

Comparing the Experiences of Refugee Women, Unwed Mothers, Sex Workers, and Women
Living with HIV Accessing Healthcare in Morocco: Narrating Citizenship and Health

By

Nashwa Lina Khan
Supervised by Dr. Sarah Flicker

A Major Paper submitted to the Faculty of Environmental Studies in Partial fulfillment of the
requirements of the degree of Master in Environmental Studies

York University, Toronto, Ontario, Canada
Dish with One Spoon Territory, Turtle Island

Foreword

This major research paper weaves together my Plan of Study and nicely amalgamates my three components. I have to thank Sarah Flicker for working with me endlessly on my Plan of Study and Proposal, something I admittedly struggled with, and Sarah's patience has been invaluable. When I began thinking of a project at the intersections of my three components, I had what I would describe as a "sticky thought." I became excited about doing something that would be fulfilling in a way that went beyond my academic goals. It dawned on me that I wanted to feel more whole; I was compelled to trace my own roots as I conducted research.

I first felt a hollowness gnawing at me when I began to focus on the component *social location and inequity*. I felt that I understood how social location and inequity existed in a very superficial sense: I could name theory and discuss microaggressions in Canada. But I did not know about and or have enough experience with my own history, critical race theory, colonialism, and forced migration. I also never considered how race and space interact. My coursework in urban planning changed this. It made me understand the natural and built environment in a much deeper way. As a result, my learning objectives for this component mirrored my desire to learn more on such subjects.

I also had a surface level understanding of health studies from my undergraduate education and knew that I wanted to delve deeper into understandings of the healthcare services we all are impacted by, no matter where we are in the world. Thus, another pillar of my Plan of Study was shaped by my drive to learn more about *public health and community health* and its manifestations.

The last component of my area of concentration in my Plan of Study is related to *narrative methods and storytelling*. I specifically mapped out learning objectives related to critical narrative methodologies such as counter storytelling, narrative medicine, and narrative therapy in social work practice. For each of the three components, I embarked on coursework, extracurricular activities, employment, and conferences to ensure an understanding of the subject matter. For instance, to gain competence in narrative therapy I took a narrative therapy course for social workers focusing heavily on theory but also client interactions, counselling, and application of the methods in research.

I then, with the support of Sarah Flicker, found a project that was at the nexus of all three components. My area of concentration is Narrative Methods for Community and Public Health. This project explored women's health in Morocco across age, socioeconomic status, social

location, and citizenship. The project allowed me to merge academic theory and literature and apply it through field research.

The MES program gave me the opportunity to connect these three areas that I cared so deeply about and create a latticing research project. The plan of study and preparation needed to outline my proposed research, equipped me with the required background knowledge to carry out my work. The project has culminated in this major paper. This paper accomplishes the objectives I mapped out. My learning objectives broadly encompassed critical narrative theories, race and forced migration, as well as health studies. Throughout the research, I had to iteratively refine my own skills at interviewing, writing, and analysis.

After completing coursework, research assistantships, publishing writing, and my own field research, I feel I have met the objectives of my Plan of Study. My time in the MES program has prepared me to be a more thoughtful scholar. The program has also challenged me academically. It is a great feeling to be able to meet these challenges head on and succeed.



Abstract

Although research on women's health has been conducted throughout Morocco there are still significant gaps that require our attention. This is a result of the ever changing political, physical, and social environment in Morocco and across the world. Furthermore, the majority of emerging literature from Morocco with a focus on women's health has traditionally been conducted in silos focusing on women from very specific social locations. Intersecting factors impact health for women in Morocco, and this study hopes to bridge some of the existing gaps and speak to women's health in Morocco beyond the identity specific silos while also acknowledging nuances and differences in lived experiences amongst women. This research investigates, compares, and contrasts four groups of women and their experiences accessing healthcare, specifically: 1) unwed mothers 2) women who are HIV positive 3) sex workers and 4) Syrian refugee women. The data was collected using semi-structured interviews and critical narrative methods. Furthermore multiple bodies of work in the fields of public health, community health, gender studies, narrative theory, and refugee and forced migration studies were examined to supplement this research. The data was coded three times using open coding and then coded using axial coding. The results of this small qualitative study illustrate that much of the previous literature provides a good foreground for research in this field, however, the results also disrupts notions perpetuated by siloed research of the past. By examining the four groups identified together, counter-narratives are formed that illuminate new findings and challenge older ones. For instance, some studies conflated the experiences of some of the groups of women I interviewed when in fact their experiences are diverse and should be complicated. The results will be shared back with community partners, non-governmental organizations, and published in both print and digital forms that are academic and nonacademic with the goal of enhancing health outcomes for women in Morocco.

Keywords: Women's health, Morocco, narratives, stories, healthcare, reproductive health, birth, unwed mothers, HIV, refugees, sex workers

Acknowledgements

When I entered the MES program I was extremely intimidated. I must admit academia still makes me feel out of place. For a variety of personal and professional reasons, completing this degree was an uphill battle. So many people helped me along the way.

I appreciate the many individuals who took time to speak to me casually or even just connect me to someone who eventually connected me to someone else that led to an interview. For those small encounters and the warmth: Thank you. This paper was possible because of countless people who supported me in big and small ways.

For funding parts of this research, I am grateful to the La Marsh Centre for Child and Youth Research, The Harriet Tubman Institute, the Graduate Environmental Studies Student Association, and the Faculty of Graduate Studies. A sincere thank you to the York Centre for Asian Research, South Asian Research Group and Alicia Filipowich for providing me with space on campus and a community when I needed it most. For making me feel welcome in academia, airing complaints about racist encounters, check-ins and support, I want to thank Kelly Lui, Shannon Holness, and Hawa Sabriye, three friends that have shaped the way I think about friendship between women of color in higher education. Friends who check on me even when I ghost everyone. Much love to you three. Thank you Ali for being my friend and editing my work since we were Iroquois Ridge babies. Thank you Marten for being my biggest cheerleader throughout all of my schooling, listening to my wins and losses and being a sounding board. Love you to the moon and back.

Each section of this paper is indebted to specific people. For the sections on HIV and sex workers in Morocco I need to firstly thank the executive director of OPALS, Dr. Azzouz Ettoussi – thank you for your kindness on both of my trips to Morocco. Thank you to the OPALS administrative staff for keeping the office open beyond business hours for me. A warm thank you to Madame Kareema for arranging the interviews and staying past her work hours during her vacation week to give me the space. Madame Kareema insisted she organize interviews because she felt so strongly that the stories and experiences of HIV positive women should be shared. An additional thank you to Huda, a peer outreach worker who facilitated the interviews and even fact checked information with me.

For the section on unwed mothers, I thank Oumaima from Amal Restaurant and training center, Madame Najat from Amane Shelter and the social workers Ibtissam and Mounia. They allowed me to spend weeks with unwed mothers through an internship. I am deeply indebted to Madame Hafida at Association Solidarité Féminine (ASF) and Salma Yousef for arranging the logistics. I am awed by the work I was able to participate in and witness while at ASF and I am grateful to Madame Ech-Chenna for allowing me access and sitting down to talk to me in-depth about the situation for unwed mothers in Morocco. At ASF, I am also so thankful to the three social workers who embraced me and connected me with their clients to interview while also providing me with spaces when resources are scarce. Thank you Madame Hooria, Soumiya, and Najah for your warmth, generosity and inviting me to a wedding. Thank you for answering all my

annoying and constant questions and for your interest in my work. The positive work everyone at ASF does is unexplainable.

Thank you Rachid Jankari for connecting me with Soltana who I am so grateful for and indebted to. Thank you Soltana for hosting me in your living room while I interviewed women.

Thank you OSAS staff who were patient with me and my procrastination/inability to use dossier. Specifically thank you to Theresa for magically fixing things for me and Josephine Zeeman for supporting me more than one time. Also, a shout out to Lisa Dennis for being a friendly face and always being interested in me and my work.

I would also like to acknowledge Debra Pepler and Angela Salamanca for having me as a research assistant on a project, supporting me and letting me learn so much in preparation for my own project.

A warm thank you to Anders Sandberg for covering my teaching assistance absences while I was in Morocco and making me feel like I did belong at the front of a classroom.

For making me think more critically about how the built environment shapes our social relations and for introducing me to feminist Marxism, I am grateful to Punam Khosla and honored to have learned under her. Another person I am thankful for is Liette Gilbert for her patience and guidance throughout this program.

I would like to also acknowledge Ellie Perkins. Her sense of justice and empathy truly taught me a lot about care in research. Ellie has taught me so much more than research methods, from witnessing her passion for equity through committee work and research, I believe that my own research practice has become more compassionate. When I was struggling to wrap up, Ellie reminded me why we research and collect stories and of the duty we have to do something with the stories we collect as researchers. Thank you, Ellie, for always having an open door and constantly being a source of support.

A warm thank you to my aunts and grandfather for giving me a warm welcome in Morocco and hosting me. Thank you to my dad for arguing with people when they questioned why you “let your daughter do graduate school.” An immense thank you to my mom. Thank you for helping me navigate your motherland and taking me to so many places as I tried to seek out connections. I learned immensely from your research support, thank you for sitting with me as I waited, hugging women as they cried, and having words when I did not. Thank you for giving me feedback on some of my interpretations and sharing insights with me, thank you for walking with me to my internship, and accompanying me throughout Morocco. Thank you for your humility and thank you for giving me insights on a world I did not know, thank you for being there and making women feel safe(r) talking to me. Thank you for believing in me and my work.

Lastly, I am deeply grateful to Sarah Flicker for believing in me when I did not believe in myself. Sarah has provided me with far more than supervision, she has been a mentor and supporter in innumerable ways. When I first got to MES and found out my advisor was Sarah

Flicker to say I was excited would be an understatement. I remember being drawn to the program after hearing about Sarah from a peer and reading some of her work in a class. Knowing Sarah as a supervisor and a mentor, she has far exceeded all of my fangirl expectations. Having a student like me must feel analogous to herding cats, yet Sarah did it with the utmost compassion. Sarah's care, empathy, understanding and feminist approach to research and learning is a big part of what helped me find a project I cared about and stay afloat. Unquestionably, without Sarah this paper would not have been possible. Sarah helped me through a tough two years and although I often felt out of place in academia and worried about being different, Sarah's compassion and belief in my dreams drove me to finish. Shoukran bezaf for constant guidance and support in all stages of my MES journey.

Finally, I would like to dedicate this to paper to the women I interviewed and other women like them. Globally, being a woman is already a disadvantage. In Morocco I witnessed how womanhood compounded with other marginalized identities stripped people of their ability to receive stigma-free comprehensive healthcare services. I also learned that health is not the only dimension where women are marginalized and stripped of basic human rights. My grandmother could not read or write. My first encounters with the healthcare system in Morocco were through her when I was a teenager. To women like my grandmother, your stories matter. You deserve dignified care.

History, like trauma, is never simply one's own ... History is precisely the way we are implicated in each other's traumas.

- Cathy Caruth, *Unclaimed Experience: Trauma, Narrative, and History*

CHAPTER ONE: INTRODUCTION	10
Introduction	10
The Moudawana	11
Historical Context	14
CHAPTER TWO: METHODS	18
CHAPTER THREE: UNWED MOTHERS IN MOROCCO	21
Historical and Policy Context	21
Unwed Mothers, Extramarital Relations in Morocco, and Article 490	21
Unwed Mothers, Article 475 and Fatiha Marriages	23
Birth Certificates and the Livret de Famille	25
Accessing Healthcare	28
Surveillance and the Birth Experience	28
Healthcare for Unwed Mothers and their Children	29
Shame and Violence	32
Shame and Social Isolation	32
Organizational Prenatal and Postnatal Supports	34
Social Death, Unwed Mothers, and Violence	36
CHAPTER FOUR: HIV/AIDS IN MOROCCO	38
Historical and Policy Context	41
Accessing Healthcare	44
Health Literacy and Understanding of Services	44
Public Healthcare Experiences	45
Shame and Violence	47
HIV/AIDS and 7ashuma	47
Public Shame	48
Familial Relationships and Disclosure	50
Shame and Social Isolation	52
Circumventing Shame	53
CHAPTER FIVE: SEX WORK IN MOROCCO	55
Historical and Policy Context	55
Social Landscape of Sex Work in Morocco Today	55
History of Prostitution in Morocco: Medically Licensed and Legislated	56
Accessing Healthcare	60
Experiences of Abortion, Birth, and Miscarriage	62
Differential Treatment Accessing Healthcare Based on Marital Status	65
Shame and Violence	66

Precarious Work as Economic and Social Violence	68
CHAPTER SIX: SYRIAN REFUGEES IN MOROCCO	71
Historical and Policy Context	71
Accessing Healthcare	76
Shame and Violence	77
Isolation from Moroccan Society	77
Journey to Morocco and Carrying Violence/Trauma	78
Gendered Subjugation in Society as Social Inequity	79
CHAPTER SEVEN: CONCLUSION	80
Cross-cutting Shame and Violence	80
Gendered Service Access	83
Possible Solutions and Interventions	86
New Findings and Strengths	90
Limitations	91
Implications for Future Research	93
Discussion	95
References	99
Appendices	110

CHAPTER ONE: INTRODUCTION

Introduction

Just over 18 years ago in Morocco's largest city, Casablanca, and Morocco's capital city, Rabat, there were mass protests. The protests were not one-sided. Adjacent counter-protests also occurred in parallel. The subject of the protests was the *Mudawwanat al-Aḥwāl al-shakḥīyyah*, referred to most commonly as *Moudawana*, which translates as the Personal Status Code, which is also known as the Moroccan Family Code (Maddy-Weitzman, 2005; Zvan Elliot, 2009). The code outlines a number of laws that govern the lives of Moroccan citizens

Less than a year after the large protests, the King formed a commission to reform the *Moudawana*. In 2003, three years after the large protests in Casablanca and Rabat, King Mohammed VI proposed an overhaul of the code which subsequently resulted in the ratification of the newest iteration of the Family Code in January 2004 (Bordat & Kouzzi, 2009; Jay, 2013; Zvan Elliot, 2009). As growing feminist movements emerged, conservative Islamist movements also rose to counter them. Nevertheless, women made significant gains on paper. While legislative reforms are vital for change, they are not enough.

