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Madelyn R. Haden April 9, 2021

# Externalized Migration and the Securitization of Health:

## A case-study of how EU-Moroccan relationships influenced healthcare accessibility within sub-Saharan Migrant Communities in Morocco during the Coronavirus Pandemic

by

Madelyn R. Haden

Rkia Cornell
Adviser

Department of Middle Eastern and South Asian Studies

Rkia Cornell
Adviser

Michelle Lampl
Committee Member

Florian Pohl
Committee Member

Devin Stewart
Committee Member

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An abstract of
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Abstract

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Using sub-Saharan migrant communities in Morocco as a case study, this research evaluates how EU-externalization policies contributed to the externalization of migration and the subsequent securitization of migrant health. By conducting a literature review on the current theories of migration and histories of politicization and securitization in the region, holding 27 semi-structured interviews with sub-Saharan migrants and community stakeholders in Morocco, and conducting a large scale financial analysis of the sources of externalization funding in Morocco, this research aims to present the consequences of international policy on personal and intra-communal access to healthcare. Furthermore, this research evaluates the potential of implementing migrant-conscious public health systems within externalized and securitized international systems.

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**Contents**

**Acronyms**

AMDH- Independent Moroccan Association of Human Rights

AMERM- Moroccan Association for Studies and Research on Migration

AMPF- Moroccan Association for Family Planning

ASCOMS- Platform for the Association of Sub-Saharan Migrant Communities

AU- African Union

CVE- Economic Watch Committee

CNSS- National Social Security Fund

EUTF for Africa- European Trust Fund for Africa

GADEM- Anti-racist Group for the Support and Defense of Foreigners and Migrants

GCM- Global Compact for Safe and Orderly Migration

IGO- International non-governmental organization

IOM- International Organization for Migration

NGO- Non-governmental organizations

ODA- Official development assistance

OMDH- The Moroccan Organization for Human Rights

RAMED- The Medical Assistance Plan

UNDP- Universal Declaration of Human Rights

UNHCR- United Nations High Commissioner for Refugees

WHO- World Health Organization

WMR- Western Mediterranean Route

## Introduction

*Morocco, Members of Migrant Communities, and COVID-19*

In many countries, public health systems reflect the priorities of a nation-state (Schick 2018). This reflection means that public health systems respond to stationary populations of normalized, registered, or nationalized residents, while people with migrant status, asylum-seekers, refugees, and nomadic groups are historically under-served by the health infrastructure (Papadopoulou-Kourkoula 2008). The nature of public health systems and migrant bodies contributes to the politicization, securitization, and externalization of migration. The 2019 coronavirus pandemic highlighted numerous shortcomings in healthcare systems around the world, revealed the interconnectedness of migrant bodies and health and international relations, and demonstrated the necessity of migrant-conscious public health approaches.

A migrant-conscious health approach, in this research, is the development of "migrant-sensitive health systems and programmes which aim to incorporate the needs of migrants into all aspects of health services, financing, policy, planning, implementation, and evaluation" (WHO 2017, 52). Many of these "needs" include access to primary health care, language services, and culturally informed care, for non-citizen groups. Taking a migrant— or mobility— conscious approach to healthcare requires adapting national disaster preparedness and response plans, establishing health system reporting mechanisms, capacity building within public systems to support migrants, and maintaining data to monitor and plan for migrant needs (WHO 2017, 9-10; IOM 2019). A migrant-conscious public health system also means creating and supporting platforms for people with migrant status, community advocates, and community representatives to have a dialogue about access to healthcare.

This definition and action plan for creating or adapting public health systems are important to investigate because of the considerable gap in the existing literature on migrant-conscious health delivery. This gap is especially prevalent in regard to international cooperation, the "international" norms of health provision, and the political determinants of health (Koehn 2020, 5-7; Kickbusch 2020). Moreover, the current literature on the intersection of public health and migrant needs has focused on migrant health policy in high-income destination countries, in specific health issues prevalent in various migrant communities, the legal or political categories of migrants, or the role of origin countries in promoting migrant health (IOM 2019; Brandenberg et al 2019). Very few studies have focused on migrant health and the creation or support of migrant-conscious public health systems within developing economies (Sweileh et al 2018, Papadopoulou-Kourkoula 2008, 7-8). There is even less literature on the role of public health systems within transit countries and the newly burgeoning category of transit-destination countries.

These categories are important for discussions of migrant-conscious public health systems because they assist in the analysis of a country's capacity to adapt to migrant needs (Papadopoulou-Kourkoula 2008). The intersection of these geopolitical categories, the adaptability of a country's health systems, and the individual consequences of mobility are also under-researched within the fields of international relations, public policy, global health, and migration studies. For example, in 2018, the International Organization for Migration (IOM) funded a large-scale literature review of 21,457 migrant-health oriented research papers published between 2000 and 2016. Out of these publications, 89.6 percent of all research focused on migrant health in (World Bank defined) high-income countries, just 9.6 percent focused on middle-income countries, and a staggeringly low 0.8 percent focused on low-income countries

(Sweileh et al 2018). Because almost all high-income countries are considered destination countries, this study highlighted that there is extremely limited analysis of healthcare in the context of transit regions or migrant mobility. Furthermore, the study concluded that 25.4 percent of the research focused on the well-being of refugees and asylum seekers, 6.2 percent focused on migrant workers, 3.2 percent on human trafficking and smuggling, 2.1 percent on international students, and 0.1 percent on patient mobility across international borders. Although individual studies highlighted the multiple topics that a study could examine— such as health among international students or the well-being of migrant workers— there is still not a system-focused analysis of access to care for members of migrant communities. With regards to thematic areas, the IOM study concludes that 47 percent of studies focused on mental health and psychosocial well-being of people with migrant status, 13.7 percent focused on communicable diseases, and 8.9 percent focused on non-communicable diseases (Sweileh et al 2018). These thematic areas demonstrate the incomplete repertoire of migrant-health and public health studies and suggests the need for more research on access to care. This literature review also highlights the gap in knowledge on migrant health and well-being in low-middle-income countries, and further highlights a lack of discourse around migrant-conscious health systems in developing economies.

A case study that allows us to analyze the importance of developing migrant-conscious public health frameworks, and to demonstrate how migrant-conscious health can develop within the real world, is Morocco. As a lower-middle-income country, Morocco has a public health infrastructure that used just 3.2 percent of its national budget in 2013 (Alami 2013) and 5.25 percent of its overall GDP in 2017 (World Bank 2020). Despite two regularization campaigns in 2013 and 2017, the migrant community is largely unregistered. The health system depends on a paper-based social security system, and thus, a large population of undocumented people inhabit

a challenging place within this underfunded healthcare framework. The place of transit migrants'— or people who have been kept in transition, externalized, and forced to reside in Morocco— within the healthcare system is challenging because of their liminality and being "stuck in between" (McGuire 2003; Alexander-Natahani 2020). The fluidity of the transit migrants group composition and position and the lack of subsequent integration contributes to a large gap in the research pertaining to access to health among migrant communities in transit-destination countries. There is also a large gap in the research on external influences of health systems and how these influences affect people with migrant status.

The conditions of Morocco's public health system and the ways in which it shapes the lived experiences of sub-Saharan migrants, specifically, were made more apparent by the 2019 coronavirus pandemic. This heavy strain on the public health system highlighted the inefficiencies and lack of migrant-consciousness within the framework of health delivery. The pandemic also presented migrant communities with a series of complex challenges that revolved around public health requirements, maintaining a standard of living, and finding adequate protections for self and loved ones. Individuals faced medical discrimination, inadequate public policy implementation, unequal access to care, and state-sponsored displacement during the pandemic. To address these challenges, many people turned towards community-based initiatives to assist them in their time under lockdown, to gain access to medical care, and to have a semblance of medical choice, and to benefit from health advocacy.

Ultimately, the influences of mobility-aligned public health systems can be seen not only in policy and legislation but also in oral stories and first-hand accounts of medical access. To understand the human cost of these systems, I conducted research with the sub-Saharan migrant community in Morocco between March and September 2020. During this time, I employed a

Moroccan translator to conduct nine virtual, semi-structured interviews in French. I conducted virtual interviews with an additional five individuals in English, without the assistance of a translator. Each of these individuals self-identified as having regularized or unregularized migrant status, lived in the cities or suburbs of Tangier and Rabat, and above the age of 18. All interviewees were contacted through chain-referral sampling. The individuals were from the countries of Senegal, Nigeria, Côte d'Ivoire, Guinea, Cameroon, or the Democratic Republic of Congo. I interviewed an additional 12 individuals who work with local NGOs, international non-governmental organizations, national government ministries, or national think tanks.

I placed these interviews into a historical and legislative framework to analyze how migrant experiences in transit-destination contracts fall with the legislative system. I also paired these interviews with a financial analysis of Morocco's public health system. My research has endeavored to understand how public health frameworks are created within transit-destination countries, how international influences have securitized access to care, and how securitization has affected relationships between members of the migrant communities, hospitals, NGOs, local healers, and community leaders. My research also explores how international financial pressures due to Morocco's position as a third-country border nation have politicized and securitized access to care among the migrant community. The purpose of my research, overall, is to answer:

1. How do EU-externalization policies influence the implementation and accessibility of migrant-conscious healthcare in Morocco?
    a. How do international policies affect security in Morocco?
    b. How does security affect people with migrant status?
    c. How do relationships with security affect interpretations to access to care?
2. How are migrant bodies securitized and politicized through access to care?

3. How can migrant-conscious health systems be effectively supported and implemented within Morocco?

By answering these questions, I will address my theory that, because the EU securitizes migration through externalization programs, migrant health also is heavily influenced and thus transforms from a politicized to a securitized element of migration control within the Maghreb. Secondly, these questions will discuss how this transition from politicized health to securitized health has been exacerbated by the COVID pandemic and heavily influences the formation and support of migrant-conscious health systems.

The analysis takes place over five chapters. The first chapter begins with an introduction to theory and the international legislation that dominates migrant rights and health rights discourse. These topics explain some aspects of the lived realities of people with migrant status, and help us to understand the type of geopolitical system that Morocco creates and operates its migration response within.

The second chapter introduces Morocco as a case study. This chapter begins with a history of Morocco and its development as both a transit and a destination migration country before introducing the complex relationships among Morocco, the AU, and the EU. The chapter continues with a discussion of the role of international donors in forming the migration system, and it concludes with an overview of the EU and Morocco's last century's migrant-related political history that is so important to understand how migration is interpreted, how migrant interpret access to the public health system, and how people with migrant status in Morocco are (un)protected by the current legal framework in Morocco.

The third and fourth chapters present the findings of my research. Chapter 3 discusses my methodology and introduces the findings of my financial analysis. This chapter analyzes the

quantitative relationships between Official Development Assistance (ODA), budgetary health, and security presence. Chapter 4 introduces the interviews that were conducted through the study and describes the experiences of different people living and working in Morocco during the pandemic. Through these two chapters, I present an understanding of how externalized migration became a securitized health issue within Morocco, and how individuals and communities were deeply impacted by these policies.

The fifth chapter discusses the implementation of a post-pandemic, migrant-conscious public health system in Morocco. This chapter also pays homage to the advocacy efforts of migrant-run NGOs throughout Morocco and discusses the different policy proposals and coronavirus response papers from the *Platform for Sub-Saharan Migrant Communities* (ASCOMS), the UN Special Rapporteur, and other representative bodies. By incorporating local opinions and networks into an analysis of migrant-conscious public health frameworks, this not only offers a more informed perspective on how migrant communities are affected, but is, in itself, an act of migrant-conscious public health.

Ultimately, this study analyzes how the pandemic has affected EU-Moroccan migrant policy, Morocco's relationship to migration, and the migrant experience of life and health within Morocco.

This case study of the experiences of the sub-Saharan population in Morocco demonstrates the nuances of social determinants of health, the complexities of public health implementation, and the politics of migrant health. It further highlights the need for more resilient, migrant-conscious public health systems that are capable of providing for all members of society regardless of legal status. The findings of this work will contribute to the literature of

migration within low-middle-income countries, as well as to the literature on politicized health and securitized and externalized migration.

# Chapter 1:

## Theories and Legislative Histories

*A brief introduction to migration theory*

In December of 2020, Ylva Johansson, the EU Commissioner for Home Affairs, gave a speech at a meeting of the EU Action Plan on Integration and Inclusion (2021-2027). In her statement on the importance of promoting integration for members of the migrant community within EU territories, she stated the fundamental truth that "migration is normal. It is part of humans' past, present and future. That means it is part of us" (EU Debates 2021, 0:18-0:24).

Migration has always been part of humanity. Long before the concept of a nation-state was ever imagined, humans were nomads. We walked everywhere. We hunted for food, and we traveled with the weather. It was not until the first sedentary civilizations formed that the concept of protected, stationary areas emerged, and the defense of these areas cost human lives. Over the millennia, these early settlements grew from small harvest fields, to small plots of agricultural land capable of sustaining more than a single family, to interconnected plots of land and rudimentary villages. The first small towns emerged, connected with each other by trade and social relations. Over the centuries, these towns grew into cities and then from cities to states. Each of these stages was guided by leaders whose primary purpose was to protect the people and the land. And so the idea of borders, and its subsequent host of social and political consequences, emerged.

The consequences of these borders have surfaced in thousands of different ways. From war to economic schemes to transnational identities, borders define the systems within which every human being lives. Even within the classification of human movement, borders determine who is considered a traveler, refugee, historically nomadic person, or an international displaced

person. Within the field of migration studies— an interdisciplinary field which draws on anthropology, colonial studies, history, politics, economy, and social law— borders are part of the framework used to understand human migration. By focusing on the relationship an individual has to a man-made construct and a land-based power construct, however, much of this field of study becomes state-centric and lacks a humanistic lens of analysis. The hegemony of inter-state relationships and the lack of non-state actors in determining migration law and theory explains much of this state-centric focus, though it contributes to a lack of individual-based theories. Although it is impossible to create a theory that encompasses every reason and circumstance for which people choose to migrate, it is still possible to critique existing theories for their political and economic foci.

Neoclassical economic theories, for example, focus on wages and employment conditions, perceiving transnational movement as an individual decision based on the desire to maximize their income (Lewis 1954; Todaro 1980; Massey et al. 1993). While acknowledging the perception of the individual in this decision making, the ultimate focus is on the economy and the ways in which various nations— and not regions, cities, or states— may inspire movement through financial incentives and economic opportunities. Being economically oriented, this theory fails to acknowledge periods of crisis, environmental challenges, love, wars, or non-economic reasons for movement. According to Massey et al., this theory directly links immigration to state-oriented, modern industrial economies (1993).

Another theory that bridges the gap between the individual and the economic is the "new economics of migration" (Stark & Bloom 1985). This theory acknowledges the existence of non-labor markets and "views migration as a household decision taken to minimize risks to family income or to overcome capital constraints on family production activities" (Massey et al.

1993, 432). This micro-level consideration acknowledges that the individual is the decision maker and also places the individual within a cultural context. However, this theory does not acknowledge individuals operating outside of their own culture, individuals with limited family or friends, or people who choose to migrate without economic considerations in mind. This theory considers migration as permanently linked to economic globalization and the market.

A theory that attempts to address the issue of economizing migrant motivations is the microeconomic model of individual choice (Sjaastad 1980; Massey et al. 1993). This theory approaches migrant decision making as a form of cost-benefit analysis. This includes perceived costs of learning languages, traveling expenses, entering new labor markets, and the psychological burden of leaving a place of origin. The perceived benefits are some form of "expected destination earnings" over an individual-specific time period (Santiago & Borjas 1993; Massey et al. 1993). While focusing on the individual's role in migration, the theory fails to acknowledge instances of forced displacement or non-consensual human trafficking.

Within each of these three broad types of theories, there are hundreds of variants. In development studies, alone, additional migration theories include neo-classical equilibrium perspectives, historical-structural and asymmetric growth theories, mobility transition theories, social capital theories, chain migration theory, and network theory among others (de Haas 2009; 2010). The overarching framework of these theories places individuals within a literal, national border. Transnational, or transborder, movement is standardized through the economic framework with limited elaboration into sociological influences. Hein de Haas' new aspirations-capabilities framework theory, however, addresses this theoretical literature gap. In his study, de Haas argues that migration is a part of social change and that "macrostructural change shapes people's migratory aspirations and capabilities," which in turn influence their

migration journey (2021, 1). De Haas calls for conceptualizing "migration as an intrinsic part of broader processes of economic, political, cultural, technological and demographic change" (2021, 12). This theory is an example of a small group of migration-related scholarly work challenging economic and state-centric conceptions related to migration.

A majority of migration theories are focused on trans-economic and trans-border movements (Massey et al. 1993). However, a majority of the world's migrants are internally displaced peoples who operate outside of the frameworks of the dominant border-focused migrant theory. The current literature thus focuses on the systems of operation and the experiences of those within destination countries (Sweileh et al. 2018). This focus creates a gap in knowledge acquisition regarding internal movements, migration in transit countries, and transit destination countries.

A destination country is a state or regional body that is the intended or accidental location for a person who has left his or her home country or country of origin. Likewise, a transit country is a country or region that people travel through with the intent of reaching a different location. A country or region may assume the status of a transit-destination country if there has been an event— such as a shift in public policy, regional conflict, or environmental change— that influences the ability or desire of people with migrant status or mobile tendencies to enter, travel through, and exit the country or region. With the internationalization of migration and the emergence of externalization policies across the southern borders of the EU and the USA, a new category of country has emerged: transit-destination. This category refers to a state or regional body that assumes the characteristics of a destination country as an accidental host, while also maintaining migrant flow to the destination country (Papadopoulou-Kourkoula 2008, 5). These types of locations are important to differentiate not only for the sake of theoretical,

scholarly categorization but also because national and international border policies are based on the movement of people to, from, and within states.

It is almost impossible to ignore the consequences of borders, and thus the states that enforce these borders, when discussing migration. The nation-state exists, borders are protected, and human bodies are politicized and securitized by the assumed threats and benefits they impose on transit, destination, and transit-destination nations.

*The EU created the current migration framework*

The importance of borders in the field of international relations, political sciences, and migration studies has drastically changed over the last 80 years. These transitions— beginning with World War II and continuing until the post-Arab Spring present day— can be divided into five phases. The first phase, from 1948 to 1961, featured large scale South-North and East-West migration as a devastated Europe sought to rebuild after World War II. Years of conflict created a near ideal neoclassical employment gap, with severe labor shortages in France, Belgium, the Netherlands, Germany, Luxembourg, Switzerland, and Sweden, and severe unemployment in Spain, Italy, Greece, Turkey, and the Maghreb (Van Mol & de Valk 2016; 31-35). Prior to WWII, labor movements tended to be from neighboring countries, but, following the creation of new labor opportunities, international migration spiked tremendously (Massey et al. 1993, 431). What is more, many western European nations actively recruited foreigners to work on temporary visas. During this time, concepts of borders represented jurisdictional inhibitions, but rarely prohibited the movement of migrants.

The formal recruiting period was between 1961 and 1973. The earliest European nations to create “zones of influence” did so through bilateral migration agreements with Turkey (1961),

Morocco (1963), Portugal (1964), Tunisia (1965), and Yugoslavia (1968). These agreements opened the door for more than 10 million labor migrants prior to 1973 (Ambrosetti & Petrillo 2017, 14). These mobility strategies contributed to the de-escalation of formally contentious East-West mobility and simultaneously legitimized labor migration. This legitimization, however, was quickly politicized as reconstruction projections concluded and the need for a large influx of migrants gradually waned in the mid-70s.

From 1973 to 1995, the continuous presence of immigrants across Europe shifted focus. Most of the original bilateral migration agreements— though focused on temporary or seasonal labor migration— included stipulations for family reunification (Van Mol & de Valk 2016, 35-38). Following a "new economics of migration" schema, millions of North African, Italian, Greek, and Iberian families permanently migrated to more economically-resilient parts of Western Europe. This demographic transition was accompanied by a drastic change in Europe's economic conditions, and thus in migration policy (Attinà 2018; 51). The 1973 Oil Crisis and the 1979 Energy Crisis brought rising oil and energy prices and created high rates of unemployment in Western Europe. Politicians advocated for tighter migration policies and caps on how many people would be accepted in each fiscal year. These European nations, which had opened their borders for the previous 40 years, hosted millions of Mediterranean families, and represented a significant job-providing destination block, gradually became "off-limits" (Ambrosetti & Petrillo 2017, 16).

The fourth period, between 1996 and 2010, saw an oscillation of pro-mobility and constrictive migration legislation. After Europe economically recovered, there was increased demand for agricultural, small retail, and construction laborers. Young people who had grown up in economies hit hard by the previous decades of poor oil and gas prices embraced this new

political atmosphere, and hundreds of thousands of people migrated to Europe. With more constrictive policies, however, there was an uptick in clandestine, or paperless, crossings, that accompanied registered labor workers. This pattern grew substantially after the 2008 economic crisis (Van Mol & de Valk 2016, 45-48). Borders were tightened, migration was limited, and yet people still traveled to Europe in search of work.

The final period of migration begins with the Arab Spring protests of 2011 and extends to the present day. All across North Africa and the Middle East, hundreds of thousands of people advocated, rioted, and demonstrated for anti-corruption policies and democratization transitions. Large scale institutional instability contributed to large-scale economic and political migration and the eventual escalation of large-scale refugee movements from the Syrian Civil War. Responding to this sudden influx of migration and the change in institutional capacity, "North African states' abilities to exert socioeconomic control [of migration were] acutely affected the dynamics of regional and international migratory flows" (Ambrosetti & Petrillo 2017, 17). The increased migration and decreased capacity of border states during the period of political instability created a more heavily involved EU approach (Del Sarto 2016, 220). The decade became marked by the European Union adapting Official Development Assistance (ODA) strategies to allocate hundreds of millions of euros of migration-oriented grants and programmatic aid to various governments in North Africa.

It is from this most recent development that the securitization of migration has emerged. As Attinà notes, it is from this demographic transition that the concept of the "age of migration" and the subsequent phrase, the "management of the migration crisis" emerged (2018; 50). Consequently, Attinà's work describes what Hein de Haas calls the "myth of invasion," or the political consequence of obtuse, anti-immigrant rhetoric that led to increased externalization of

migration in third-border countries (2008). The consequences of this increased EU-externalization is the creation of a new standard of othering— consequently meaning that the image of the immigrant has become innately negative and the concept of "migrant" no longer describes a single person, but a large, threatening mass of Africans. Self-cycling media, such as the satirical publication of MarocHebdos' *LE PÉRIL NOIR (The Black Peril)* in 2012, contributes to this false image. The concept of the threatening migrant wave continues when "political leaders make no timely, effective and legitimate decisions to both manage the migrant entry and influence the citizen perception" (Attinà 2018, 52). The subsequent lack of infrastructure and legislation contributes to the "myth of invasion," as the citizens of host-countries perceive that their cities are insufficiently prepared for increased immigrant populations. The anti-immigrant rhetoric gets recycled, and public leaders search for cheaper and more effective off-shoring of migration control, which produces a whole system of externalization.

