things. So in the Congo what they do is they pay a chequer - and a chequer is like a smuggler, as we would have it in some of the literature that you've read. And she paid 4,500 Euros, and I asked her how did she save all of that, in how much time. And she said from 1994 to 2009, she saved all of that so that she could leave.

Alex: Was she intending to go to Morocco, or Europe, did she know?

Evelin (Z): The chequer would take her to Europe, doesn't matter which country, he said that he would drop her in - or drop her off in London or Paris or something like that, but Europe was the goal. And the smuggler was also Congolese.

Victoria: So how far did she get with the smuggler? Did she come to Morocco, or just to Chad?

Evelin (Z): From Kinshasa to Brazzaville they went by boat, there were about 50 people in her group. And then from Brazzaville to Chad, they took a flight. The problem was apparently once they got to Brazzaville, that's where a lot of groups congregate, then they kind of go their separate ways. So apparently the smuggler (I really don't like that term), but the handler or middle man, he left them in Brazzaville to accompany another group, whether they were from Gabon, Cot d'Ivoire, Ivory Coast, Cameroon, so from there they were kind of left on their own. Apparently, the chequer, he was arrested in Italy, so that's why he couldn't travel around with them for fear of being caught. And the problem was, once they arrived in Chad, and I asked her if she knew anyone in the group, and she said yeah, even from the same city, just to give you the group dynamics. They were in Chad, they stayed about three and a half months in a hotel, but that was not included in the 4,500 Euros that she paid him, they had to figure out how to pay that themselves. And each night, she said, she said it in Frank, but in dollars - she said it was about 25 to 30 dollars each night, and she did that for two and a half months. Then during that period, she was getting sick. Showing signs and symptoms. During her stay at the hotel, she met a Congolese pastor who had a church there, and after the three and a half months, she went to live with him, and he like prayed over her and helped her out.

Alex: How did she get the money pay for the hotel?

Evelin (Z): What she had to do, was, she luckily has gold jewellery, so she sold that. And she said if you really weren't able to pay, they'd take your passport, and then you were really stuck because then you couldn't travel. But other people in her group, they were able to contact family or friends in Europe, and they would send money so they could pay for the housing. Once she was living with the pastor, she was able to take medicine. So she was really sick, and apparently there was a brother of the church who also helped her, because at that point she couldn't even walk, she lost 32 kilos. So that's about 70 pounds. So even though Chad is technically a francophone country, everyone speaks Arabic, Chadian Arabic. So normally of course she would go to the hospital, but she couldn't because of the language, she paid the doctor to do like a house visit, and that's how she was able to get medicine.

(...)

So I was trying to get like a timeline of where she was staying in Chad. She spends 2.5 years in Chad, the first 3.5 months in the hotel, then a little bit of time, she was in the church. But she fell in love with the brother of the church, and she became pregnant. When the pastor found out about it, he said she had to leave the house, because she was living in his house.

Zerlina: And after that?

Evelin (Z): So apparently, the brother, so I'm guessing he's just a congregation member. He was married to a woman who lived in Europe, and they had two small boys, but he told her that they were separated and so she just lived with him while he was in Chad, because they (he and his wife) were physically not together. So after four or five months, they found out she was carrying a girl, and that caused problems in the family because girl children are considered like not as valuable as boy children, so that caused problems with the family.

Alex: In the brother's family?

Zerlina: In Chad, this is all in Chad. His family.

Evelin (Z): So, when she gave birth and they did see that she had a girl, that caused even more problems. And so apparently her partner reunited with his wife in Europe during that time. And because he thought that girl children are less valuable, he was unhappy and so he started beating both her and the child.

Victoria: Before he left to Europe?

Zerlina: She didn't say that yet.

Victoria: Didn't you just say that?

Zerlina: He wasn't in Europe.

Victoria: I thought you said he reunited with his wife.

Zerlina: Yeah, like reunited.

Victoria: Oh, she came back.

Zerlina: No, no, they started talking again. Reunited as in, started to speak. Sorry, should have clarified that. No, he was still in Chad, they were still physically separated.