Katja Elliot Zvan (2009) maintains that after the 2004 reforms, additional changes need to be made in both the public and private realms. In order to achieve a lasting positive impact for women in Moroccan society, education and economic structures need to be modified in tandem with legislative reforms. Despite the introduction of the 2004 reforms, the laws still impact women in ways that are gendered and inequitable (Eisenberg, 2011; Wuerth, 2005; Zoglin,

2009). This paper will briefly touch upon the ways legislation, policy and practice impact the lives of women in Morocco.

The Moudawana

In Mounira Charrad's (2001) book, *States and Women's Rights: The Making of Postcolonial Tunisia, Algeria, and Morocco*, she explores Islamic legal codes in Tunisia, Algeria, and Morocco, while situating them as part of power in a nation state. These legal codes are important to understand because they serve as the foundation of Moroccan society and governance. The book highlights the importance and power that Islamic family codes have and how they shape the lives of women and their rights in Muslim countries using them. Asma Khader, a Jordanian human rights lawyer and activist said in 1996, "family law is the key to the gate of freedom and human rights for women" (Charrad, 2001, p. 5). In Morocco today, this is still a belief many hold in both the public and private sector. Social workers and lawyers will evoke the family code to attempt to enforce women's rights, although these efforts do not always prove successful. From my own work and interactions, I gathered that people do try to go through the Moudawana for justice, but many women still encounter a variety of issues including barriers related to access, sexism, and social taboos.

The Moudawana governs and regulates legislation related to kinship and familial relationships. This includes rights and obligations regarding marriage, divorce, custody of children, alimony, and inheritance. It is vital to mention that child support is not a sanctioned obligation if a couple was not legally married in a court, and it is barely enforced in situations with court marriages. In the 2004 Moudawana reform, advances made for women included over

100 amendments and incorporated raising the minimum age of marriage to 18 (judges can still decide on marriages for individuals under 18), the right to paternal acknowledgement for children born out of wedlock, and adult women to be autonomous and not need a male relative to make decisions on their behalf (Harrak, 2009; Tamanna, 2008). As the 2004 reform occurred, King Mohammed VI mandated that ten percent of seats in the lower parliament to be allocated to women and promoted a few women to senior administrative positions. The legislation and respective changes in institutional makeup were celebrated by some, however, it is important to note that opposition still remains.

The practical implementation of the legislation and policy changes still does not necessarily meet the needs of Moroccan women. For example, although the Moudawana does govern everything related to family, including custody, much of the legislation is taken up in a way that does not always protect women. Oriana Wuerth (2005) emphasizes that the Moudawana changes in rural areas of Morocco are a secondary concern, as often destitute conditions remain a priority. Further, underage marriages are still occurring in Morocco; some have argued that they have increased. Judges still hold power to allow underage marriages as well as mandate family reconciliation efforts which can trap women who want to leave violent situations (Zvan-Elliot, 2009; Wuerth, 2005). Additionally, women continue to need their husband's permission to be issued a passport, there is no legislation that criminalizes violence against women (although it has been debated and drafted for over a decade), and unwed mothers continue to be criminalized today (Wuerth, 2005).

Elizabeth Warnock Fernea (1998) describes how although family law has origins in the Maliki tradition of Sharia law, it was shaped by lawyers, judges, and Islamic scholars known as

Ulemas. The majority of Morocco is comprised of Sunni Muslims. It is important to note that there has been an emergence of a Salafi (conservative reform movement in Sunni Islam) movement in Morocco, in opposition to feminist and progressive changes to the Moudawana. The Maliki tradition of Sharia law, which is currently a framing for the Moudawana, also features elements and influence from customary law - some of which originates in customary tribal law, as well as remnants of the French penal code (Fernea, 1998). As Amy Young Evrard (2014) notes, the laws witnessed today include "... foundation in a tribal notion of family as patrilineal, clan based, and patrikin" (p. 29). As a result of the laws being a consequence of a mixture of so many of the aforementioned elements, a complex relationship for Moroccans and legislative reform has manifested. Many are torn between ideas of Westernization and Islamic interpretations of law, others advocate for complete reform while other social movements wish for partial reforms.

Pertinent to my fieldwork is the fact that Moroccan family law specifies both rules and regulations for marriage, divorce, custody, and inheritance. The governance models of family relations have changed a number of times after Morocco gained independence from France. While unpacking the Mudawwana, it becomes obvious that there are roots in the law based on religious interpretation. These laws shape the cultural and social dimensions of Morocco today. Inheritance laws are one example that can be clearly linked to religion. The laws surrounding inheritance in Morocco are rooted in Sunni Islam, the Islamic jurisprudence is known as fiqh which covers laws on a breadth of subjects that govern and guide Muslims' lives. This includes widowers inheriting more than widows, and sons inheriting two times more than their sisters. These gendered differences in legislation impact women's ability to be equal citizens. In very

real and tangible ways, they impact financial stability and housing security, substantially shaping the everyday lives of women. Social and cultural patriarchal norms exacerbate gendered differences introduced by legislation, further limiting Moroccan women. Even after reforms to laws in Morocco, it is important to note that the foundations of some of the legislation matters and as a result created a social space that continues to perpetuate sexist ideals and values.

Delphine Perrin (2011) explains:

Morocco's citizenship Code was inspired by the principle of family national unity on a paternal basis, which implied one family, one nationality. It explains the denying of citizenship rights to women, and the attribution of the father's citizenship to his wife and children (p. 7).

Arguably, laws in Morocco rooted in sexist ideologies can never merely be reformed; rather, they must be changed entirely and then fully enforced.

Historical Context

In 2011 another series of protests, often described as an uprising, occurred. They coincided with the Arab Spring. In Morocco this movement is known as *Mouvement du 20-Février* which translates into "the 20th of February Movement". In Morocco, women seized the opportunity to advocate for legislative changes again, joining the protests for constitutional reform (McKanders, 2014). Karla Mari McKanders (2014) writes of *Mouvement du 20-Février*, explaining it:

... was composed of student activists, leftists, Islamists, and [Amazigh] Nationalists.... [i]n a series of protests, Moroccans called for democratic constitutional reforms, release of political prisoners, and social rights, including health and education reforms and rights for the [Amazigh] people" (p. 154-155).

The responses to this spring were varied. One large shift included a vote to alter the government power structure in Morocco. To placate the uprisings, King Mohammed VI agreed to a vote on constitutional reforms in June 2011; the proposed changes passed with a majority popular vote (McKanders, 2014). The reforms included a redistribution of the King's previous absolute power, where today the leader of parliament in Morocco is the elected Prime Minister (McKanders, 2014). As previously mentioned, feminist movements in Morocco have been propelling Moroccan legislation forward. For women, the role of women's civil society organizations is undeniable (Wuerth, 2005). Although none of the organizations I encountered during my research would identify as feminist, they all embodied feminist ideals. Their origins in the anti-colonial movement still influence Morocco today. McKanders (2014) gives some insight into the women's rights movement in Morocco, writing, "[a]long with other movements for liberation from colonial rule in the region, the secular Moroccan feminist movement developed from the nationalist movement's struggle against French occupation. Accordingly, colonial occupation definitely colors perceptions of feminism in Morocco (p. 166)."

Today, in 2017, Morocco remains at a crossroads. It is currently undergoing a huge socio-political shift. Morocco is one of the only Middle East North African (MENA) countries to avoid an Arab spring since the start of the revolutions throughout the MENA region in 2010. This is not to dismiss the protests which have happened since 2010, or the country's current vulnerability as Daesh/ISIS and other political groups fight for influence. In the last year, Morocco has experienced uprisings again in the form of regular protests and strikes. This occurred after police reportedly ordered the brutal killing of Mouchine Fikri, a fishmonger, in a

trash compactor where he was retrieving his confiscated fish. This incident sparked a local, primarily Amazigh, movement calling for an end to police and government corruption and investment in the region in the form of improvements to education, health services, and road infrastructure; this coupled with mass arrests of local activists has sustained concerns from civil society (Lindsey, 2017). On July 29th, 2017, during the Throne Speech, King Mohammed VI responded inadvertently to protesters and corrupt government officials. He addressed the need for transparency from the government and pardoned 1,178 protesters who had been arrested. During this speech, the King also criticized politicians and officials for not fulfilling their duties after social reforms in Morocco. Some view this as his way to appease the public.

Morocco's positioning as a westernized Muslim nation has left it as a target for ISIS and other conservative movements. This position is worsened by the economic concerns many of the working poor in Morocco also have, which was a major factor for other MENA countries to succumb to revolutions. Morocco currently has a mixed monarchy political system. The country is a Kingdom which has been run by the same ruling family for generations. There is also a prime minister and elected government officials which form parts of the country's governance structure. Today, Morocco sits at its most susceptible state and continues to work around concerns that every MENA country has today, such as revolution, security, and civil unrest. Although many position Morocco as a progressive Muslim nation, especially since the social reforms and human rights commission implemented by King Mohammed VI, the country has also been under global scrutiny for gender based violence. The suicide of Amina Filali made headlines around the world. In 2013, the teenager, who was forced to marry her rapist, committed suicide by ingesting rat poison. Many activists viewed the law, Article 475, as

contradictory to Morocco's global image of modernity and democracy. The law, which trumped Morocco's legal age of marriage (18), allowed young girls to get married underage due to "special circumstances" including rape. Although Article 475 was repealed in early 2014, repercussions for years of forced marriages still exist. Currently a number of laws are in draft phases in parliament to address gender-based violence, including marital rape in Morocco. At the same time, laws protecting and formally recognizing refugees are also in draft phases in Moroccan parliament. Moroccan women who are sex workers, women living in Morocco who are HIV positive, Moroccan women who gave birth out of wedlock, as well as Syrian refugee women, are all left in a precarious states as laws which shape their realities, futures and citizenship remain in draft stages of legislation.

It is in this context that my research investigates, compares, and contrasts four groups of women and their experiences accessing healthcare, specifically: 1) unwed mothers; 2) women who are HIV positive; 3) sex workers; and 4) Syrian refugee women. My research is conducted from the perspective that social location and understandings of citizenship impact these four groups of women in specific ways. I examine these four groups of women through three lenses: historical and policy contexts, shame and violence, and their experiences of accessing healthcare.

Moroccan women's lives and their healthcare experiences are shaped by their civil rights. My study focuses on how women navigate healthcare systems. It highlights similarities between barriers specific to healthcare and more general barriers Moroccan women face in their everyday lives. In fact, globally women's experiences of violence is closely related to their reproductive and maternal health outcomes (Chibber & Krishnan, 2011).

CHAPTER TWO: METHODS

This project used ethnographic research methods to learn about the lives, narratives and challenges of four distinct groups of women. I travelled to Morocco initially in 2016 to build rapport and connections with local community-based organizations. When I returned in 2017, these organizations assisted with recruitment. I conducted face to face semi-structured qualitative interviews; here I report on 26 of these. A semi-structured interview guide attached as Appendix A in English was used to interview all four groups of women. The questions were translated as needed in the language the interviewee was most comfortable with. For Moroccan women this was typically darija, which is the Moroccan dialect of Arabic, with the exception of two interviews that were conducted in English. For the Syrian women, this was done by translating the questions into the Syrian dialect of Arabic. For the two women who were HIV positive and also refugees from Sub Saharan Africa, the interviews were conducted in French. My quadrilingual mother was present for all the interviews. She helped translate and facilitate the questions, which aided in comfort and accuracy. A demographic survey was also done during my interviews, it is attached as Appendix B. For each of the four groups of women, I interviewed and analyzed the data from between five to eight women. In some cases, I interviewed more than eight women, but for the purposes of this paper, I limited the number I included for consistency amongst the groups. The questions are intended to give insight into women's health in Morocco.

This is the first study of its kind to analyze the experiences of women from four specific categories. Below, I describe recruitment and data collection procedures used for each group; I

have amalgamated HIV positive women and sex workers because my interviews with these two distinct groups of women were facilitated by the same NGO through a similar process.

Unwed Mothers. My access to unwed mothers was very much facilitated through non-governmental organizations in Casablanca and Marrakech. I was supported by two organizations in different capacities: Amane, and Association Solidarité Féminine (ASF). Amane is a women's shelter for women leaving violent and/or difficult situations on the outskirts of Marrakech in a rural community. ASF is a multi-service day program for unwed mothers/ Prior to beginning data collection, I interned there for two weeks. Two women at ASF declined to be interviewed; one woman at Amane declined an interview.

HIV Positive Women and Sex Workers. Organisation PanAfricaine de Lutte contre le Sida, also known as OPALS, operates throughout Morocco. I facilitated interviews with seven HIV positive women and six sex workers recruited via OPALS in one of their private offices. It is important to note that none of the women I interviewed reported contracting the disease from drug use (Gökengin et al., 2016).

Syrian Women. I interviewed a total of five Syrian women on two occasions, but continued ongoing interactions with some of the women after the initial interviews. I initially interviewed two women, that I met in front of a mosque after Friday prayers. These first two interviews were conducted on a curbside outside of the Masjid Zoubair in the Oulfa neighborhood in Casablanca. Both women were accompanied by a male relative. The second interviewee, Soltana, hosted my mother and I in her apartment for the other three interviewees in this group. It is important to

note that the interviews I conducted with Syrian women felt different from the interviews I conducted with the aforementioned groups of women. This is perhaps due to a variety of factors including: (1) the women's relatively recent migration to Morocco, (2) that these interviews were not facilitated in a NGO-space, and as a result there was limited privacy; (3) several were done with others (including male relatives) around; and (4) my own social location as a westerner with full citizenship rights.