*Declarations, Conventions, and Human Rights Promises regarding healthcare*

The externalization of migration is checked by international declarations, conventions, and human rights promises (Betts and Collier 2017, 211). European bodies operate within these systems to justify their migration response. Human rights doctrine such as the Universal Declaration of Human Rights (UDHR), the Universal Declaration of the Rights of the Child, and the 2018 Global Compact for Migration (GCM), represents some of the responsibilities and ethical imperatives that a government has to incorporate into their migrant response.

According to the UDHR, migrant rights are individual human rights that are enforced by state bodies. Because people are people no matter their affiliation with government paperwork,

every Article within the UDHR is important to the rights of people with migrant status. Articles 13, 14, 15, and 23— which respectively state that all people have the right to freedom of movement both within and between countries, that everyone has the right to asylum, that everyone has the right to a nationality, and that everyone has the right to work— define four of the most essential rights to people with migrant status. Likewise, Article 25, which states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family…." (UDHR 1948, 7), and Article 26, which relates to access to education, are important to the rights of migrants and directly related to the responsibility of governments to provide adequate public service systems.

In addition to the UDHR, the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention relating to the Status of Refugees and the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families are crucial for the foundation of migrant protections. Of all these legal documents, one of the most recent and most well-known is the Global Compact for Migration (GCM). Overall, the compact:

1. aims to mitigate the adverse drivers and structural factors that hinder people from building and maintaining sustainable livelihoods in their countries of origin;
2. reduce the risks and vulnerabilities migrants face at different stages of migration by respecting, protecting and fulfilling their human rights and providing them with care and assistance;
3. addresses the legitimate concerns of states and communities, while recognizing that societies are undergoing demographic, economic, social

and environmental changes at different scales that may have implications for and result from migration;

4. creates conducive conditions that enable all migrants to enrich our societies through their human, economic and social capacities, and thus facilitate their contributions to sustainable development at the local, national, regional and global levels (GCM 2018).

Different countries have responded to this document in different measures. In Morocco, for example, King Muhammed VI ratified the document and made numerous public statements to support the document's claims of being

> ...grounded in values of state sovereignty, responsibility-sharing, non-discrimination, and human rights, and recognizes that a cooperative approach is needed to optimize the overall benefits of migration, while addressing its risks and challenges for individuals and communities in countries of origin, transit and destination (GCM 2018, 3).

Subsequently, Morocco released the *Global Compact for Migration: Morocco's Migration Policies and the Global Compact for Safe, Orderly and Regular Migration* in 2019. The purpose of this document was to support the strengthening of institutional cooperation and the improvement of complaint and redress mechanisms— with particular focus on the National Human Rights Commission (CNDH), to build the capacities of Morocco's public administrations and civil society organizations to prevent and address racism and xenophobia against migrants, and to support sensitization and awareness-raising of the media and the general public. The

report also presents Morocco's accountability and adherence to the principles and guidelines of the GCM.

Despite the commitments of signatories and ratifiers of these conventions, very few nation-states are legally bound to uphold the principles of the documents they sign (Cole 2015). These "guidelines" thus shape the realm of politicians and international negotiations long before they shape the daily life of people with migrant status or non-political communities, if at all.

*Governments' Roles in the Rights to Health*

Of the many rights promised by the UDHR and its successors, one of the more ambiguous concepts is the right to health. Health is intersectional and vast. It incorporates mental, physical, social, and emotional health, which are each affected by factors such as racial tensions, housing, access to medicine, and language usage. The broadest way to describe human health is through the system under which the individual operates. As nation-states create the system in which most people live, work, travel, and die, this draws attention to the role of that system and of the governors in promoting the many facets of health.

At a national level, General Comment 14 of the Committee on Economic, Social and Cultural Rights explains that, in relation to health as a fundamental human right, a nation-state's central government violates its obligation to respect a person's rights when its "actions, policies or laws… are likely to result in bodily harm, unnecessary morbidity and preventable mortality" (2000, 17). The General Comment adds that "the denial of access to health facilities, goods and services to particular individuals or groups [is] a result of de jure or de facto discrimination" (2000, 17). For both citizens and people with migrant status, this standard of respect for human rights extends to the availability, accessibility, acceptability, and quality of health goods and

services available in any given country and incorporates protections for underlying determinants of health (Carmalt 2014).

Carmalt further defines the obligations of the state as: “the obligation to respect, or refrain from interfering with health (directly or indirectly)... to protect the health of populations against third party actions, and… to fulfill the right to health by implementing measures that will ensure that residents achieve the highest possible standard of physical and mental health” (2014, 43) By expanding these obligations to include not only “residents,” but also all people, public policy and migration law would more diligently reflect dignity and equality among migrant populations.

The government's role is also to promote the highest attainable standard of health. Following these standards, governments are then responsible for the “prevention, treatment and control of diseases and the creation of conditions to ensure access to health facilities, goods and services required to be healthy” (Braveman 2003, 540). Under the Western concept of indivisible and interdependent rights, governments are thus held accountable for improving human health and increasing access to care among all people groups (Cole 2015). Since health is both a biological and a social phenomenon, this includes access to education, safe work conditions, freedom from discrimination, and other health-related human rights (Braveman 2003). However, the stipulation of the ‘highest attainable standard’ of health allows for governments to claim that they lack adequate means, and thus the responsibility, for providing basic services (Chapman and Russell 2002; Forman et al 2016). This loophole in human rights doctrine allows for hundreds and thousands of people to fall through legislative gaps.

There are numerous international, intraregional, and local bodies whose primary purposes are to document violations of these rights, close up loopholes, and hold all forms of persecutors

accountable. Amnesty International, Human Rights Watch, and the UN Special Rapporteur are examples of non-state accountability mechanisms. The organizations are defined by their commitment to recording and responding to the actions of centralized governments and the various actors working under them. Under these mechanisms, different governing bodies are expected to acknowledge and respond to the needs of migrant populations at different degrees. These different degrees are attributable to the type of population, the population's perceived needs, and the capacity of the government or state body in response (Fisher 1999, 83; Falk 1999, 124-125). These traits and needs are represented though categorization, which includes the people groups of refugees, asylum seekers, undocumented migrants, seasonal or temporary labors, stateless peoples, and historically nomadic peoples. Each of these categories requires a specific level of assistance and protections from governing bodies.

Refugees receive the highest level of international institutional support (Ormsby 2017). This category describes individuals who are "unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (Convention Relating to the Status of Refugees 1951). International customary law dictates that states be held responsible for defending the right to non-refoulement, or the right not to be removed to a country where lives and freedoms are at stake, protecting families, respecting the unity of a family, and providing a certain level of welfare services. In multi-generational refugee crises, such as those of the Palestinian communities in Jordan or the Sahrawi refugees in Algeria, the state has a different function than in more acute refugee crises, such as the Yemeni and Syrian refugee crises. While the performance of rights protections varies, refugees are protected under both international law and international customary law.

The second level of protection which focuses on migrant rights tends to be less international and varies from state to state. For many countries, seasonal labor is protected by national law and, in instances such as Morocco and Spain, labor migrants' rights are protected by specific legislation between the two nations. However, because seasonal migration is often irregular, many states prosecute individuals who seek work outside of the specifically designated and legislated seasonal labor process (Greene 2018; Caballero-Anthony 2018). This level of protection, or un-protection, is similar to that which is accorded to asylum seekers. Asylum seekers, such as the many Congolese and Cameroonian migrants in Tunisia, are often individuals who have been displaced from their place of origin by violence and are in the process of applying for refugee status. Because not all claims are granted, asylum seekers have limited protections and are in legal limbo until their status is addressed.

Less protected peoples are undocumented migrants, stateless persons, and historically nomadic groups. Each of these groups lack institutional recourse or services that state infrastructure may provide. For nomadic groups, such as the Maasai people of central east Africa, the Quechua of western South America, the Misseriya of the Sudan, and the Roma of Europe, mobile living has often been frictional to sedentary legislation and nation building. As transnational migrants, nomadic groups lack centralized protections and are thus vulnerable to the varying territorial laws that the countries through which they pass may choose to enforce. Stateless persons, or people who are not considered citizens by any country, lack similar institutional protections and face paperwork and legal challenges in territories through which they pass (UNHCR n.d.). Lastly, undocumented migrants lack institutional protections and have limited access to legal recourses, but they are often persecuted by the states where they are living and working, through which they are traveling (Weissbrodt & Collins 2006).

A person's relationship with the state in which he or she resides determines their status. Institutional practices that are designed to protect and support a nation's citizens prior to serving the needs of outsiders politicize and securitize human bodies. The inherently state-based definition of a person's rights, in addition to the international and interregional weight of migrant rights treatises, declarations, compacts, conventions, and international accountability mechanisms, contributes to the politicization of the sphere of migration.

*Politicizing Migration*

The complicated status of migrants and refugees in today's world is shaped by the policies written at both international and state levels. International refugee conventions that emerged after the atrocities of World War II showed the world what happens when international customary law fails to pressure states into intervening for human life. These customary laws are implemented by national-level entities (Cole 2015). It is from this origin of failure of accountability that migration, and its many facets, became political at the state level.

For nation-states, unusually high levels of emigration may indicate some form of internal or intra-regional catastrophe, such as war, drought, persecution, or economic disaster. The failure of a state to provide its population with security or basic political goods is often perceived as a failure of those in power, more than a failure of the system within which the powerful operate (Brooks 2005; Rotberg 2003). When people flee across borders and become international migrants, receiving nations are placed in an unequal power dynamic, and suddenly, the political relationships developed between the two (or more) states become brittle. Human beings, rather than trade commodities, become the political pawns that allow for a different style of negotiations to emerge between the sending and the receiving country.

An example of the *politicization* of migration can be seen in the 2020 refugee crisis between Ethiopia and Sudan. Following an Ethiopian government attack on the Tigray Region of Ethiopia by the Ethiopian military, more than 62,000 Ethiopians fled to eastern Sudan as of April 1, 2021 ("Ethiopia" 2021). Whereas the previous political contention between the two countries was the Ethiopian Grand Renaissance Dam, the refugee crisis allowed Sudan to use human beings and humanitarian assistance as a bargaining chip with the Ethiopian Government, giving Sudan some political weight in succeeding dam talks (Manek & Kheir Omer 2020). The act of using human beings as political tools not only dehumanizes people but directly impacts the negotiations of which government is responsible for protecting and promoting access to healthcare, food, water, and shelter. Refugees no longer become people, but strategic pawns.

Migration is also politicized on an intra-community and intra-personal level. In the United States, for example, Haitian migrants are associated with the spread of HIV/AIDs. During the 1980s, this stereotype shaped the way in which US foreign policy affected the country of Haiti and the people who were attempting to migrate to Florida and other southern states. At the community level, the stereotypes made it more difficult for Haitians and people of Haitian descent to live within the United States and build their communities. The stereotypes affected access to healthcare, housing opportunities, and access to education, and political participation (Santana 2000).

Because migration is politicized at multiple levels for multiple reasons, and securitized when it gains national relevance and international consequences, it is important to take an intersectional approach to its study. Migration studies demand the examination of the community, national, and international engagement with migrant communities *and* a study of the journey of migration, integration, and social formation of people with migrant status. Morocco is

an excellent case study to demonstrate how EU externalization politicizes migration and securitizes health. The migration dynamics within the country have been directly affected by EU policies and health securitization, especially during the pandemic. With tens of thousands of people from half a dozen countries, Morocco has transitioned from a transit nation, or one that facilitates movement between countries, to a destination state, or a country where people end their migration journey. By analyzing the role of the state, utilizing various migration theories, and pursuing an intersectional approach, this study will also examine how the securitization and politicization of migrant bodies affects access to healthcare for people in Morocco and how this internationalization affected access to state-provided healthcare during the coronavirus pandemic.

# Chapter 2:

## Migration in Morocco, International, Intraregional, and Domestic Frameworks

### *Securitizing Migration*

Securitization is an evolution of the complex facets of politicization. From a social-psychological perspective, groups of people become politicized when they "intentionally engage, as a mindful and self-conscious collective (or as representatives thereof), in ... a power struggle knowing that it is the wider, more inclusive societal context in which this struggle takes place and needs to be orchestrated accordingly" (Simon & Klandermans 2001, 454). However, the accuracy of this perspective requires that groups of individuals have the ability to organize in collective, politically-minded groups, and that there is a capacity for political participation. For many immigrant communities with a larger population of undocumented individuals, the ability to form politically active groups is hampered. Thus, it is difficult for politicization to be considered an automatic or independant action— politicization must come from an external source. Simon and Grabow, discuss politicization at a systematic level, stating that "politicization, then, involves political means and ends that may be more or less conventional but nevertheless stay within the limits of general normative acceptance in the larger polity" (2010, 718). Under this premise, the politicization of migration becomes a society-level process.

Eisenfeld takes a similar perspective to Simon and Grabow, but argues that politicization is relative to power and influence. Eisenfeld argues that one type of politicization that directly affects migration, as understood within international relations, is "top-down" (2017, 83-84). This term stresses the primary importance of policy makers in determining political conclusions. It implies that politicization of an idea, group of people, or object, occurs from a position of power. Factors that might influence actual or perceived politicization include negative or positive media

attention, the activity of political lobbyists, or public discourse on the subject. Under this preface, and in contrast to the social-psychological perspective, politicization becomes a system, a framework of operation, in which individuals are politicized by external actors. These politicized individuals must operate within artificial systems that contribute to inequitable power structures and a lack of representation.

Almost all people with migrant status inadvertently operate within these systems throughout their journeys and during their stays in host countries. Mass movements of migrants across national borders are associated with public discourse, and political leaders attempt to leverage opinions of migration to their own benefit. When migration is politicized at a systemic level, legislation and national interests are influenced by people (or groups) in power who address immigration.

It is only when migration has become politicized that it is then possible for it to become securitized. According to Buzan et al., securitization is "an extreme version of politicization that enables extraordinary means to be used in the name of security" (1998, 25). Ole Waever expanded this concept by introducing the concept of speech acts (or, uttering security) and modalities (threat-defense security) (1993, 51). Speech acts securitize objects, peoples, or concepts by "declaring" and existential threat. This type of securitization is thus defined as:

> [A] speech act where a securitizing actor designates a threat to a specified referent object and declares an existential threat implying a right to use extra ordinary means to fence it off. The issue is securitized— becomes a security issue, a part of what is security— if the relevant audience accepts this claim...

The securitization of a concept through a speech act is an inherent abrupt, or isolated event (Robinson 2017, 506). As Kelle points out, for a concept to be securitized, it must be targeted by a securitizing actor, it must be the object of securitization, and there must be an audience that either rejects or denies the existence of the securitization (2011, 218).

Aside from refugee crises, acts of migration are generally prolonged periods of human movements that allow for political discourse to emerge and societal interactions between migrants and non-migrants to evolve. Because of the evolving nature of migration, Waever's concept of speech acts cannot fully describe its securitization. According to Robinson, theories that best describe migration have considered, "securitization as an iterative and dynamic process" that adapts with time (2017, 506). Securitization is thus a distinctive reflection of the relevant actors and the political system in which it emerges. For trans-Mediterranean migration, the securitization of migrant-response programs and its various forms reflect EU involvement.

*Externalizing Migration*

Eisenfeld's assertion that top-down influences politicize migration and Kelle's description of the traits of a securitized body suggests that one of the causes of the politicization and securitization of migration is EU-externalization policies. These policies are Euro-centric (Kramsch 2011) and fail to create equitable bordering responsibilities and relationships between the EU and their African counterparts (van Houtum & Boedeltje 2011; Del Sarto 2016; Cuttitta 2020). Within the Maghreb, EU-externalization and the relationship between migration management, Official Development Assistance (ODA), and security personnel dehumanizes migrants and essentializes migrant bodies as tools for political manipulation.

Externalization, or the out-sourcing of migration control, has transformed externalized nations, including Morocco, from the passive receiver of ODA, to an active participant in the securitization of the EU's Mediterranean borders (Casas-Cortes et al 2014). This large scale externalization process has been collectively called "Fortress Europe."

The name "Fortress Europe," as described by journalists Kenan Malik, is "The quid pro quo for Schengen… a citadel against immigration, watched over by a hi-tech surveillance system of satellites and drones and protected by fences and warships" (2018). The "Fortress" describes how the EU's immigration strategies actively externalizes the financial and physical borders intended to keep out immigrants from European soils to nations across the Mediterranean. Using a three-pronged strategy of "criminalising migrants, militarising border controls and externalising controls by paying non-EU states" (Malik 2018), the EU thus presents migrant bodies as a securitized threat. Paying non-EU states, specifically, is one way in which the relationships between payments (in this case through Official Development Assistance (ODA)), migrant populations, and health can be analyzed.

Since 2014, Morocco has received more than EUR 174 million in ODA through *just* the EU Emergency Trust Fund for Africa (EU TF for Africa) for the purpose of "improved migration management" (EUTF for Africa 2021). This money directly funds 19 national and local institutions within the country and supports 7 different projects:

- "Support for the actions of the Moroccan authorities against networks facilitating irregular migratory flows" (funded by the EU Emergency Trust Fund for Africa, EUR 101,750,000)

- "Support for integrated border and migration management in Morocco" (funded by the International and Ibero-American Foundation for Administration and Public Policies, EUR 44,000,000)
- "South-South cooperation on migration" (funded by German Society for International Cooperation, EUR 8 613 500)
- "Deployment of Migration Policies at Regional Level" (funded by ENABEL, the Belgian Development Agency, EUR 8,000,000)
- "Living Together Without Discrimination: Human Rights-based approach with a gender dimension" (funded by the Spanish Agency for International Development Cooperation, EUR 5,500,000)
- "Assistance to migrants in vulnerable situations" (funded through the EU Emergency Trust fund for Africa, EUR 6,500,000)
- "Legal Empowerment of Migrants" (funded by ENABEL, the Belgian Development Agency, EUR 4,580,000)

In 2019, EUTF for Africa funds represented 12.4% of all EU funding for Morocco. This does not account for bilateral migration agreements or for migration-oriented funding that is not streamlined through EUTF for Africa. According to the European Court of Auditors, between 2014 and 2020, the majority of Morocco's EUR 1.4 billion of annual aid was earmarked for the sectors of social services, rule of law, and sustainable growth. Within these categories, the auditors found that the European Commisions had "not allocated funding to sectoral programmes using a transparent method and coordination of donors amongst the sectors was uneven" (ECA 2019). Additionally, between 2014 and 2018, EUR 266 million was classified as unallocated ODA. The relationship between unallocated ODA and general funding for migration in Morocco

from the EU is important because the financial analysis conducted in this research demonstrated that, between 2009 and 2017, 88% of the variance in unallocated ODA received by Morocco from the EU is attributable to irregular border crossings. Given that the p-value for this correlation was p= 0.00017, there is a 99.983% chance that the correlation was not random and that there is a direct relationship between unallocated ODA and the European Union's response to irregular border crossings. It is through this unallocated ODA, in addition to the earmarked programs and funding channels, that migration is externalized in Morocco.

The interpretation of this information has historical premises, as Morocco is not the only country that receives EU ODA for the purpose of migration management (Smith 2019, 128). Since 2011, the EU has imposed the "externalization of migration controls on Tunisia by linking effective 'migration management' to the substantial financial assistance provided by the EU to Tunisia" (Badalič 2019, 87). In 2016, likewise, the EU transferred 6 billion euros to Turkey to close migration routes in the Aegean Sea region and to prevent Syrian migrants from entering Europe (Ambrosetti & Petrillo 2017, 26). Migrant bodies have also been used as a political tool in the Arab World. In 2010, towards the end of Omar Gaddafi's rule in Libya, migrants were used as a political pawn; Gaddafi demanded 5 billion euros of EU funds to prevent migrants in Libya from crossing the Mediterranean. Gaddafi notoriously threatened, "tomorrow Europe might no longer be European, and even black, as there are millions who want to come in" (BBC 2010). Smith describes the funding of immigration prevention within transit nations as "cash for kettling" (2019, 128) He points out that the EU has negotiated "immigration conventions" with Ethiopia, Nigeria, Niger, Mali and Senegal— five nations that serve as origin and transit nations.

Within the Maghreb, African nations are also beginning to externalize their migration. In 2018, Algeria implemented Law 08-11 and formed a formal relationship with the Nigerien

government to regulate the travel of foreigners entering and residing in Algeria. As Niger is one of the key smuggling routes along the Central and Western Mediterranean Route, Algeria is working with the International Organization for Migration (IOM) and the Nigerien military to enforce stricter migration laws (which they have done so by enforcing Nigerien Law 2015–36) (Fargues et al 2020, 5). By preventing migration on the southern border, Algeria decreases movement from its northern port cities to the EU or other Maghrebi nations. This decrease makes Algeria's own EU-funded immigration programs appear to be more successful.

One of the issues with this policy, despite the stipulations of international law, is repatriation. Internationally-supported, legal repatriation requires that individuals be granted proper and thorough review of their immigration documents prior to their deportation from any country. Once deported, people with migrant status must be provided safe, free transportation to their country of origin. Despite, or perhaps, because of the EU's externalization programs, people who have been intercepted in their travels have been systematically denied legal access to repatriation across the Maghreb. In Algeria, multiple news organizations have reported that at least 30,000 individuals— instead of being repatriated— have been abandoned without food, water, or cell phones in the Sahara Desert (McCarthy 2018; "Report: Algeria," 2018). Thousands of people have died or are currently missing. In Morocco, the vast majority of improper repatriation cases occur from the Spanish enclaves of Ceuta and Melilla. The only European settlements within Africa, the enclaves are a hotspot for undocumented border crossings and the migration attempts that are made there are the basis of Isabella Alexander-Nathani's book,

*Burning at Europe's Borders.*

In describing both "Fortress Europe" and overall externalization practices, Alexander-Nathani states that the "EU has skillfully exerted pressure on Morocco to amend its immigration policies, strengthen its own borders, and sign agreements leading to the illicit "repatriation" of thousands of African migrants" (2020, 27). This statement is supported by the 2013 MSF report, *Violence, Vulnerability, and Migration: Trapped at the Gates of Europe* which states that as "the European Union has increasingly externalized its migration policies,… [and] the longer sub-Saharan migrants stay in Morocco, the more vulnerable they become" (2013, 3). The report also states that migrants are subjected to policies and practices that exclude, neglect, and actively discriminate against them (2013, 4).

By preventing migration along the way, before it ever becomes an issue with Mediterranean-bordering countries, this "wall of money" is securitizing human bodies throughout central and north Africa (Smith 2019, 128). North African and West African nations are dependent on the EU-funded aid that continuously promises development assistance in exchange for the securitization of migration.