Virginia (Z): But yeah he was starting to be aggressive and hitting both her and her child, even at 4 months old. She didn't know anyone to help her. So, because she didn't know anyone to help her, she had to stay with him. She became pregnant again, it was going to be another girl. He was still there, he was not happy that she was having girls. When her she was three months pregnant (...) So she took money from him so that she could leave Chad, her and her child, at 3 months pregnant. Yeah she was still in her first trimester, with her second child - second girl, when she left Chad.

Zerlina: What was the route? On foot or by car?

Virginia (Z): She was in a car, made for four but they were 20, like you know the little cars that you see here. 20 of them, it was mixed of men and women, she had a child and was three months pregnant, and they were crossing the desert. She said, depending on the driver, it can take from 3 days to one week to cross the desert. Luckily for her, it took three days. And I asked, did you have access to water? And she said yes, what they do is they have like a reservoir of 20 litres, and so it's connected. Each person gets like 5, but do people really follow that, no. So the water did run out.

(...)

So because of the aggressions that she experienced and the trauma, she has hypertension. So whenever she gave birth, her blood pressure would go up. And so she took medicine to help with her blood pressure. (...) So I know the route that she took. Let me clarify what I meant by the hypertension. The entire route from Chad to Morocco took them a month, because they took it little by little. But the most dangerous part took three days, in the desert. What she was saying about the high BP is that after, yeah because of the trauma she experienced, she had to

take medication, but she didn't take it during that stretch of travel, but with her second birth she had to.

Victoria: When was she first told that she had to take the medicine?

Evelin (Z): In Chad, when she had her first child, that's where they took her BP and diagnosed her with high BP postpartum, and so she got the medicine for three months. And during the second pregnancy she didn't have any issues with high BP, until it was time to give birth.

(...)

So she goes from Chad, and then there is a town in Algeria called Tamar Asset, it's kind of one of the main points that migrants stop at on their journey, and then there's Oujda, which is the first Moroccan city people get to. But there is a region, like a border between Algeria and Morocco called Maghnia, I'll ask her how to spell that, and from there you have another route of chequer - smugglers. And I asked her what nationality are they, and she said all the nationalities are represented, so the Congolese go with the Congolese, Malians with Malians, Cameroonians with Cameroonians, so it's kind of like a system. From 11pm to 9am, they had to walk from Maghnia - sorry I guess Maghnia isn't a region, it's like a town - to Oujda. And at this point, she was still, what, 3 - 4 months pregnant. And her 14 month old daughter, walking. And it was very cold there, they didn't know it was going to be cold because like in their country, it's not very cold in the winter. And you have to do it at night so that they can avoid police and border control. And so with the chequers in Oujda, what they do is they produce fake papers so you can take the train from Oujda directly to Rabat, which is why she came here. So as soon as she arrived to Rabat, she asked for asylum at the UNHCR. At this point, she was 5 months pregnant when she asked for asylum. So she was 5 months pregnant, they said that they wouldn't be able to give her a response until her second, unborn child, turned three years old. And they didn't give her anything.

Victoria: Did they give her a reason why?

Evelin (Z): No, "it just is that way". In the winter of 2012 is when she got to Rabat and asked for her asylum, and the rapport between the UNHCR and the Moroccan government was not as good as you might think it is today, and so perhaps that was the reason why it was going to take three years. Even though she was registered, they didn't give me monetary aid, didn't give me any money, medicine, lodging, nothing.

Alex: Where was she living with her daughter?

Evelin (Z): She was part of the migration reform policy, where 100% of the women apparently, who applied, got registration permits, so she got hers last year. Her and her daughters.

Victoria: Sorry, before that her daughters didn't have papers?

Evelin (Z): She found a room, but she had to go into prostitution because that was the only means to make money. And she was explaining that for men, they had to prove that they had lived here for 5 years, but for women in was completely free.

Zerlina: Did you daughter have Chadian nationality when she was born?