Categorization and Data Analysis. Grouping participants strictly into the aforementioned categories was difficult because they were all dynamic and diverse individuals. Intersectionality existed throughout my interviews. For instance, it emerged through my interviews with the six sex workers and seven HIV positive women, that some were also unwed mothers. For this analysis, I grouped the women based on the organizational referrals where applicable. The interviews were analyzed using thematic qualitative analysis. Each audio file was listened to a minimum of three times. The transcripts were translated and also read a minimum of three times. Emergent themes were then identified throughout each category of women, subsequent sub-themes were also identified and coded. The four sets of coded transcripts were then examined collectively to identify similarities and distinctions. Upon multiple readings, themes were further refined. These reflected findings in secondary data. Sources of secondary data included academic literature, grey literature, news media, non-governmental agency reports, legal reports and government reports. Four demographic tables with an overview of the interviewees in each category are found as Appendix C to help contextualize the answers. Across

the four groups of women, three larger themes emerged: historical and policy contexts, shame and violence, in addition to experiences of accessing healthcare.

CHAPTER THREE: UNWED MOTHERS IN MOROCCO

Historical and Policy Context

Unwed Mothers, Extramarital Relations in Morocco, and Article 490

Like in many Muslim countries, having sex outside of marriage is illegal in Morocco. Due to laws intertwined with patriarchy, women are subject to criminalization if they engage in pre-marital sexual relations. In Morocco, unwed mothers and their children hold a type of contested citizenship that is important to document for my research. This manifests in a number of important ways. Unwed mothers and their children are both alienated from society and heavily surveilled. A number of social workers in Morocco had previously told me about the birthing experience of unwed mothers in Morocco. During pregnancy, the hospital becomes a site of many mixed feelings and perhaps the first overt site of surveillance. The surveillance is so crude and overt that once an unwed mother gives birth, nurses call the local police to fingerprint her and take prints of the baby's hands and feet. Fauster (2014) explains some of this surveillance pointing out,

Article 490 of the Moroccan Penal Code deems sexual relations outside of marriage illegal and punishable by one month to one-year prison time. But in a society where marriage is often delayed due to financial restrictions, premarital sex is common and pervasive. (p. 3)

Laws regulating female sexuality and behavior are heavily enforced. By contrast, laws protecting women and their children are not always enforced. This is illustrated through the

example of hotel bookings in Morocco where “[t]he manager of a riad¹ in Marrakech that takes bookings through Airbnb said, ‘[i]t’s not uncommon to have spies in the medina who let the police know about riads who do not respect the law’” (Moss, 2015).

Article 490 of the Moroccan Penal Code is the law that governs adultery. Under Article 490 of the Moroccan Penal Code, neighbors, a spouse, essentially anyone, can file a complaint and charge against an unmarried couple. Thus, unwed mothers can never escape surveillance whether governmental or social. The same standard does not hold true for fathers. Despite being more progressive than the former 1993 iteration of the Moudawana, the 2004 Moudawana still lacks clarity regarding circumstances when women are not married, engaged, or raped.

Alexia Sabbe et al. (2013) conducted a study entitled *Determinants of child and forced marriage in Morocco: stakeholder perspectives on health, policies and human rights*. She reports: “[p]articipants pointed out that unmarried women are not considered to have any rights and are abandoned by their families. Unwed mothers, and their children, are among the most legally and socially marginalized people in Morocco” (p. 5). In Morocco unwed mothers are known as “al-ommahat al-‘azibat,” which translates into “single mothers.” Regardless, in Moroccan society, everyone knows that this name is only assigned to unwed mothers, not divorcees or widows. The term is popular in Morocco and the category of women is its own distinctly stigmatized group. While I was in Morocco at Amal, Amane, and ASF, I found out that although there have been a number of reforms, unwed mothers face very specific legal limitations that hinder their lives and their participation as full citizens in society. The rights of their children continue to be obstructed despite the reforms.

¹ A riad is a traditional Moroccan house, historically built with a courtyard or interior garden. Although the initial use of Riad’s was for families to contain social life in the interior spaces today many are used commercially for tourists and rented by room.

Unwed Mothers, Article 475 and Fatiha Marriages

There are many circumstances that lead to women becoming unwed mothers. While some are consensual, many are not. Some women who are unwed mothers in Morocco have been recognized as victims of rape. Article 475 is legislation that was commonly known as the “rape marriage” law in Morocco; it enabled rapists to avoid jail time if they marry their victims. This article has created horrendous consequences for women who give birth prior to marriage. This legislation has created a binary in which girls and women who choose not to marry their rapists are forced into social isolation and social death. In Morocco, societal and familial pressure forces women to marry their rapists because of the dishonourable standing non-virgins hold in society. Although not every unwed mother has been raped, many have been, and many have also been forced into situations of transactional sex or exploited into survival sex. Many who did not identify themselves as survivors of rape, were minors at the time they got married. They also identified that they did not always choose to get married, but rather, were told they were to marry an older man. This general trend is exemplified in my data set, but has also been widely covered in the media, including the documentary *475* by Nadir Bouhmouch (2013).

The result in many cases of minors “marrying” and having a baby in these circumstances is complex because the marriages are rarely witnessed or recorded. As a result they are difficult to prove. They are typically performed using a *surah* from the Quran, the Fatiha. These marriages are conducted using the short prayer, often in a rural community or sometimes even just between a couple. Changes in the law to increase the age of marriage were intended to combat this practice, however, clearly this is not the case. The young girls are then put in a situation where they believe and are told the man is their husband and they have sex with him (or

are arguably raped). However, if they get pregnant, they can, and many do, end up as unwed mothers because the “husband” denies responsibility and therefore has no obligation to acknowledge the girl as his bride. There is no documentation affiliated with these “*Fatiha marriages*” as they are called. As a result, girls and women who are married using surat-al Fatiha become pariahs in society if their husbands decide to no longer acknowledge them and deny the marriage sealed with a prayer. Some men will deny the marriage altogether; others may use the Islamic divorce loophole known as triple-talaq. A man simply stating the word “talaq” which translates into divorce, three times can unilaterally end the marriage. Although the 2004 Moudawana outlawed the use of “triple talaq” divorces, like Fatiha marriages, they are still practiced in rural areas and used as a loophole to avoid both financial and legal repercussions of a government recognized marriage.

Eman was my youngest interviewee. At 16 she was pregnant and coming to ASF for external support because the 26 year old man who had sex with her was no longer claiming the child. Although the age for marriage was raised from 15 to 18 under Article 475, Eman was pushed into an engagement and described the days she lived with the man and his mother as the worst days of her life. She put into words this experience,

I had a problem with his family, his mother doesn't like me and wants me to miscarry. She wants to take me to go to a doctor and miscarry me. When I used to live with him and his mother they used to go to work and not leave me food ... At night when they came they just cooked for themselves.

Her mother and neighbor chimed in explaining that she dropped a significant amount of weight and was abused there. Like many of the women, Eman however was a girl, and should have been protected by Article 475.

Birth Certificates and the Livret de Famille

Unwed mothers are further stigmatized in the process of obtaining birth certificates. In theory, an unwed mother today can obtain a birth certificate for her baby. Although some women from rural areas mention the shame and stigma they face when obtaining one. One woman I met from a rural community in the Sahara mentioned that she was not given one.

Previously, birth certificates for the babies of unwed mothers read “bastard.” With legal reform, the term “bastard” has now been replaced by an x when there is no father on record. While the practice is perhaps less immediately alarming, the symbol is still equally stigmatizing. A subsequent reform allowed a woman to put her own last name on the birth certificate if her father or another paternal member of her family gave permission. As of today, women can choose from a list of predetermined names, however these names arguably do little to hide the fact the children that bear them are born to unwed mothers. Further, women can also give their own names, but this has other implications. One interviewee told me that she did not want to give their own name because then everyone would know that her child “had no father.” Another interviewee whose child’s father refused to acknowledge paternity told me that she was lucky enough to find the last name of the father on the available list, so she chose it. Although their children’s birth certificates do not explicitly draw attention to their fatherless status by grossly reading “bastard” or bearing an “x” in place of a last name, some participants explained that the current system still allowed others to insinuate and decipher that their children did not have fathers that claimed them. Despite the fact that the birth certificate has progressed from its

archaic labelling of children as “bastards,” there are still many citizenship issues the children of unwed mothers face.

In Morocco, at the courthouse, there is a Livret de Famille also known as a Family Booklet. One exists for every family in Morocco. Lacking a name in the Livret de Famille, fatherless children essentially lack legal existence. For Moroccans, basic rights and the ability to engage in basic activities is contingent on their name being listed in the booklet. According to the Institution Nationale de Solidarité avec les Femmes en détresse, also known as INSAF, approximately 150 babies are born out of wedlock every day in Morocco (AFP News Agency, 2014). (This is a conservative number, as NGO workers I spoke to estimated the reality to be much higher). After the implementation of a NGO pilot program in 2007, a small fraction of women were able to appeal existing legislation and attain a Livret de Famille with heavy pro-bono legal and financial support (Bordat & Kouzzi, 2010). To put this into perspective, Stephanie Bordat and Saida Kouzzi (2010) write that only 11 Livret de Familles were obtained by four local NGOs who were trained during the pilot program working with the Court Accompaniment Program structures. Meanwhile a child’s name not existing in the Livret de Famille disbars them from attaining a National Identity Card, a passport, and driver’s license. Accordingly, without these documents, the children of unwed mothers are perpetually undocumented. The lack of a National Identity Card fails to secure rights for children born to unwed mothers and haunts them into adulthood. They exist as ghostlike non-citizens. National Identity Cards are necessary in Morocco for even small tasks. From my own personal experience, as someone without a National Identity Card, I struggled getting a phone plan in Morocco.

Throughout some of my interviews, especially those with unwed mothers, I learned that the National Identity Card is necessary to attain RAMED, a subsidized healthcare plan for public healthcare. For some of the unwed mothers, a lack of RAMED can be financially devastating. Doubly important, women who do not have RAMED are told to leave their National Identity Card at hospitals until they can come back and pay for their births. National Identity Cards held in lieu of payment for medical services is common in Morocco. Therefore, it becomes that much more difficult for children of unwed mothers, who are often unable to easily purchase a phone plan or leave their National Identity Card, to receive healthcare services until payment can be made.

Simultaneously, unwed mothers have issues using their RAMED cards because so many move in their third trimester to avoid the shame of their parents and communities. One woman I interviewed named Laila explained “I don’t have RAMED so I had to pay because I used to live in Sidi Kausam, but now I live here.” What Laila expressed is an issue social workers in Morocco, and the women I interviewed, mentioned numerous times: when a change of address occurs without a man, women are often unable to take their public health insurance cards with them. In addition to this, when unwed mothers attempt to exercise some of their rights, they shared multiple stories with me about being called slurs by government and hospital employees. A study conducted by Bordat and Kouzzi (2010) found that “... four NGOs all describe how unwed mothers are humiliated at the Civil Status Office, and are the target of insults and inappropriate behavior by the civil servants working there (p. 189).”

Accessing Healthcare

Surveillance and the Birth Experience

As aforementioned, unwed mothers are heavily surveilled in Morocco. According to social service workers and other non-governmental employees I spoke with, there have been circumstances when they have been arrested. A few unwed mothers explained how police came to the hospital when they gave birth to take information and fingerprint the women and their babies. This practice is used against unwed mothers as a way to demarcate unwed mothers as deviant in contrast to women who are considered respectable because they are married at the time they give birth. One woman described how a nurse directed the police to where they had left her in what she described as “filthy” conditions. Another interviewee who described the experience, Rachida, explained “they printed me and my baby. Leaving me in a ward with bad conditions ... I was poorly treated.” Rachida would later explain that she was not provided with a blanket until a stranger bribed a nurse. Based on a conversation she overheard between two nurses, she believed she was not given a blanket because she was poor and an unwed mother.

Bribes to nurses in public hospitals was a reoccurring theme throughout my interviews.

Hayat, another interviewee, also described the process saying,

if you go to the hospital and they know you are from the association they don't treat you nicely, you will have to use your paper [a piece of paper given by an NGO declaring that you are an unwed mother] or they will ask for your marriage certificate. They call the police like every case of this kind, they ask you if you know the father, then they fingerprint the baby's feet and hands so you are responsible if anything happens to the baby.

It is clear that from the minute an unwed mother gives birth, she knows that she holds a substandard place in Moroccan society.

Healthcare for Unwed Mothers and their Children

Labour is the first of many discriminatory experiences for unwed mothers accessing healthcare. Nisrine, a beneficiary at ASF responded strongly to the question “do you think your experience as an unwed mother is different from other women accessing healthcare? How? Why do you think that is?” She explained immediately,

“[t]here is a difference between unwed mothers and married women, at the hospital. The woman with a husband, it’s like she has a business card and you don’t. They [hospital staff] always put you down.”

Similarly, Meryim, responded “... there is a difference for sure, there is a difference between married and unmarried, there is *lhiba* between married and when you are unmarried.” In classic Arabic, *lhiba* means gift whereas in Moroccan darija, the word extends to mean a form of respect that is immediate once someone sees a person.

Rachida, a 21 year old unwed mother who hid her pregnancy from her parents, went to the hospital in labour by herself. Explaining her experiences, she mentioned the treatment of unwed mothers as teaching tools for students saying,

when they put you on the high table they let the interns do what they want with you when you are an unwed mother there were many interns, one by one they examined me down *gesturing downwards* she continued ‘some have long nails’ *showing hands and describing pain*

Rachida is not the only unwed mother to mention such neglect and ‘use’ as a subject by students.