*Internationalizing Migration*

Much of the legislative work and 'paper development' that Morocco has published regarding migrant rights and protections reflects its intra-regional political relationships. In 2017, King Muhammed VI gave a speech during the African Union (AU)'s African Agenda for Migration. The speech suggested that the AU could

1. Set up an African Migration Observatory to develop observation and information exchange between African countries in order to promote controlled management of migration flows.

2. Use this new program and position to inform and apply the process of developing the then-new Global Compact for Safe, Orderly, and Regular Migration (IRES 2018).
3. Create a position of African Union Special Envoy for Migration, who would be tasked with coordinating AU policies in this area ("HM the King" 2018).

Following this speech, Morocco was named the AU Special Envoy. The country has now been praised as one of the most migrant-friendly African nations.

Another regional commitment from the government of Morocco was the proposed creation of an "African Alliance for Migration and Development" during a UN High-level Dialogue on International Migration and Development in 2013 ("HM the King" 2018). Although Morocco was phased out of the program by 2017, the main goals of this program were:

1. Promoting better coordination and cooperation between African countries on migratory matters
2. Sharing national expertise and best practices on migratory governance
3. Integrating migration into national and sectoral development plans of member nations ("Migration Profile: Morocco" 2016).

The African Development Bank's Migration and Development Fund (MDF) is another regional initiative that includes Morocco, along with five other countries. The MDF, whose goal was to "explore ways and means of mobilising migrant resources and using them in the best interests of the recipients and [the] migrants themselves, as well as in the service of the development of the recipient countries" granted 1.4 million euros for migration development ("Success Story" 2019).

At a regional level, thus, the politicization of migrant legislation has enabled members of the Moroccan government to gain political positions with the AU and has brought in non-EU development funds.

On an international level, since 1960, Morocco has signed 11 labor mobility agreements with Germany, France, Belgium, the Netherlands, Spain, Italy, Libya, Qatar, Iraq, Jordan, and the UAE (Kingdom of Morocco 2018, 28-29). But the 2013 Mobility Partnership Agreement (MPA) with the European Union has arguably had the greatest impact on Moroccan migration policy. This Agreement was designed to "establish a set of political objectives and provides for a series of initiatives which… ensure that the movement of persons is managed as effectively as possible." The language of this policy is a reflection of Morocco's status as a third-country party in migration management. This third-country party status is influenced by the geopolitical significance of the two Spanish enclaves, Ceuta and Melilla, within Moroccan borders, and the 15 km distance between Morocco's northern cities and Spain's southern border across the Strait of Gibraltar (Kingdom of Morocco 2018, 39-41; Seymour 2019).

For regularized migrants, the MPA promises negotiations between the EU and Morocco to assist students and business professionals, as well as select other groups, to obtain visas. Other objectives for this Agreement have been to "improve the information available to qualified Moroccan citizens on employment, education and training opportunities available in the EU …. to make mutual recognition of professional and university qualifications easier… [and to] support the integration of Moroccan citizens who regularly visit an EU Member State" ("Migration and Mobility Partnership," 2013).

For unregularized migrants who have successfully crossed Morocco's northern borders, survived the trip across the Mediterranean, and arrived in Europe, these negotiations are

designed to assist in the return of people who lack proper documentation. Likewise, the Agreement states that "the EU and Morocco will work together in order to combat the smuggling of migrants and trafficking in human beings and to provide assistance for victims of these crimes…. [and] ensure that Morocco can establish a national asylum and international protection system" ("Migration and Mobility Partnership," 2013). As a byproduct of the MPA and increased advocacy from Spain, the European Neighbourhood Instrument (ENI), the EU Emergency Trust Fund for Africa (EUTF Africa), and the Development Cooperation Instrument (DCI), as well as other institutions and programs, there have been more than 232 million euros have been invested in 27 programs across Morocco. The foci of these programs have been:

1. Socio-economic integration of migrants
2. Governance of migration policies, institutional support, and capacity-building
3. Protection, resilience, and the rights of migrants
4. Migration management, border management, and mobility
5. Fighting against migrant smuggling and human trafficking ("Success Story 2010")

Within Morocco, these EU-supported programs have sponsored the creation and development of entrepreneurship projects and cooperatives among refugees. Programs like *Work4Integration Morocco*— whose goal is to assist in the economic integration of migrants through access to self-employment— have enacted government initiatives to strengthen the implementation of national migration laws. EU funding also has supported the creation of the Mediterranean City-to-City Migration Profiles, the Euromed Migration IV, and the Facility for Migrant Protection and Reintegration in North Africa. Overall, the funding has increased focus on the discussions and policies of South-South migration and integration.

Additional social development assistance in the form of EU-funded programs has also contributed to the dismantling of cross-border smuggling networks involved in the human trafficking of individuals in multiple North African nations ("Success Story" 2010). It has been claimed that these initiatives, programs, and international cooperatives have reduced irregular crossing attempts from Morocco to Spain by 93% between 2004 and 2015 ("Forward Defense 2015"). For Morocco, one of the main incentives to foster EU-Maghrebi relations and implement externalization policies is the desire to ensure stable trade between the EU and Morocco and to gain political support for Morocco's hegemonic control over the Western Sahara.

*The Western Sahara and the Western Mediterranean Route*

To understand the significance of the Western Sahara within Moroccan politics, one must review the colonial histories of the region. Between 1912 and 1956, the northern half of Morocco was a colony of France. The southern half of the country was colonized by Spain. These "zones of influence" serve as the outline for modern Morocco and the controversial southern territories of the Western Sahara. After gaining independence from France in 1956, these colonial divisions contributed to decades of conflict between Morocco's north and south.

As is, one of the most continuous political contentions in Morocco is the Western Sahara. Much of Morocco's international and interregional policies are influenced by the balance of political and economic power in regard to the southern half of Moroccan territory. Algeria, which was once also a French colony, has been accused by the Moroccan government of funding the activities of the Polisario Front. This political group is composed of Western Sahara nationalists who have claimed the right of self-determination for the Western Sahara. Morocco denies that the Western Sahara has the right to self-determination, and Algeria's funding of the Polisario

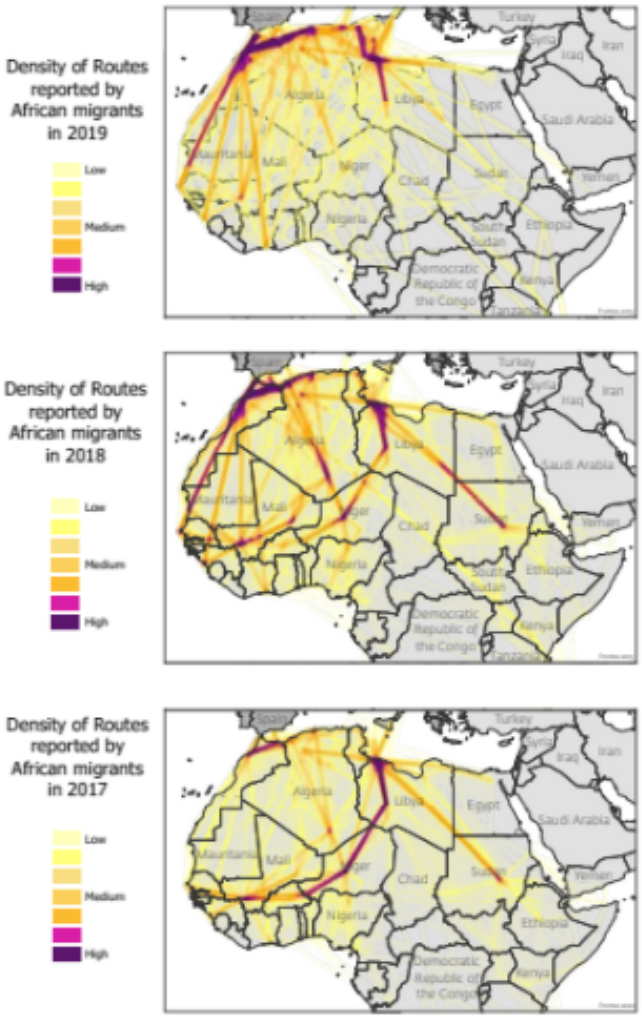
Front pits the two countries against each other in the tertiary field of the Western Sahara. Because of these long-standing political tensions, international economic partnerships and financial aid between the two countries has become politicized. Thus, the fields to which EU-associated aid contributes— such as border control, integration policies, and security— also become politicized and securitized as both countries fight for regional influence in the Western Sahara.

Morocco is also a key geopolitical player on a different front— the Western Mediterranean Route (WMR). The WMR describes the path that individuals from West Africa follow from their country of origin, to the western Mediterranean, to Europe (Alexander-Nathani 2017; Papadopoulou-Kourkoula 2008; Smith 218). Thousands of individuals attempt to cross the Mediterranean through Tangier, Tetuan, Oujda, and other northern cities in Morocco. However, because of Morocco's proximity to the European Union and recent EU-externalization policies and changes in EU-Moroccan funding, there have been increased border-security measures (Valdivia 2018). These measures have increased the presence of security forces throughout the country and led to extra-judicial actions to mediate migration, leading much of Morocco's funding to be funneled into regional security and the control of the Moroccan coast.

As demonstrated in Figure #1, Morocco is a key destination for migrants, and thus a target of externalization funding (Frontex 2020, 50). Following political and humanitarian challenges in the last three years, there has been a substantial shift in how and where people attempt to reach Europe. As relations between Libya and Italy shift and the Central Mediterran Route becomes more difficult, for example, more people have sought access to Europe through the WMR. The changing demographics have resulted in changing ODA and the securitization of migration and migration funding. A vast majority of this funding stems from the European

Union, as well as numerous other international organizations and independent governments. These organizations and institutions have signed budgetary support programs to securitize Morocco's northern border. Through these programs, more than 35 million euros have been allocated to the improvement of the implementation of Morocco's interception and detention policies (Frontex 2020, 75-76). For Morocco, the relationship with Europe is very important to keep balanced and the ability to monitor the border and to help regulate migration has allowed for Morocco's relationship with the EU to earn "Advanced Status Partnership." This special status "affords the country certain economic and political advantages when working with EU countries" (Seymour 2019).

Figure #1:
Migrant Routes, 2017-2019
Frontex 2020, 50




As a WMR country, the government of Morocco receives substantial funding from the European Union and international donors and has created numerous legislative acts with the benefit from the EU as a goal. This framework offshores migration responsibilities and "strengthen[s] a discourse that degrades the migrant 'other' and pushes their human rights to the bottom of geopolitical priorities" (André & Jacobs 2012, 7). The increased funding has also

made it more difficult for people with migrant status to travel through Morocco, which has led to Morocco becoming a transit-destination country. As more people are forced into conditions of liminality (Alexander-Nathani 2020, 213-214), more people are seeking social services, jobs, and housing in Morocco. This demographic transition as a migrant-hosting nation, had led Morocco to alter both its domestic budget, intra regional strategies, and relationships with the European Union.

On account of the increased use of the WMR and account of Morocco's regional policy on the Western Sahara, Morocco's EU aid is attributed to the securitization of borders along both the Mediterranean and the southern Western Sahara. Emeritus Professor Mohammed Boudoudou, one of Morocco's leading experts on migration, has stated that the EU "wants Morocco to act as its police dog, and Morocco accepted this role because it is still a poor country. It accepted this role in exchange for money, for protection, for the promise of development" (Alexander-Nathani 2020, 88). Morocco-EU relations are thus interlinked: if Morocco continues to limit migration into the Mediterranean, some aspects of the EU's financial assistance will find its way to the southern border to contribute to Morocco's negotiations with the Polisario Front. In this way, the securitization of migration through the externalization of migration response is an international policy tool that Morocco can use to gain economic support for its political domination of the Western Sahara.

*Domestic Policies and Strategies*

The pre-pandemic policies and laws that dominated Morocco's legislation emerged after the Arab Spring. In 2011, the socio-political movement spread throughout Iran, Egypt, Tunisia, and Morocco and placed the monarchies and leadership of the Arab World at a crossroads. Of the

22 states that constitute the Arab world, 4 governments were deposed, and others faced large-scale protests, riots, and civil wars. In Morocco, protestors took to the streets to demand political reform and the end of corruption, police brutality, and high unemployment. The February 20th Movement garnered so much national support that, on March 8, 2011, King Mohammad VI gave a televised speech to announce the revision of the constitution. Although many of the criticisms were that the new writers of the constitution were simply the new faces of old politics, the constitution was considered a resounding success. On July 1, 2011, a national referendum took place, and the new constitution received a 98% affirmative vote (André & Jacobs 2012, 6).

For members of the migrant community and the civil society organizations that presented migrant and refugee concerns, the new constitution seemed promising. The document, which promised to increase the mobilization of youth into politics, brought hope for the revitalization of human rights and the democratization process. However, despite its novelty, the Constitution did not fundamentally change migration law in Morocco (Haden 2020). The only part of the constitution which addresses foreigners in the country is part of the preamble, which promises:

> To ban and combat all discrimination whenever it encounters it, for reason of sex, of color, of beliefs, of culture, of social or regional origin, of language, of handicap or whatever personal circumstance that may be…(Maroc: Constitution. Preamble).

The Constitution formed the basis of Morocco's later laws and Law 02-03 was established by *dahir*, or royal decree, number 1-03-196 on November 11, 2003 (André & Jacobs

2012, 17). The law is the primary legislation that addresses the rights of all foreigners— from tourists to undocumented migrants to refugees— within Morocco. The Law begins by defining foreigners as "persons who are not Moroccan nationals, who do not have a known nationality, or whose nationality has not been determined" (2003, 1). Law 02-03 further states that all foreigners, whether they arrive by land or by sea, must be obliged to follow all of the subsequent rules and regulations of the country (2003, 2). Articles 5 through 20 dictate the reasons that foreigners might obtain a residence card versus a visa for work or education and the steps whereby these statuses must be observed and regulated in the context of time and changing regions (2003, 2-6).

Chapter III of Law 02-03 relates to the entrance and movement of foreign nationals in Morocco. Regarding both documented and undocumented migration, the article states that "the foreigner cannot justify having entered Moroccan territory regularly unless his situation has been regularized after his entry" (2003, 6). This regularization refers to the process through which a migrant gains status as a legal traveler, and it dictates how migrants are able to find legal work opportunities, education, and medical treatments.

*Regularization and its Benefits*

The Moroccan government, through the Office of Refugees and Stateless Persons (BRA) in the Ministry of Foreign Affairs and International Cooperation and the Inter-Ministerial Commission, works in tandem with the UNHCR to recognize refugees and migrants in a consistent process (Courtay & Mokadader 2019, 2) This regularization process allowed for 23,096 migrants to be regularized in 2014 and more than 28,400 migrants to be regularized in 2017 ("HM the King" 2018). Once migrants are regularized, various government organizations

like the Ministry of Moroccans Living Abroad and Migration Affairs are designated to provide advice and orientation to them at local levels ("HM the King" 2018). The National Committee Setup to Handle Migrant's Regularization Appeals and Grievances works as an auditing agency to reexamine the regularization applications pf those who were approved ("National Committee Set up" 2014). Although there have been reports that this regularization process is not efficient and that paperwork has been mishandled, the regularization process *exists* and offers a path to legal status in Morocco.

Regularization is one of the most important factors in the Moroccan migration system, as it allows for migrants to obtain an official ID. This process helps migrants to obtain free education and access to healthcare. These free educational and healthcare provisions are conducted in partnership with the UNHCR. However, with this partnership, the government is able to provide free public education to specifically *refugees* in Morocco (Courtay & Mokadader 2019, 3). The UNHCR does not address educational opportunities for asylum seekers, regularized migrants, or undocumented migrants. This creates a gap in institutional protections that local NGOs, such as the *Fondation Orient-Occident*, have attempted to remediate for all members of the migrant community.

Regarding healthcare, both refugees and people with documented and undocumented migrant status have legal rights to free consultations from public primary health centers. The UNHCR partners with the Moroccan government through organizations like the Moroccan Association for Family Planning (AMPF) to ensure that refugees and migrants are able to find available resources. For *refugees*, the national insurance medical system (RAMED) provides medical coverage for drugs, lab tests, and hospitalization (Courtay & Mokadader 2019, 3). For both regularized and unregularized migrants who do not have refugee status, medical attention is

supposed to be guaranteed under the 2011 Rules of Procedures of Hospitals (RPH). The RPH states that "non-Moroccan patients, diseased or wounded, are admitted in hospitals, irrespective of their administrative situation, under the same conditions as Moroccan patients" (Kingdom of Morocco 2018, 53). However, as becomes evident in the interviews introduced in the later chater, the RPH fails to address the payment of medical expenses and fails to account for medical bias, racism, and poor medical practices with regard to members of the migrant community. The varying levels of medical protection for members of the migrant community have affected access to care and trust within the medical system.

Outside of medical services, and for people with regularized migrant status, there is access to vocational training services through the National Mutual Aid, as well as the National Office of Vocational Training and Promotion of Employment (OFPPT). Foreigners in Morocco can additionally benefit from "self-employed" status and can create cooperatives, while migrants and refugees, irrespective of their formal administrative status, can join labor unions (Kingdom of Morocco 2018, 30).

*Deportations, Non-refoulement, and Protections*

Returning to the migration procedures described in Law 02-03, one of the major criticisms of this law is that it conditions residency permits for refugees on legal entry into Moroccan territory. These conditions directly contradict the Geneva Convention of 1951 (André & Jacobs 2012, 18). Another major criticism of the law is that it is relatively unknown and thus not followed by the police and border patrol units that are supposed to enforce its stipulations. Problems with the document also include the denial of entry and the return of the migrant, internal deportation— both immediate and delayed by an appeal before a judge— and temporary

bans or restrictions placed on immigrants who are charged with crimes of varying levels. These discussions are generally held when the regularization process has been denied on account of a lack of identifying documents or because of unregularized entry into the country. Migrants who are exempt from deportation, no matter the circumstance, are mentioned in Articles 26-29. Article 29 states,

> No pregnant foreign woman and no foreign minor can be removed. Likewise, no alien may be removed to a country if he establishes that his life or freedom is threatened or is exposed to inhuman, cruel or degrading treatment.

The right to non-refoulement and the protection of women and children is a positive addition to Article 29. However, the entire process of deportation is convoluted and often violated by officials who lack knowledge of the complexities of the document— or who choose not to apply it.

For example, the 2012 Euro-Mediterranean Human Rights Network (EMHRN) Moroccan report found that "Moroccan authorities have retained practices which are in contradiction to the provisions of the law 02-03." These practices result in multiple anti-migrant and illegal actions, which include immediate expulsion upon arrival and interception in Morocco. This action denies a person who may be seeking asylum from making a claim or having access to any legal recourse (André & Jacobs 2012, 38).

On interception, articles 4, 14, 17, 21, 25, 35, and 42 of Law 02-03 justify immediate deportation for acts that endanger the "public order," "State security," or "public safety." These concepts are not defined and, according to the EMHRM, are

claimed without the written justification of the migration official and may bet cited at the individual's discretion (André & Jacobs 2012, 34-35).

For individuals who are deported, the report states that the "notification of a decision to expel is only rarely made in accordance with the provisions of the law." This notification is further given in Arabic and is often not interpreted in English, French, or the migrant person's spoken language. On the rare occasion that the procedures are translated, the EMHRM found that a majority of interpretations are done by a bilingual police officer. This is both a conflict of interest and against the law.

In addition to these findings, the EMHRM reported that intercepted individuals are often not informed of their right to legal representation or are denied representation when they request it (André & Jacobs 2012). In my own research, I heard stories of a man who was arrested during the pandemic for making face masks without a license. Because the man did not have any paperwork, he was sentenced to 6 months in prison. During his very brief trial, the man had no legal representation, and it was unclear whether he was provided a translator. When the mask-seller was able to contact a lawyer, through a friend, the lawyer was denied access to the holding center and to his claimant. According to my interviewee, the fate of the man remains unresolved.

Morocco has had multiple waves of international headlines for its actions towards the migrant community. One of the most shocking and the most common actions is the mass deportation of regularized and unregularized individuals into the Western Sahara and the Sahara desert. In 2014, Human Rights Watch reported that the Moroccan government successfully deported thousands of migrants to the Algerian border and into the Sahara desert ("Abused and Expelled"). In interviews with members of the migrant

community between 2013 and 2018, Alexander-Nathani reported numerous illegal 'droppings' of black migrants into the desert without food, water, or their cell phones (2020). In conversations with my interviewees, a majority of the people I spoke with had been deported to the Algerian border or into the Western Sahara, knew someone who had been dropped, or knew someone who had yet to return from the desert.

The difference between the legislation and the practice of deportation and detention within Morocco shapes the perceptions of the legal system within the migrant community. For individuals who are aware of their legal rights, there is systematic distrust and there is an understanding that, even in an emergency, the police are the most dangerous people to turn to.

For Morocco, ultimately, migration has a deep historical presence with a contentious political and socio-economic face. Various NGOs, international non-governmental organizations (IGOs), and government ministries have worked hand-in-hand to create new ways to respond to migration issues, largely sponsored by EU-funding. Since the early 2000s, there have been many constructive partnerships with international and regional partners, and many new opportunities to respond to migrant needs. As migration challenges continuously change in Morocco, the gap between policy and implementation must be continuously monitored to adapt to the needs of individuals and communities. It is within this context that Morocco's health system has evolved to respond to the migrant community, and the migrant community has evolved to respond to the gaps in institutional protections.

# Chapter 3:

## Analyzing the Official Development Assistance

### *EU-Externalization Policies Influence on Public Health*

As explained in Chapter Two, one of the ways that international actors are able to influence Moroccan politics is through migration policy. Migration policies that are influenced, created, and funded by international actors have the potential either to support migrant communities or to work against integration and well-being. One key social service that, prior to the COVID-19 pandemic, was not funded by the EU is access to healthcare. The Coronavirus pandemic exacerbated the consequences of many of the EU-backed migration policies within Morocco. This shaped the way that the pandemic was responded to within the health system, and contributed to the strategies used to test, treat, confine, deport, or support members of the migrant community.

Although excluded from many internationally-funded development programs, migrant health was politicized and securitized. For example, the RAMED insurance system for low income and rural peoples in Morocco does not, in practice, include people with migrant status. In an already underdeveloped and over-strained public health system, politicians and funders focus on access to care for Moroccan citizens. People with migrant status were purposefully— or at least consciously— excluded from health initiatives.

The securitization of health came to a forefront with the pandemic. When undocumented migrants were tested positive after being detained from irregular border crossings into the Spanish territories of Ceuta, Melilla, and the Canary Islands, migrant health became securitized at a new level. There were large scale sweeps of predominantly migrant neighborhoods, forced kidnappings and testings, arrests, and community-wide mobility limitations that were more

intense than nation-wide periods of forced confinement. These movements are representative of a large scale trend in migration and migration management in Morocco.