Evelin (Z): So, with her first child, she was born in Chad, so she was had attestation, a birth certificate in Chad, but also she registered her child with the Congolese embassy in Chad, so that she has papers as well. But with her second child, she was born here, in Rabat. So what she did, was, her child - because she didn't have a residency permit, she couldn't register her child in Morocco, even though she was born here. So after six months, she went to the Congolese embassy, and she got her papers there. And when she got her residency card in 2015, at this point her child is 4, three or four years old, she could then register her child. Because what normally happens, and this is not just in Morocco, throughout the region, you have to register your child after 30 days. So while she's on record having a "life" certificate, they couldn't give her a birth certificate because the mother didn't have papers.

(...)

Her significant other in Chad, the father of her two children, found out where she was and he came to Morocco, and they started living together. In 2014, and for the third (fourth) time, she became pregnant. So he came to Morocco in 2014, but she became pregnant in 2015. During this time, even though he was with her, he still was in a relationship with his former wife who is in Europe. She couldn't tell him no, because he would beat her. From 2012 to 2014, until his arrival, she was doing prostitution. He became like the sole source of income, so what he did was like kind of like construction work, he did hand work - carrying things, that type of thing. But she didn't work, she was with the kids.

Alex: Before he came to Rabat, when she was working in prostitution, did she use any type of contraception to prevent getting pregnant?

Evelin (Z): Yes, she used condoms with clients. I got them from the associations (organisations).

Alex: What organisations?

Evelin: Caritas, ALCS

Alex: Did she go to them to receive the contraception, or did they come to her?

Evelin (Z): I went to them, because you have to register with them to receive services. And the medicine is free, for your children and yourself. If you register.

Alex: Can you ask about the clients? Give a general description.

Evelin (Z): They were never Moroccan. Not minors. They were Africans, except Moroccans. West Africans mostly. (Why?) Moroccans don't like that, they don't like seeing Moroccans with a black woman - a black person. And vice versa, you just can't be seen with a Moroccan.

Alex: So she used contraception when she was in prostitution, but did she ever use it when she was in Chad, or still in the Congo? Why, why not?

Victoria: And depending on timing, also asking how she came to finding out about Caritas and ALCS?

Evelin (Z): She didn't use condoms when she was in Chad, for two reasons because 1) she was with this one man, the father of her children, and 2) she wanted to have a child, she was at that time in Chad, she was 34 years old, she thought "oh, I don't want to die without any children". When she started her work here, she of course used condoms. Oh and in Chad, she took an HIV test and it came back negative. So she decided then, like OK I'm not going to use condoms. And here, when she started the work that she mentioned before, she started using condoms all the time. And she took several HIV tests to make sure she was fine, and they always came back negative.

Victoria: Did she only use condoms? The pill?

Evelin (Z): What happened was, sometimes with her clients, she didn't use condoms, but that was because they trusted one another, but the price would change. And so I asked her did she provide the condoms or did the client provide the condoms, she said well it's always better if you provide the condoms, but I mean clients provided them as well. But, for instance, with the price change. For regular interaction it was 100 durham, without a condom it was 300 durham.

(...)

Before she used, this is before this whole voyage, she used the pill and condoms too. But because of the blood pressure (...) when she got diagnosed with hypertension, high BP, the doctor said she couldn't use any contraception - oral contraception. In Chad. But when she came here and got registered with the organisation, ALCS, specifically, they give that as well for free, so she started using it. And she was using it when her husband was here. When her husband came, she decided not to take the pill anymore, because she went to the hospital here and they told her she shouldn't do that.

Victoria: When was that?

Evelin (Z): In 2015, last year. In my third pregnancy. At five months pregnant she had a miscarriage with the third, and it was a boy.

Alex: During her work, did she ever have an unplanned pregnancy?

Evelin (Z): No, she did not (from 2012-2014). In May, because she had her miscarriage in September of 2015 (...) He was still in contact with her ex, still unclear what their legal situation is, during her third pregnancy, he would beat her. And eventually what happened was the wife, his ex wife, sent him money so that they could, so that he could leave Morocco and be in Europe with her and her two sons. He left six months ago.