Rachida described the days after she gave birth saying, “I stayed for five days, no one checked on me, they leave you like an animal.” Nurses did not check on Rachida, she teared up as she

recalled “I was left for five days with a urine bag, IV, the bed I was on, you could squeeze them, they were full of pee, only interns took blood from me three times a day.”

Fatima, a 22 year old who gave birth by candlelight as the electricity went out in the delivery room, explained her own unpleasant encounter with medical students. She recalled “[f]or sure treatment is different [between unwed and married] women, the difference when women are in labour, student doctors insult [unwed mothers].” In response to the same question Khansat, an unwed mother whose warmth, determination, and strength were always apparent as she greeted me daily grinning ear to ear, broke down for the first time in front of me. Her voice shaking, she said “[o]f course, for sure, I witness this I’m sure all the other unwed mothers experience bad things, I speak on behalf of all we are in the same situation.” Khansat continued through tears to explain the changes in her hospital experiences since giving birth as an unwed mother passionately saying,

[f]irst sister Hooria used to go with me, now I go by myself. A nurse wrote in my folder ‘unwed mother’ so last time I went even though I was number three they told me I was at the end... I left and called Hooria, and went back with her.

As aforementioned, when Khansat gave birth they marked her file “unwed mother,” which continues to haunt her and detrimentally impact her and her son’s healthcare experiences. So much so, that she needs to bring a social worker with her to her appointments. Eman, a 16 year old who was the only unwed mother I interviewed with a parent, came in with her mother and a supportive neighbor. She also cited negative experiences and shared an encounter with me saying “something happened to me, I have my own story, one time the nurse gave me an anal thermometer and I said ‘no,’ she took it and hit me, saying ‘that’s it you won’t be checked.’”

Eman disliked accessing healthcare services after her experience and the experiences of others she had heard of, although she described her current physician as nice. She described accessing healthcare services in Morocco pointing out,

[f]irstly when you go to the hospital doctors don't give you time, they don't do a good checkup. They have to have inspections, they don't take care of you. I know someone in my family who had a cut on his arm and he died. He went to the ICU, got an infection from the ICU and [the] shot didn't go well with him.

Eman was not alone in discomfort with physicians. A different form of discomfort was expressed by Meriem, an unwed mother whose wedding I later had the pleasure of attending. She explained that she felt ashamed going to see a male physician. In her interview she explained her shame seeing male physicians "... I was embarrassed to let the doctor the doctor check me down there but at the end he convinced me to check, I was one month pregnant." Meriem, like another girl I spoke to named Fatima, was embarrassed to discuss birth and sexual health. Both cited that the only times they had sex led to pregnancy. Fatima in response to the first question, showed me her severely burned legs, a result of a kitchen accident. Her interview began in tears. She explained that although her treatment for her burns was reasonable, as the organization supported her and paid for all associated costs because it was a workplace injury, her pregnancy and subsequent birth experience was not as pleasant. Fatima, reflecting on her birthing experience in detail recalling,

I went inside, security let me in, they told me to stay in a room where other women were in labour and they checked me, then they knew and took me in. They used to go outside and leave me alone, I used to scream and scream and then the doctor came inside and yelled at me, 'why are you screaming?!'

Fatima was alone for this whole experience. She was 21 at the time and had never been to school. At 15 she was sent away from her rural home to work as a maid for a family that “barely paid [her].” Today the minimum age to work as a maid in Morocco is 18. However, many of my participants and their social workers, would vehemently refute that Moroccan society acknowledges or abides by this law. Furthermore Fatima, like Rachida was encouraged to give away her child. While Rachida’s sister insisted she sell her child to a stranger, Fatima’s employer since the age of 15 (who paid her the Canadian equivalent of 94 dollars a month for 12 hours of work a day, seven days a week) insisted Fatima give her son to a woman she knew.

Shame and Violence

Shame and Social Isolation

Fatima, like all of the other women I interviewed, with the exception of Eman, hid her pregnancy from her family. She laughed though when explaining the inability for the social workers at ASF to locate the father of her child. She explained that she did not even know his last name. A common trend amongst the women was living with their families until their last trimester. Alternatively, many of the women who were not in the preceding situation, were from rural communities and worked in cities to financially support their families. Fatima, Jamila, H.T. and Meriem were women I spoke to who were in situations similar to this. Three of the women still have not shared the fact that they have given birth with their families.

Jamila, a woman I met at Amane, was pregnant with her second baby. Her family believes that her first baby was adopted, and she sends money to her family in the *aerobia* which means “the countryside” in Morocco. Like another interviewee H.T., Jamila planned to tell her

family that her second baby was also adopted. Since these women financially support their families, there is a hesitation for the families to readily cut them off or pursue the legitimacy of the claim that the child is adopted.

When I asked Jamila what would happen if her family knew the five year old she “adopted” and they raised was her biological child, she responded quickly without hesitation: “my brother would kill me.” When I asked Fatima about supports in her life she quickly maintained

I don't make friends, my family still doesn't know, I went to visit them during the yearly holiday. I left my son with my roommate. I have a mother and a father but they won't accept it because we are from the countryside ... only my older sister knows.

At the time of the interview her son was a year and three months old and Fatima planned to keep this secret with her as long as she could. The majority of participants cited their babies as the reason they survive and feel supported. Rachida whose hospital stay was extremely difficult stated “the only thing that supported me and lifted my spirits is that my baby slept with me, I turned on my side, saw my baby and cried at night.” Rachida knows that her baby will never have a father because her boyfriend died prior to the baby's birth. Reflecting on barriers she disclosed “the thing that really challenged me was when [the hospital] refused to let me in because they kept asking questions because I was an unwed mother.” Unlike the other women who the social workers are able to assist with family reconciliation by persuading the partners to marry the women or acknowledge a fatiha marriage and divorce, Rachida will never have this opportunity. She knows that life will be difficult for her and her child as a result; she remains estranged from her family.

Organizational Prenatal and Postnatal Supports

All things considered, the innate rights of unwed mothers and their children are not divorced from their access to healthcare. Madame Hafida, the Director of ASF, and Madame Soumia, a social worker who I shadowed while completing my internship, shared a number of stories with me that confirm this. Undeniably, unwed mothers in Morocco are discriminated against in multiple realms, and although it will take significant work to change the social and cultural norms, surely there is room to change attitudes amongst civil servants and healthcare employees. This could be done in several ways: one could be the deployment of more resources towards accompaniment programs for unwed mothers, such as the pilot ones Bordat and Kouzzi (2010) evaluated at four NGOs. Further, birth accompaniment which could take the form of a social worker, doula, or nurse specifically trained to support unwed mothers, could be introduced. Many unwed mothers are isolated from their families in their last trimester as they move away and hide their pregnancies. Five out of the six unwed mothers at ASF that I interviewed and two of the unwed mothers I interviewed at Amane mentioned that they were able to conceal their pregnancies from their families in different ways. In some cases, they were able to go to prenatal NGO organizations. However none of the women overtly liked their experiences at the prenatal organizations. Just as interesting, Hayat one of the women who went to a centre for unwed mothers before she give birth said "... the other organization [prenatal shelter] would criticize us ... make us clean a lot ... they punish you for what you did, no one stood by my side." Hayat was not the only participant to share such a sentiment.

As aforementioned, many of the women do not even feel wholly supported by the organizations. I asked one participant who had said that she had no friends and no family support about how the social workers at the centers she had accessed supported her and other unwed mothers. She countered immediately “no, who will make you laugh? Nobody stands for you they just tell you go cook.” Similarly in Hayat’s interview she mentions that the organization meant to support her before giving birth had her cleaning floors while nine months pregnant. Many of the women in the formal and informal discussions mentioned that the labour they give in exchange for support can often be demanding and exploitative. These women are in desperate and precarious situations. The vast majority of people I spoke to who were not unwed mothers, expected unwed mothers to be infinitely grateful but rarely recognized the labour these women provide to the organizations while pregnant and almost immediately after giving birth. Arguably this viewpoint is a result of the subpar standing unwed mothers have in Morocco.

This is by no means to discredit the work that these organizations do, nor is it to say that the beneficiaries are not grateful. The interviewees in the ASF program split their day between literacy education (if needed), skills training, and labour. I got to participate in a few literacy classes with the women where they were at different stages of learning. The women are supported for up to three years and social workers strive towards having the fathers recognizing the child legally. Financial recognition and social recognition are not priorities, as they are even rarer than legal recognition which is already uncommon. It must also be acknowledged that the women do immense amounts of labour and express their worth or lack thereof in relation to their perceived value as mere labourers.

Currently although prenatal organizations exist, they do not provide any birth support or accompaniment. Hayat emphasized this when asked questions about her birth experience, saying, “[organization name redacted] don’t stand with you, they don’t go with you, they just give you a paper and send you.” Fatima who was similarly given a form and took a taxi by herself to the hospital, was also at a pre-natal birth organization. She also described a lack of support, retorting “nobody supported after the birth the organization isn’t good, they sheltered me, that’s it.” With this in mind, I do not believe that the current services that support unwed mothers prior to labour are as holistic with support as they could be. This is notably palpable in Khansat’s story about taking her son, who could not breathe and she felt was dying, to the hospital. At the end Hooria, the social worker, had to come and support her to receive services because her folder read “unwed mother”. ASF does provide a very particular type of support though as the only program of its kind with a three year contract between the organization and the women. Perhaps more long term programs would be beneficial during the prenatal period for unwed mothers.

Social Death, Unwed Mothers, and Violence

Social death can manifest in many different ways. Stefan Timmermans (1998) writes, “[a]lthough death is supposedly the great equalizer, social scientists have abundantly documented the social inequality of death via mortality statistics” (p. 453). Beyond the hospital the women have a hard time accessing other parts of society that would ensure them some form of security. Meryim who was abused by her partner, had visible scars on her face left by a knife. She described the scars he left on her face as she pointed to them she said “I look kloshar² now,

² In darija kloshar is similar to the word homeless but at the same extends to the colloquial english word “sketchy.” Meryim arrived at the center with a friend, both mentioned that she had been on the Moroccan national news for the injuries her partner had inflicted on her. Although the story is known in the Moroccan

no one will hire me.” The social isolation unwed mothers face disallows them from fully engaging in society or being able to maintain an income to provide a life that is healthy and secure for themselves and their children. Responses like this were common and it is conceivable given such points to understand the existence or lack thereof for unwed mothers as a dead living.

One unwed mother I spoke to responded to challenges of her pregnancy and care with “everything, whoever you talk to they say you did it, you should have aborted.” This constant blame on unwed mothers was a reoccurring theme and although these women had no avenues for accessing safe abortions (as abortions have only recently been permitted in very specific circumstances), and often lacked financial resources, they were often blamed with such a sentiment.

Before they even give birth, they are marked as unwed mothers. As they labor, they are reminded again of their newly minted subpar status in a society that is not forgiving towards them or their children. Later in life, this status (via permanent marks on their health charts, lack of birth certificates or inscriptions in Family books) follows them as they register their children for school, search for jobs, attempt to move or travel and/or try and access care again.

Social reforms to the Moudawana and legislation such as Article 475 have not changed the lives of unwed mothers in significant or meaningful ways. Khansat passionately explained through tears the status of rights for unwed mothers in Moroccan society. She exclaimed, “[a]s unwed mothers our rights are erased, society has no mercy for us, if not for this organization [ASF] ... we would find ourselves on the street.”

mediascape Meryim received no justice, this I can infer is related to her status as a woman but more closely linked to her subpar standing in Moroccan society as an unwed mother.

Bruce Maddy-Weitzman (2009) suggests “...unwed mothers were often viewed as no better than prostitutes...” (p. 406). Based on my fieldwork, although small scale in nature, I would contest this. From what I gathered, sex workers are able to conceal their jobs. Unwed mothers, however, are often unable to hide their social location especially when they go into labour. Given these points, navigating healthcare for unwed mothers is complex and intrinsically tied into their navigation of Moroccan society and family life. As has been noted, a type of social death plagues these women and haunts their children. Their inability to add their children to their family book at city hall, escape their label as al-ommahat al-‘azibat, precarious housing situations causing them loss of RAMEL, and beyond, drive them to avoid healthcare services. When they do access healthcare services they are demeaned, neglected, or refused proper services. Unlike some of the other women I interviewed, unwed mothers rarely have friends or family that go with them to the hospital. There is no doubt that NGOs are working towards supporting this vulnerable group, as can be seen throughout the interviews. Nonetheless, although this may be true, more resources and supports, both financial and social, must be implemented to change the current lived realities of unwed mothers in Morocco. A disconnect in legislation from the deep-rooted discriminatory social practices towards al-ommahat al-‘azibat continues in Morocco and can arguably be combated with shifts in perspectives, appropriate training, and adherence to legislation.

CHAPTER FOUR: HIV/AIDS IN MOROCCO

Human Immunodeficiency Virus (HIV) is a viral infection that attacks the immune system, and can develop into the life threatening Acquired Immune Deficiency Syndrome

(AIDS). The illness has a significant impact on many individuals throughout the world, including women in Morocco. The purpose of this section is not to homogenize the experiences of Moroccan women living with HIV/AIDS, as they are vast and varied. This section, however, will attempt to explore the issues faced by Moroccan women from different parts of the country in experiencing HIV and AIDS. Exploration of the intersection of multiple identities, womanhood, indigeneity and being diagnosed with HIV/AIDS is important. To date little qualitative work has been produced regarding narratives of women throughout Morocco navigating healthcare while HIV positive. This section will attempt to surface some common themes, key quotes, and add to a body of work that has been lacking in published research.

The ways illness manifests in society are socially constructed through larger prevalent discourses. It is fundamental to recognize how illness exists, becomes, and shapes people, as well as how people concurrently shape illness. Recognizing that as individuals in a larger culture we inevitably do not exist alone, nor do we form opinions, make decisions, or shape our worldviews individually, is of utmost importance. The construction of illness narratives can illustrate both the dominant and subjugated stories of illness. Acknowledging how dominant narratives of illness inform how individuals live with specific illnesses is essential when examining specific embodied experiences of illness (Hill & Kurtz, 2008). For women experiencing HIV/AIDS in Morocco society is unforgiving and this is perhaps why little qualitative research has been produced about these women.

