ORIGINAL ARTICLE

Improving access and utilization of sexual and reproductive health services by migrant women in Morocco: A qualitative study

Améliorer l'accès et l'utilisation des services de santé sexuelle et reproductive par les femmes migrantes au Maroc: Une étude qualitative

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Abstract

Introduction-Aim: Over the past decade, Morocco has become a major migratory corridor in the Mediterranean, hosting an increasing number of migrants, particularly from Sub-Saharan Africa. This study aims to identify the barriers and facilitators to accessing sexual and reproductive health (SRH) services for migrants in Morocco, while exploring the socio-cultural, economic, administrative, and linguistic factors that influence access.
Methods: We employed qualitative methods through focus group discussions (FGDs) with migrant women (n = 24) and men (n = 24). A total of 48 participants, residing in Morocco for at least three months, were selected, all of whom had experience with public healthcare facilities for SRH services. The study was conducted in July 2024 in two regions (Rabat and Casablanca).
Results: The majority of the 48 participants were young adults aged 18 to 34 (61%), mainly from Côte d'Ivoire (60%). Although all spoke French, only 6% had medical coverage, and 23% had a source of income. The main obstacles identified were lack of information, stigmatization, language and cultural barriers, as well as administrative and economic difficulties. Facilitators included a quality welcome, support from associations and NGOs, confidence in Moroccan health services, support from health professionals, and free access to certain services.
Conclusion: The results highlight significant difficulties migrants face in accessing healthcare in Morocco. Efforts are needed to enhance inclusion, reduce discrimination, and simplify administrative procedures to improve access to healthcare for migrants.

Key words: migrants, migrant health, access to health, health services accessibility, sexual and reproductive health, Morocco.

Résumé

Introduction-Objectif: Au cours de la dernière décennie, le Maroc est devenu un corridor migratoire majeur en Méditerranée, accueillant un nombre croissant de migrants, surtout d'Afrique subsaharienne. Cette étude vise à identifier les obstacles et les facilitateurs de l'accès aux services de santé sexuelle et reproductive (SSR) pour les migrants au Maroc, tout en explorant les facteurs socio-culturels, économiques, administratifs et linguistiques qui influencent cet accès.
Méthodes: Des méthodes qualitatives ont été utilisées via des groupes de discussion (focus groups) parmi des femmes (n = 24) et des hommes migrants (n = 24). Les 48 participants, résidents au Maroc depuis au moins 3 mois, avaient tous une expérience avec les établissements publics de santé pour les services de SSR. L'étude a eu lieu en juillet 2024 dans deux régions (Rabat et Casablanca).
Résultats: La majorité des 48 participants étaient des jeunes adultes âgés de 18 à 34 ans (61 %), principalement originaires de Côte d'Ivoire (60 %). Bien que tous parlent français, seuls 6 % bénéficiaient d'une couverture médicale, et 23 % avaient une source de revenu. Les principaux obstacles identifiés étaient le manque d'information, la stigmatisation, les barrières linguistiques et culturelles, ainsi que les difficultés administratives et économiques. Les facilitateurs incluaient un accueil de qualité, le soutien des associations et des ONG, la confiance dans les services de santé marocains, le soutien des professionnels de santé, et l'accès gratuit à certains services.
Conclusion: Les résultats montrent d'importantes difficultés d'accès aux soins pour les migrants au Maroc. Des efforts sont nécessaires pour améliorer l'inclusion, réduire la discrimination et simplifier les procédures administratives.

Mots clés: migrants, santé des migrants, accès à la santé, accessibilité des services de santé, santé sexuelle et reproductive, Maroc.

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Introduction

In the 21st century, migration has become a significant phenomenon, as people seek better opportunities, greater security and a higher quality of life (1). Currently, there are approximately 1 billion migrants worldwide, which represents about one in eight people globally (2). According to the United Nations estimate, this figure includes 281 million international migrants and 82,4 million forcibly displaced individuals, comprising 48 million internally displaced persons, 26,4 million refugees, and 4,1 million asylum seekers (3).

Morocco is the nearest country to Europe on the African continent. Due to its geographical situation, Morocco has increasingly become the destination of choice for a large number of countries, particularly in sub-Saharan Africa (4). In 2021, the International Organization for Migration estimates that Morocco hosted 102 000 migrants (0.3%), half of whom were women (5). The High Commission for Planning (HCP) conducted a second national survey in 2021 on international migration, estimating that the main countries of origin for migrants and refugees in Morocco are the Democratic Republic of the Congo (19.1%), Côte d'Ivoire (16.7%), Senegal (15.9%), and Guinea (13.2%) (4). Many migrants originate from countries characterized by structural violence, economic hardship, and political instability (6). Moreover, during their migration journey and in their host countries, migrants face further challenges, including xenophobia, discrimination, poor living, housing, working conditions, and limited access to health services (2). Upon arrival in their destination country, refugees and migrants frequently carry untreated non-communicable diseases due to insufficient care during transit (7). Maternity care often serves as the primary point of entry into healthcare systems for female refugees and migrants (7). In addition, women and girls are often faced with sexual and reproductive health (SRH) challenges, including limited access to maternity services provided by qualified personnel (8), unplanned pregnancies and cases of voluntary abortion (9), inadequate prenatal care (10), and poor use of contraceptive methods (11).