*Funding Analysis*

To understand fully how the externalization of migration services affects the health sector and the way in which this abstract concept presented itself on the community and interpersonal level, I conducted a large scale analysis of sources of healthcare funding, official development assistance (ODA), and demographic transitions. My findings overwhelmingly support the thesis that healthcare was securitized as a byproduct of border securitization. This analysis used 25 indicators to run more than 120 linear and multiple linear regressions. After analysing these relationships, 35 correlations stood out as the most relevant and informative. However, given that 120 linear regressions were conducted with a p-value of 0.05, there is a 1-(1-0.05)^(120) chance that at least one non-significant observation appears significant when it is not. To account for the potential of a false discovery, I used the Bonferroni Correction. The Correction finds the p-value at which false discoveries are statistically unlikely. In the case of this data set, 0.5/120= 0.0042. Thus, all correlations with a p-value greater than 0.0042 are statistically significant *and* unlikely to be the result of false positive correlations. Because the Bonferroni Correction produces a very conservative estimate of what is likely to be a true correlation, statistically significant p-values less than 0.05 were also recorded. Figure #6 distinguishes between which variables are corrected and which are not. Because there were so many statistically significant correlations, however, the subsequent analysis of these relationships is also included. In interpretation, the information needs to be understood as potentially hiding a false correlation.

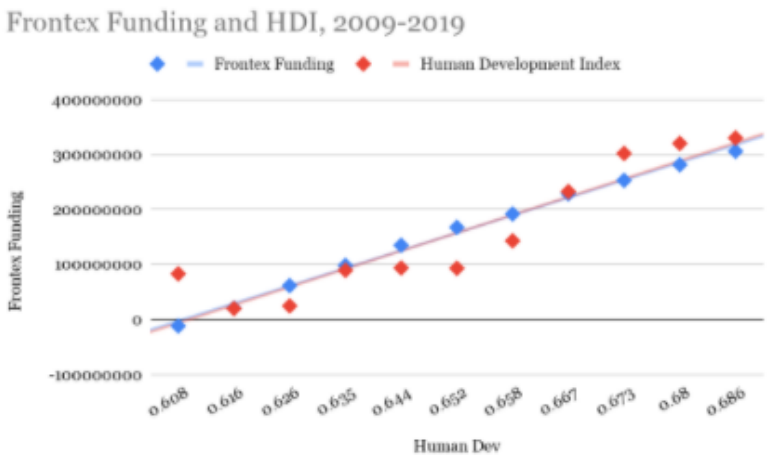
Notably, the data set revealed important relationships that were supported through oral interview and general bibliographic research. However, the data were limited in time, as a majority of policy funds and migration demographics transition significantly after the Arab Spring in 2011. To account for this limitation, I chose data that ranged from 2008 to 2021. Most financial data was self-reported by the Country Secretariat for the Organisation for Economic Co-operation and Development (OECD). Irregular Border Crossings (IBCs) were reported by Frontex, and the populations of migrant communities in Morocco were reported by the UNHCR. Other information was collected by the author from a variety of sources.

For health in its most basic sense, the data showed that between 2009 and 2019, there was a significant correlation between Morocco's Human Development Index (HDI) rank— which is a measure of human longevity and health, education, and standard of living— and the total number of people with migrant status living in Morocco. In fact, 86% of the variance in the migrant population was found to be due to pull factors (such as an increase in the standard of living and perceptions of increased employment) that are reflected in the HDI. Between 2008 and 2018, the national budget of Morocco reflected the magnitude of health spending, with a 40% variance in the correlation of HDI. This number suggests that, when more people with migrant status are residing in Morocco, more money is spent on the national budget for health. This increased health spending contributes to higher HDI and, thus creates even more pull factors for people with migrant status.

The securitization of health begins with security presence and movement. Thus, incorporating the relationship between increased migrant populations and increased irregular border crossing attempts (which, alone, was correlated to 60% of the variance between 2009 and 2020) found that 88% of the variance in irregular border crossings and in the population of

people with migrant status was correlated to the HDI (between 2009 and 2019). This correlation is represented in Figure #2. Thus, the greater the *perceptions* of healthier, more educated, and better off citizens in Morocco, the more likely that people with migrant status will attempt to migrate to or through the country. Thus, the more people in the country who were drawn towards better living and working conditions, the more people who attempt to leave the country through irregular border crossings. These relationships contribute to a change in overall development assistance, sources of funding, and migration response in Morocco. When ODA and other sources of funding changed, programmatic efforts were also heavily influenced. This type of change affects the lived experiences of people, which includes access to health, education, and work opportunities. This change contributes to the vulnerability of people with migrant status, and indicates a decrease in resilience as people with migrant status adapt to new policy environs.

Figure #2:



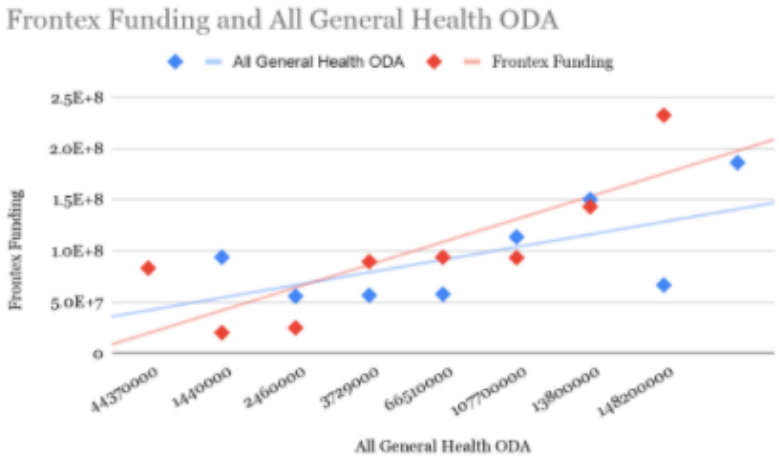

Another direct impact of increased migrant populations and changing sources of funding is security. As more people entered Morocco as a consequence of the perceived pulls, funding for national security, deportation services, and border management simultaneously increased. In military spending, between 2009 and 2019, 40% of the variance was correlated to migrant populations, and 39% of the variance was correlated to irregular border crossings. Thus, both IBCs and increased migrant populations affected the funds the Moroccan government allocated

towards border defense and domestic security. Between 2009 and 2019, likewise, 82% of the variance in the HDI was correlated with increased Frontex funding. This suggests that, as more people were drawn to the perceived benefits of Morocco's increasing HDI, more people committed IBCs, and that the international community (the European Union) responded by securitizing the border with increased Frontex funding. Additionally, 38% of the variance in percent of military spending in the national budget was also correlated with Frontex funding. This suggests that border security operations with both the Moroccan military and Frontex work in tandem and lower operational costs for each other. For perceptions of risk and security, the analysis shows a statistically significant relationship with various security fundings and migrant populations and movements: the more people were drawn to an environment with a perceived high HDI, the more Frontex and national security funding was utilized to curb migration flows.

The changing ODA and monetary flows that contributed to increasing security also affected social services such as healthcare. The percent of the national budget dedicated toward healthcare and the rate of Frontex funding has a 49% correlation between 2009 and 2019. Between 2009 and 2018, 89% of the variance in healthcare *and* in military funding in Morocco's national budget was correlated to the population of people with migrant status. Notably, Frontex funding alone and the percentage of the military budget did not display statistically significant correlations. These numbers suggest that overall security costs in Morocco increased as the population of migrants increased, which led to the reorganization of the financial allocations of sectors in the national budget, as military spending increased and health spending subsequently decreased. Alternatively, these correlations may suggest that the securitization of borders consequently securitized health, as it decreased the percentage of available healthcare funding and thus healthcare outputs.

This secondary interpretation is supported by the relationship between Frontex and General Health ODA. This type of health spending— which the OECD includes as health policies and administrative management, medical education and training, medical research, and medical services— was correlated with a 53% of the variance in all General Health ODA and funding for Frontex between 2009 and 2016. This relationship is shown in Figure #3. The data suggest that as Frontex funding increased, a lower amount of gross health ODA was given to Morocco. This suggests two things: 1) that the action of border security personnel negatively influences access to care (and so it appears that less ODA is necessary to meet community needs), or 2) more people with migrant status are present in the country, but fewer people are utilizing health services provided by this access to care (and so it appears that less ODA is necessary to meet community needs, which creates a negative feedback loop, and less ODA is dedicated toward health in subsequent funding). Conversely, this may also show that securitizing the border is more important to EU policy makers than supporting healthy populations in Morocco, and health is just less prioritized by international ODA donors.

Figure #3:




However, when migrant population numbers are incorporated, the correlations indicate that the actions of border security personnel do, in fact, negatively affect access to care. This conclusion is based on a 73% variance in all General Health ODA and migrant population and Frontex funding between 2009 and 2016. Adding in the weight of IBCs, between 2009 and 2020,

82% of the variance in IBCs and the total number of people with migrant status (which, alone, was 81% between 2009 and 2020) in Morocco was correlated with Frontex funding. This suggests that the presence of Frontex dually and heavily affects the lived experiences and efforts of mobility of migrants in the region. Thus, the relationships show that funding for Frontex increases when there are reports of increased migrant populations and that, when Frontex funding increases, less proportional General Health ODA is given to Morocco. When Frontex funding increases, the actions of border security personnel negatively impact access to care.

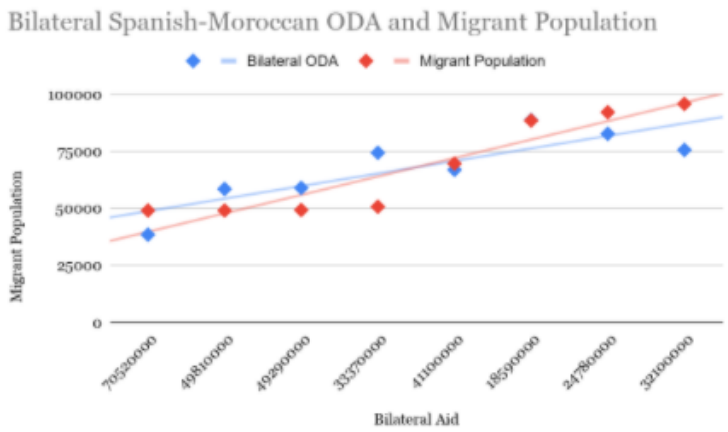
At the government and intra-regional level, another factor that affects the Moroccan national budget is migrant popualtion. Between 2009 and 2018, 84% of the variance in health funding at the *national level* was correlated with the population of people with migrant status. Likewise, between 2008 and 2016 there was a 67% variance in health funding as a part of the national budget when correlated with all General Health ODA, all Population Policies, Programmes and Reproductive Health ODA (which includes HIV/AIDS response and family planning programs), and all Basic Health ODA (which includes infectious disease control, healthcare access, healthcare infrastructure, nutrition, health education, and healthy personal development). This increase in external funding for health initiatives could be linked to a decrease in budgeting for health services as the national level. Given that there is a relationship between health spending percentage at the national level and migrant population, it is unsurprising that there is also a 92% correlation when these two factors are considered with overall health ODA between 2009 and 2016.

Also at the national level, there was also a significant (65%) correlation between military spending and health-related bilateral ODA between 2010 and 2018. A specific form of this ODA is Humanitarian Aid. The direct correlation between Humanitarian ODA and military spending

may be due to the effects of the percentage of health budgets on the proportion of military spending. However, between 2009 and 2017, there was a 50% correlation between population density and humanitarian ODA. This suggests that, when the migrant population in Morocco is bigger, more programmatic and health-related ODA is allocated. There is an additional 71% correlation between humanitarian ODA, migrant populations, and increased funding for Frontex between 2008 and 2018. This correlation suggests that the more people present in Morocco with migrant status, the more CBP funding and the more border security funds are made available. This also demonstrates how progamatic assistance and health can be securitized, as ODA donors are responding to increasing migrant populations by sending humanitarian aid *and* by sending in more border security.

Spanish-Moroccan relations, as historically intertwined as they are, also produce various correlations. Between 2009 and 2017, for example, 59% of the variance in Frontex funding and irregular border crossings (which, standing alone, is a 70% correlation from 2009 to 2020) is correlated to bilateral aid between the Spanish and Moroccan Governments. Likewise, there is a complementary 57% correlation between irregular border crossings and Frontex funding and bilateral aid between the Spanish and Moroccan governments between 2009 and 2017. This suggests that, as Frontex funding increases to meet the demands of more irregular border crossings, bilateral ODA between Spain and Morocco decreases on account of the outsourcing of externalization through the border security bureau rather than Spain's own finances. There is also a 57% correlation in the variance in Spanish and Moroccan bilateral ODA and the sheer presence of migrant populations in Morocco between 2010 and 2017. This information is demonstrated in Figure #4.

Figure #4:




At the financial systems level, migration population also affects government borrowing and international aid transactions. Between 2010 and 2018, 54% of the variance in government borrowing was correlated to the migrant population and between 2010 and 2019, 47% of the variance in government borrowing was correlated to bilateral ODA for population policy and administrative development. Between 2008 and 2016, also, 46% of the variance in government borrowing can be explained by Spanish and Moroccan bilateral ODA. There is a very heavy consequence of this relationship, since between 2008 and 2017, 60% of the variance in HDI growth was also explained by Bilateral Aid between the Spanish and Moroccan Governments. The HDI growth is important to Morocco not only for the prosperity of its citizens, but for its financial capacity. Between 2008 and 2017, 41% of the variance in HDI was correlated with gross ODA to Morocco from DAC countries.

Aside from health indicators, international ODA and its correlations are perhaps the strongest indicators of the securitization of migrant health. Between 2009 and 2017, 88% of the variance in Unallocated Official Development Assistance can be explained by irregular border crossings. This relationship is shown in Figure #5. These numbers suggest that the European Union funded the externalization of its borders through unallocated and unearmarked ODA. Likewise, 91% of the variance of total humanitarian ODA, project-type ODA, EU Institutional ODA and programmable aid was correlated with irregular border crossings between 2010 and 2017. This is paired with a 67% variance in HDI and humanitarian ODA between 2009 and

2019; a 65% variance in HDI, Bilateral ODA for Environmental Health, Environmental Health Policy, and ODA for Population Policy and Administrative Management between 2010 and 2017; and an 83% variance in All General Health ODA, All Population Policies, Programmes and Reproductive Health ODA, and All Basic Health ODA and migrant population between 2009 and 2016.

Figure #5:

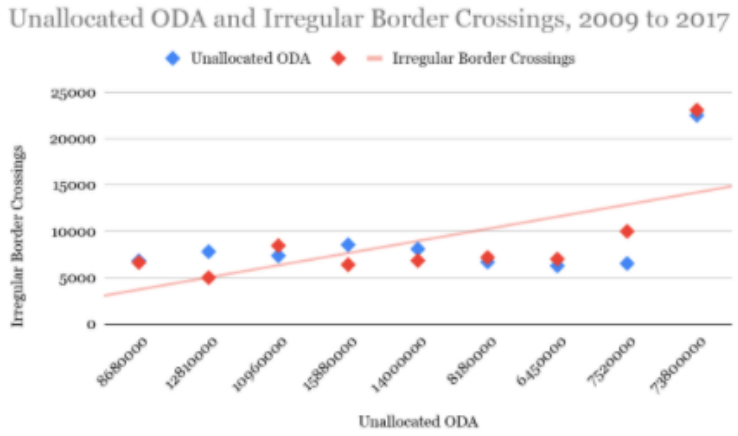



**Figure #6: Summary of Financial Analysis**

| Summary | R-square | Significance (p-value) |
|---|---|---|
| Migration Population and Human Development Index | 0.86 | 0.00004 |
| Migrant Population and Frontex Funding | 0.81 | 0.00006 |
| Frontex Funding and Human Development Index | 0.82 | 0.00012 |
| Irregular Border Crossings and Unallocated ODA | 0.88 | 0.00017 |
| Migrant Population and Percent of Health Funding and Percent of Military Funding in National Budget | 0.89 (adjusted) | 0.00018 |
| Migrant Populations and Percent of Health Funding in National Budget | 0.84 | 0.00019 |
| Frontex Funding and Irregular Border Crossings and Migrant Populations | 0.82 (adjusted) | 0.0002 |
| Human Development Index and Migrant Populations and Irregular Border Crossings | 0.88 (adjusted) | 0.00026 |
| Frontex Funding and Irregular Border Crossings | 0.7 | 0.0020 |
| Migrant Populations and Irregular Border Crossings | 0.60 | 0.0029 |
| Irregular Border Crossings and Human Development Index | 0.63 | 0.0033 |
| Humanitarian ODA and Human Development Index | 0.67 | 0.0037 |
| *The following correlations are not free from the potential of a false* | *positive,* | *as* |

*ascertained through the Bonferroni Correction.*

| | | |
|---|---|---|
| Percent of Military Funding and Bilateral ODA for Health Policy | 0.65 | 0.0083 |
| Bilateral Aid between the Spanish and Moroccan Governments and Human Development Index | 0.60 | 0.0082 |
| Frontex Funding and Humanitarian ODA and Migrant Population | 0.71 (adjusted) | 0.011 |
| All Population Policies/Programmes & Reproductive Health ODA and ODF as Reported by Morocco | 0.65 | 0.015 |
| Human Development Index and Bilateral ODA for Environmental Health, Bilateral ODA for Environmental Health Policy, Bilateral ODA for Population Policy and Administrative Management | 0.83 (adjusted) | 0.016 |
| Overall health ODA and Migrant Population and Percent of Health funding in the National Budget | 0.92 (adjusted) | 0.016 |
| Frontex Funding and All General Health ODA and Migrant Population | 0.73 (adjusted) | 0.017 |
| Migrant Population and All General Health ODA, All Population Policies/Programmes & Reproductive Health ODA, and All Basic Health ODA | 0.83 (adjusted) | 0.017 |
| General Government Net Lending and Borrowing and Migrant Population | 0.54 | 0.023 |
| Frontex Funding and Percent of Health Funding in the National Budget | 0.49 | 0.023 |
| General Government Net Lending and Borrowing and Bilateral ODA for Population Policy and Administrative Management | 0.47 | 0.028 |
| Frontex Funding and Bilateral Aid between the Spanish and Moroccan Governments and Irregular Border Crossings | 0.59 (adjusted) | 0.028 |
| Migrant Population and Bilateral Aid between the Spanish and Moroccan Governments | 0.57 | 0.031 |
| Migrant Populations and Humanitarian ODA | 0.50 | 0.033 |
| Irregular Border Crossings and Frontex Funding and Bilateral Aid between the Spanish and Moroccan Governments | 0.57 (adjusted) | 0.033 |
| Percent of Health Funding in National Budget and All General Health ODA, All Population Policies/Programmes & Reproductive Health ODA, and All Basic Health ODA | 0.67 (adjusted) | 0.036 |
| Irregular Border Crossings and Humanitarian ODA, Project-type Interventions, EU Institutional ODA, and Country Programmable Aid | 0.75 (adjusted) | 0.037 |
| Human Development Index and Percent of Health Funding in National Budget | 0.40 | 0.037 |
| Migrant Populations and Percent of Military Funding in National Budget | 0.40 | 0.038 |
| Irregular Border Crossings and Percent of Military Funding in National Budget | 0.39 | 0.040 |
| Frontex Funding and All General Health ODA | 0.53 | 0.041 |
| General Government Net Lending and Borrowing and Bilateral Aid between the Spanish and Moroccan Governments | 0.46 | 0.043 |
| Frontex Funding and Percent of Military in National Budget | 0.38 | 0.043 |
| Current Account Balance (as a percent of GDP) and All Basic Health ODA | 0.46 | 0.045 |
| Gross ODA to Morocco from DAC countries and Human Development Index | 0.41 | 0.047 |

This funding analysis, complemented by the interviews conducted with members of the migrant communities, NGO leaders, and ministerial personnel, demonstrates the extent of the securitization of migrant health in Morocco.

## Chapter 4:

## Stories of Life and Health During COVID

*Interviews: the personal and community-level consequences of externalization*

The living conditions that produce this large-scale distrust manifests in a variety of ways. The interviews that I conducted between March and September of 2020 place the analytical analysis above the literature review and financial analysis in a particular human context. Many of the men and women I spoke with talked about atrocious experiences and human rights abuses in both sorrowful and casual manners. Rape, kidnapping, expolitation, death, and illness marked many of their journeys from their origin countries to Morocco. Integration into the Moroccan community, either with the intention to travel on quickly to Europe or to settle, was often marked by similar unsettling events.

My interviews were conducted in semi-structured virtual settings. Contact between interviewees and myself were made through chain-referral sampling. This method, though the most efficient for a virtual setting, limited the people in whom I was able to contact. The demographics of these individuals I spoke with, as demonstrated in Figure #7, were Nigerian, Cameroonian, DR Congolese, Guinean, and Ivorian. Of these nationalities, I spoke with six women and eight men. Four of the interviewees were located in Rabat, while ten interviewees were living in Tangier. Six of my interviewees were regularized, and eight were undocumented. Eight

Figure #7: Country of Origin of Interviewees

of my interviews were conducted in French through a translator, and six were conducted in English. Five of the men and women with whom I spoke were parents with children living in Morocco. None of my interviewees entered Morocco through regularized or documented ways. Those who were able to gain paperwork by the time of our conversation were part of the 2013 or 2017 regularization campaigns established by the government. At least seven of my interviewees came from areas of active conflict, and two had had immediate family members killed by Central Afican terrorist groups. Three of the women described acts of sexual violence during their journies to Morocco or while living in the country. All of the interviewees described some sort of other life-threatening events. Some of these events include being abandoned in the Sahara desert by smugglers, being held hostage by Algerian militias, and watching other traveling companions pass away as a result of exhaustion or physical injury.