Beyond government control of healthcare, Michel Foucault's evocation of the panopticon has been used by many scholars to describe how social discourses of health imposes a kind of control (Hartwell, 2013). Alyssa Hartwell (2013) argues that there is an increase in surveillance

medicine supplemented by other critical arguments, noting the neo-liberal binary of abnormal and normal in medicine and healthcare in contemporary cultures. Individuals also self-regulate and govern one another where Hartwell (2013) argues that understandings of both health and illness are constructed through governance and surveillance. By analyzing health utilizing Foucauldian discourse, it becomes evident that regulation, both state sanctioned and social regulation carried out by other members in society, impacts not only how individuals navigate the world but also how they perceive the world and the world perceives them. For women experiencing HIV/AIDS in Morocco surveillance at the neighborhood level is a large part of their lives and the reason many of the women travel to Rabat to access services.

Hartwell (2013) discusses how social control is advanced through two mechanisms - risk and responsibility. Hartwell (2013) outlines, “[t]hose who are included in the category of being an ‘at risk’ population are generally those who are gendered, ethnic, Aboriginal, and from poor socio-economic backgrounds” (p. 6). Pulling from a variety of scholars, Hartwell (2003) makes a strong case for understanding how the neoliberalization of health discourse and medicine has created a system where:

[t]he salient discourse that pervades health understandings and illness thus creates a polarization of those who do not have the ability to attain or access the resources needed to attain ‘good health’ which thus renders them ‘bad citizens’, and those who do have this ability are rendered ‘good citizens’ (p. 6)

It is important to have this understanding applied to health and wellness, especially when recognizing the multiple scripts that govern individuals. Throughout my interviews with women experiencing HIV/AIDS in Morocco, all of the women expressed reasons they hid their diagnosis. All of the reasons were rooted in the belief to that society would perceive them

differently. Some of the women blamed themselves for contracting the illness although none of the women used substances. All of the women, with one exception, spoke of the HIV/AIDS diagnosis as something that was linked to bad behaviour; I would extend this argument to bad citizenship. In Morocco specific gendered cultural norms impact women living with HIV/AIDS in ways that are complex and multifaceted, as revealed in interviews with seven women conducted at OPALS.

Historical and Policy Context

In Morocco the first reported case of HIV occurred in 1986 (Elmir, Nadia, Ouafae, Rajae, Amina, & Rajae, 2002). There has been some study of HIV/AIDS in Morocco but it is scarce and has largely focused on statistical analysis and rarely delved deeply into the lived experiences of HIV positive people in Morocco. The majority of information regarding HIV/AIDS in Morocco is not very recent, there is however some documentation of efforts to counter the increase of HIV/AIDS. A newsclip from seven years ago highlights the efforts to circumvent HIV/AIDS in Morocco as a combination of public health and religious efforts (PBS NewsHour, 2011). In 2011, Moroccan public health supported efforts with religious leaders across Morocco to train 20,000 Imams³, “trained to promote better understanding of AIDS by teaching congregations to treat HIV positive people with compassion and mercy instead of fear and isolation” (PBS NewsHour, 2011). Further, the program went beyond messages of empathy, “Imams [were] taught basic science about the HIV virus, prevention, and the fight against AIDS in Morocco and throughout Africa. The program aims to reach 45,000 Imams” (PBS NewsHour, 2011). This

³ In the (Sunni) Muslim community the Imam is the spiritual religious leader and worship leader at a mosque. The Imam leads prayers and offers sermons known as khutbahs. Imams also advise and teach within the community.

educational initiative is notable, however, through all of my work and experiences in Morocco I never heard of the program. Further, this program highlighted something my own fieldwork, life experiences, and research, contradict; it reflects an initiative that utilizes religious leaders and religious space as a forum to destigmatize HIV/AIDS and prevent spread of the disease. As a medium, I do believe religious forums could significantly shift understanding of HIV/AIDS in Morocco. One important element to note, nevertheless, is that obligations to attend the mosque are largely gendered. My work exploring women's experiences of healthcare and women's health literacy would benefit from destigmatized discussions of HIV/AIDS in Morocco however their literacy would likely not be significantly altered from the initiative of Imams being trained in Morocco to educate their congregations. The 2011 PBS NewsHour video titled *In Morocco, 20,000 Imams Trained to Teach HIV/Aids Awareness, Compassion* reflect on Imam Ziane educating what is shown as an all male congregation during Friday prayers through the khutba.⁴ Although Ziane shares that he has been thanked and appreciated for sharing educational information on HIV/AIDS as well as teaching compassion, my own work and discussions with professionals as well as women living with HIV/AIDS suggests that Moroccan society is currently unforgiving of anyone with the illness. Importantly, the newsclip, like some of the staff I spoke to, reiterate that public health campaigns in Morocco, unlike other parts of sub-saharan Africa, need to be approached in a different way that is mindful of the culture and religion of the country (PBS NewsHour, 2011). The newsclip mentions that large advertisements on billboards would not work in Morocco in the same way that they have in other parts of the continent, a staff member I spoke to shared this sentiment when he explained that while living in sub-Saharan

⁴ Religious sermon. On Fridays, the Muslim holy day, Jumma (Friday Prayer) is mandatory for able bodied men and must be prayed at the mosque. Two *khutbas* (sermons) occur before Jumma is prayed to validate the prayer.

Africa he would see educational advertisements about HIV/AIDS on billboards, on television, or in magazines but in Morocco he felt this would be considered shameful, and as a result people would not engage with the content and be deterred from learning. Although, the programs shown in the 2011 news clip were supported through government funding they operate in what is described as “secrecy” when conducting educational workshops, I also witnessed this at OPALS (PBS NewsHour, 2011). Understandably, many individuals who attend places like OPALS, where I interviewed HIV positive women and sex workers, desire the utmost confidentiality.

As mentioned in the methodology section it is notable that none of my interviewees cited drug use as their method of transmission. In Morocco, like much of the Muslim world, very little is known about women who have HIV/AIDS. In the book *Characterising the progress in HIV/AIDS research in the Middle East and North Africa*, Hanan Saba, Kouyoumjian Silva, Mumtaz Ghina, and Abu-Raddad Laith (2013) write “[t]he hardest-to-reach population of IDUs⁵ in MENA is that of the female IDUs; therefore, knowledge of this risk group is limited” (p. 16). Further, in their book which is one of the most comprehensive books on the landscape of HIV/AIDS in the region, Saba et al. (2013) write “... in a study of IDUs in Morocco, 16% were females” (p. 16). Saba et al. (2013) also note “... [Injected Drug Use] has also contributed substantially to the epidemics in Algeria and Morocco” (p.13). This is significant, illustrating that there is transmission of HIV for women in Morocco through drug use, although my sample does not reflect the healthcare experiences of these women. This is likely due to the social stigma associated with women who are HIV positive, even those who were infected by a male partner feel shame, those who contract the virus through drug use would face the multiple stigmas of

⁵ Injecting Drug Users

drug use as well as an HIV diagnosis. On July 23rd 2017, months after my interviews with women, an article came out by Amira El Masaiti, highlighting HIV/AIDS related trends in Morocco based on the Global Aids Update 2017 issued by UNAIDS. El Masaiti (2017) writes:

UNAIDS asserts that the Middle East and North Africa recorded the most AIDS-related deaths in the world. The annual number of adults and children dying due to AIDS-related illnesses increased from an estimated 3,600 in 2000 to more than 11,000 in 2016. In Morocco, Sudan, Egypt, Tunisia and Yemen, AIDS-related deaths more than doubled between 2000 and 2010.

Nevertheless, access to treatment in Morocco has significantly expanded, “from 16 percent in 2010 to 48 percent in 2016” (El Masaiti, 2017). Moreover, “[i]n countries where treatment coverage has expanded, including Morocco, AIDS-related deaths have decreased significantly since 2010” (El Masaiti, 2017). As of November 2017 it was estimated approximately 22,000 Moroccans were living with HIV according to a study by UNAIDS (Elouazi, 2017). The report revealed that “[o]nly 8,500 out of 22,000 of the people diagnosed follow the necessary treatments, while 35 percent of the diagnosed people had to stop their treatment out of a lack of means” (Elouazi, 2017). Today, a new National Strategic Plan is in place in Morocco as per the 2017 UNAIDS report the “... National Strategic Plan 2017-2021 commits Morocco to an acceleration of the HIV response and aims to reduce AIDS-related deaths and new infections among the most vulnerable populations” (Elouazi, 2017).

Accessing Healthcare

Health Literacy and Understanding of Services

The women in this group had some understanding of health literacy and services. They did have perhaps a better understanding of where to go for HIV services due to its specificity and the fact that in Rabat there is an HIV specific treatment wing at Suisse. The women could all also identify which services they used in the mixed public and private tiered healthcare system. OPALS offers support to these women in the form of psychological counselling, educational workshops, access to physicians, and medicine. The latter two are also available at Suisse.

Although the women understood HIV-specific systems, they did not have as much in-depth knowledge regarding general women's health. Across all seven interviews, when asked about the signs of breast cancer, none of the participants could readily respond. One participant, Malika, responded "no, don't know signs of breast cancer" but then followed with "they [people] say it is a cyst." None of the women had ever had a pap smear, although Justine believed she had something similar during a vaginal examine. In fact, my mother who helped with these interviews, had to help interpret what a pap smear was in more simplistic language because the knowledge was not readily expressible.

Public Healthcare Experiences

For the group of HIV positive women, public healthcare was important. The women were all from lower socioeconomic status and paying for healthcare services was not an option. From my understanding, the OPALS clinic as well as the HIV specific pavilion at Suisse provided my Moroccan interviewees a space to access not only medication and treatment for their physical health, but also helped address their mental health concerns. The exceptions were the experiences of Justine and Emilia. Justine had been in Morocco for less than six months at the time of the interview, she was also new to Rabat, the city where the interviews were conducted.

As a result she had not used HIV services at Sussie yet. Whereas Emilia had previously come to OPALS to get tested after the encouragement of a friend. After the test she came to OPALS to receive her diagnosis as well as counselling. Due to her own denial of her HIV positive status she refuses treatment and shared healthcare experiences that were about other health concerns she has faced. The Moroccan women, as well as the migrant women, accessed public healthcare services. They also located the classism they faced while accessing care. Malika mentioned at the beginning of her interview, “[healthcare professionals] go after appearances if you are dressed well, carry a nice purse, speak well.” This comment resonates with many comments women shared throughout my interviews about their experiences. Remarkably, this category of women were able to circumvent classist experiences of healthcare when they accessed OPALS or the HIV specific wing of the Suisse hospital. One aspect of public health programming administered through OPALS that was different from other groups I engaged with, read about, and spoke to, was the incorporation of peer outreach workers. This method coupled with grassroots community outreach (i.e. staff went to vulnerable groups like sex workers and sub-Saharan African migrants) was unique in Morocco. OPALS did not solely rely on individuals coming to them, they also encouraged people to educate and tell their friends about the service, as witnessed by Emilia’s referral. Other women I spoke to also discussed how they heard about OPALS through street outreach or friends, and how they now share the service with them. The positive experiences are notable, surely both of these spaces are operating in a way that makes vulnerable individuals feel welcome and best practices from both places should be further explored in future work.

Shame and Violence

HIV/AIDS and *7ashuma*

While HIV/AIDS is declining in some countries, in Muslim nations it is on the rise (Hasnain, 2005). This is something that was echoed by OPALS staff. Although OPALS works tirelessly with limited resources to educate in both rural and urban areas and has a number of peer outreach strategies to combat cultural notions of *7ashuma*⁶, especially for women, social norms and conservative approaches to education actively work against any form of HIV-control strategy. The taboo of discussing HIV/AIDS is so immense that one of the women I interviewed was in denial of her HIV status, and another said that although she believed her husband gave her HIV she would not discuss it with him. Two sisters from a rural community said little boys in their community would follow them and throw stones at them because of their HIV positive status, so they do their best to hide it and not seek help or support from their community.

These micro-revelations in interviews are important to unpack. Although, as aforementioned, this group responded with a wide range of experiences, there were also commonalities. For instance, the women who use the OPALS service all reported the ability to access an Obstetrician/Gynecologist. The Moroccan women interviewed all also accessed Suisse-a large hospital in the capital Rabat, the same city as OPALS. In the past, people from all over Morocco used to come to Rabat to go to Suisse given it is arguably Morocco's most well-known hospital. Suisse features a unit solely dedicated to HIV/AIDS making it an ideal

⁶ In Morocco *7ashuma* is a word that is similar to shame. It demarkates instances and acts that are deemed shameful, deviant, or immoral. The word is complicated and holds heavy cultural significance. Although used in many contexts it is important to note that *7ashuma* is deployed in ways to surveil and police women who are considered non-respectable.

place for the women to go for medication and tests. Two of the women who accessed this unit at Suisse, Zahra and Fatima, mentioned the oncologist there being kind and important in their care.

Public Shame

Feelings of shame and hiding HIV positive status extend far beyond family. All of the Moroccan women made efforts to hide their illness. Emilia from Congo did not identify as having HIV. Only Justine from CAR was open about her status. It is important to understand why the Moroccan women felt the need to hide their diagnosis from their families and the public.