In 2014, the Ministry in Charge of the Moroccans Residing Abroad and Migration Affairs adopted a National Strategy of Immigration and Asylum due to the increased flow of migrants (12). The objective of this strategy is to facilitate the integration of regularized immigrants, to manage migration flows while respecting human rights, and to establish an appropriate regulatory and institutional framework (12). This strategy also aims to improve all fundamental areas of human rights, including education, health, housing, social and humanitarian assistance, vocational training and employment, management of migration flows and the fight against human trafficking, international cooperation and partnerships, the regulatory and conventional framework, governance, and communication (12). In 2017, the Ministry of the Interior, the Ministry responsible for Moroccans residing abroad and migration affairs, the Ministry of Economy and Finance in charge of the budget, and the Ministry of Health signed an agreement to provide immigrants and refugees with a healthcare package similar to the Health Insurance Scheme for economically disadvantaged individuals (RAMED) (13). The following year, the Ministry of Health, in partnership with non-governmental organisations (NGOs), organised a two-month national tuberculosis screening campaign with partners from migration organisations in Morocco (12). 5553 migrants were tested for human immunodeficiency virus (HIV) and 12 013 migrants were trained and informed about HIV prevention (12). The Ministry of Health has offered national programmes that benefit migrants, including family planning, maternal and child health and reproductive health care (14).

Despite these governmental efforts, migrants in Morocco still encounter difficulties in accessing health services (15) due to linguistic and cultural barriers, administrative barriers, economic barriers, a lack of health professionals trained in cultural diversity and a lack of information on available health services (15). Therefore, this study aims to identify the barriers and facilitators that prevent migrants from accessing SRH services in Morocco and to explore the socio-cultural, economic, administrative and linguistic factors that influence access to these services, taking into account the migrants' own perspectives and experiences within the Moroccan health system.

Methods

Study design

A qualitative study was conducted using focus group discussions (FGDs) with migrants (men and women) who had been residents in Morocco for at least 3 months and who had experience with Moroccan public health facilities for SRH services. The study was conducted in July 2024 in two regions of Morocco (Rabat and Casablanca) with a high concentration of migrants.

Data collection and population

During the month of July 2024, a total of four FGDs were conducted in two regions in Morocco with a high concentration of migrants: Casablanca and Rabat. The inclusion criteria for participating in the FGDs included: 1) Being a migrant: a woman aged between 18 and 49 years or a man at least 18 years old who has a wife, a sister, or a daughter with experience in healthcare facilities: SRH services; 2) having been in Morocco for at least three months; 3) having experience with Moroccan public healthcare facilities for SRH services; and 4) being a French speaker. Non-inclusion criteria included migrants residing in Morocco for less than three months, non-French speakers, those who had never attended Moroccan public health facilities for SRH services, and minors (under 18). Exclusion criteria included voluntary withdrawal of participants at any time before or during the FGD and inability to participate actively due to a physical or psychological health condition.

The focus group was conducted by research team members. This approach aims to capture the different

voices and experiences of these migrant communities. Hence the FGDs were held in French to ensure maximum participation.
Each region has hosted two FGDs: one for women, where French was used, and one for men, also in French. There was a total of 4 FGDs spread across the two regions: 2 FGDs per region. We had 48 participants, in total: 24 women and 24 men, offering a diverse perspective on SRH issues in the context of migration in Morocco.
Semi-structured interview guides have been developed to gather the participants' views on sexual and reproductive health services for migrant women in Morocco.
On average, each FGDs lasted between 100 and 120 minutes. Audio recordings were made during the session to ensure accurate data collection, and then we transcribed it and analysed it manually.

Analysis

The semi-structured interview covered several key sections to assess barriers and facilitators to accessing SRH services for migrants. The sections assessed by the interview guide included, knowledge of SRH services, to assess migrants' familiarity with these services, accessibility to health facilities, by examining physical, administrative and logistical barriers, relevance of SRH service provision, to assess whether services meet migrants' needs, universal health coverage in SRH, by exploring perceptions of free services and indirect costs; individual barriers, linked to migratory status, language, gender, age and literacy; and perceptions of stigmatization, by assessing experiences of discrimination encountered in healthcare facilities.
Each audio recording has been transcribed to preserve the authenticity of the exchanges. The notes taken have also been recorded in French for analysis purposes and translated into English. During the transcription, the names of the participants were removed and replaced with an assigned identifier to maintain their confidentiality.
The transcripts were analysed by grouping the data collected by theme. This analysis was carried out methodically, following essential steps to ensure the reliability and rigour of the results. The data collected during the FGDs was then transcribed manually, which preserved the integrity of the participants' words. This manual stage also allowed for in-depth familiarisation with the data. The transcripts were then read several times to identify key findings.
Once this in-depth reading was complete, the data was classified by theme using thematic analysis, a method commonly used in qualitative research. These themes were grouped into two main categories: on the one hand, the barriers to access to SRH care encountered by migrants in Morocco, and on the other, the facilitators of this access.