Once in Morocco, many of the interviewees described failed integration and assimilation. This failure to be incorporated into society heavily influenced people's experiences before and during the pandemic. To account for the variety of experiences described in the interviewees, I created a codebook. The categories in which the interviews were analyzed, in a simplified presentation, include:

**Figure #8: Codebook**

| | | | | | |
|---|---|---|---|---|---|
| **General Health and Well-being** Descriptions of non-COVID related health experiences | **Integration** Descriptions of social, economic, and legal integration measures, services, and/or events | **Pre-COVID and In-COVID financial challenges** Descriptions of issues the individual faced regarding money or financial provision | **Pre-COVID and In-COVID Police and Security** Descriptions of interactions with, security and border personnel, including reflections, fears, and thoughts about security | **COVID experiences** Descriptions of COVID-related health events and events lived through during Morocco's public health response | **Policies** Descriptions of the impacts of policies or descriptions of policy implementation and implications |
| **Healthcare providers** *Relating to the type* | **Friends and Family** *Relating to* | **Dependencies** *Relating to formal and informal relationships* | **Arrests** *Relating to different outcomes of arrests,* | **Confinement** *Relating to the "period of forced* | **COVID policies** *Relating to public health, security, and* |

| | | | | | |
|---|---|---|---|---|---|
| *of person an individual communicated their health situation with* | *relationships with friends and family while in Morocco* | *with local, national, and international NGOs or service providers who provide some form of assistance during or before the onset of the COVID-19 pandemic* | *including jail, deportation, arbitrary confinement, and cause of arrest and/or release* | *confinement" and any social, economic, or personal consequences that emerged from the policy* | *other policies discussed or implemented as a results of COVID* |
| **Information on care**<br>*Relating to how people perceived their care, including access to medication, prognosis and diagnosis* | **Rent and Eviction**<br>*Relating to the non/payment of rent and different forms of evictions, specifically during the national lockdown* | **Lack of food or other expense**<br>*Relating to descriptions of experiences in which an individual lacked food of other common goods, and how they responded to this need* | **Borders**<br>*Relating to the location of, type of, and emotions towards experiences associated with borders* | **Certificate of Mobility**<br>*Relating to access to and use of the certificate of mobility* | **"Essential Workers" Policy**<br>*Relating to the essentialization of certain jobs or sectors of the workforce due to the pandemic* |
| **Medical challenges**<br>*Relating to medical issues experienced by interviewee, including communication with medical service providers, payments, and accessibility* | **Non-NGO Assistance**<br>*Relating to inner-community assistance efforts and other forms of help* | **Medications**<br>*Relating to the cost of medications, medication acquisition, and financial concerns regarding medication* | **Monitoring**<br>*Relating to different levels of monitoring, such as migrants monitoring police or police monitoring migrants* | **Statistics**<br>*Relating to COVID cases or number of people affected by COVID-related processes* | **Externalizations**<br>*Relating to acts of, descriptions of, or perceived externalization of consequences of externalization* |
| **Mobile Care**<br>*Relating to any form of mobile care, such as traveling medical service providers or non-stationary clinics* | **Language**<br>*Relating to the use of English and French in Morocco, and how these languages enabled or prohibited community engagement* | **Employment acquisition**<br>*Relating to direct-financial concerns regarding employment or employment acquisition, including stories of work experiences* | **Harassments**<br>*Relating to relationships with others and descriptions of physical or verbal comments, abuses, or other harassments* | **PPE**<br>*Relating to accessibility, access to, cost of, of perceptions of PPE* | **Economic or Political System**<br>*Relating to descriptions or expressions of the system in which people operate within* |
| **Patriarchal care**<br>*Relating to descriptions of or experiences of acts of medical paternalism* | **Race**<br>*Relating to any conversation about race, including descriptions of acts of racism and perceived stigma from color of skin* | **Worries**<br>*Relating to financial worries and stressors not caused by employment acquisition, medication, or access to food.* | **Innaction**<br>*Relating to a lack of action by security personnel following reported abuses* | **Public behavior**<br>*Relating to acts of moving away from someone, being followed, having the virus blamed on people with migrant status, and acts of physical and/or verbal abuses* | **European-Influenced Policy**<br>*Relating to descriptions or implications of Moroccan policy that relate to relationships with the EU or European bodies* |
| **Place of Care**<br>*Relating to where and how a person receives medical assistance, with a specific focu on care in hospital setting versus informal setting such as NGOs* | **Relationship to Citizens**<br>*Relating to descriptions of both everyday relationships and interactions with citizens and specific events between citizens and people with migrant status* | | **Kidnapping or taking**<br>*Relatings to the improper arrest of people with migrant status in which the individual expressed not know why they were detained, where they were going, or what was happening* | **Rumors**<br>*Relating to what people had heard in regards to how the government was involved in the testing and vaccination processes and other rumors* | **Migration Policy**<br>*Relating to Morocco's migration policy and how it was implemented or detected* |

| | | | | | |
|---|---|---|---|---|---|
| **Telecare**<br>*Relating to any act of contacting a medical service provider through digital services* | **Religion**<br>*Relating to mentions of Islam, Christianity, or other religions and their types of representations and acting bodies in Morocco* | | **Places of detention**<br>*Descriptions of the location individuals and groups were taken to after arrest or detainment* | **Test Results**<br>*Relating to whether or not an individual received a positive or negative test results* | **Securitization of Health**<br>*Relating to descriptions or implications of policy on health, COVID, security personnel, security practices, etc* |
| **Mental health**<br>*Relating to descriptions of mental and emotional well being, including self-diagnoses, descriptions of others, and descriptions of access to care* | **Paperwork**<br>*Relating to types of documentation that people knew of, attempted to access, or obtained while in Morocco* | | **COVID-Centers**<br>*Relating to descriptions or suggestions that security personnel intentionally used COVID centers to detain members of the migrant community* | **Treatment method**<br>*Relating to how people who tested positive for the virus were treated by health professionals and what the medication and confinement procedures were* | **Western Sahara Influenced**<br>*Relating to descriptions or implications of Moroccan policy that relates to hegemonic control over the Western Sahara* |
| **Work with or as a healthcare worker**<br>*Relating to individuals who partnered with health care providers to deliver services* | **Positives practices and helping others**<br>*Relating to Moroccans, NGOs, or people with migrant status serving other community members with intentional acts of compassion or general positive practises* | | **Fear of Security**<br>*Relating to descriptions of emotional response to security personnel and descriptions of the relationship between security and access to health* | **Testing and facilities**<br>*Relating to where people received treatment and how they felt during this experience. This also includes observations the individuals made about the testing location and who was present during the process* | |
| **Suffering**<br>*Relating to events or acts that imparted undue and/or indescribable suffering onto an individual, as described by themselves* | **Changing Anything**<br>*Relating to the answers of the questions: "If you could change anything related to Morocco, what would it be?" and "If you could change anything related to COVID, what would it be?"* | | **Trafficking**<br>*Relating to descriptions of how people entered Morocco through clandestine measures, with a focus on the use of smugglers, camels, or other services* | **Intensity of illness**<br>*Relating to the illness experience and how people within the migrant community described others who had contracted the coronavirus* | |
| | | | **Reason for Traveling**<br>*Relating to the reason people traveled from the country of origin to reach Morocco.* | **Population affected**<br>*Relating to how certain covid procedures, illnesses, events, or policies impacted specific populations* | |

Using public health and healthcare accessibility as a microcosmic example of the implications of externalization at the community and individual level demonstrates the human cost of international policy. An important reason that this sector was chosen for analysis is that the coronavirus pandemic exacerbated the individual-level involvement within this sector, and policy level responses are seen in the funding. Changes in how this sector is involved with and interpreted among members of the migrant community were also demonstrated throughout the interviews conducted during the pandemic. However, before analyzing how the pandemic exacerbated these underlying consequences of externalization, we must analyze some of the daily conditions of people with migrant status prior to the coronavirus pandemic.

*Measurement of Integration*

For many of my interviewees, daily life before the coronavirus pandemic was marked by periods of financial struggles and community disengagement. Daily life prior to the pandemic was mainly focused on ease of integration and methods of integration. The Council of Europe defines integration, in this sense, "a common framework of legal rights; active participation in society, on the basis of minimum standards of income, education and accommodation; freedom of choice of religious and political beliefs, cultural and sexual affiliation, within the framework of basic democratic rights and liberties" (Coussey & Sem Christensen 1996, 15). Using the CoE definition to evaluate integration within Morocco is intentional, as many of the integration programs for members of migrant communities are EU-funded, and thus perpetuate these integration assessment standards.

Participation in the market is one way to evaluate integration. To evaluate participation, the CoE considers:

- Employment and unemployment rates across time
- Proportions of subject populations in dangerous or "dirty" jobs
- Proportions of the subject population in key professions such as architects, lawyers, teachers, engineer, doctors, and in managerial and governmental posts;
- Proportions of the subject population in vocational training
- Proportions of the subject population gaining vocational and professional qualifications
- Relative earnings, hours worked, self-employment (Coussey & Sem Christensen 1996, 18).

Though the EU has dedicated millions of euros in ODA to the promotion of access to employment and overall integration, the economic conditions of Morocco do not facilitate an opportunity for systemic, successful integration. In Morocco, the pandemic increased unemployment from 9.1% in 2019 to 10.15% in 2020 for citizens (World Bank 2021). Prior to the pandemic, many migrants found temporary employment in construction, gardening, working in small businesses, and serving as janitors or street sweepers. This informal work left thousands of people without any form of social or economic insurance when the pandemic began and the national lockdown limited non-essential personnels' movement.

In the interviews, I asked volunteers of migrant-run NGOs what their estimate of the unemployment rate among the migrant community was compared to Moroccan citizens. According to Moussa (name changed) from Cameroon, before the pandemic there was "95% unemployment…. even 5% [employment] is maybe too much. So maybe 96% of migrants don't work and only 4% do. Work is for someone who has papers and a contract and the right to

[work], but most of them don't have that." Likewise, Alphonso (name changed) from Guinea, suggested that "out of 100 you'll find something like 90-95 people don't have a job. Only 5 % are lucky enough to be able to work… maybe 5-10% work in the informal sector… [and] 80-90% either stay home and don't work." Both men estimated that less than 1% of people with migrant status were employed during the pandemic. Those that were working, they suggested, were Moroccan-educated sub-Saharan students who were working in call-centers. These individuals who work in call centers have official employment contracts and thus qualify for the *Caisse Nationale de Sécurité Sociale* (CNSS) or the National Social Security Fund. In addition to providing social security benefits during the pandemic, the CNSS also guaranteed employer-provided access to medical care.

One of the consequences of the massive unemployment and the sporadic participation in the informal workforce is "the black economy" in Morocco. In this economic system, as described by Alphonso, people with migrant status lack all forms of civil and legal protection and are easily taken advantage of by employers. A lack of documentation becomes a lack of recourse should an employer refuse to pay daily fees or should working conditions be inhumane or dangerous. This financial vulnerability contributes to the destabilizing of any progress from integration programs and contributes to a low economic status for many members of the migrant community. Likewise, this lack of stable employment perpetuates cycles of illness and quietude, as people are unable to pay for medical expenses, guarantee an adequate, healthy diet, or advocate for their own interests at the larger-community level.

*Discrimination as the Antithesis of Integration: "Living in Morocco is hell for black Saharan Africans"*

Lack of employment also contributes to negative social images. A majority of migrants in Morocco rely on hand-outs and informal, public work such as street-hawking— or the selling of second-hand goods in crowded streets. Because so many migrants work in the sector, the vocation has become closely associated with "illegality" (Alexander-Nathani 2020, 100-106). This status also contributes to the socially-constructed, racist, and discriminating image of "dirtiness" that is both verbally and non-verbally perpetuated by Moroccan nationals. These negative stereotypes also place migrants in danger— both physical and emotional— and can lead to active violence against people perceived as "illegal." These images of illegality and dirtiness thus make people with migrant status easy targets of blame for the pandemic and contribute to a higher level of insecurity among migrant communities.

This insecurity prevalent in the working sphere is indicative of the larger lack of integration of people with migrant status in Morocco. As described by Aminata, a 20-year-old woman from the Ivory Coast who makes her living from street hawking and begging, "Sometimes when you ask them [Moroccans] for money, they insult you. Some throw water at you. Sometimes they even spit on you if you're begging for money to eat." Mary, a Nigerian woman, also described Moroccan children throwing stones at her and her young daughter, saying that after this happened, her daughter asked "Why do they treat us like we are not human?" These insecurities and overtly racist acts were compounded by the pandemic. In describing COVID-specific discrimination while getting onto a bus, Emile, a woman from the DRC, states, "If a black man comes to sit next to a Moroccan, the Moroccan stands up and gives him his spot… they thought it was us, the Africans, who brought the coronavirus." Mahir, a young man from Cameroon, also describes the current pandemic being blamed on migrants. He reported that he was called racial slurs (*Aazi (عزي))* and referred to in derogatory ways ("*mon amie")* and that

Moroccans covered their faces with handkerchiefs when black men and women walked past them.

This discrimination is the antithesis of economic integration as well, as represented by Moussa's experience working at a store front: "In 2015 I met a Moroccan who sold some stuff in a hardware store, and then I worked with him. I started working with him and he was paying me 180 euros, so around 1800 MAD [Moroccan dirhams a month]….. I quit a long time ago because the Moroccans did not decide to come buy stuff because it's a black man who was selling. So they shut down. He stopped the hardware store… and I had nothing to do." Moussa also described competing with Moroccans for work, and feeling "targeted… that you're different because you're treated differently." He later stated that "[Moroccans] take us for animals– illiterate, stupid people." During the pandemic, Mahir and other interviewees also described how their status as migrants prohibited them from earning an income: "Before the corona, it was more about maintenance jobs and sweeping the streets- find if someone needs to move, [and you can help him move]... But after the corona, everything has changed. People are more reluctant, they tell themselves that the black man is the source of this virus."

*Distrust and Rumors*

The public blame and interactions between members of migrant communities and Moroccan citizens contributed to a myriad of public health problems. Distrust shaded interpretations of public health messages, including access to testing and opportunities to receive medical care. However, many interviewees explained that this distrust was based on reality in which members of Morocco's security forces used the pandemic as an excuse to illegally arrest,

deport, and test migrants for coronavirus without their consent. These actions securitized access to healthcare and alienated people without documentation who may have otherwise sought care.

According to a mid-level employee at the Laayoune Ministry of Health, conspiracy theories heavily influenced the participation of migrant communities in COVID health initiatives. Some theories include that Moroccan authorities "just wanted to test medicine on them [migrants], and that the Moroccan authorities only wanted to raise the number of cases" of COVID among the migrant communities; or that the authorities inject people with the virus to eliminate the migrant population; or that COVID originated from 5G network services in a plot to ruin the African continent. At an international relations level, another theory or rumor is that, in the eyes of the government, higher numbers of cases in the migrant communities may be a positive thing that can be used as a "manipulation [between] Spain and the detention centers in Laayoune and Dakhla." This manipulation, if true, would constitute externalization for political gain, since migrants would be leveraged for relational negotiation power. The effect of Spanish-Moroccan relationships and rumors on access to healthcare will be discussed later in this chapter.

Many other rumors emerged through a variety of communications. Mahir and Aminata described learning all of their news from Facebook and general social media, while François (name changed), a Congolese man and a migrant-run NGO volunteer, described receiving a majority of his news from friends within the migrant community. Emile described receiving her news from WhatsApp, Moussa described using all of the above sources, and only Adama (name changed), a Guinean migrant who leads a conglomeration of migrant organizations in Rabat, described reading about public health measures through the Ministry of Health. Additionally, English-speaking Nigerian migrants John, Lorina, Dahlila, Gabriel, Mary, and Harmonie (all

names changed) described being fundamentally dependent on bilingual migrants within the community and on international media sources readily available through social media. The dependency on informal means of public health communications indicates a lack of targeting by the public health system. The lack of linguistic diversity, additionally, decreases the health and informational capacity of non-Arabic and non-French speaking individuals residing in the country. The inability to receive official information about the virus likely contributed to the variety of rumors around COVID-19 policies and public health actions.

*Life during the period of forced confinement: "I say to God 'when will this be over' and then I cry"*

The most influential public health initiative was the period of forced confinement. On March 2nd, 2020, the first positive case was reported in Casablanca, Morocco, from a Moroccan expatriate living in Bergamo, Italy. By March 24th, the Moroccan government closed public and private schools and restricted meetings of more than 50 people. A few days later, the government enacted a strict quarantine and a national curfew. Under the national curfew, or the "periods of forced confinement," only one member of any group residing together was able to leave for essential materials and foodstuff. The process of registering and enforcing the one-person rule represented a major logistical challenge among Moroccan nationals but a discriminatory and dangerous process for many members of the migrant community.

Apart from the difficulties English-speaking migrants experienced in their attempts to learn about the period of forced confinement and the resources that may be available to them, this public health strategy failed to account for non-regularized and undocmented people without resilient social and economic networks. Harmonie, a single mother from Nigeria, reported being

able to feed her children only water, sugar, and bread for the more than two weeks it took her to be connected with an NGO. Emile likewise described the confinement as a devastating blow for the migrant community, saying, “We had nothing. We were there stuck in our houses just like animals.” François also stated that, “We can’t pay for rent anymore, we cant feed ourselves,” and John, a Nigerian man, described having “No food, no sanitizers, nothing” to prepare himself and his roommates for being inside for such a longer period of time. These descriptions of the early lockdown highlight how the migrant community was unsupported by the government and more deeply affected— given that a majority of people depend on daily, informal work— than many other sectors of Moroccan community.

Soon after the lockdown was implemented, Moroccan officials announced a variety of changes. Acknowledging the necessity of movement, authorities implemented “Certificates of Mobility” to one indidivudal *per family*. However, ASCOMS reported that many migrants were refused the certificate on account of their “irregular administrative situations.” In apartments where up to 8 people resided, the organization reported that just a single person received the certificate of mobility.

As the report indicates, despite the various declarations of assistance, few details published by the government included any consideration of the migrant community. According to Adama and ASCOMS, because “migrants and asylum seekers are not beneficiaries of the RAMED card— despite all the agreements and promises that have been made to them— and because 90% of migrants work without a contract, they are unable to access the CNSS [benefits]” (ASCOMS 2020, 5). The lack of CNSS affiliation, despite promises by the government that non-RAMED households would receive compensation, has limited who has received economic assistance.

This lack of government-level financial support led many migrants to depend on NGOs and simply to go without during much of the pandemic. The moratorium on rent collection that was mandated throughout much of Morocco (with landlords receiving government compensation) was disregarded in which migrants lacked legal recourse. ASCOMS reported multiple incidences of landlords removing people with migrant status from their residences during the pandemic because they could not pay for rent. Moussa, in his capacity as a service-provider, also reported these evictions. He observed, "there are some Moroccans that don't pay rent, for instance. For instance, my neighbour said he doesn't pay his rent. He told me he doesn't pay it. But the migrants do. Do you get it? It's a little bit… that's what I've experienced. For me they told me, 'you have to pay.'" Lorina also described her experience with landlords during the pandemic. She said, "you must pay for the house. You cannot say you cannot pay, or then you will stay outside. You have to do it." Harmonie also described paying rent in Tangier. She said, "for the Moroccans, there is special help [to help pay rent]. For us, there is nothing like that. The landlords have been strict." In response to this lack of support, Harmonie reached out to fellow migrants and heard of a rent relief program run through the NGO Caritas. She was unable to benefit from the services because the program dictated that her land-lord vouch that she was his tenant, so she was unable to receive help.

These financial and emotional situations contributed to the overall stress of the population and to a general decrease in access to mental health support. Lorina, John, and Alphonso all discussed how the pandemic influenced people's mental health. Lorina reported that she received counseling for depression through an NGO, prior to the national lockdown. But at the time of our interview, she was unable to travel to the counseling services, and she could not afford the minutes on her phone to call the counselor from her apartment. John also described

many of his friends facing depression from being indoors without Certificates of Mobility. Alphonso, in describing his work with ALECMA, stated that migrant-run NGOs were well-aware that people were struggling. He described a series of initiatives that the organization was attempting to implement— including conversations during food deliveries and staying connected on social media. The lack of mental health support during the national lockdown was indicative both Morocco's underdeveloped and underfunded health system and the general stigma and lack of mental health professionals in the Middle East and North Africa.

*Security, Arrests, COVID, and Migrant Health*

The experience among the migrant population with arrests and deportations was nearly universal. Multiple of my interviewees had personally experienced deportations and arrests. Prior to the pandemic, these relationships materialized through the illegal internal deportation of people with migrant status to southern territories in Morocco. As Mahir stated, "When you're paperless, the police arrest you, and they throw you in [detention]." He later described the 500-mile return journey from Agadir, the city he had been internally relocated to, to Tangier, the city where he was living at the time of our interview. François spoke to the systematization of these internal deportations, saying that in 2018,

> There were a lot of arrests, around 18,000 people, people that were arrested near the border cities like Tangier, Nador, and Oujda. All these people were transported against their will to the south, and among these people there were approximately 1000 women. And when we went with our mission in the southern regions, we

noticed a massive presence of women and children that were living in tremendous precariousness."

Figure #9 demonstrates the distance between places of detention and destinations of internal deportation. The northern cities in blue are places specifically mentioned by interviewees as cities where they or someone they knew were arrested and deported. Likewise, the cities in red are specifically mentioned as places where people were deported by security personnel. Marrakech, in the near-center of the map, was the only city mentioned as a place where people were both deported from and deported to. The information related to inter-city mobility was also a reflection of the UNHCR Country Evaluation of Migration in Morocco, which illustrated internal mobility as concentrating on a North-South gradient (UNHCR 2019, 17). Figure #10 demonstrates the UNHCR evaluation.

Figure #9: Inter-city Mobility Described by Interviewees

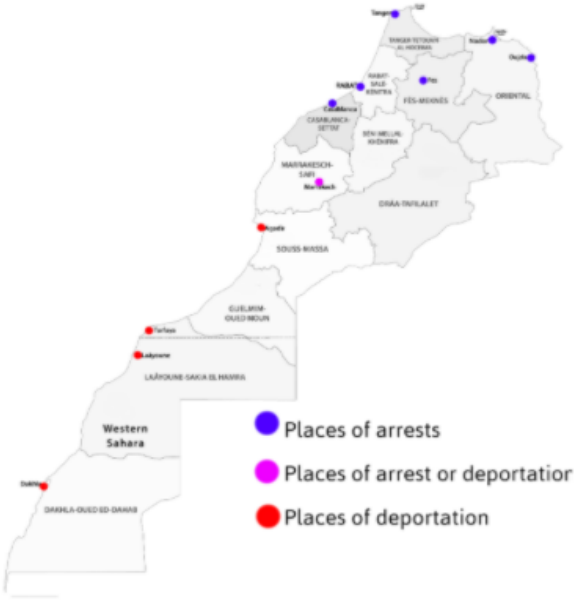
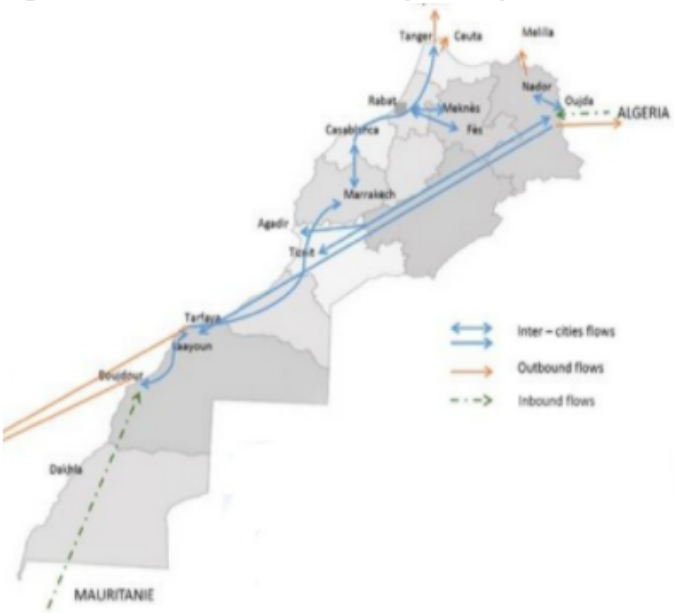



Figure #10: UNHCR-described Inter-city Mobility




Aminata offers another description of these deportations. She stated that she has been arrested three times and deported from Tangier to Tiznit. When asked to share her story, she said, "One time the police came to look for us at 1 a.m. At 1 a.m. they took us and put us in a bus and

sent us directly to Tiznit. That day I was sleeping, the police broke the door, they gathered us up and sent us to Tiznit…. [but] sometimes when the police come to get you, they'll take the men and leave the women." Likewise, Mary reported that the police usually come late at night. She described the last time the police came as follows:

> They [the police] come and they start hitting the door. Sometimes my kids are in the room and they start shouting "Mommy! Mommy! Mommy!" and I hold them and they start crying because they are scared. When the police come they use their sticks [batons]. They hit the doors. They hit them very hard, and if you don't open the door for them they will break down your door. And you open the door and they all come into your house. Some are asking you 'where is your paper?' Some are telling you 'move.' Some are taking the things from inside your house. Anything they know they can take, they take. They will even steal a child's shoe… they can steal your clothes, they can steal your shoes and your bag. And you? You cannot even talk to them…. The way they are talking to you, the way they are shouting at you: 'Yalla! Yalla! Yalla!' All the shouting and the children crying… I say, 'God when will this be over?' Then I cry— We have been suffering here.