Alex: And now she lives with, her two daughters?

Evelin (Z): Yes, they live alone, just the three of them. The apartment is shared, they live in one room. With one other person, women. They are Congolese, from Kinshasa. For rent, it's 1200 durham a month, that's out of her budget, especially considering she has two younger daughters, so she rents it for 800 durham. And her roommate is another woman from the Congo, from Kinshasa.

Alex: Does she work?

Evelin (Z): No, because she has medical issues. She has uterine cysts.

Victoria: When did she find out about that?

Evelin (Z): After her miscarriage. So he beat her, and then two days later she had her miscarriage, and it was at the doctor's that she found out that she has uterine cysts, in September 2015.

Victoria: How did she go to that doctor, through an organisation?

Virginia (Z): She went to the UNHCR, because she was all by herself. (...) And she has refugee status, she received it during her third pregnancy. And then she could benefit from UNHCR services, so she she went to the UNHCR doctor, and that's how she found out about the cysts, and that's where she went when she had a miscarriage.

Victoria: So since she got refugee status, the UNHCR has been taking care of all her medical needs?

Evelin (Z): Because she has two - the benefits she received, they don't give anything in terms of food and clothing, the UNHCR doesn't provide for that. They give a housing allowance of 800 durham per month, that's why she pays 800 durham. And because she has two daughters, they are 20 US dollars, so 200 durham a month, 400 durham total, per month for the two girls. So she gets 1200 durhams total each month.

Zerlina: How long does this stipend, how long does this assistance last?

Evelin (Z): I don't know, it's up to them. There have been cases where they have told women that they're gonna get like 200 durham per month for her and her children, but she only get 1000. And I asked her why, she said that's just how it is. So often times what happens is, she said it's a big problem, because this is a tough financial situation, especially for a woman who has children, they can't just find somewhere and stay wherever they can. So they're kind of between a rock and a hard place in terms of where to live. Even feeding themselves, because it's not enough. 20 dollars a month for a child? And that's assuming they get all of it.

Victoria: The medicine that she gets for herself, for the uterine cysts, everything, and then also her children's doctor's visits, are those included in the benefits, or is she supposed to pay for those with the money that she's given?

Evelin (Z): With the medicine that she gets from UNHCR, what she gets it for free, basic things, topical cream, things like that. But for more complicated things, they're supposed to pay, but with what money. She doesn't buy it, what she does, from time to time, she goes to the church with the prescription and get its, the Protestant church. And since they have a partnership with an American church (mine), she gets whatever she needs but the UNHCR won't cover, she gets from them.

Victoria: And what about her daughters? Have they...

Zerlina: This is for both of them, but of course again if it's something more expensive that the UNHCR can't provide she has to look for it.

Victoria: And is she on any course of treatment for the cysts?

Virginia (Z): In order for the UNHCR to give her any medicine for her uterine cysts, they told her that they have to grow, like get bigger, become more of a problem. Because at this point they weren't considered urgent. But this past Monday, she went to the health center here in the neighbourhood, not far from the UNHCR, and they told her there are cysts in her uterus that have grown, and also cysts in her breast, cancer. And so now what she has to do is go to the gynaecologist at the UNHCR so that she can write off, in order to get medicine to get the cysts.

Victoria: Because now it should be urgent enough, right. Well that's what she thinks, it should be urgent enough?

Zerlina: Yeah, because they've grown, they're inflated. Are the cysts they found in you dangerous?

Evelin (Z): The doctor at the health centre said they have to do more testing to figure that out, so what she's going to do now is go to the UNHCR to see if they can cover that and see if they can help, because again she can't pay. She's never been 100 percent healthy, she has welts that you can see, it's like small cysts. They might be like sebaceous cysts, and even when she goes to the doctor, she's never healthy. That's how she lives, just not 100% healthy.

Victoria: How did she find out about this health centre that she went to?