Ethics/Approval

This study has been approved by the ethics committee. Participants were informed of their right to withdraw from the study at any time. They had the option to respond individually or as a group, to abstain from answering a question, after which the facilitator would move on to the other members of the group before returning to them for the next question. They were also informed that the information they provided would be strictly confidential and would only be shared with the members of the research team. Anonymity has been preserved to ensure data confidentiality and protect the participant's identity.

Results

Demographic and socio-economic characteristics of the study population (Table 1,2,3 and 4)

We had 48 participants included in our study and the majority were young adults: age between 18 to 34 (61%). Majority of them was from Ivory Coast (60%), Cameroon (14%), Mali (10%), and then, the rest was from Guinea and Guinea Conakry (8%). Finally, Sierra Leone, Burkina Faso, Central Africa and Congo Brazzaville represent in total 8%.
All participants spoke French. Hence, the majority had secondary or have been at university (61%). However, a significant percentage were illiterate (17%). Majority of those migrants (92%) have been living in Morocco for more than one year in irregular situation (no residency card). Despite their long period of presence in the country, only 6% had medical cover and 23% said that had a source of income.

Barriers to access SRH services in Morocco

Analysis of the data collected through those 4 FGDs—24 men and 24 women in the Casablanca and Rabat regions—enabled us to identify six main barriers faced by migrants in accessing healthcare services in Morocco. These barriers are: lack of information and education, stigmatisation and discrimination, challenges due to geographical access, linguistic and cultural barriers, administrative and documentary barriers, and economic barriers.

Lack of information and education
Lack of information about services available in health facilities is one of the main barriers to accessing care. All the participants emphasized on the importance of knowing all the information needed to access, easily SRH services, mainly because of the risks associated with unwanted pregnancy and childbirth and sexually transmitted infections. A participant expressed the need for receiving accurate information on how to take precautions during sexual relations.
« *Yes, it's important because we have needs: we are all human beings. If we want to have sexual relations, we want to know how to protect ourselves with men. It is normal for us to be given information so that we can take precautions to avoid pregnancies. If we are taught, it would allow us to protect ourselves well and avoid unwanted pregnancies, disease, and violence.* »

Table 1. Demographic and socio-economic characteristics of migrant women (Rabat)

Participant ID (CI) Code	Country of origin	Age	Level of education	Number of children	Length of stay in Morocco	Migration status in Morocco	Type of medical coveage in Morocco	Employment in Morocco	Health establishment visited during the stay in Morocco					
									Public hospitals	Health Centres	Clinical	Private medical practices	Laboratories	Other
FGF201	Ivory Coast	41 years old	No	3	1 year	Irregular	No	No	No	Yes	Yes	Yes	No	No
FGF202	Mali	36 years old	No	3	8 years	Irregular	No	No	Yes	Yes	No	No	Yes	No
FGF203	Ivory Coast	34 years	No	2	4 years	Irregular	No	Not	Yes	Yes	No	Yes	No	Association
FGF204	Ivory Coast	28 years old	1 Primary	2	3 years	Irregular	No	No	No	Yes	No	No	No	No
FGF205	Ivory Coast	32 years old	3rd middle school	1	2 years	Irregular	No	No	Yes	Yes	Yes	Yes	Yes	No
FGF206	Ivory Coast	35 years	No	1	7 months	Regular	Not	Not	Yes	Yes	No	No	No	No
FGF207	Ivory Coast	23 years old	Third grade	1	1 year	Irregular	Not	No	Yes	Yes	No	Not	Not	Not
FGF208	Ivory Coast	24 years old	2 Primary	3	6 years	Irregular	Not	Not	Yes	Yes	No	No	No	No
FGE209	Ivory Coast	57 years old	No	7	3 years	Irregular	No	Maid	Yes	No	No	No	No	Pharmacy
FGF210	Ivory Coast	22 years old	3rd middle school	1	2 years	Irregular	No	Maid	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGF211	Ivory Coast	29 years old	2nd year bachelor's degree	0	4 years	Irregular	No	Maid	No	No	Yes	No	No	No
FGF212	Ivory Coast	23 years old	1 Primary	1	3 years	Irregular	No	No	Yes	Yes	No	No	No	No

Another participant also spoke about the importance of access to reliable information on how to navigate in the healthcare system and obtaining the necessary documents.

« *Everyone needs to go to the source of information, if you don't even have the information you need. Maybe your experience is better than someone else's. Everyone needs to go to the source of information to do what's necessary and get the documents they need, to get reliable information and have your own experience* »

On the men's side, there is a general lack of understanding of the Moroccan healthcare system, particularly among those coming from rural areas in their home countries. A participant said that he doesn't know the procedures and the necessary information to obtain care, which leads to delays and treatment refusals.

« *No, we are not sufficiently informed about that. We are not informed about which structures in the health centres can consult a patient.* »

Stigmatisation and discrimination

Health-related stigmatisation and discrimination were identified as major barriers to accessing healthcare. The majority of participants reported experiences of discrimination based on their migratory status and ethnic origin. One participant described a situation where sub-Saharan migrants were treated differently from Moroccans during a strike.