A migrant social worker who runs HIV/AIDS programming geared towards sub-Saharan African migrants identified *7ashuma* as the reason why many Moroccans still have a hard time discussing sexual health education and HIV/AIDS in family and public spheres when compared to sub-Saharan Africans. He mentioned that the rates of HIV/AIDS in Morocco were still extremely low when compared to countries in sub-Saharan Africa, and he identified religion as the reason he believed this was true, saying it was Morocco's Muslim majority that contributed to these low numbers. I pushed back on this, mentioning that the numbers may be lower but cases of HIV/AIDS are on the rise in Muslim countries including Morocco, he agreed (Hasnain, 2005). OPALS employees mentioned *7ashuma* again and explained that in other parts of Africa, the non-Muslim majority countries in sub-Saharan Africa, it would be normal to see public health information about HIV/AIDS in a magazine or on television, but in Morocco that was *aaib*⁷. Dr. Ettoussi conveyed a similar sentiment to me, that HIV/AIDS, although present throughout Morocco, was still heavily stigmatized and sexual health education is still contested. This is

⁷ *Aaib* is a word in Moroccan darija that indicates shame as well. *Aaib* can be tied to religious and cultural taboos and is often ascribed to women more than men from what I have witnessed. In this context it is referring to the inability to have public discussions about sex education in Morocco.

where shame emerges. Due to the taboo nature of HIV/AIDS, people (rightfully so) fear becoming pariahs if their status is disclosed. One of the many overlaps between those supporting unwed mothers and those supporting women who are HIV positive, was the desire to implement more sexual health education programs, especially in primary school. This however is a much-contested idea as the topics of sex remain both *Tashuma* and *aaib*.

Hassna, an interviewee who was tested with her spouse, relayed the humiliation her diagnosis story. She went to a *homa*, a local neighborhood hospital. Later that day she went to *hammam*; a communal bathhouse facility that is an important part of religious and social life in Morocco. There, she was approached by a nurse from the *homa* who very publicly announced, “oh yeah, you’re the one who has AIDS.” As Hassna relayed this story to me her voice got shaky, she continued, “I denied it and said maybe you’re mistaken.” She returned home in tears and upset, she let her husband know, he was furious and wanted to report the nurse. Hassna said “I told him let it go.”

For Hassna this episode was devastating, in part because the *hammam* was such a special, and sacred place, an integral part of her life in the community, as it is for many Moroccan women (Aksit, 2011; Davis, 1978; Graiouid, 2004; Staats, 1994). Understanding the significant space of a *hammam* in communities, it is obvious why navigating neighborhood spaces like the *homa* and *hammam* became much more complex for Hassna. Today Hassna still avoids her neighborhood hospital when she feels sick.

Fatima, one of the two sisters from a rural community, expressed fears of her community finding out she is HIV positive. In her interview, she explained the journey she and her sister took to come to the city for treatment. Rabat is expensive for them to travel to and they have to

take multiple forms of transit, including riding in a truck for hours. Fatima and her sister made the journey nonetheless. Both explained their fears of social isolation in their communities, including stigma and harassment they believed would occur. Specifically, Fatima said, “kids would throw stones at us if they knew our sickness,” referring to her community and avoidance of any neighborhood medical facilities which are much more accessible and affordable. Fatima identified transit as a barrier to coming to the Suisse HIV/AIDS medical wing but was adamant that she and Zahra had to be far from their rural community in order to access care.

Despite the existence of neighborhood hospitals that are much more convenient to access, Hassna's story of public shaming by a nurse at *hammam* demonstrates the well-founded fear these women have of accessing such hospitals. In fact, the *hammam* as a space where social stigma and isolation could spread re-emerged again during my interviews. Fatima, who also avoids the *homa*, mentioned, “if I knew people wouldn't say bad things I would say it, people would benefit from my experience but even at *hammam* they wouldn't sit next to me.”

Avoidance of local hospitals was not isolated to this group of women; other groups of women I interviewed avoided neighborhood hospitals for some similar reasons such as fear of isolation, shame, breaches of confidentiality, and poor treatment.

Familial Relationships and Disclosure

Each woman has a unique relationship to her family and her diagnosis. Emilia, still in denial about her diagnosis being real, has not shared it with anyone. Malika who was nine months pregnant at the time of her interview and separated from her husband had not disclosed her status to her husband because “I found out a year ago, don't know how I got it, he has to tell

me. I know myself.” Malika has only disclosed her status with one of her eight siblings and her mother. Disclosure of HIV-positive status with mothers was a complex task and resulted in varied relationships for many of the women. Although Malika was able to tell her mother and one sibling, she intentionally withheld her status from her spouse. Hassna had the opposite experience. Hassna’s spouse was supportive and accepting of her diagnosis. Her sister had been HIV positive and died due to a fall that led to medical complications, but Hassna witnessed her sister’s experiences of revealing her status to her family. Hassna relayed the shame her sister faced saying, “I don’t tell my mom, she will tell people, even my brothers - one especially will insult me.” Hanane also did not disclose her status to her mother, she said this was because she feared for her mother’s health if she were to find out. Sisters Fatima and Zahra, who were both the oldest women interviewed in this category, only shared their status with one another and their mother. Both of their spouses who infected them are dead, and both women found out about their HIV status after their husbands’ deaths. Emilia is still in denial of her HIV status, as shown by her responses throughout the interview where she denies her HIV positive status, instead insisting it is diabolic in nature. I also confirmed that Emilia is in denial of her HIV positive status with Kareema, a staff member at OPALS. As a result, she does not share her HIV status because she does not believe she has HIV. Justine did not mention her parents explicitly, but she did mention that when she was still back home in the Central African Republic (CAR) her brother was supportive when she disclosed her status.

Although Malika, Fatima, Hanane, and Zahra all identified their husbands as the reason they contracted HIV, only two women of the seven interviewed identified that their husbands did not want to use condoms, Hanane and Emilia. Both Malika and Hanane confirmed that their

husbands both had the disease and were the reason they got it, both also spoke of their husbands not admitting infidelity. Hanane knew her husband went to Suisse for treatments but would make up excuses that he was going to run errands (e.g, getting milk) whereas Malika, as stated previously, was waiting for her husband to admit it because she knows herself.

Shame and Social Isolation

The static narrative of life being halted by an HIV/AIDS diagnosis is slowly being chipped away as treatment options have turned HIV into a somewhat manageable chronic disease rather than a death-sentence. Nevertheless, care delivery is not perfect and there are pervasive false narratives that continue to circulate, as well as negative judgement. This judgement is illustrated in the fears expressed by Fatima who believes people would no longer sit next to her in *hammam*. The association of HIV with something diabolic by Emilia also illustrates pervasive false narratives that persist. Although Emilia was in denial of her diagnosis, she did readily express that she believed the OPALS clinic telling her she was HIV positive must be a result of being possessed and not biological. Educational and practical community health-based efforts have and can continue to combat the aforementioned stigma and misunderstandings. All of the women accessing health-based services at OPALS were also able to receive counselling and attend educational workshops. The counselling and workshops attempt to combat and mitigate the social aspects of HIV/AIDS. The impact the programming at OPALS has on the lives of these women was evident in some of the interactions I witnessed. In two of the interviews Dr. Ettoussi and Kareema from OPALS were cited as sources of support, one interviewee even saying, “without them I would think of suicide.” Malika also described death, saying after she received her diagnosis: “[w]hen they told me, it’s hard you don’t accept it.

I went home, cried, screamed, you think of death, what else to think about?” Fatima also said in her interview that she “[w]ould rather die than live like this.”

Circumventing Shame

As aforementioned, many of the women expressed feelings of sadness, despair, loss, and isolation. Although these emotions and feelings exist as illustrated above, they were not the only feelings. There was a strong sense of strength and resilience amongst the women. One example is when asked if there was anything else she wanted to share, Malika suggested, “[e]ven though I am not educated I still look at the computer and look up illness, I check what is going on.”

Hassna, in response to this question, also had a response that was unwavering as she said:

[t]he good thing I have left in my life is the thing that keeps me alive, I write poems, paint, have a book, it keeps me alive that’s what I love to do, this is what keeps me holding onto life and kids.

Both of these women wanted to end the interview by sharing their ability to do things in the world. They wanted to impart to me that they do more than what some may imagine and that they are empowered and driven. Justine, the refugee from CAR who was at OPALS for the first time, also responded passionately, speaking to her HIV status by saying:

I accepted it right away, I just have to take medicine and ... because people without it die before me with car accidents and by bullets I am angry because I am a refugee, and do not have anyone here, first time I come here [OPALS clinic] I came from where I live in Rabat by three hours walking

These small glimpses into their lives when ending the interviews are invaluable moments that can help us understand the plague and static narratives of those who are HIV positive. The women subvert social understandings of what HIV positive status means for women in Morocco.

Perhaps one of the most interesting takeaways from interviewing this group was the fact that although globally they have one of the most stigmatized diseases, they cited good experiences when they went to the HIV specific treatment pavilion at the hospital. Five of the seven women interviewed used OPALS and the HIV treatment wing, they were all also Moroccan. The two women who did not use that wing were Emilia and Justine who identify as migrant/refugee. It is important to note that Emilia is still in denial of her HIV positive status and Justine is new to Rabat. This group was also the only group to explicitly describe death, wanting to die, or suicide. This is not necessarily shocking considering how stigmatized HIV/AIDS is and how many still conflate the illness with a death sentence. Another important observation is that these women defied social understandings of what someone who is HIV positive looks like in Morocco. When I first mentioned that I was or had interviewed women who are HIV positive many responded with similar reactions. They either believed that this group was also the group of sex workers, or that they would not be religious women or monogamous in their relationships. This is far from what I understood once I went to OPALS in July 2016 to make connections and develop a background. I continued to meet people when I went back to conduct interviews over the course of December 2016 and January 2017. Every time I interviewed a woman, her story was different, and the stories of the Moroccan women broke the dominant social narratives I heard about HIV positive women in Morocco.

CHAPTER FIVE: SEX WORK IN MOROCCO

Historical and Policy Context

Social Landscape of Sex Work in Morocco Today

Sex workers in Morocco are heavily politicized. The topic is extremely taboo even in popular culture with a 2015 movie about prostitution in Morocco titled *Much Loved* being preemptively banned in the country. The banning of the film was a result of religious and social contestations to the film presenting Moroccan women in a demeaning manner, where many argued the portrayal was inaccurate and offensive to Moroccan culture and Islam. The hesitation around the film in Morocco went beyond mere vocal, written, and physical protest; the lead actress in the film was assaulted in public for her portrayal as a prostitute after the film's release, prompting her move to France. Other female members of the cast received death threats and a male actor was also attacked with a knife. Although the film provided potential to rupture the stigma around sex work and begin a public discourse, the country's preemptive ban of the film to appease more conservative voices rectified silencing discussions about the realities of sex workers in Morocco.

With the exception of the Atlas Mountain region in Morocco, today, sex work is illegal and heavily criminalized. Many Moroccans reference the Atlas region or sometimes the tourism hot spot of Marrakech as the only places where sex work exists in Morocco. The Atlas Mountain, where some argue sex work is permitted due to economic influences in the region, is believed to be an exception due to the fact that "... among the Berber people of the Middle Atlas, many

divorced and widowed women see no economic alternative to becoming a prostitute.” (Venema & Bakker, 2004, p. 51).

It is important to note however that this economic pressure is not only felt by women in the Atlas region. A 2012 study conducted by the Ministry of Health found that over 50 percent of the 19,333 sex workers surveyed throughout only four cities in Morocco, Agadir, Fez, Rabat, and Tangier, support their families through the sex trade (Alami, 2015; Morocco World News, 2015). Though the Atlas Mountain region is known as a “permissive zone” for sex work in Morocco, there is a deficit of recent study of sex work in the region, which has undergone a grassroots Islamization (d’Adesky, 2006; Daley, 2012; Venema & Bakker, 2004). In her 2012 article titled *Villagers in Morocco Drive Out Prostitutes*, Suzanne Daley writes of the Ain Leuh village in the mountain region having a grassroots community based campaign to end prostitution in tandem with the Arab Spring uprisings. The methods of the Ain Leuh community campaign to drive prostitutes out of the village were varied and included

... us[ing] padlocks to imprison the prostitutes in their houses after a customer had gone in. Then, they called the police... Mourad Boufala, 32, who runs a cigarette and candy shop in the main square, said he was not in favor of prostitution. But he was offended by the Islamists’ methods. ‘The way they did it was really rough,’ he said. ‘They hit girls and scared them. And the problem is that they offered them no alternatives’ (Daley, 2012).

Ain Leuh is not alone, parts of Morocco are rapidly changing with the political climate. As a more Islamic Moroccan identity continues to cement itself while women live at the margins of a society with few economic prospects, it becomes obvious that a disjunction exists when a fictional film about the lives of sex workers in Morocco cannot be screened in Morocco.

History of Prostitution in Morocco: Medically Licensed and Legislated

When discussing prostitution in Morocco, it must be known that its origins are very different from its present-day iterations. Although many in Morocco do not know of the medicalized and colonial origins of prostitution in Morocco, the built remnants of the compound of the public health project, akin to an open-air sex prison, remain (Staszak, 2014). It is impossible to divorce the history of sex work in Morocco from public health and physicians. During the colonization of Morocco, prostitution was institutionalized by French authorities in the compound-like district that was regulated by police, judges, and physicians (Staszak, 2014; Taraud, 2006). The area called Bousbir featured neo-colonial architecture which satiated orientalist sexual desires. Bousbir was established in Casablanca in 1923 and shut down in 1955, a year before the French occupation of Morocco ended (Staszak, 2014). In 1921 “... prostitution came to be increasingly seen as a public health issue, Casablanca’s municipal health and hygiene services took charge of the prostitution ‘problem’ and proposed Bousbir as its ‘solution’” (Staszak, 2014, p. 6). This history of public health and the physician role in licensing and containing sex workers in Morocco is vital to understanding a fraught and buried past of sex workers and healthcare systems in Morocco. Physicians regulated the women, many of whom made no money, and they exercised immense biopower and surveillance as

... sex workers were registered and not authorized to exit the compound, except twice a week after getting a special permit approved by both the police and a doctor. Each sex worker had to visit the doctor once a week, and go each morning to the dispensary to have her genitals checked and cleaned. (Staszak, 2014, p. 9)

The sex workers I spoke to were not regulated in such a way. If they wanted to access public health and explained their profession or their concerns as unmarried women, they would likely be ridiculed as well as turned away from such services. The women can access some forms of

reproductive healthcare because they go to OPALS, but from my interviews with six women sex workers using OPALS, I understood that prior to attending OPALS, they had limited sexual and reproductive health services. Of the six sex workers that I interviewed, two participants had never been married and the other four were divorced. Unmarried women are assumed and expected to not be sexually active, hence the shame and stigma attached to unwed mothers and prostitutes and the conflation of the two leading to arrests under Article 490.