While not every arrest is attributable to the externalization of migration, there was a consistent association among the professionals *and* the migrant community regarding arrests. For example, Hachim, the mid-level official at the Ministry of Health in Laayoune, described the

securitization of health and the cost of the coronavirus pandemic on migrant deportations. He stated,

> The European Union exerts a lot of pressure on Morocco concerning the management of migration, notably on the control of its borders. At the level of Spain, we could consider that the European Union shares the same borders as Morocco since there are a lot of migrants that get in through Spain. Spain and its bilateral relations with Morocco and the EU… there's a lot of pressure that they exert on Morocco so that Morocco strengthens its borders' security. … [in Tangier] the Moroccan authorities took the decision to evict all the illegal migrants which led to mass arrests which, like I said, was an official measure because the Ministry of the Interior had reacted [to migrants testing positive for COVID in the Canary Islands]. …. So people were arrested to be evicted and displaced, to take them away from those cities because those cities are very close to Europe. The authorities considered that all of the illegal immigration that was happening in those cities … had to be emptied out. … The moment they spot a migrant, they arrest him and ask him if he has a residency card. If you don't have it, they put you in their van and take you to the commissariat. Once there's enough of them they're put in buses and taken to the south. Mainly to Agadir and Tiznit.

This quote describes externalization in process. In using Morocco as a third-country partner to curb migration, the EU also externalizes its COVID response to the Moroccan government.

François also described his work with an NGO. As follows:

> The sub-Saharan migrants are living in an alarming situation, especially in this time of confinement. The information that reaches us from the south of Morocco is really worrying. There are some migrants that were arrested because they wanted to reach the Canary Islands; they've been locked down for three months now. It's been three months. Not only are they detained in illegal detainment centers, it's outside of any legal framework. We are constantly denouncing this, all while doing advocacy work targeting the authorities so that those migrants are freed and can follow the measures that the authorities have determined. This is because, while they are detained, no single measure prescribed by the authorities is respected. Neither the social distancing nor the mask wearing are respected.

François stated that detention centers were located in Dakhla, Laayoune, and Tarfaya. Describing how people were deported, he stated, "The transportation is done by bus, and in the bus they [the migrants] are handcuffed. They are tied first, and then they are handcuffed additionally."Mahir also described arrests during the pandemic, stating that "when you are arrested you are put in certain centers, and they force you to take a test when you're not sick… They put you in a place [of detention], and you spend months there without any care. The coronavirus has made things even harder." Likewise, Delilha reported that "Sometimes there are two or three migrants on the street, and the police just take them. And they are gone."

As seen in these interviews, first-hand accounts of police interaction have strictly defined how people interpret the role of security personnel in the national system. Thus, task-shifting

police and security personnel not only to mass-arrest individuals who are violating public health protocol but also to enforce public health policy through COVID testing, has produced an incredible distrust in the system. The overall way in which people with migrant status learned about the pandemic, lived through quarantine, and were addressed by public health personnel attributes to the distrust that many people felt towards the formal health system. The incorporation of the police and the perceived influences of international actors failed to present an image of a health system that was migrant-conscious or migrant-inclusive.

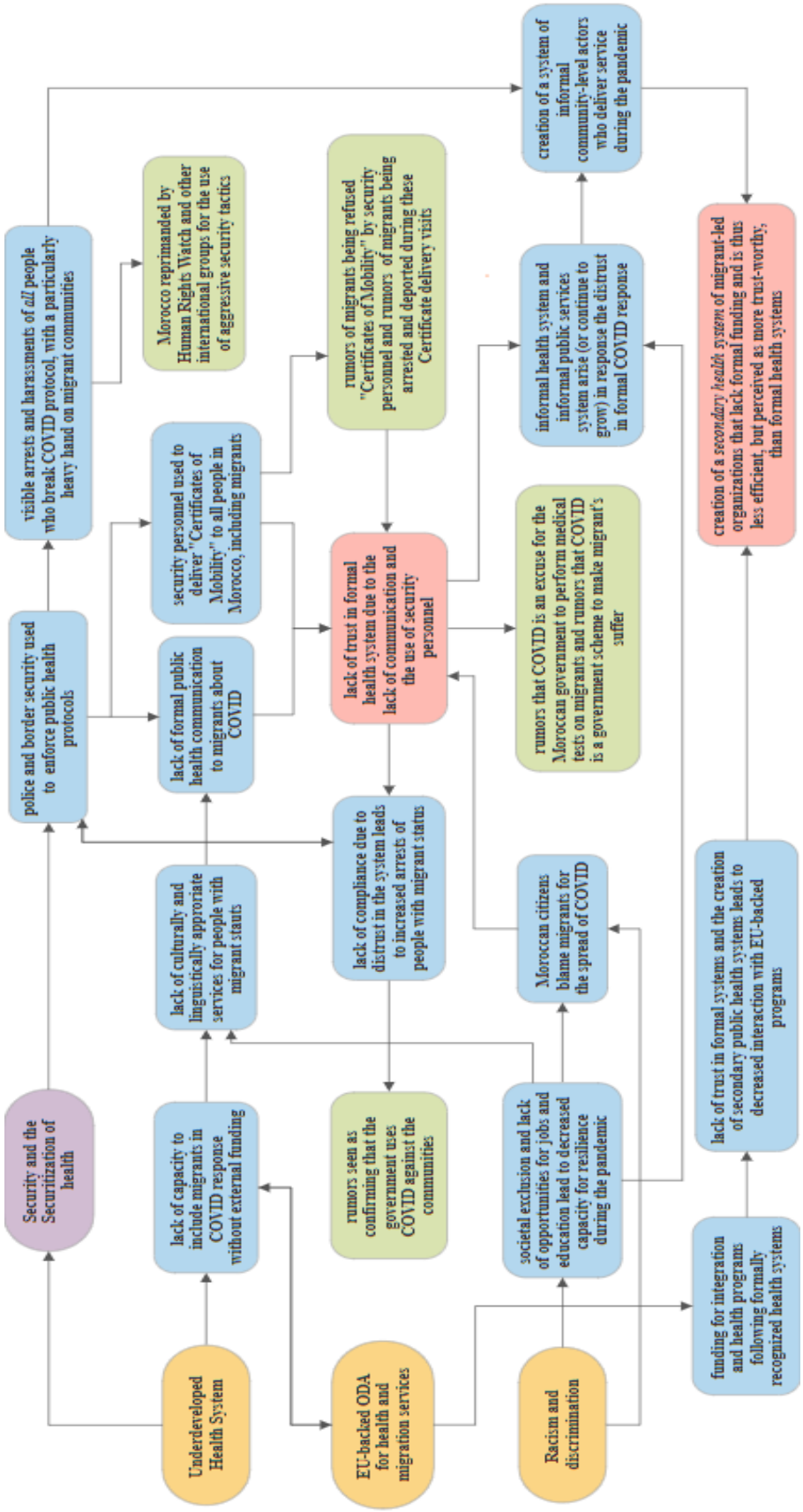
My interview with Koffi (name changed), a man from Cameroon, aptly reveals how security personnel and a securitized approach to health affected people's access to healthcare:

> During this pandemic, I think that Morocco has just proved in many ways that it could fulfill [the needs of] people despite the difficulties that exist at the level of its health system... If it is true that some people found themselves locked up in screening centers. We have a problem here. On one side, the health system is doing its job, on the flipside, there's border control. It is something that indirectly gives a negative image of the health system. This means that, on one side, the medical services do their job— to control and test people— and on the other side, border control locks up people so frequently and causally
>
> So they [migrants] are suspicious of everything. You know, let me give you an example. If during a whole week, you feel threatened by a person, and one day, this person tells you "Alright, I'm with you, I will take you to the hospital, I will feed you and everything", you will be suspicious [of him]. This means that every day, they know they are being tracked by the border control forces and

> others. And eventually, it's the police that come to take you for a screening test. That is really the problem, it's this mediation that is problematic. "Should I trust this man who, two days ago, was hunting me down like a thief to arrest me, and today wants to take me to the hospital?"
>
> The state takes you to a center without warning you beforehand that it is for screening purposes. Without telling you anything, tests are performed on you, there are injections and a treatment without your consent, without telling or explaining to you [what is happening]. This is a problem between the public police force and the medical professionals.
>
> This means that [when] the medical staff comes to do its work; it does not know what happened. We may tell them "here are some immigrants, test them". They do their work; they do the tests. But did the police, did the authorities take the time in advance to explain to these people why they are there? What must be done with them, what process, how things should go… No, I don't think this communication happens... I think that everything that is problematic is the lack of communication, and also the problem of border control.

Koffi's words describe a system in which the externalization of migration securitizes healthcare. Healthcare, as a result, comes under the influence of the states, which is viewed as a threat to migrant well-being. As both the interviews and in the qualitative analysis demonstrated, the pandemic exacerbated these existing relationships. The overall relationships between EU ODA, the foundations of the health system, security and securitization, and the racialization of the migrant experience can be seen in the below flow chart, Figure #11.

Figure #11: Relationships between ODA, Health Systems, Securitization, Racism, and Trust



**NGOs and Moussa**

The failure of the public health system and the social services system to respond to the needs of migrant communities created space for migrant-run and international NGOs to step forward. Although some NGO programs were terminated because of the national lockdown, international non-governmental organizations (IGOs) such as Caritas in Tangier and the national-level NGOs such as *Fondation Orient-Occident* (FOO) in Rabat were able to provide services such as temporary rent relief, food delivery, and telehealth services. Local and community-based NGOs such as *Association lumière sur l'emigration clandestine au Maghreb* (ALECMA), *Groupe antiraciste de défense et d'accompagnement des étrangers et migrants* (GADEM), and *La Plate-forme des associations et communautés subsahariennes au Maroc* (ASCOMS) served as social and legal representatives and work to meet the extra needs of community members.

Throughout the interviews, I had the pleasure of speaking with a representative of ASCOMS, the president of one of the Central African countries' diaspora population in Morocco, a representative from the Council of Sub-Saharan Migrants in Morocco, and two representatives from ALECMA. One of these NGO representatives described their impact as follows:

> Migrants live, now, thanks to some support, social actions that are established by some associations [NGOs]… There are a lot of associations that distribute food packs, and a lot of Moroccan associations that are doing it. So it is that support that helps the population which is in a vulnerable situation, and helps them survive the situation [period of forced confinement].

Without detailing the specific roles of each organization, it is important to note that these migrant-run, community centered NGOs were a lifeline to migrants before and during the pandemic. Many of these organizations support emergency housing for people who are new to Morocco, especially children and single mothers. Likewise, cultural organizations provide opportunities to get involved with the migrant community, offer culturally-sensitive support, and develop networks of associations, friendships, and need-based contacts. The migrant-run NGOs also offer psycho-social care for individuals who have been trafficked and raped, beaten, or are traumatized from another horrific event or series of events. During the period of forced confinement, members of the NGOs were able to deliver food packets, materials, and monetary resources to people without certificates of mobility. Importantly, and as will be discussed in the following chapter, these NGOs also help to nuance and lift the voices of the constituency they serve. Because the NGOs are so deeply ingrained into the migrant experience in Morocco— with *every* interviewee mentioning seeking and receiving services from NGOs— these organizations can serve as indicators of integration and community engagement.

As important as IGOs, NGOs, and migrant-run NGOs among the migrant community are, few organizational efforts could be compared to those of Moussa. As mentioned above, Moussa is a Cameroonian man who has lived in Tangier for the last 8 years. His primary job is to support migrants in the city. He originally arrived in Tangier with the "hope of crossing the sea" but, after many attempts, he saw too many people die and decided that it was not worth risking his life to continue to try to get to Europe. After he stopped attempting passage, he began working in a hardware store and using the spare money he accumulated to pay the rent of his neighbors. While

he was working at the store, Moussa became acquainted with a man who connected him with European journalists.

Serving as a guide, Moussa would bring the journalists to "go meet the migrants to distribute clothes, to distribute food, bags." However, this distribution became dangerous when Tangier police began following Moussa and disrupting his deliveries. Moussa said, "Distribution [of goods to migrants] was illegal, so we had to hide sometimes to do it. Sometimes the police would disturb us, and sometimes they stopped a little. So we would deliver clothes and stuff in hiding, and I would distribute those myself." Criminalizing the delivery of humanitarian aid and public goods, as described by Moussa, reflects the trends found in the data analysis conducted with this research. As migrant lives become securitized commodities, access to food, clothes, and social goods like health become difficult to acquire.

During the 2017 regularization campaign, Moussa was able to receive his regularization card and to go about his deliveries with more ease. He also was able to attend Arabic classes at a local NGO. Through this NGO, Moussa was connected with an (unnamed) European-based NGO, who hired him to work as a "field-agent" over a three-month contract. The purpose of this NGO was to "make the migrants benefit from the financing that the European Union gave them." Through this program, Moussa worked with the community to have "three groups of people make companies. They made small stores, and some others paid the hairdressing salons. And others made a small laundry." However, Moussa distinctly stated that not everyone was intended to benefit from the integration program. Only regularized, Moroccan-educated students were allowed to receive training and funding. Moussa believed that the NGO was "afraid of financing migrants because migrants can always go to the [European] cities with that money."

This statement demonstrates that community-level consequences of one of the trends demonstrated in the funding analysis. As integration pertains to employment acquisition, education, housing, social services, and medical care (as defined by the CoE), EU-backed programs that focus on these services can be measured for their impact. Thus, as was represented in the health-focused data, 92% of the variance in all forms of DAC-contributed health ODA *and* the percentage of the national budget spent on health is attributable to size of the migrant population in Morocco. Seeing how Moussa navigated these EU-backed programs, who was affected by the programs, and where the gaps in audience revealed a variety of themes. Namely, these themes were that many integration programs are internationalized efforts of community incorporation.

After his three months of working with the NGO was completed, Moussa received a contract extension for seven additional months. He described feeling a moral conundrum in his work, knowing that the particular migrants he helped to integrate were already established and more financially stable compared with the majority of the migrant population. So, Moussa saved his money and began distributing daily supplies to people living in the forests outside of Tangier: "In the beginning I did 15 baskets of food to distribute to my migrant friends that were sleeping in the forest once a day. I spent 2000 dirham in the beginning because I wanted to bring some support." Soon after his delivery, one of the European journalists he had originally worked with reached out and helped Moussa establish a GoFundMe page. Cementing his place as a goods-provider, Moussa said "since then, people have been calling and I haven't stopped answering the phone… I have here a Cameroonian, a Senegalese, a Congolese, a Nigerian, a Guinean, an Ivorian, there's even more nationalities here."

As a one-man delivery service, Moussa represented a life-line to the migrant community in Tangier. Throughout the pandemic, he continued to work with European NGOs, serving as the middle man between humanitarian donations, populations of undocumented people living in the forests outside of the city, and the many hundreds of people who live in the crowded neighborhoods of Tangier. When we spoke in July, 2020, Moussa had collected hundreds of bags worth of eggs, bread, condoms, medications, toys for children, masks, hand sanitizers, and clothes. Figure #6 shows what a single room in his apartment in Tangier looked like:

Figure #12, provided by interviewee

Moussa also used donations received through GoFundMe to pay for the rent of migrants who were about to be evicted, and to provide more expensive medication to those who became ill during the period of forced confinement and were unable to seek medical attention.

Outside of service delivery, Moussa offered medical mediation to people who had been detained by police. He often traveled to hospitals to speak with members of the migrant community who were refusing to be tested for COVID. He describes this work as advising, saying, “If I know that they are there [the hospital], I will also go there. I will go pay them a visit. I can advise them what to do... that’s my purpose. Because I’ve already gone through that. So I give you some advice, and I can help out.” Moussa also served as a defacto health

middle-man. His services were used to respond to non-serious conditions. Mahir stated that, "if I had a small thing, I would turn to [Moussa] and he would know; if I had a headache I would talk to him because he has some medicine with him. I would basically turn to him… [because] he has some contacts. Because he can find you something. That's why I go to him."

In describing how the pandemic affected his distribution work and his work in hospitals, Moussa said, "with the coronavirus this has become too hard. Too hard, too hard, way too hard, even for me. But I make the effort of giving them more than I give myself." The struggles of always trying to serve the community has taken a toll, and Moussa described the most difficult thing about his job: "Sometimes I lose my motivation because it's not easy working there. You can be called at any time and you have to take action when a migrant calls you….Sometimes I turn off my phone because when they ask you for help and you can't provide any, it really hurts you." The sense of frustration, hurt, and hopelessness was a common theme throughout my interviews. It pervaded conversations about life in Morocco, about deportations, daily life, employment, fear of police, providing for children, rape and sexual vioelnce, and illness.

*Stories of healthcare*

When I asked him how people in the migrant community deal with these struggles, with a particular focus on illness, Moussa described his role as a pharmacist. He stated that the top two medications that people asked for were Doliprane and Zentel. Doliprane, or Acetaminophen, is a common over-the-counter medication used for headaches, cramps, fever, and soreness. Zentel, or Albendazole, a less common medication in the global north, is used to kill dog-derived tapeworm (*Echinococcus granulosus)* and pork-derived tapeworm *(Taenia solium)* ("Albendazole" 2021). Moussa also described recommending a variety of medications for people who were

experiencing nausea and stomach issues, and providing physical bandages and alcohol for open wounds.

Serving as a medication-distributor, in addition to a food provider and everything else that Moussa does, is the role of most NGOs. According to my interviews, the easiest place to get medication is not the pharmacy or the hospital, but the NGO Caritas and the Catholic Church. For people who are able to gain access to these locales, medication may be acquired by being associated with the organization and simply asking. This medication is free and quickly provided when compared to medication provided by formal distributors.

Many of my interviewees reported that this informal medication was crucial to maintain health and wellbeing. An example is Gabriel, a Nigerian man who lived in the forests with other people who could not afford to pay rent in Tangier. The police repeatedly destroyed migrant community centers in the forests, and during one of these raids, Gabriel ran from the police, who were using dogs to tackle and arrest migrants. As he was running, he tripped on a rock and broke his leg. He was able to hide himself until the dogs got distracted and, later, a friend found him and took him to the hospital. After waiting for four hours, Gabriel was told that he would have to return the next day because the "scanning machine wasn't working." The next day, Gabriel was admitted and scanned with the machine, only to find out that he would be refused further treatment unless he could prove that he would be able to pay for his medical bills and medication. He described his shock by saying, "I cannot even buy food. How am I supposed to buy drugs?" Gabriel then left the hospital and sought pain care from local community members who helped him gradually, and imperfectly, heal his leg. He said he treated his leg by: "massaging my leg with hot water... Massaging the mass was the only medication I took. The hospital requested for me to pay for all the medications, all the types of drugs for me, I needed to

go to the pharmacy but I can't even afford to buy food and so I left. This is the truth. This is what it is like to live in Morocco."

Lorina, likewise, shared her story about gaining access to medical care prior to the pandemic. After being trafficked from Nigeria to Sierra Leone to Morocco, Lorina had a series of complicated pregnancies. For her first child, she was taken to Maternity Soussi in Rabat, where she underwent an emergency c-section. Following the birth of her baby, she was immediately released without postnatal care instructions and without any sort of maternity care follow up. The way in which her c-section healed was botched, and she said "when I walked, I could hear the wind whistle through my belly." This open wound continued to cause her major health problems and, when she had her second child, she was taken by ambulance to Maternity Soussi for a second emergency c-section. The wound from this birth healed with limited issues and, by the time we spoke for our interview, she had had a third child and described only occasional abdominal pain.

Lorina's experience with the hospital did not end with her births, however. Because Lorina was undocumented, there was a miscommunication between her doctors. Under the impression that Lorina was covered by RAMED and the CNSS, her doctors agreed to perform the emergency c-sections she needed to deliver her baby. However, when she was unable to produce a regularization card, doctors determined that her children's birth certificates would not be released until all of the accrued funds were paid for. Six years after her first birth, Lorina's first child has not been eligible to enroll in public school because Lorina has never been able to accrue enough money to pay off her debts and to obtain the birth certificate. This is an active violation of human rights, as will be discussed in the next chapter.

What makes Lorina's experience far from unique, however, was the rushed and improper maternal care she received. Mary, who is also an English-speaking woman from Nigeria, described giving birth at a hospital in Tangier. In her story, she was unable to communicate effectively to the doctors and nurses that her child was crowning and that she was ready to give birth. This lack of communication led Mary to give birth alone, in an empty room without pain killers, sanitary wipes, or medical assistance. Doctors only checked on her condition after they heard the scream of the newborn baby. She described her birth experience as follows:

> I was in labor for a while and they [doctors] left me there [in the waiting room]. Even when the child was coming out, they left me there. They said 'its not yet time' and I said 'yes, it is time. See? I can feel my babies head' because I put my hand between my legs. I was telling them that I could feel my baby, and they said 'no, it's not yet time. Be quiet." and then they left me…. What I did is that I saw a vacant space [room] and I went there to the bed myself. And when I put my hands inside my body, I saw that the baby was coming out. And I started pushing and the doctor came in and said 'stop pressing, stop pushing, stop pressing! Do you want to kill yourself? It's not yet time.' And I did not take orders from them and then before you know the baby came out on my hand. The baby came out on my hand.