« *In my case, my daughter is nine months old, and I went to the vaccination appointment. They told me they were on strike. But we sub-Saharans were told to wait in the other room. But the Moroccans were allowed in. My child is already a year old, and he wasn't able to have his nine-month vaccination. When you go over there, you're told to stay out. You stand in a vacuum. Even if they tell us there's a strike, we'd like to have some explanations. We're abroad and we need communication. But at least half of it to know what attitude to adopt. Communication is necessary.* »

Another migrant said:

« *Sometimes they'll look at you badly or behave in a way which is not normal. They won't take care of you.* »

Table 2. Demographic and socio-economic characteristics of migrant men (Rabat)

Participant ID	Country of origin	Age	Level of education	Number of children	Length of stay in Morocco	Migration status in Morocco	Type of medical coverage in Morocco	Employment in Morocco	Health establishment visited during the stay in Morocco					
									Public hospitals	Health Centres	Clinical	Private medical practices	Laboratories	Other
FGH201	Guinea	27 years old	Bacca-laureate +4 years (Master's)	2	5 years	Irregular	No	No	Yes	Yes	No	No	No	No
FGH202	Guinea	18 years old	2nd year middle school	0	6 months	Irregular	No	No	No	No	Yes	Yes	No	No
FGH203	Ivory Coast	32 years old	No	2	1 year and 4 months	Irregular	No	No	Yes	Yes	No	No	Yes	No
FGH204	Sierra Leon	18 years old	6th high school	0	2 years	Irregular	No	No	No	Yes	No	Yes	No	No
FGH205	Guinea Conakry	25 years	Baccalau-reate	0	5 years	Irregular	No	No	No	Yes	Yes	No	Yes	No
FGH206	Ivory Coast	35 years	Fifth grade	0	6 years	Irregular	No	No	Yes	Yes	Yes	No	No	No
FGH207	Ivory Coast	25 years	1st middle school	0	2 years	Irregular	No	No	Yes	No	No	No	Yes	No
FGH208	Ivory Coast	18 years old	Baccalau-reate	0	3 years	Irregular	No	No	Yes	No	No	No	Yes	No
FGH209	Ivory Coast	35 years	Baccalau-reate	0	14 years old	Irregular	No	No	Yes	Yes	Yes	No	No	No
FGH210	Guinea Conakry	30 years	Bachelor's level	0	6 years	Irregular	No	No	Yes	Yes	Yes	Yes	Yes	No
FGH211	Burkina Faso	21 years old	Technical Diploma (Electricity)	0	8 months	Irregular	No	No	Yes	Yes	Yes	Yes	Yes	No
FGH212	Ivory Coast	19 years old	5th high school	0	3 months	Irregular	No	No	Yes	Yes	Yes	Yes	Yes	No

A migrant described his experience of blatant discrimination, and felt ignored and treated poorly by Moroccan doctors.

« *In SOUISSI, not all the doctors treated me. It was the [Spanish doctors] who treated me if I didn't want to die. All the doctors in SOUISSI are racists. Moroccans are racist towards us. I went to SOUISSI and none of the doctors looked at me as if I wasn't human. I come up to the doctor and he runs. In SOUISSI, if you go there, the doctors don't even look at you. Even though I spent the money, I didn't get any treatment. I don't know if it's because we're black, even though we were created by the same God.* »

Another migrant man expressed the idea that discrimination goes beyond financial resources and is deeply rooted in mentalities.

« *Even if you have the means, it doesn't change anything. Discrimination is also a question of mentality: you can have money, but you don't have what [you need].* »

Difficult geographical access

A migrant woman told the story of a young Ivorian woman who arrived in Morocco in precarious conditions and suffered from a serious infection that went untreated due to a lack of rapid access to medical care.

«*Last week, last week, we learned that an Ivorian woman was under contract.' She looks like she comes from a village in Ivory Coast. She's 19 years old and now she's ill. Her illness has got worse: she has developed an infection. When she showed it to her aunt, she had a serious injury (the front of her body is damaged). They took her to hospital and said she had an infection. At Hay HASSANI hospital, the director was very angry; he wanted to go to the police. She is still ill. 'We need to do some tests to see exactly what's wrong with her.* »

Language and cultural barriers

Participants also mentioned language and cultural barriers. The lack of communication is effective in strengthening access to services, as one participant pointed out.

« *I think there's a problem of communication. In a country like this, we know that the people at the main entrance have to be able to express themselves in French, because we're blocked because of the lack of understanding. You don't know which direction to take, where to go. You have to put the right people in the right place. I arrived earlier but I didn't get any information about this meeting we're having, for example.* »

Table 3. Demographic and socio-economic characteristics of migrant women (Casablanca).