Rarely addressed is the colonial history of prostitution in Morocco and how police played an integral role in keeping sex workers in Bousbir, taking them there, and acting as gatekeepers to the compound with their own headquarters at the gate and only entrance of the walled compound (Staszak, 2014). Today, police are more concerned with policing sex workers in a different way. Bousbir housed between 450 and 675 sex workers at a time, another location in Meknes, Morocco was built and regulated 200 women. Additional alternative locations were planned for other cities where French men lived in Morocco but were not fully realized, although Bousbir was used as an example to build similar compounds around the world (Staszack, 2014). There were also sex workers outside of Bousbir that French doctors exerted biopower over, they were registered and expected to “... [go] to the dispensary once a week to get medical check-ups” (Staszak, 2014, p. 10). As Jean-François Staszak asserts “... Bousbir could be defined as an entangled assemblage of materiality and ideology exercising medical, social, racial and sexual control” (Staszack, 2014, p. 13).

Sex workers, historically and presently, are rarely believed about their accounts of violence. The women I spoke to will avoid police in fear of abuse and arrest. Moreover, disclosing their sex work to healthcare providers was also avoided. Anyone can report sex

workers to the police in Morocco, similar to unwed mothers, who are consequently charged with adultery. As a result, sex workers accessing healthcare services outside of OPALS could not be honest about their sexual health for fears of stigma, shame, and personal safety. The women I spoke to used two methods to recruit clients, they primarily posed as freelance domestic labourers at the old city square or went to a park in Rabat at night. Some rented rooms in what would be similar to a brothel.

Today sex workers in Morocco do not see physicians regularly, are not licensed, and they are no longer contained in walled compounds like Bousbir. In fact, the face of sex work in Morocco would shock many who presume a certain archetype coined in Morocco as *9a7ba*. *9a7ba* roughly translates into prostitute and/or whore but is much more loaded in meaning as it is often also used loosely as a word to degrade women. It can be presumed that by comparing women to sex workers by using the word *9a7ba*, sex workers hold an undignified substandard place in Moroccan society. One example of this that is commonplace in Morocco occurred during my interview with a divorced woman at Amane shelter who described some of the other girls at the shelter who were unwed mothers as “*9a7bas*.” Prior to meeting the six sex workers I interviewed, everyone that I interacted with painted a picture of sex workers in Morocco as living very different lives than the lived experiences of other women. The women I met disrupted much of the imagery of Moroccan sex workers depicted in media and described by Moroccan people. Their stories ruptured social and cultural understandings of the sex work landscape in Morocco.

Accessing Healthcare

I interviewed all six women after they participated in a workshop in an unoccupied office at the OPALS clinic in Rabat. All of the women relayed that they avoid their local clinics due to reasons such as corruption, long wait times, lack of money with which to bribe hospital employees, the belief that the public healthcare system did nothing and the inability to access private care. When I asked Mourabit, a 29 year old sex worker from Casablanca who takes a train and taxi for over an hour to access OPALS, if she has avoided going to the doctor or the hospital, she immediately responded, “[y]es I have avoided because of money and how they treat people.” The frustration was evident in her voice as she continued,

I had a breast issue, and felt something and then I thought they are going to send me to x-rays and many tests but I didn't have money so I didn't go. I felt maybe I have something but I cannot go.

This is because although Morocco offers a public healthcare system for those who can prove their residency in a specific community with the confirmation of a community watchmen, and prove their low socio-economic status if they do not have the official RAMED plan, Moroccans do still pay for health services. Many women reported that even when they had RAMED they were pressured into paying for certain aspects of their healthcare. Recurring costs included medicine and lab tests which are meant to be part of the public health care plan in Morocco. One interviewee, Ruby, had given birth three times. She had experienced the process as an unwed mother, a married woman, and a divorcee. She had extensive experiences navigating and negotiating health care services in Morocco throughout these three social statuses in her life. She gave birth to her two oldest children in the same public hospital and the youngest child in a

private clinic. She was well aware of the fact that she was entitled to free medicine that staff nevertheless expect bribes for administering. She explained, “[d]octors do come and give medicine to neighborhood hospitals. When you get checked the doctor will give your medicine to receptionist and they will say ‘don’t have it,’ the lady next to you will give money and get medicine.” Comparatively, Salwa a 34 year-old sex worker from Rabat shared a similar sentiment stating,

... what can I say the government hospital doesn’t take care of you they don’t give you medicine. The medicine is there and they don’t give it, they only give it to people they know. When you bribe they give you medicine, there is stock. You need responsible people to check.

Salwa and Ruby were not the only two women to share such feelings with me. Bribery and corruption as barriers to accessing healthcare services re-emerges throughout my interviews with unwed mothers and Moroccan women living with HIV. The only women who do not mention bribery in the public health system are the Syrian women and two women I interviewed from Sub-Saharan Africa. Khadija, who avoids healthcare services if she is ill (unless they are life-threatening), rationalized this choice. She clarifies, “I go to private when I need medication, public doctors didn’t work. I have to think about the money to go to private but if it’s bad and private doesn’t do much I will borrow money.”

In brief, a substantial barrier to care is the financial component of healthcare for women who understand that although they may have a RAMED card they will still be forced to pay for various tests or bribe a hospital employee for their government provided medication. As a consequence, the women are limited in their ability to access a full range of healthcare and OPALS, although it provides blood testing, a gynecologist monthly, and workshops, is a non-governmental organization with a mandate to focus on AIDS/HIV in Morocco.

Experiences of Abortion, Birth, and Miscarriage

The six sex workers I interviewed at OPALS all had a variety of reproductive health experiences. All of the women except the youngest, Mourabit, had experienced an abortion, birth, or a miscarriage. The women shared reflections on their experiences. Some of the women also shared their thoughts on what had to change. Hannan, a divorced mother of two shared her thoughts on what needed to change. She shared her feelings with tears in her eyes saying, “[t]hey have to make situation better they have to give women rights and more comfortable, there are women giving birth on the floor.” Ruby, in her interview similarly disclosed witnessing women in unfortunate circumstances while delivering their babies saying, “I saw women delivering themselves.” Like Rachida, the unwed mother who was given a blanket by a nurse after an onlooker witnessed her physically shivering, Ruby also had to bribe hospital staff to be treated better during one of her birthing experiences. The night Ruby went into labour and saw women delivering themselves she explained what she did to avoid a similar fate, explaining,

I started my labour I kept screaming I am going to give birth, I gave one nurse money and she left me in a room by myself screaming and cursing and the head midwife came to see if my water broke. I offered her money.

Under such circumstances it is evident why disparities in treatment become deepened. Khadija a divorced woman who miscarried after abuse from her ex-husband and mother-in-law also faced financial barriers. When I asked her about a memorable healthcare story she instantly responded as tears welled in her eyes,

When I went to the hospital to get a certificate that the baby dropped and that the husband hit her on x day, you have to put the baby in the fridge and have to pay for the certificate. I couldn't afford it. When I went to Suisse [the hospital] to get the certificate for the lost baby, I took the fetus, they said 'no we won't do it' it was 1800 dh autopsy [approximately \$237.06 CAD] and it was the only way I could prove I miscarried.

In Morocco, like many places in the world, women who miscarry must prove that they indeed miscarried or risk being charged with a self-induced abortion. Huda, an interviewee who had an illegal abortion shared her account of being an unmarried sex worker who found herself pregnant. She stated,

I had a problem, I got pregnant and I wanted to abort the baby. I had a problem I didn't have money and didn't want to face the community. After 1 month, not even a month, my friend helped me. My secret stayed with my friend and my head. My friend gave money and the guy who got me pregnant gave me money, he wanted it but he was married and I wanted out.

Huda's situation is not rare, many women globally are forced to have unsafe illegal abortions. In Morocco, legal abortions are now allowed in three circumstances, where a woman can prove: "... health problems, foetal abnormalities, rape or incest" (Abdesslam, 2011, p. 64). In 2011 it was reported that there were approximately "150,000 illegal abortions performed annually" (Abdesslam, 2011). This number is likely far less than today, and underreported, as having and performing illegal abortions is criminalized in Morocco. Huda is one of thousands of women who pay for an "illegal assisted" abortion in Morocco conducted by doctors who risk their license and being imprisoned (Abdesslam, 2011). Huda was only able to access an illegally assisted abortion because of the money her friend and her client gave her. Women who are unable to afford an illegal assisted abortion are forced to "... resort to traditional and dangerous

practices with unpredictable results that may lead to death” (Abdelsalam, 2011, p. 64). Huda knew as an unmarried woman, a pregnancy would bring shame to her family in the community, saying she could not face them.

It is also common for unwed mothers to be synonymous with prostitutes when being spoken about in Morocco. Although many in Morocco have praised new legislation which enabled the three circumstances in which women can have an abortion, it is evident that presently there are many more circumstances in which women need legal abortion services. Those who use back door abortions risk their lives and those who access illegal assisted abortions debatably share similar risks, as they cannot report an unsafe clinic for fear of arrest. In a society that is unforgiving to unwed mothers and where financial stability is rare for women, causing some to resort to sex work, there is a paradox in burying discussions around sexual and reproductive health. There needs to be an expansion in services to keep women safe and a reform in social attitudes to make way for that expansion. Women in Morocco are having abortions: “... despite the ban, between 600 and 800 abortions are carried out every day with medical care in Morocco while 200 others take place on the back streets” (Abdeslam, 20122, p. 65).

Several women throughout my interviews mentioned witnessing scenes similar to Ruby and Hannan: women giving birth on the floors in and around hospitals, delivering themselves, getting stitched after cesarean sections without anesthesia, being in labour two to a bed, and more. The healthcare systems women in Morocco navigate are heavily influenced by financial standing and as witnessed through accounts from the unwed mother Rachida and Ruby, those who are unable to bribe hospital staff are subject to unjust healthcare experiences.

Differential Treatment Accessing Healthcare Based on Marital Status

One trend across sex workers was reference to marital status and its correlation to treatment while accessing healthcare services. When I asked Salwa whether her social location impacts her healthcare experiences, she explained “[d]ivorced, yes, for sure. If you go to get birth control they will not treat you the same as a married woman.” In Morocco, birth control pills presently do not require a prescription. Although they should be easy to attain, as any woman can in theory go to a pharmacy and purchase the pills, this is not the case. Neighborhoods in Morocco are small and insular which can subsequently lead to a lack of confidentiality when accessing contraceptives. If a woman wants an IUD however, they must go to a doctor who has the right to ask about their marital status and even inquire about the husband’s family planning wishes.

Salwa was not the only interviewee to mention that her status as a divorced woman could impact her treatment when accessing reproductive health services. Hannan expanded the commentary to overall healthcare experiences saying, “[d]epends on the people you are dealing with, if good people they will be nice if not nice they will find out you are divorced and treat married women better.” Salwa ended her own interview re-iterating this one point saying, “[i]n Morocco the divorced women always have a different look, different you look like *hand gesturing over her body.*” In Morocco, despite divorced women having more social status than unwed mothers because they gave birth and/or had sex in what is deemed an Islamically acceptable way, they still lack much social and financial stability. This is often augmented by the number of children they have. In Morocco it is common to hear the words “poor thing,”

following mention of a divorced woman regardless of the circumstances which led to divorce, including domestic violence. So, although there is a social understanding that being divorced forces women into vulnerable situations, there are not necessarily mechanisms in place to protect them, provide them with increased social security or even empathy. It is notable however that there was one voice that diverged from the majority of the interviewees. Huda, a peer outreach worker at OPALS, has never been married and is an active part of her community. She shared her opinion saying, “[n]o on the contrary, I feel like I’m better than the one who is married they don’t have some stuff available to me.” It is imaginable that Huda’s views were distinctive because she did not experience social standing as a divorced woman nor did she have children to support. Due to the fact that she had never been married, no one blamed her for a divorce like the other women. She was also able to conceal her pregnancy and attain an abortion discretely, thus her social standing in the community has never been impacted nor has she been forced to stay at home to do chores and endure abuse from her husband and in-laws which the divorced women reported.

Shame and Violence

Beyond the criminalization of sex work, there is familial and community shame in addition to cultural and religious norms resulting in isolation. These themes emerged throughout my interviews and although families will readily take money the women make from sex work, they would publically shun them if community members found out. In fact, women who do not even work as sex workers can be imprisoned if they are accused of being “prostitutes.” As previously mentioned, the Moroccan darija equivalent to the word prostitute is a loaded insult

akin to slut and whore in Morocco. The built environments of Moroccan neighborhoods are ideal for surveillance, coupled with the social surveillance conducted by neighbors, a designated community watchman, and the eyes of men who watch and supervise street parking in Morocco. Overall, there is a prevalent culture of scrutiny and supervision. Although the days of Bousbir are over, the vigilance over women and women's body continues to be regulated through social mechanisms, as well as physicians and other healthcare providers.

As previously mentioned, unwed mothers have been impacted by the criminalization of sex work, subsequently unwed mothers accused of being sex workers can be charged in court with prostitution. Unwed mothers are also heavily surveilled and documented through the printing of both them and their children when they give birth. When sex workers are charged and imprisoned they are also printed. As sex outside marriage is basically considered a form of prostitution in Morocco, the lives and social experiences of both groups of women inevitably intertwine.