Mary went on to describe how, as she was giving birth alone, the only person who responded to her cries of pain was a janitorial woman who happened to walk past the room. When her child was fully delivered, Mary said that the doctors and nurses came into her room and started

apologizing, saying they "Didn't know it was time." In anger, Mary told her story about how her voice was not heard when she delivered her child.

During the pandemic, these types of poor medical response continued. However, because of the periods of forced confinement and the lack of mobility to and from health care services, fewer of my interviewees were able to comment on experiences related to the hospital in the previous year. However, Alphonso described how people's inability to attain Certificates of Mobility heavily affected migrant's access to care, since they were generally too afraid to violate quarantine to seek medical assistance lest they be arrested and deported without questions. He said,

> I think the pandemic has made the migrants very vulnerable in terms of access to healthcare… because they could not access treatment like they would under normal circumstances. Most of them face difficulties because, to go out, one needs authorization and not all migrants have gotten that authorization. Those that were sick couldn't get treated, and then there's the issue of transportation; for those that didn't have a vehicle a lot of the times an ambulance had to be called and for that, we're the ones that do that job of orienting them to emergency services. Someone who is sick and called me, asking about what he or she should do, I ask them to call the ambulance driver to go to fetch him from his house if it's really urgent. And in most cases the ambulance drivers manage to come get them to the emergency room. In most cases it [the pandemic] has made things hard for migrants for the reasons I have just enumerated: the Certificate of Mobility. Because if you need to get treated you need to go out to go to a hospital or an

> NGO, and since the NGOs had stopped their services, and since people don't have an authorization, it has really complicated things.

Many of the stories shared by my interviewees provided evidence for medical paternalism and medical racism. Lorina, Gabriel, and Mary's stories share themes of incompetence on the behalf of the doctors and nurses. By not listening to their patient's self-assessment, as in the case of Mary, by refusing post-surgery care and paperwork, as in the case of Lorina, and by refusing treatment based on the capacity to pay, the medical professions devalued the lives and voices of their migrant patients. This unequal access to care has many sources.

*Contextualizing the Public Health System in Morocco*

Unequal access to care can be attributed to racism, xenophobia, poor funding, national health policy, and a whole host of other concepts. Analyzing public health accessibility through the individual and through the community, however, provides a sectoral example of the public health system. Particularly, this type of analysis speaks to how health has become securitized. However, to see how health is made accessible for people with migrant status, one must first understand the Moroccan medical system.

The Moroccan medical system is primarily made up of the public sector, the private not-for-profit sector, and the private-for-profit sector. The public sector is funded and served by the Moroccan Ministry of Health, the medical-sector of the Royal Armed Forces, and various local community initiatives that are able to receive government funding. Morocco has taken an flexible approach to service providing in this sector, and there are three major strategies deployed by healthcare personnel: "fixed" access, "mobile" access, and "roaming" access (Semlali 2010,

17). These three strategies are designed to meet the healthcare needs of the diverse Moroccan population— from city dwellers to rural farmers. In the fixed strategy, the person seeking healthcare may gain access to medical attention through established hospitals, clincis, and pharmacies. The mobile strategies describing traveling healthcare workers who are able to promote public health campaigns, deliver vaccines, or provide basic health services. The roaming strategy describes community health workers who travel by motorbike or donkey "to distribute certain medicines (oral rehydration, contraceptive pills, eye cream, etc.), and to promote health care procedures in particular for pregnant women, diabetics and other chronic diseases" (Semlali 2010, 16). Because of these strategies, the public sector is the most widely accessible health system for a majority of people in Morocco.

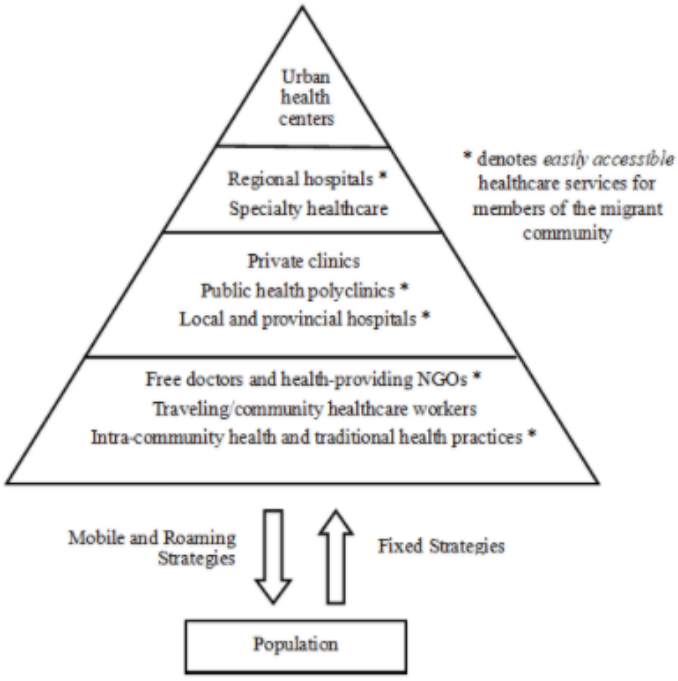
The private sector is divided into two sub-sections: not-for-profit and for-profit. The nonprofit group is funded by organizations and administrations like the Moroccan Red Crescent (MRC), the National Fund for Social Security (NFSS), the Mutuals and the National Fund of Social Welfare Bodies (NFSWB), Caritas, and dozens of local and international NGOs. Likewise, the for-profit private sector is largely made up of specialized groups of doctors or health professionals that provide services such as post-trauma care and rehabilitation. The service fees at many of these institutions are unaffordable for a majority of the Moroccan population and, therefore, private for-profit services are often reserved for the upper-echelon of the Moroccan society.

The number of hospitals, clinics, pharmacies, and healthcare providers is concentrated in the most urban areas of the country. These locations have enabled 100% of the urban population to have physical access to a care facility within 5 kilometers of their homes. For rural populations, 89% of the population lives within 10 km of a health center (Semlali 2010, 18).

Despite the fact that a majority of the migrant population resides in urban areas of Morocco,where healthcare is more available, there is still some disconnect in equitable access to health. As described by Adama, where and how he accesses health care, is affected by these levels of healthcare services:

> For primary care, it's for everyone– the access is for both migrants, regulars and irregulars. But the problems arise at the secondary level. That's where there are administrative issues and that's where you need to identify yourself and pay fees and a lot of other things. So it's in the secondary level that we are having problems. But for primary care, it is access that is unbiased for both Moroccans and migrants.

Figure #13:
Healthcare services in Morocco, by accessibility
Adapted from Semlali 2010




As demonstrated in Figure #13, this accessibility is tiered. People with migrant status have easiest access to public services, NGOs, and hospitals that happen to be located in the region in which they are staying. Because of this, residency status, the color of a person's skin, language, and mobility all contribute to access to these centers.

As suggested or indicated by the lack of universal access to healthcare, the interviews, and in the financial analysis, Morocco ranks 121 out of 189 countries for the Human Development Index. While improved over time, Morocco still struggles with large-scale unemployment, unequal access to education and health services, and housing problems. For members of the migrant community, these development challenges are very apparent in access to medical care— which is largely out of reach. According to the 2020 IOM *Migration in West and North Africa and across the Mediterranean,* less than 55% of migrants in North Africa believe that they have access to healthcare in case of an emergency. The report lists lack of information, disinformation, financial challenges, discrimination, and fear of being reported as the primary reasons for the lack of involvement with the healthcare system (Fargues et al 2020, xxvi).

A challenge that the public health system faces in its efforts to overcome this fear is regionalization. Established in 2011, Article 101 and Law 47-96 led to the central government creating 16 regional bodies to create and maintain a standard of health-related fiscal autonomy. By developing regional-specific legislation, the local leaders were able to negotiate resources to best meet the needs of their communities. However, this regionalization led to the decentralization of promoting universal access to care among all peoples, regardless of legal status. Without this national approach, there is a risk that migrant health will not be included in the development of the health system in the region. This may be due to a lack of resource availability, a lack of need (i.e.: a very small population of non-citizens), or the fact that the migration "issue" is not within the public purview.

At the national level, the government worked to overcome these challenges by developing new partnerships among the private industrial, military, and public health sectors. One relationship was increased to produce personal protection equipment (PPE) and medical supplies. From this new

partnership, a 3-billion dollar solidarity fund was raised to support the public health response. The Moroccan Ministry of Health used this fund to increase the number of intensive care units (ICU) beds in the nation from 1,600 to 3,000 (Soudka et al 2020). The Government also implemented a COVID fund: the "Special Fund for the Management of the Coronavirus Pandemic." This fund was endowed with 10 billion dirhams to "cover the costs of upgrading the medical device, including appropriate infrastructure and additional resources to be acquired in an emergency" (ASCOMS 2020, 4). The fund also accrued 32.2 billion dirhams in donations from the king, private businesses, companies, state employees, and professional associations (Abouzzohour 2020, 16). The non-endowed funds were used to subsidize the CNSS system and to provide support for people left unemployed by the pandemic. Regionalization occured, as is seen in Laayoune, with geographically specific responses to the migrant community and through regional Ministries of Health outsourcing their funding to local partners and local community leaders.

The health system in Morocco also had an international response beyond migration control. In the first half of 2020, the EU contributed EUR 450 million to the COVID response; the IMF opened a $2.97 billion line of credit to the Moroccan government; the Arab Monetary Fund contributed $127 million; the French Development Agency contributed EUR 150 million; and the US contributed $730,000 to assist in COVID relief efforts (Abouzzohour 2020, 16). This funding strongly bolstered the capabilities of the medical system and increased the influence of international actors on the medical system. International influence on the Moroccan public health response can be seen in the regional government of Laayoune's response to the pandemic.

*Laayoune: a look at COVID from the administrator's perspective*

Understanding how both the formal and the informal health systems operate in Morocco is crucial for understanding how the pandemic operated within Laayoune. Laayoune is the largest city in the disputed territory of the Western Sahara. As an act of institutional control, the Laayoune Regional Ministry of Health is under the direct purview of the Moroccan National Ministry of Health. The employees of the ministry thus follow Moroccan national health guidelines and are privy to national public health and migration strategies.

During my interviews, I had the opportunity to speak with the previously mentioned mid-level employee located in Laayoune, whom we will call Hachim. He described the medical system, the onset of COVID, and how the region responded to migrants who were deported from Morocco-proper into the Western Sahara. Importantly, Hachim also gave key indicators of how Spanish-Moroccan relationships affect the public health protocol for people with migrant status and what this protocol looks like.

Spanish-Moroccan relations had a strong influence on how COVID was addressed in Laayoune. As a consequence of the securitization of the Western Mediterranean Route, the West African Transit Route— which exclusively describes Moroccan to Canary Island migration — has emerged as a popular transit route. Thus, the Spanish government has an incentive to increase ODA to Morocco to implement stricter border controls if there is a perceived threat from the migrant population in their territorial islands.

Hachim addressed these relationship by affirming that, in fact

> Authorities did not start carrying out tests [in the migrant community in Laayoune] until some journalistic reports from Spain came saying that some immigrants were able to get to Tenerife in Spain and Las Palmas [two of the

> Canary Islands], and when they [the migrants] were tested it was found that they had the coronavirus. This is when the [Moroccan] authorities decided to carry out a large number of tests among the migrants. So when we found out about the big number of infected cases, it was very hard to convince them that they were infected and, unfortunately, many conspiracy theories were present among them.

The financial analysis supports the relationship between Spanish-Moroccan ODA, funding for Frontex (whom *is* operable on the West African Route), and the number of irregular border crossings from Morocco to European territories. There is a 57% variation in the relationship, which suggests that the Spanish play a role in securitization of their border using EU funds.

The securitization of health and COVID-related protocol was thus influenced by Spain. As Morocco tried to curb COVID infections among its own citizen population, it curbed infection among migrant communities as well. The motivation behind both types of response varied, and one could suggest that migrants were only later included in the large scale testing and COVID procedures because of 1) fear that they would infect locals and 2) retaliation from the Spanish government who pressured Morocco into carrying a heavier health burden as a consequence of the externalization process. The fact that COVID-positive immigrants entered the Spanish-controled Canary Islands thus instigated the first large-scale testing of people with migrant status. As Hachim revealed, there was little communication between migrants and health care personnel. This lack of communication contributed to large-scale distrust between the migrant communities and the formal public health system.

This distrust manifested during the pandemic in a variety of ways, including through quarantine. With work limited, hundreds of people with migrant status were seeking financial aid during the period of forced confinement. The population of people on the street incited the public security forces to act, and the response by the government was abrupt. Hundreds of people were arrested by Moroccan police and placed in "community centers." Hachim described this as a necessary measure that only affected "homeless people," "families without a home," and "immigrants without shelter." However, when I interviewed members of the migrant community who had experienced these community centers, or who knew people who had, it was clear that, at least on the surface level, immigrants were detained indiscriminately. Video evidence showed empty rooms with loose blankets on the floor, buckets in the corner, and small windows. Video evidence showed men demanding bread and water and asking to be released to return to their homes. Video evidence did not show what Hachim described as "a normal situation, meaning that they [migrants] were fed and dressed."

The rumors about these COVID-related arrests spread very quickly. Information about testing, quarantine, and symptoms of illness diverged into rumors that the government was using the pandemic to conduct medical tests on people with migrant status. People refused to be tested for the virus, uncertain of what it meant and what its consequences were. Hachim described non-compliance in the migrant community. He directly stated that:

> Some nationalities, especially ones related to Nigeria and Ivory Coast, refused to take the test. Naturally, for public authorities, they couldn't just leave them in the street like that, interacting with citizens without tests. So the public authorities went to their houses, the health authorities accompanied by the public ones, and

> they were forcing them in a mandatory way to take the test, otherwise they wouldn't leave their houses. Naturally, these are conditions that were imposed by the circumstances because it is not possible for someone to refuse taking the test.... Some of them did not want to accept taking the test but the local authorities were imposing their authority to the extent allowed by the law under the state of emergency's framework that imposes taking tests for all the Moroccan citizens and immigrants.

Even regarding work, after the Ministry of Health deemed that the "essential workers" of the fishing factories in El Marsa would be able to return to work, migrants distrusted everything related to the health system, the police, and COVID. Knowing that mostly migrants worked in the factories, police trapped people in factories and in apartment buildings during the testing procedure. To maintain transparency, Hachim stated:

> The health authorities would go to buildings that had a lot of migrants and would test them in their houses, which is the same operation it did for the [people] working in factories. They would do the test for the whole building that the factory worker or the migrant from one of the infected factories was living in. The auxiliary forces and the police forces would close off the street with barriers and keep people from getting out of the building until the results were pronounced the following day, or in the worst case, [after] 48 hours, although it's usually only 24. Once the results are out, the barrier is removed and freedom of movement is restored. This practice was enforced from both migrants and Moroccans to stop

> circulation [of people]. Because in any way, you're going to go to a house and take a test while they're free to move around, and then the following day you find out they had the coronavirus and so what do we do? So the moment the tests are carried out the street is closed off until the results come out.

To try to build trust in these communities, Hachim described a policy of involving local NGOs and community leaders to mediate the test taking. He also stated that National Health authorities and Laayoune regional authorities partnered with associations to "raise awareness among migrants, to talk to them in their languages, to distribute leaflets, or to distribute some food rations to their houses and raise awareness about the dangers of the virus." Hachim also stated that the National Ministry of Health released a public health announcement at 11 am and 6 pm daily in French and Arabic to maintain transparency regarding the public health initiatives.

For many migrants, this mediation proved too little and too late to attain their trust. There was already another rumor circulating about false-positive COVID tests that the government was giving only to migrants. This rumor made its way to Rabat, where Alphonso was the first to inform me of it. He described it as follows:

> We have received some information that says that the people in charge of those tests have crossed the part where it's written "negative" to write "positive " So basically some results were falsified.
>
> This must be said. It is a worrying situation. It could be some kind of manipulation because whether it is Spain or the EU, they are always looking to curb illegal immigration. And for that, they'll use all means, like discrediting the

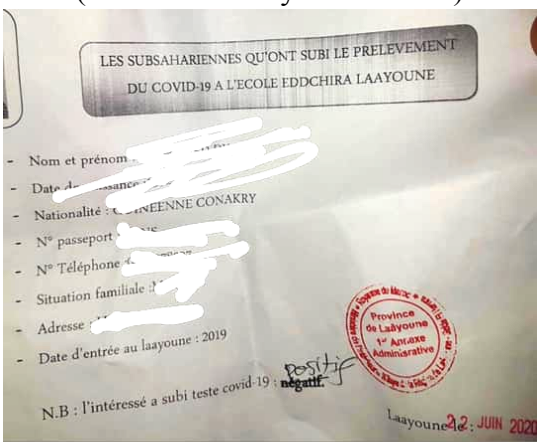
> health of the migrants by declaring that 14 people had tested positive among the group [of people who had been intercepted trying to reach the Canary Islands]. For us it's a way to discredit and force the Moroccan authorities to double down on the fight against illegal immigration and heighten their vigilance with migrants. This is what is behind hundreds of people today being detained in detention centers between Laayoune and Dakhla. They are locked down there, there were some revolts there, but the police were able to control the people. But the fact of the matter is that the people are still in those detention centers. Me, personally, to this day, I don't know anyone who has tested positive. No, I don't. In the documents that we have received, it's written "negative" but they crossed it and wrote with a ballpen "positive." There were some tentative attempts to explain that there; they defended themselves by saying that the machine made a mistake and they should have put positive instead of negative.

When I asked Hachim if he was aware of this rumor, he stated there was only a single case of a person with migrant status who received a positive test result instead of the appropriate negative result. Hachim stated that the distrust behind this result begins on paper, as Moroccans were given verbal results about the COVID tests but, because of migrant-led protests, migrants were given physical copies of their COVID test. This distinction between test results resulted in a transparency issue with members of the migrant community who believed that the administering officials were recording special, falsified tests. The particular individual who received a positive test demanded to be shown his result. Hachim said that the doctor showed the result, only to find

that the test had been checked “negative,” but stamped “positive” by health officials. Hachim attributes the error to human mistake.

The nature of the rumor makes it impossible to verify whether the case Hachim described is the same as the one that had made its way north, to Alphonso. A picture of the positive test was provided by Alphonso, who had received it from a friend, who had received it from someone in the Laayoune facilities. The photo, Figure #14, shows the result crossed out and “positif” written in black ink.

Figure #14. Provided by interviewee
(self-censored by interviewee)




For people who legitimately tested positive for COVID, the treatment was standardized across nationality and citizenship status. Hachim stated that people were typically hospitalized for 1 to 15 days after a treatment with the controversial malaria drug, hydroxychloroquine.

A second interviewee, Moussa, reported that less serious cases of COVID were treated with a different combination of medication, which included:

- Hydroxychloroquine— 200 mg, three times a day, for ten days
- Azithromycine (or a “Z-pack”)— 500 mg the first day, then 350 mg the next four days
- Vitamin C— 1000mg tablet twice a day
- *D-Cure* (or Colecalciferol, for vitamin D deficiency)— 25,000 IU once a week

- *Zinaskin* (or Zinc-sulphate)— one tablet, twice a day for ten days

For the most severe cases of COVID,

- Enoxaparin (or *Lovenox*, an anticoagulant)— 0.4mg, injected subcutaneously for ten days
- Omeprazole (or *Prilosec*)— 20mg a day, for ten days
- Alprazolam (or *Xanax*)— 0.5mg, or half a tablet, twice a day

Throughout my research, I was unable to verify if this regime of care was a standardized practice for all people in Morocco, or one based on regional-level resource availability. Regardless, gaining access to care is a crucial human right that must be observed by all health practitioners, policy makers, and medication providers.

*Health and Migrant Rights*

No matter the securitization or politicization of migration or migrant health, the human right to health is incredibly important in migrant communities. Specifically within undocumented communities, having access to healthcare is integral for survival and integration with host communities or within periods of transience. Based on the evidence, undocumented sub-Saharan migrants living in Morocco lack basic access to care due to security, financial, and racial challenges. The daily experiences of people within the migrant community contributes to a lack of access to healthcare, a lack of communication, and a lack of trust between the Moroccan and the migrant community. Compounded over a period of time, this contributes to a higher-than-average prevalence of morbidity within the migrant community. The right to health for undocumented migrants within Morocco is, thus, inhibited by the conditions of life in Morocco.

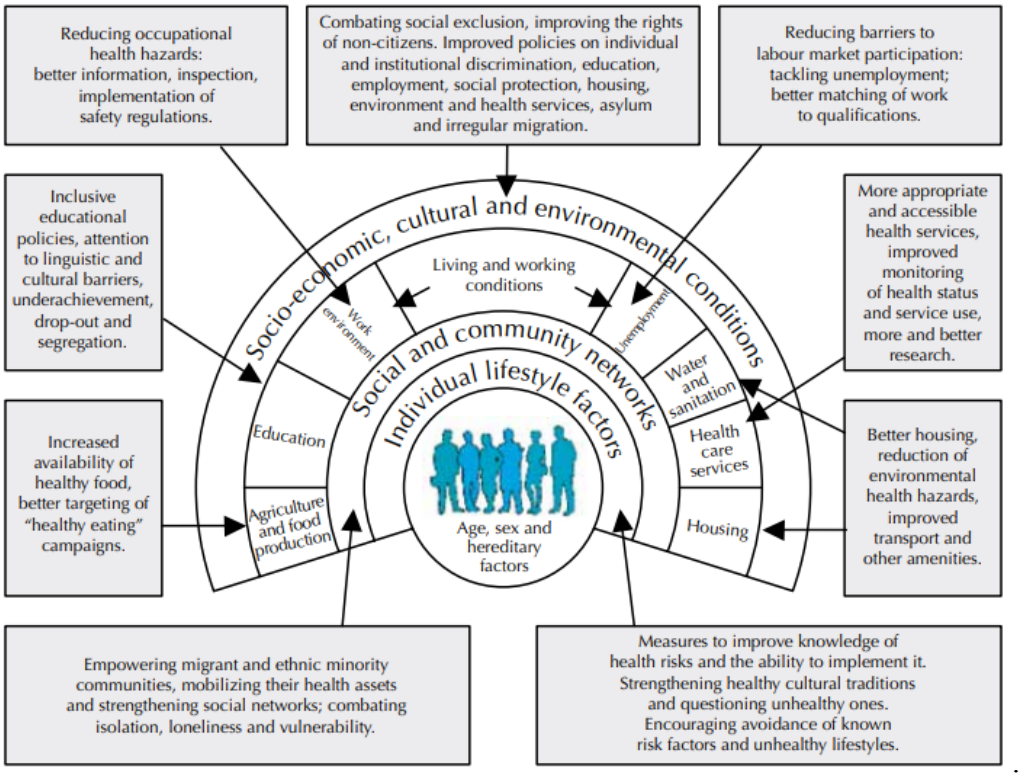
This right to health, according to the Committee on Economic, Social and Cultural Rights is not the right to be healthy, but the right to equitable access to facilities, medical equipment, medical services (Forman et al 2016). Access to these three factors, at both a governmental and an ideological level, are crucial to be considered the "highest attainable standard of health." Because health and healthcare are immensely complex, all public health systems are limited in their ability to reach this level of health. One of the greatest limitations of a purely health-system approach to well-being is that the health sector has very limited influence on the rest of a person's life (Braveman & Gruskin 2003). This includes determinants to health, such as housing, the environment, work conditions, education, food and nutritional availability, water, and medicines. Thus, approaching health care solutions from an intersectional perspective is the only way to combat preventable morbidity and mortality effectively. For migration and migrant health, incorporating conditions of travel, stress, unstable nutritional access, exposure to the elements, mental health, and other conditions, is crucial in a migrant-conscious approach to health.