Participant ID	Country of origin	Age	Level of education	Number of children	Length of stay in Morocco	Migration status in Morocco	Medical Coverage in Morocco	Employment in Morocco	Health establishment visited during the stay in Morocco					
									Public hospitals	Health Centres	Clinical	Private medical practices	Laboratories	Other
FGF401	Ivory Coast	49 years old	Fifth grade	0	5 years	Irregular	No	No	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGF402	Cameron	34 years	2nd primary	1	5 years	Irregular	No	No	Yes	Yes	No	Yes	Yes	Pharmacy/ AMPF
FGF403	Ivory Coast	34 years	Baccalau-reate	1	4 years	Irregular	Yes (CNSS)	No	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGF404	Ivory Coast	40 years	Fifth grade	4	5 years	Irregular	No	Hairdresser	Yes	No	Yes	Yes	No	Pharmacy
FGF405	Mali	49 years old	3 Emme College	3	1 year	Irregular	No	No	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGF406	Mali	45 years	Koranic school	2	6 years	Irregular	No	Beautician	Yes	Yes	No	No	Yes	Pharmacy/ AMPF
FGF407	Ivory Coast	36 years old	No	4	2 years	Irregular	No	No	No	No	No	No	No	Pharmacy
FGF408	Mali	25 years	1 Primary	2	1 year	Irregular	No	Maid	No	No	Not	Not	Not	Pharmacy
FGF409	Ivory Coast	24 years old	BTS Technical Diploma in Communi-cation	2	2 years	Irregular	Not	Not	Yes	Yes	Yes	Not	Yes	Pharmacy
FGF410	Ivory Coast	34 years	4th pri-mary	1	2 years	Irregular	Not	Not	Not	No	No	No	No	No
FGE411	Cameron	40 years	2nd year high school	0	5 years	Irregular	No	No	No	No	No	No	No	AMPF
FGF412	Central Africa	40 years	1st year high school	0	4 years	Irregular	No	No	Yes	Yes	No	No	Yes	AMPF

Some participants emphasized the importance of learning the local language to make access to services easier, while some participants expressed their personal difficulty in learning Arabic despite her efforts.

« *Regarding the language, there are those who want us to speak Arabic, even if they understand French.* »

« *I have been here for eight years, and with my daughter, I went to the civil registry. They asked me to speak the language, but I don't understand. I left with some people to help me.* »

« *My daughter speaks the language very well; she doesn't speak my mother tongue or French, but she manages to speak Moroccan. But for me, I find it hard to learn this language. It's very difficult for me. There are others who learn very quickly.* »

« *We have the language problem, it's a bit difficult, we have the language barrier because a lot of people don't speak French very well. With the nurses, it's all about listening. If you speak French quickly, they can't understand you. Sometimes they call other people to help us communicate, because they don't understand the French we speak.* »

Administrative or documentary barriers

Another participant described other administrative barriers, such as the requirement to provide a tenancy agreement to access hospital services.

« *For me, it wasn't easy, it was in Casablanca.' When I first went to the hospital, the lady asked me for a tenancy agreement. I asked around, and the girls told me to leave with the bill, I left with a bill, she said I needed a tenancy agreement and didn't accept the bill. I stayed at home; I didn't go to hospital any more. I asked around and came to Rabat. I went to Médecins du Monde and they took me to hospital. I was six months pregnant at the time. In Rabat, they took care of me.* »

Other participants mentioned administrative or regulatory barriers, such as the requirement for a lease contract. A participant expressed her frustration about this regarding her child's vaccination.

« *At the hospital in Riyadh OULFA, to vaccinate African children, they ask for the lease agreement. This is a problem. While not everyone is able to secure housing with a lease agreement. So, without a lease agreement, it's difficult to get the children's vaccinations.* » Some women have shared similar experiences regarding access to healthcare. Some have benefited support and

Table 4. Demographic and socio-economic characteristics of migrant men (Casablanca).

Participant ID	Country of origin	Age	Level of education	Number of children	Length of stay in Morocco	Migration status in Morocco	Medical Coverage in Morocco	Employment in Morocco	Health establishment visited during the stay in Morocco					
									Public hospitals	Health Centres	Clinical	Cabinets	Laboratories	Other
FGH401	Congo Brazzaville	48 years old	Baccalaureate +3	2	5 years	Irregular	No	Yes	No	No	No	No	No	Pharmacy
FGH402	Cameron	30 years	Baccalaureate	0	10 years	Irregular	No	No	Yes	Yes	No	No	No	Pharmacy /ONG
FGH403	Cameron	24 years old	No	0	5 years	Irregular	No	No	No	No	No	No	No	Pharmacy
FGH404	Cameron	21 years old	3rd year of secondary school	0	5 years	Irregular	No	No	Yes	Yes	No	No	Yes	Pharmacy
FGH405	Cameron	45 years	Baccalaureate +2	7	17 years old	Regular	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Pharmacy /ONG
FGH406	Ivory Coast	21 years old	Baccalaureate	0	2 years	Irregular	No	No	No	No	Yes	Yes	No	Pharmacy
FGH407	Ivory Coast	27 years old	Baccalaureate	0	2 years	Regular	No	No	No	Yes	No	Yes	No	Pharmacy
FGH408	Ivory Coast	38 years old	Baccalaureate +4	1	5 years	Irregular	No	Yes	No	No	Yes	Yes	Yes	Pharmacy
FGH409	Ivory Coast	43 years	BTS Technical Diploma in Communication	3	2 years	Irregular	No	No	No	No	Yes	No	No	Pharmacy
FGH410	Ivory Coast	32 years old	Baccalaureate +2	1	5 years	Regular	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGH411	Ivory Coast	37 years old	Baccalaureate +2	2	13 years old	Irregular	No	Yes	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGH412	Mali	41 years old	Baccalaureate +1	1	4 and a half years old	Irregular	No	Yes	Yes	Yes	Yes	Yes	No	Pharmacy