Evelin (Z): It's public, it's free, it's of the government. It's free for everyone, Moroccans, migrants, etc. the consultations are free. These are public health centres sponsored by the government, so consultations are free for everyone whether they're Moroccan or not Moroccan, migrant whatever. So, and because she has refugee status, she then takes the consultation, and then she goes to the UNHCR to see what additional assistance they can give her.

Victoria: So she basically steps over the UNHCR to get the consultation, and then?

Zerlina: Why do you go to that health centre, rather than the UNHCR for clarification?

Evelin (Z): You have to start at the public health center, apparently. And then if you need a specialist (dermatologist, cardiologist, gynaecologists, etc.) you go to the UNHCR for help. This is for general check-ups that they have to go to the health centre for the consultations, but if you need something specific, UNHCR has their own doctors, and they set up the appointments for you.

Victoria: And are they accompanied, or do they just show up?

Evelin (Z): She visited a health centre during her third pregnancy, and they told her that the baby was not breathing, so it had passed away, this was at the 5 month mark. So what she did was, she went to UNHCR, and what's supposed to happen is that they take you to a private hospital. But they didn't want to take her to a private hospital because it was expensive, so they took her to a public hospital because it was cheaper, where she stayed for two weeks. During those two weeks, no one from the UNHCR came and visited her, or accompanied her or anything. It was friends that came and say her, and it wasn't until she called and said, hi I'm being discharged, that someone came from UNHCR to accompany her. And they asked her where was her husband, she said he wasn't present, and they asked her where are her two

children, and she said that neighbors were taking care of them during that time. They visited her in the morning, and they would leave the hospital to go sleep at night. But basically, the UNHCR was not present during this time.

Victoria: Where did she give birth to her second daughter?

Evelin (Z): In a public hospital, it's all public. For hospitalisation it's all public. The things that are private are check-ups and specialisations. Because birth requires hospitalisation, they send them to public hospitals because it's cheaper. And I asked, did you have refugee status before your child was born, but she told us earlier she got it three years after her birth.

Victoria: So she just went to a public hospital? And so, even though she was undocumented, they let her in (the public hospital)?

Virginia (Z): The hospital doesn't have a problem if you enter, as long as you pay for the bill. And they'll give you a life certificate (birth certificate). Certificate of birth distributed by the hospital is different from that from the police. It's the one from the police that's most important and that gives you official status, and she couldn't get it because she didn't have papers.

Victoria: How was her experience at the public hospital?

Evelin (Z): Bad. She would never go back to a public hospital. At this public hospital (in Rabat), her experience was terrible, especially with her third pregnancy that was the miscarriage. What happened was, she went to the hospital, they didn't even speak French, only Darija; her feet and hands were swollen, but no one came to help her; and when they changed the IV, there was blood everywhere. She had a very bad experience there.

Victoria: But the public health centres are a little bit better?

Evelin (Z): At the health centres it's better, because you have a consultation so it's one-on-one, at the public hospitals you have like 12 people in the same room, it's especially difficult if you don't speak the same language. So if you don't speak Arabic, they won't even come to you.

Victoria: I just have one more question from a really long time ago, how did she first find out about ALCS and Caritas that helped her get the condoms?

Evelin (Z): From awareness raising programs. What they do is, representatives from these organisations hold public information sessions and they go door to door.

Victoria: So for her, did someone go to her door or did she hear about it somewhere?

Evelin (Z): She heard it by word of mouth, someone told her, you should go to these centres, and they offer free services.

Victoria: What public places?

Evelin (Z): These public spaces are basically like waiting rooms in these institutions, so you go there and they have like a new patient, new person welcoming, or like if you're sick you go. And during these sessions, they tell you about all the services they provide. Also on

Mondays apparently they do courses at the centers, at all of them (caritas, ALCS). For various kinds of maladies, for AIDS, HIV, STIs.

Victoria: A closing question, about her friends, if any of them have similar medical issues?

Evelin (Z): Many maladies and issues, fibroids, cysts, genealogical issues. Female issues, and others: fibroids cysts, hypertension because of stress, diabetics.