The poor approach that the health system has towards the migrant community has multiple causes. A majority of health systems around the world are designed to respond to the needs of stationary, civilian populations, and are not equipped to handle the needs of refugees and migrants, who are often mobile. Additional challenges emerge from the underfunding of the medical system, the lack of culturally-diverse medical care, the lack of public health educational programs around the country, and linguistic challenges. However, a commitment by government and civic actors to improve access to healthcare for all members of society has been correlated to social and economic development (Fiddian-Qasmiyeh et al 2016; Aguenane 2020).

One way to support the right to health for migrant populations is through continual adaptation and development of migrant-conscious public health systems. A mobility-conscious health approach is thus the development of "migrant-sensitive health systems and programmes which aim to incorporate the needs of migrants into all aspects of health services, financing, policy, planning, implementation, and evaluation" (WHO 2017, 52). Many of these "needs" include access to primary health care, language services, and culturally informed care, for non-citizen groups (Wan & Tarver 1972). Taking a migrant-conscious approach to healthcare requires adapting national disaster preparedness and response plans, establishing health system reporting mechanisms, capacity building within public systems to support migrants, and maintaining data to monitor and plan for migrant needs (WHO 2017, 9-10; IOM 2019).

As described in the 2010 WHO *How health systems can address health inequities linked to migration and ethnicity,* health systems can incorporate migrant populations by supporting integration, reducing inequalities, and making social and health services more accessible. Figure #8, from the paper, describes how external societal conditions and relationships impact migrant health. By supporting and elevating migrant voices, descuritizing public health, and increasing accessibility to care, there would be increased trust in the health system. Increased trust contributes to active engagement in the health system and healthier lives for all people in the community.

Figure #15: *How Health Systems Can Address Health Inequities Linked to Migration and Ethnicity* (WHO 2010, 14).




Many of these suggestions for improving healthcare accessibility and overall health among migrant communities are a reflection of the suggestions and criticisms provided by migrant-run NGOs communicated with throughout the interviewing process. The work of many of these groups extends beyond providing immediate support for migrants during the pandemic and has a strong legislative and advocacy component. By critiquing the health system from internal sources, community-centered improvements can be incorporated into the national and international responses to the externalization process that impacts health securitization and access to health overall.

Going back to the introduction: many of these "needs" include access to primary health care, language services, and culturally informed care, for non-citizen groups. Taking a migrant— or mobility— conscious approach to healthcare requires adapting national disaster preparedness

and response plans, establishing health system reporting mechanisms, capacity building within public systems to support migrants, and maintaining data to monitor and plan for migrant needs (WHO 2017, 9-10; IOM 2019).

# Chapter 5:

# Law, Migrant Conscious Health, and Recommendations

## *The Legality of Morocco's Public Health Response*

The way in which the Moroccan government institutionalized COVID-19 public health responses is indicative of the system in which public health operates. Due to the financial and sociological constraints, as well as the interference of international actors who have stakes in the performance of the health and migration system, the legality of many public health actions come into question. The following internationally-protected rights are analyzed:

- Right to Life
- Protection against Arbitrary Arrest and Detention
- Protection against Torture or Inhuman Treatment
- Non-Refoulement
- Prohibition against Collective Expulsion
- Equality and Non-Discrimination
- Right to Social Security
- Right to Highest Attainable Standard of Physical and Mental Health

By interpreting the migrant experience in Morocco through this legal analysis, systematic responses to the public health and migration system are addressed.

## *The Right to Life*

The Moroccan government is responsible for protecting the right to life. Under international conventions, all people have the right to life. As vulnerable populations, state and

government bodies must have special intentionality to protect the right to life of people with migrant status (ICCPR 1966, Article 6; ICRMW, Article 9). Governing bodies must also seek justice for those whose lives were lost or taken in transit through, too, and from their territories (UN 2013, 4). This special intentionality includes protecting the right to life of people attempting irregular border crossings, including people attempting crossing at seas, deserts, and forests (IJRC 2018).

The current migration framework, with international pressures dictating that ODA funding, intraregional and international trade, and political representation are linked to migration, has securitized many aspects of migration. The right to life, as observed under international conventions has simultaneously been both respected and ignored, though not in equal proportion. Prior to the pandemic, Human Right Watch reported that the Moroccan government had sanctioned the deportation of hundreds of sub-Saharan migrants into the Saharan desert ("Abused and Expelled" 2015). This informal death sentence clearly violates the right to life of migrants. Likewise, in interviews with Gabriel, the only person with migrant status who regularly inhabited the forests around Tangier, there were reports that police and security personnel had used dogs, sticks, and weapons to severely injure, and sometimes kill, migrants. These direct actions by inadvertent representatives of the state body directly constitute murder and the disregard for the right to life. Finally, the initial public health response to the pandemic failed to include migrant lives. Though gradually incorporated, the public health system's absence of inclusion violated the right to fair treatment and thus the right to life and health.

*Protection against Arbitrary Arrest and Detention*

The Moroccan government failed to protect migrants from arbitrary arrest and detention. Like the right to life, states have the obligation to protect people from arbitrary arrests and detentions. No person, regardless of migrant status, should be detained without reason or without communication pertaining to the detention. Numerous international conventions, such as the European Convention on Human Rights (ECHR) and the International Covenant on Civil and Political Rights (ICCPR), describe the roles of the government in *preventing* arbitrary arrests and detentions. However, as demonstrated in Morocco's COVID-19 response, the arbitrary detainment of people with migrant status violates these international standards. The gross misappropriation of public health policy and public health response is a violation of migrants' innate human rights.

*Protection against Torture or Inhumane Treatment*

The Moroccan government failed to protect migrants from inhumane treatment. The gross conditions of COVID-related detention centers constitutes inhumane treatment. According to the Universal Declaration of Human Rights (UDHR), ICCPR, the ECHR, and the African Charter, inhumane treatment is "at least such treatment as deliberately causes severe suffering, mental or physical, which, in the particular circumstances, is unjustified" ("The Greek Case" 1970). Specifically, Article 7 of the ICCPR states that, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation."

The oral testimonies of non-consent relating to COVID tests is a clear violation of the government's role in preventing torture and inhumane treatment. By failing to provide culturally-sensitive, linguistically appropriate instruction regarding the COVID tests and

COVID procedures, the Moroccan government failed to justify the large-scale detentions of people with migrant status in Morocco. Likewise, though not an "experiment," forcibly and non-consensually conducting COVID tests on any person is a violation of his or her human rights. Descriptions of COVID detention centers show a clear violation of the protections against inhuman treatments. Interviewees told stories of empty rooms, sleeping on floors, excrementing into buckets, and being denied food and changes of clothes. Despite the claim of the mid-level Ministry of Health employee that "these [detained] immigrants stayed in a normal situation, meaning that they were fed and dressed," testimony and rumors challenge the official report.

*Non-Refoulement*

The Moroccan government failed to uphold the right to non-refoulement. The principle on non-refoulement was first addressed in the 1951 Convention and the 1967 Protocol on the Status of Refugees. As described by the OCHCR, "The prohibition of refoulement under international human rights law applies to any form of removal or transfer of persons, regardless of their status, where there are substantial grounds for believing that the returnee would be at risk of irreparable harm upon return on account of torture, ill-treatment or other serious breaches of human rights obligations" (2019, 1). Accepted as international customary law, non-refoulement is a crucial aspect of migration legislation (IJRC 2018). Under human rights law, returning any person to their origin country, or transporting them to another location that poses the individual any sort of harm is illegal. This includes deportations *within* third-country territories (Frelick et al 2016, 199). Due to Morocco's relationship with the Western Sahara, it is politically contentious to define the region as an independent state. If the Western Sahara is deemed an

autonomous region, then Morocco is violating the right to non-refoulement across international lines. However, if the Western Sahara is deemed a non-autonomous region of Morocco, the internal displacement of migrants remains a domestic issue.

Under the most commonly accepted definition of non-refoulement, one of the limitations is the OHCHR's conditioning of non-refoulement with "irreparable harm." Thus, deporting people with migrant status from Tangier to Laayoune does not qualify as a violation of non-refoulement as there is limited proof of "irreparable harm." However, the reports that Morocco systematically deports into the Sahara Desert and to the Algerian border does constitute irreparable harm, since individuals' lives may be lost. These actions show that the Moroccan government has institutionalized migrant practices that actively violate the right of non-refoulement.

*Prohibition against Collective Expulsion*

The Moroccan government failed to protect migrants from collective expulsion. The prohibition against collective expulsion is deeply related to the right of non-refoulement. Migrants are continuously deported en masse and, according to interviews and in documents provided by NGOs, many migrants are deported without any legal counsel or judgment. The right to legal representation and due process and the prohibition of collective expulsion is addressed in the African Charter, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW), the ECHR, and other international conventions. Significantly, the General Comment No. 29: States of Emergency of the UN Human Rights Committee has stated that,

> As confirmed by the Rome Statute of the International Criminal Court, deportation or forcible transfer of population without grounds permitted under international law, in the form of forced displacement by expulsion or other coercive means from the area in which the persons concerned are lawfully present, constitutes a *crime against humanity* [emphasis added].

Morocco's expulsions of migrants are thus a violation of their human rights.

*Equality and Non-Discrimination*

The Moroccan government failed to promote equity and protect against discrimiantion among the migrant community. The right to equal services and opportunities and the right to non-discrimination is addressed in the International Covenant on Economic, Social and Cultural Rights (ICESCR), ICCPR, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the International Convention on the Elimination of all Forms of Racial Discrimination (ICERD) (IJRC 2018). Within Morocco, systematized non-equality and discrimination are exemplified in birth certificates. Lorina reported she was denied the birth certificates of her three children because she was not able to pay her medical fees. Without these birth certificates, Lorina is unable to register her children for public school and is severely limited in her ability to gain access to government-level social services. The policy of retaining paperwork is discriminatory against people in poverty, which targets many more migrants than Moroccans (who are mostly provided for under the CNSS). Likewise, the arrest and detainment of black Africans, the forcible administration of COVID tests, the denial of services to migrants, and the lack of

enforcement in rent moratoriums for migrant households during the period of forced confinement constitutes active discrimination against migrant communities.

*Right to Social Security*

The Moroccan government failed to protect the right to social security.. All people have the right to social services regardless of their citizenship status. However, according to the ICRMW, if a state denies an individual these rights, the government must defend its decision for refusing social security. In Morocco, access to the RAMED card and the CNSS system is guaranteed under national law for people with migrant status. However, in the fourteen interviews conducted with migrants, only a single person was aware that RAMED existed and that migrants had the right to apply for services. According to one of the ALECMA representatives,

> No migrants benefit from RAMED. But it was promised, though. It was a promise from the authorities since the start of this new migratory policy. There was even a convention that was signed.... between the Ministry of Health and an agency that should normally treat this RAMED issue [and] provide this RAMED card to the migrants. But unfortunately this convention never came to fruition…
> Unfortunately, no migrant, and I say no migrant, has the RAMED card. None.

Though written into legislation, the gap between policy and practice heavily impacts access to health and the human right to health for members of the migrant community in Morocco.

*Right to Highest Attainable Standard of Physical and Mental Health*

The Moroccan government failed to promote the right to the highest attainable standard of physical and mental health among migrant communities. Regarding health and access to healthcare, the right to the highest attainable standard of physical and mental health is a pillar of the ICESCR and the Committee on Economic, Social and Cultural Rights (CESCR). Both documents contribute to international human rights law, which stipulates that states have a responsibility to provide for the health of people with migrant status. Although the ICRMW dictates that states are only required to provide medical attention when a person's life is in immediate danger, many other international documents attest that primary and secondary medical care is of great importance (IJRC 2018).

For example, the Committee on the Elimination of Racial Discrimination (CERD) states that states have an obligation to "ensure… the right of [undocumented] non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services" (2004, 5). General comment 14 of the CESCR expands this requirement, stipulating that nations have an obligation to respect, protect, and fulfill the right to health for all people regardless of the documentation or citizenship status. Through this requirement, CESCR requires that states

> Refrain from denying or limiting equal access for all persons... and abstain from imposing discriminatory practices relating to women's health status and needs. Ensure that third parties do not limit people's access to health-related information and services.

> [Ensure the] state to take positive measures that enable and assist individuals and communities to enjoy the right to health. (“About the Right to Health, n.d.)

As demonstrated by Morocco’s public health response to COVID, the violation of the right to health was continuous and reflected in a multitude of ways.

It is important to note that many of Morocco’s public health responses affected not only migrant communities, but all people in Morocco. Throughout the summer of 2020, videos of Morocco’s police force hitting unmasked civilians with batons went viral. Likewise, videos of the military in large tanks rolling through Rabat, the capital, shook the Maghreb and those watching events around the world. While every single person in Morocco felt the consequences of these lockdown procedures, migrants remained the most vulnerable group and felt the weight of poorly implemented COVID legislation the most intensely.

*ASCOMS, representing domestic critiques of the system*

Many migrant organizations responded to the weight of the pandemic by collaborating on documents and releasing reports to the public. One of these organizations was ASCOMS. During my interview with one of the ASCOMS represented, I was forwarded the document that his organization had created to appeal to the Moroccan government. The document was titled *Humanitarian aid mobilization campaign to support migrants in this crisis situation of the spread of the COVID-19 pandemic.* In the text, ASCOMS appealed for additional government funding under the purview of a humanitarian crisis in which migrants were excluded from the COVID-response process. The document reads, as follows:

In the context of COVID-19, it appears imperative to raise the question of their [migrants] accommodation in decent conditions, a precondition necessary for confinement and limitation of contacts, but also their access to hygiene necessary for barrier gestures, their food (insofar as these people can no longer beg on public space) and their health care in order to follow the evolution of the disease in the event of contamination.

It is also necessary to ensure the transmission of reliable information concerning the support services, the health and safety measures to be taken and the regulations concerning mobility that the Moroccan State imposes during the period of response to the crisis. It is important that these messages are available in Arabic, French, Amazigh and English.

Guarantee access to food for all people in vulnerable situations who can no longer access it as before.

Ensure the follow-up and health care in case of illness, beyond assistance in case of symptoms of COVID-19

Faced with these needs, an integrated response is essential. Civil society organizations are not able to deploy such a response in view of the resources available (material and human). An integrated response also requires the approval of the authorities, who will have to accept interventions in the public space, the provision of sufficient economic resources, support on the issue of rehousing, etc., as well as the establishment of " a risk analysis and appropriate measures to manage these risks. To date, the conditions for implementing an integrated response have not been met.

ASCOMS argues that these needs can be met through the principles of humanitarian action, which the organization cites as including Humanism, Neutrality, Impartiality, Operational Independence, and Non-Malfeasance. ASCOMS also argues for the more active inclusion of people with special needs— homeless children, victims of domestic violence and trafficking, pregnant women, and people who are sick or have a disability— in the public health response. If legislation and programs to respond to these sectors of the population are created, the organization predicts that all of the migrant community will be better off during the pandemic.

In citing the AU Displaced Persons Convention of 2009, the African Charter, the UDHR, the ICCPR, the ICRMW, the Global Compact for Safe and Orderly Migration, and the 2011 Moroccan constitution, ASCOMS also makes recommendations for change. These specific recommendations are broken into categories: the pandemic-created Economic Watch Committee (CVE), the "Authorities," and the International Office of Migration (IOM). ASCOMS recommendations are the following:

**Economic Watch Committee-CVE:**

Broadens the two support measures for employees declared to the CNSS and not declared to the CNSS who are informal workers who are RAMEDists, impacted by the Coronavirus crisis and the measures taken by the authorities to deal with them. migrants in a regular administrative situation, taking into account the database of the first and second regularization phases recorded;

To create, as quickly as possible, conditions of humanitarian and social assistance to migrants in an irregular administrative situation and seeking asylum;

Create a moratorium on the payment of rent for migrants and asylum seekers who are devoid of all activities during this period;

Total care for pregnant women.

**Authorities:**

Regularization of migrants and asylum seekers in an irregular administrative situation;

The suspension of all deportation, arrest and detention practices for migrants and asylum seekers during this delicate period of compulsory confinement;

Respect for the fundamental labor rights of all working people, including migrant workers and asylum seekers on sick leave.

**International Organization for Migration (IOM):**

The platform of associations and sub-Saharan communities in MOROCCO (ASCOMS), is concerned about the absolute silence and the lack of action of the only International Organization for Migration in favor of accompanying measures for migrants as UNHCR is already doing, for refugees.

ASCOMS concludes their formal public appeal by concluding, “No action has been taken in favor of migrants and asylum seekers outside the initiatives launched by CSOs [service-providing organizations]. This lack of attention from the authorities involved in the process of fighting the COVID-19 pandemic, gives rise to many concerns and the feeling of abandonment among migrant communities.” This report describes the consequences of an underdeveloped, underprepared public health system and system of governance that failed to incorporate people with migrant status into its COVID response. The problems cited and the recommendations suggested are attributable to pre-pandemic situational conditions, many of which have additionally been critiqued by other NGOs, national organizations, and international actors. Organizations such as the Anti-racist Group for the Support and Defense of Foreigners

and Migrants (GADEM), the Independent Moroccan Association of Human Rights (AMDH), the Moroccan Organization for Human Rights (OMDH), the Moroccan Association for Studies and Research on Migration (AMERM), and the Fondation Orient Occident have been continuously lobbying against the inequitable treatment of the migrant community both before and during the pandemic (Jacobs 2017). Like ASCOMS, these additional NGOs have called for changes regarding specific issues such as police brutality, equal access to healthcare, an end to refoulement and educational and employment opportunities (Jacobs 2013).

Even Moroccan-based media sites such as Morocco World News, Médias24, and Medi1TV frequently publish stories describing the harsh treatment of migrants. Some articles describe illegal treatments, blatant disregard for national law, forced deportations, court appearances without translators, refusals of care in medical settings, segregated education, and the murder of migrants by national security forces ("Moroccan Police Arrest" 2019; "Morocco: Relentless Crackdown" 2018; Seymour 2019).

*International critiques of the Morocco's treatment of Migrants*

These portrayals of Morocco's treatments of migrants among both Moroccan civil society and media have shaped international perceptions of the migrant crisis in Morocco. International governmental organizations (IGOs) and international non-governmental organizations (INGOs), such as the IOM, Amnesty International, UNHCR, and other groups, report and publish comments and critiques on the implementation of international policy.

The IOM has hundreds of such reports, and a general survey of their online database finds that the organization's primary opinion on migration in Morocco is that the government must drastically improve its efficiency and work against claims of discrimination. Amnesty

International has, likewise, published very explicit critiques of migration in Morocco. One 2018 article, "Morocco: Relentless Crackdown on Thousands of sub-Saharan Migrants and Refugees is Unlawful," clearly expresses disapproval for the system and cites forced "round-ups and removal" as violations of personal rights and liberties ("Morocco: Relentless Crackdown" 2018). Amnesty's *State of the World's Human Rights 2017/2018* report for Morocco was also very critical of Morocco's migration policy implementation. The release of this report led to the condemnation by the Moroccan government of Amnesty International for the presentation of "false information" ("Morocco Rejects" 2019).

The United Nations *Report of the Special Rapporteur*, another international opinion, highlighted concerns regarding racism and discrimination faced by migrants in Morocco. In addition, a major concern of the Special Rapporteur was that "pregnant women, children, sick persons, United Nations-recognized asylum seekers, and refugees, and registered migrants holding a residency card, had been forcefully relocated" (2019, 14).

Although the report also critiqued the discrimination and endangerment of LGBTQI migrants, as well as the overall discrimination faced by migrants for their race, the Special Rapporteur commended Morocco's positive responses to migration issues. These commendations included the creation of the African Union Migration Observatory in Rabat, the proposed large-scale national survey that would assist in the analysis of migrant data and trends, and the two 2014 and 2017 regularization campaigns.

The Special Rapporteur stated,

> As a matter of national policy, Morocco has generally displayed praiseworthy commitment to the human rights of migrants and refugees. Morocco's policies –

> which are still a work in progress – deserve international recognition, and in many cases, international emulation…
>
> The Special Rapporteur commends the decision of Morocco to reject the warehousing of migrants in immigration detention centres, and instead to adopt a formal policy aimed at integrating migrants into its society. The Special Rapporteur also commends the recent decision by Morocco to reject European Union attempts to locate offshore asylum processing or "regional disembarkation" centres within Moroccan territory (2019, 13).

The Special Rapporteur concluded, "Morocco must cease any and all immigration enforcement policies that result in gross human rights violations… [and] European Union and its member States, must take responsibility for the role they must play in ensuring migrants' human rights in Morocco" (2019, 14). This call for accountability is key. Numerous factors influence how health is perceived in Morocco, how members of migrant communities gain access to healthcare, and what and how international actors influence these systems and relationships. The coronavirus pandemic greatly exacerbated many of the human rights conditions and public health concerns that have characterized overall migrant health in the country. The pandemic also highlighted the human cost of EU-externalization policy among the migrant populations in Morocco.

# Conclusion

## The Future of Migrant Health in Morocco

Access to care serves as an indicator of integration as well as an indicator of the securitization of health as a consequence of the externalization. These external influences have shaped how Morocco's public health system has formed and will continue to form until there are less international sources of funding and subsequent manipulation within the system. The world's public health systems have been drastically affected during the pandemic, as has the migrant experience. Encouraging and supporting migrant-conscious health systems is key to promoting the right to health and to empowering members of migrant communities to have autonomy over their well-being.

Overall, this research has shown the human consequences of border externalization programs on the securitization of health, within the case study of sub-Saharan migrant communities in Morocco. The experiences of members of migrant communities in Morocco both before and during the COVID-19 pandemic serve as an example of this relationship. By conducting a review of the framework of international systems and conventions, this study evaluates the migration infrastructure that Morocco operates within. By placing the migrant experience within these legal and operation systems, interviewees stories are contextualized and overall experiences in the pandemic are framed by the understanding of the previous living conditions, legal protections, and systems of operation. Overall this research demonstrates the importance of migrant-conscious health systems. Only when *all* people are included in the health system can healthier communities be created, and more equitable living standards, justice systems, and migrant legislation be implemented.

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