assistance from NGOs to facilitate their access without obstacles. A migrant described this support from the NGOs:

« *My experience went well; I was accompanied by an NGO that helped us with the procedures.* »

Some participants pointed out that access to care seems to be easier for those who are accompanied by associations or who present specific documents, such as those from CARITAS or HEM.

« *I've noticed that for people who are supported by an association like MSD (Doctor of Medical Science) here or another association, or like CARITAS, they take good care of you. Or you bring the paper from HEM, they take good care of you. But if I stand up and say I'm going to take care of myself, it's not going to work.* »

« *As far as I'm concerned, with the passport, [I've shown my CARITAS card], but the lady said no, despite the CARITAS card, she told me that I need to have a residence permit. So I went to Medina, and there they took me without the residence permit.* »

Economic barriers

Finally, economic barriers are recurrent. One participant highlighted the financial difficulties associated with accessing care for a scan and the travel required to obtain and return the results to Casablanca, as well as the ineffectiveness of the drugs prescribed.

« *Once, when I had to go for a scan, it was really difficult, they made me go round: going to the cashier to pay money. People didn't want to take my money. It was difficult, even though I wanted to pay for the scan. I started shouting and speaking loudly and the director came out and took the money, he went to pay and I had the scan, then they gave me the results. On the day I had to take the results back, they told me to go back to Casablanca, because it was in Casablanca that they had prescribed the tests. So, I had to come back, which was still difficult because there were additional costs. Then they agreed to look at my results, and they told me that I had sciatica, and they prescribed the medication, but I didn't get any results after using it. Afterwards, I came back here and had another scan and I got another diagnosis: herniated disc and this time it was what I needed. They gave me the*

treatment and it worked well. »
Other participants pointed out that lack of financial means which can lead to discrimination, with people who are financially deprived sometimes being treated unequally or neglected in the healthcare system.
« This is due to a lack of resources, because when you don't have the financial means, you can be discriminated against because you don't have the resources. »
« It's both, being a migrant and not having the means. It makes the situation worse. When you're not at home, that's just the way it is. »

Facilitators to access SRH services in Morocco

Quality of welcome and personal support
Despite these many obstacles, some migrants shared their positive experiences, enabling access to healthcare. One interviewee described her experience, mentioning the quality of the welcome and personal support in certain health establishments, showing that the kindness of health professionals plays a crucial role in the accessibility of services.
« *There are hospitals where you are well looked after, like here at the health centre. They take good care of us. The lady there even gave me a massage when I had a bad back.* »
Other migrant women recounted similar experiences, particularly in hospitals where only documents such as a passport were required for access to care, and emphasised the kindness of health professionals, which facilitated access to SRH services.
« *At the Medina, they gave us a warm welcome. At the Orangers, they didn't ask me anything, just for my passport.* »
« *In any case, for my two deliveries, they took good care of me.* »

Support from associations and NGOs
Associations or NGOs as facilitators play a very important role in access to care, particularly in the provision of reproductive health services. One migrant woman shared her positive experience when an organisation helped her to obtain contraceptives free of charge, which eased the financial burden often associated with these services.
« *I was taking my little sister to give birth in SOUISI there at the hospital, in the prescription they gave the pill and we came to the association and they gave me the pills without paying. I received contraception through the association.* »
Other participants stressed the importance of associations and NGO support in facilitating their access to healthcare.
« *With the associations, the woman is well received. But if she leaves with her husband, there will be all the difficulties we've already mentioned at the hospital. But with CARITAS, we have some advantages, because CARITAS pays our bills and supports us, and everything goes well.* »
« *My experience went well; I was accompanied by an NGO that helped us with the procedures.* »
« *I had a lot of help: Handicap International, International Organisation for Migration for the difficulties, and Humanitarian Education Accelerator. The 3 NGOs help me a lot: I live with my 3 children; my daughter is 23. My husband is dead and I live alone with my children, but thank God every time I ask for help, the NGOs help me.* »

Confidence in the quality of Moroccan healthcare services
The reputation of the quality of Moroccan health services is also a very important facilitator. Several migrants expressed confidence in the quality of the care and treatment they received. As soon as they arrived, some had heard about the good quality of care, the availability of medicines and the skills of the doctors.
« *When we arrived in Morocco, we heard that we had the best doctors and the best medicines in Morocco. There's nothing to say about that.* »
« *Even in Côte d'Ivoire, we send our family members to Morocco for treatment. We don't have any problems there. There's a brother who couldn't find the treatment he needed in Côte d'Ivoire, but once he arrived in Morocco he was treated.*
There's also a mother who was treated here in Morocco, despite her serious condition. »
In addition, one migrant woman said that in Morocco, the good food and the improvement in her overall health since settling there have strengthened her confidence in the local health system.
« *I don't have any problems with that, I'm comfortable because the food is good in Morocco too. Back home, I used to get sick a lot, but since I've been in Morocco, I feel better. I'll give you my age, you won't believe it.* »

Support from healthcare professionals and hospital staff
Contact with hospital staff, including security guards, cleaners and stretcher-bearers, played an important role in the migrants' positive experience. Several of them emphasised the friendliness and humanity of hospital staff, as described by one migrant.
« *I had a good experience at Ibn Rochd Hospital; the cleaning ladies in the maternity ward are very good. They do their job; it's clean, and what's more, there's a nice lady who, on the day when my sister had to be taken off life support because her heart had stopped beating, helped me even though it was the first time I'd ever experienced that. All the cleaning staff and security guards at the maternity hospital made me feel very welcome. They're not racist. The whole team is nice.* »
Another migrant woman spoke of how a woman looked after her baby, and others said that the communication and openness of the nursing staff fostered a climate of trust and easier access to care.
« *I had a good experience: I was lying in bed with my baby, unable to move, and sometimes the baby would cry, and a lady would look after the baby. And because my baby was so bright, she would lift him up and give him to me before visiting hours. We got on really well. The lady also wanted to take the traditional herbal teas that I used to drink after giving birth.* »
« *I too had the same experience, we spent time together, so things went well. We communicated gently and with*

an open heart»

Free access to services and information

One participant highlighted two important factors in facilitating access to healthcare: fluency in the local language and the free consultations available in some health centres in Morocco. The importance of smooth communication with healthcare professionals, which helps to eliminate language barriers and facilitate access to services. In addition, the fact that consultations in Moroccan public health centres are free of charge is a significant advantage for migrants, as it reduces the financial barriers that may exist in their country of origin, where consultations have to be paid for.

« *Personally, I haven't had any problems accessing healthcare because I speak the local language well. The good thing about Morocco is that consultations are free at the health centre. But here, you have to pay.* »

A Cameroonian woman also stressed that the privileges she enjoys in Morocco surpass those in her own country, particularly in terms of free or low-cost access to medicines.

« *I'm from Cameroon, in hospital. I have certain privileges here that I don't have in my own country. During my pregnancy, I went to facilities without any problems. I was accompanied every step of the way. I didn't pay for anything apart from the prescription. But if the drugs are available on the spot, they give them to me without any problem. We're grateful for the support we get here in Morocco.* »

One participant stressed the importance of these conferences, which provide opportunities to obtain useful information to overcome certain barriers.

« *This type of conference is very welcome (Focus Group), because most of the information we get comes from our brothers who work with Handicap International. But here, by talking to you, we can get the information we need. First there is the barrier, which is a serious problem. We can talk to our community representatives and here now we can talk directly to us. That's good.* »

Discussion

This qualitative study used FGDs with migrants in Morocco to identify barriers and facilitators to accessing SRH services and to explore the socio-cultural, economic, administrative and linguistic factors that influence access to these services, taking into account migrants' perspectives and experiences within the Moroccan healthcare system.

The main findings highlight major disparities in the demographic and socio-economic characteristics of migrants (table 1,2,3,4), particularly in terms of access to healthcare services. These disparities are strongly influenced by factors such as age, origin, level of education, medical coverage, economic resources and access to healthcare and medical services as suggested by Acevedo-Garcia D et al. and Gagnon AJ et al. (16,17). Of the 48 participants included in this study, many (60%) were from Côte d'Ivoire, and the majority (61%) were aged between 18 and 34. All the participants spoke French and the majority had secondary or university education (61%). However, the majority of migrants (92%) had been living in Morocco for more than a year in an irregular situation (without a residence permit). Around 77% of participants said they had no source of income, and the majority (94%) had no medical cover.

Analysis of the data collected during the FGDs with 24 male migrants and 24 female migrants in the Casablanca and Rabat regions reveals six main barriers to accessing SRH services in Morocco. Some studies have also found that the lack of information and education about the services available is a major obstacle, compounded by migrants' lack of knowledge about the Moroccan healthcare system and their health rights, particularly among migrants from rural areas (18,19). Similarly, a study in Tunisia revealed that migrants are often ill-informed about their healthcare rights, dependent on sometimes inaccurate community networks, and that healthcare professionals lack awareness of these issues (20). We also found some studies recognising that stigma and discrimination based on migratory status and ethnic origin can affect the quality of care, with reports of racism and exclusion in hospitals (21,22). Another study highlighted that migrants often perceive discrimination in healthcare services, which can negatively influence their experience of care (23). This discrimination also breeds distrust of healthcare institutions, leading many people to avoid care even when it is available. Difficulties linked to geographical access to healthcare, in particular regional disparities, as well as topographical and climatic challenges, make healthcare infrastructures inaccessible to a significant proportion of the population as suggested by Bouirbiten S et al. (18). In addition, language and cultural barriers are a further obstacle to access to services. In particular, the lack of communication in French in some health centres prevents them from understanding procedures and navigating the health system as reported by Delescluse A and HCP (24,25). Other studies carried out in the UK and North Africa also highlight the importance of cultural and linguistic sensitivity in improving migrants' access to healthcare services (26). Moreover, Babahaji L and Haince MC et al. shown that administrative and documentary barriers include the requirement of documents such as tenancy agreements to access hospital care, as challenge for migrants who do not have formal accommodation, although some migrants pointed out that support from associations or NGOs facilitated access to healthcare services (27,28). Finally, the economic barriers associated with medical costs, tests and travel add a financial dimension to the difficulties of accessing health services as reported by Acharai L et al. and HCP (29,30). These obstacles often lead to delays, interruptions in treatment and even refusal of care due to costs, including consultation fees, transport, medication and complementary care (26). These barriers seriously impede migrants' access to SRH services in Morocco, and these results show that migrants in Morocco face complex and interrelated barriers to accessing SRH services, influenced by factors of information, stigma, geography, language, administration and finance.

Despite these numerous barriers, some migrants have shared their positive experiences in accessing healthcare, particularly in rehabilitation services. The quality of reception and personal support are essential to make services more accessible, illustrating the importance of empathy in enhancing the patient experience. Furthermore, NGOs and humanitarian organizations play a central role in filling the gaps left by the public health system. Several participants emphasized the importance of associations as facilitators, particularly by providing free or low-cost medical care, psychosocial support, and awareness programs aimed at educating migrants about their rights and the services available as reported by HCP (24). In Morocco, in the Rabat-Salé-Kénitra region, a study revealed that local NGOs play a crucial role in improving access to healthcare, by facilitating administrative procedures and offering healthcare services adapted to migrants, thus contributing to better care for their specific needs (31). Organizations like CARITAS provide crucial support that helps to bypass some of the financial and administrative obstacles that can make access to care difficult. Finally, proficiency in the local language and the free consultations offered in some Moroccan health centres are also important facilitators.

Our study has certain limitations. First of all, it focuses solely on the two major cities (Casablanca and Rabat), which limits the generalisation of the results to the entire country, particularly to rural areas that may face different barriers. Furthermore, the number of participants, while informative, remains relatively limited compared to the overall migrant population in Morocco, which affects representativeness. Finally, the impact of facilitators on access to care has not been evaluated clearly and in detail.

However, this study has several strengths. Our study is one of the few in Morocco to identify the barriers and facilitators to accessing sexual and reproductive health services among migrants residing in Morocco for at least three months. The diversity of perspectives, achieved through the inclusion of migrant women and men, has allowed for the collection of varied and detailed testimonies. Our study highlights six major barriers to accessing healthcare, thereby providing a comprehensive understanding of the challenges faced and facilitating the targeting of specific interventions. Moreover, important facilitators such as the quality of reception, personal support, as well as support from associations and NGOs have also been identified as essential for improving access to services.

To improve migrants' access to healthcare in Morocco, several actions are needed. It is recommended that the study be extended to other regions, particularly rural ones, and that the sample size be increased. Health information and education programs adapted to migrants should be developed, taking into account language and cultural barriers. Training healthcare professionals in cultural competence is also crucial to ensuring respectful care. Measures must be taken to combat stigmatization and discrimination against migrants in healthcare establishments. Strengthening infrastructures in rural areas and simplifying administrative procedures would improve access to care. Collaboration between health authorities, international organizations and migrant associations is essential to guarantee equitable access to care. Finally, mobile clinics in areas with a high concentration of migrants, offering sexual and reproductive health services and awareness-raising activities, could facilitate access to this essential care.

Conclusion

Migrants in Morocco face many barriers to accessing health services, including socio-economic, geographic, information and language factors, as well as stigma and discrimination. Despite government efforts, their sexual and reproductive health needs remain largely unmet. These challenges persist despite facilitations such as the support of associations and NGOs, free consultations, the support of health professionals and the quality of services in certain regions. It is imperative to continue to address these obstacles in order to improve migrants' access to healthcare. Increased collaboration between health authorities, international organizations and civil society is essential to reinforce social inclusion and guarantee equitable and universal access to healthcare.

Abbreviation
FGDs: focus group discussions
HCP: High Commission of Planning
NGO: Non-Governmental Organisation
SRH: Sexual and reproductive health
UNFPA: United Nations Population Fund
WHO: World Health Organisation
IDRC: International Development Research Centre
EIMPH: Mohammed VI International School of Public Health
UM6SS: Mohammed VI University of Sciences and Health

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A ch: Conceptualization, methodology, validation, formal analysis, data collection, resources, writing – original draft preparation, writing – review and editing.
Hk: Methodology, validation, data collection, resources, writing – review and editing and supervision.
Mc: Methodology, validation, formal analysis, data collection, resources, writing – review and editing.
Br: Validation and supervision.

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