Another noteworthy and unique trend specific to the group of six sex workers I interviewed, was their knowledge of reproductive health regardless of level of formal education. In the other three respective groups of women I interviewed, their reproductive health knowledge indisputably correlated to their level of formal education. This distinction can undeniably be attributed to their line of work and the peer-led workshops and outreach programs hosted by OPALS. While speaking to Ruby, she even rummaged in her bag to show me condoms she had received from OPALS to explain how she stays safe. The sex workers were also the only group of women I interviewed where participants received pap smears and knew what the exams were.

Precarious Work as Economic and Social Violence

The economic landscape these women inhabit most certainly influences their vocational choices. As divorced and unwed women ranging from age 29 to 42, their worth in Moroccan society is automatically diminished and inferior; this detail is made evident through the abovementioned reflections shared about health care access. The HCP (2012) report indicated that women in Morocco faced disproportionate rates of unemployment. In fact, women encountered an unemployment rate double that of their male counterparts who were similarly qualified with comparable levels of education in similar fields of work. Women are disproportionately marginalized in Morocco with approximately half not being able to read or write - including approximately half of the women interviewed for this paper (McKanders, 2014). In *Engendering Development*, a World Bank Policy Research report, Elizabeth King and Andrew Mason (2001) illustrate that even of the small fraction of women that hold employment in Morocco, about half hold precarious work that is unregulated, unsafe, and unhealthy. These jobs are not secure, nor do they provide a stable living wage.

HCP data indicating that employment issues impact women and render them more vital is important to understand. As the most comprehensive study conducted on women to date, the HCP data corroborates the stories of women like Ruby whose once stable and steady lives shifted dramatically after the recession. The study looked at work as well as education and gender-based violence amongst approximately one million women in the country and the links were discernable. Another woman, Hannan, forced into sex work due to financial vulnerability, was forthright about how the national economic circumstances, along with having two children, forced her into sex work. She cited the fact that her ex-husband used to stay at home while she

worked all the time. When Hannan responded to the question: Is there anything I am missing that you would like to tell me or is there anything important for me to know? She said,

I wish there is an organization for children who are developmentally delayed and help the [sic], so I can go out and work. An organization that takes care of him [her son] so I can work and they take care or help me so I can help him.

Based on my discussion with her, she lives hand to mouth and her sole focus is work to support her children who have faced health repercussions as a result of bureaucratic healthcare. She describes corruption between a public healthcare system doctor and a private lab. Hannan explained through tears,

[m]y first son I spent 4.5 million, this one [second birth] I couldn't afford it, it impacted his brain, it delayed him. ... The doctor refused to take [public] results, and next door [lab] was very expensive I stayed there until 2 am now slow and growing epilepsy something about that doctor and the clinic they have a regular connection, a deal between each other.

Hannan's answer exposes the rifts a two-tier healthcare system creates for those who are financially poor. She was not alone in addressing financial disparities.

Ruby responded to the last question emphasizing that she and many other women who had been forced into sex work once had different jobs, as did men. Jobs that were related to their education and training. Passionately she explained,

[w]hat can I say, I don't like seeing people begging, people like me for example, I used to work in clothing and textiles. At the end of 2005 I left my job because the factory closed and I wished and hoped. Now you turn left and right, you used to see no one working, everyone was working then. Now everyone is working as a sex worker ... because so many factories closed down, there wasn't work. So many supported families because they [factories] closed down people can't support. I wish the government created jobs so work would be created. Even guys who were in factories using drugs, now they use drugs, hit and yell at

their parents and families.

Sex work in Morocco is not something any of the women want to do. This was emphasized to me by employees and the women I interviewed. All resort to sex work to feed their families, buy diapers, pay rent -- essentially to survive in a society where women who are unmarried and educated in applied sectors cannot find work. Extensive studies on women's sex work in Morocco have rarely been conducted nor released until the movie *Much Loved* sparked mass controversy. Based on my own findings, grim and unfavourable economic and sexist circumstances have made sex work the only work many women can attain after the economic crash Ruby spoke of (Morocco World News, 2015).

Circling back to the film *Much Loved*, it becomes obvious that the realities of sex workers in Morocco need to be discussed rather than banned. Reproductive and sexual health is important if there are no economic alternatives to the sex trade. In one scene of the movie, a sex worker uses alcohol to clean her vagina after an encounter with a client. As illustrated, going to a gynecologist in Morocco as an unmarried woman to access any reproductive or sexual health services is shameful and considered bizarre, because why would a woman who is unmarried require such services? This leaves women in precarious situations where they make dangerous decisions while trying to take care of themselves.

Sex work has been erased from the social landscape and minds of Moroccan society. Without the OPALS clinic, the women I spoke to would not be able to access pap smears or HIV testing, they would not be able to get free condoms nor would they be attending peer-led workshops on how to stay safe. In Morocco buying condoms would have both financial and economic costs affiliated with them. OPALS, in many ways, is conducting revolutionary work

by providing such crucial supports. OPALS addresses the women's health needs holistically providing educational workshops, contraceptives, psychological support, and physician services.

The economic situation for women in Morocco, especially unmarried women, is disturbing. From my interviews with sex workers, it is discernable that their economic realities are tied to their access to healthcare services outside of OPALS. For sex workers, it is imperative that their economic realities be considered as part of improving their healthcare experiences, as they are intrinsically tied and inseparable.

CHAPTER SIX: SYRIAN REFUGEES IN MOROCCO

Historical and Policy Context

This is a brief overview of the complex historical and policy context Syrian refugee women in Morocco navigated in 2016. Many refugees have been amassing in Morocco. According to Ghita Tadlaoui, an employee of the United Nations High Commissioner for Refugees (UNHCR) (personal communication, 2016), the number of refugees, asylum seekers, and migrants has drastically increased in the last five years. Tadlaoui (2016) explained that although UNHCR, non-governmental organizations, civil society, and others, have been advocating for a formal refugee and recognition policy, as of today: none exists. Tadlaoui (2016) along with others are hopeful that the bills being tabled in parliament and the current political climate will urge the government to create a formal refugee strategy and recognition process in Morocco. For now, refugee status in Morocco is assessed at UNHCR in Rabat using the 1951 convention and then resettlement status is determined.

The Syrian Civil War, also known as *Al-ḥarb al-'ahliyyah as-sūriyyah* in Arabic, is part of this larger story. Many locate the current armed conflict in Syria as part of the much larger incidents of protest that stemmed from the Arab Spring (Sharara and Kanjj, 2014). The ongoing civil war has displaced millions of Syrians with migration, especially forced migration, and as a result the health of migrants and refugees is impacted in a multitude of ways (Grove and Ziwi, 2006; Sharara and Kanjj, 2014). For example, there have been increases in stress related illness (e.g, diabetes), mental health (e.g., PTSD) as well as injuries related to the war (e.g., missing limbs, disfigurement).

Many Syrians have since entered Morocco on foot. In 2015, the UNHCR published a briefing on Morocco specific to Syrian refugees that talked about how many live in the Algerian border towns for long periods before they arrive in Oujda. In recent years the journey from Maghnia to Oujda has become more difficult. Davide Gnes (2013) points to border securitization. Gnes (2013) also emphasizes specific health concerns which arise for refugees and migrants who take this passage into Morocco. Davide Gnes (2013) who went on two mission trips to write on the experiences of those using the Maghnia/Oujda passage reflects “[v]ery poor hygienic standards have had dire consequences on the health conditions of migrants, especially with respect to chronic diseases, while violence by security services and border guards remains the primary cause of injuries” (p. 4).

All of my interviewees took a path similar to the one UNHCR (2015) identified. They were all displaced into refugee camps or makeshift camps in Lebanon but cited the cost of living as too high to stay. From Lebanon, after saving money, they would fly to Algeria as there were still no visa requirements for Syrians entering Algeria. Their ultimate goal was to reach

Morocco. All five of the participants mentioned that their experiences in Algeria deterred them from staying longer or considering settlement there. The route they take inevitably forces them to enter Morocco on foot from Maghnia, Algeria to Oujda, Morocco. This is because the border crossing from Maghnia to Oujda has been inactive for over a decade, although police and military presence are still prominent and increasing in the area (Gnes, 2013). The stories women shared about their journey to Morocco reflect the UNHCR (2015) findings that most Syrians who have registered with UNHCR in Morocco left prior to the new visa requirement for Syrians entering Algeria. From Algeria they pay drivers to take them closer to the Moroccan border, leaving refugees at the outskirts of Maghnia. When asked why the women did not stay in Algeria, they all said that they had been told by Syrian family members and friends that life was better for Syrian refugees in Morocco. Only one interviewee claimed to have flown into Morocco; this interviewee however was also very reserved and cited being scared of Bashar Al-Assad during the interview. Her nephew also contradicted her statement and she then alluded to crossing into Morocco by foot from Maghnia. I believe this contradiction is important to recognize as it likely points to histories of trauma and distrust. The other four interviewees all learned of paths from their family network and kept in touch with family in Morocco while they made the journey. The youngest interviewee, Zaman, who crossed into Morocco while pregnant was the newest arrival. At the time of the interview she had only been in Morocco for seven months. Zaman came to Morocco in search for a better life and to be reunited with her displaced family.

Ceuta and Melilla are small Spanish enclaves bordering Northern Morocco. Due to the current geopolitical context, many refugees are seeking pathways through Morocco to get to

Europe. Interestingly only one of the five Syrian women I interviewed wanted to attempt the journey to the European enclaves and subsequently enter Europe. Although my sample is small, this finding circumvents the assumption that all refugees wish to enter Europe and Morocco serves as a route to Europe when it appears from my interviews that Morocco becomes a site of settlement for many Syrian refugees.

Tadlaoui (2016) referenced a few laws that had been passed since the Syrian Civil War began. The only vehicle for Syrian women to gain citizenship immediately was through having a Moroccan male spouse during the one-year period that a fast-track marital law existed. Through marriage Syrian women would become Moroccan citizens, subsequently they would be protected under the reformed Moudawana, (Zvan-Elliot, 2009). Tadlaoui (2016) identified that this prompted a temporary spike in Moroccan male/Syrian female marriages solely as a result of the law, since after the law ceased, the UNHCR Rabat office no longer saw inter-mixed marriages.

This speaks to a larger issue which is witnessed globally where refugees and forced migrants, largely women, are only rendered citizens of a nation-state through marriage to a male counterpart. What is particularly interesting about Morocco is that this law did not apply to Syrian men who married Moroccan women. In Morocco, citizenship is governed by the *Code of Moroccan Nationality*. This Code, as mentioned in the introduction, impacts different groups of women and their rights in very specific ways. A Moroccan woman marrying a Syrian man would have a much more difficult time. Citizenship in Morocco has traditionally been passed on through fathers and husbands, as Delphine Perrin (2011) writes, “[i]t was based mainly on *ius sanguinis*, specifically paternal descent” referring to the Code prior to changes brought in by

King Mohammed VI. Although more recent updates to the legislation have amended for more gender equity as Perrin (2011) writes:

... despite the 2007 reform, Morocco maintains harsh gender discrimination when addressing the effect of marriage on citizenship. Women are still unable to transmit their citizenship and marrying a Moroccan woman does not give any explicit advantage or priority in terms of naturalisation or access to citizenship. (p. 15)

Although the document has been revisited since its creation in 1958, there has still not been an effective shift in procedures or social views to make the new iteration of family legislation binding or adhered to. The reason citizenship is invaluable in Morocco for people seeking refuge or asylum, is that it grants them some basic rights that are already not necessarily even a reality beyond paper for women in Morocco who are citizens, let alone non-citizens (Zvan-Elliot, 2009). Without recognition as a citizen in the country, refugees continue to be stateless people lacking a number of legal rights, although some may be granted on paper due to the lack of a formal refugee recognition process in Morocco, where no services, including health-based services, have to abide by the UNHCR recognition of refugees. For the time being, laws granting Syrian refugees citizenship in Morocco remain in limbo. Although work is being done, the bureaucratic process is slow. In addition to this, although the UNHCR has designated all Syrians as *prima facie* refugees, the Moroccan government does not recognize them as such. This is due to the fact that Morocco lacks formal mechanisms in place to grant refugees formal government regulated status nor register them for social services.

Accessing Healthcare

One aspect that shocked me and people I have spoken to since conducting my fieldwork is the insistence by Syrian refugee women to only use private healthcare services, although their income relies on the charity of Moroccans at stoplights where they beg for money. I believe a number of factors shape the Syrian women's decisions to access private care. This was a bit contentious, in interviews and conversations I had with Moroccans who knew of Syrian refugees refusing use of public healthcare services. They felt this was selfish as average and working-class Moroccans do not have this privilege or alternative; they also would not seek money to do so. Some shared the sentiment that Moroccans dealt with the subpar public healthcare system because they knew they had to.

Although the Syrian women will continue to use private clinics, there were some changes in perspective since I first spoke to them. Zaman who gave birth while I was in Morocco met me at Dr. Lahna's Injab clinic located in the Oulfa neighborhood to pick up some money she had asked me to collect for her cesarean section. She arrived with her husband and the baby from a clinic where the newborn was being treated for gas poisoning. The new couple burned gas to heat their apartment not knowing how it would affect the baby. When I initially interviewed Zaman, she had adamantly insisted with three other Syrian women in the room that they use private healthcare services because of scenes they had witnessed. Zaman specifically reflected on watching her mother give birth recently where "women [got] stitches in public hospital without anesthesia." When she met me at Injab she was pleasantly surprised. After the couple was introduced to the midwife they made an appointment. Despite the fact that the women knew of

the clinic from myself and Mariam, due to its public status they did not want to go. I would argue that this clinic is overlooked as it is not government run and has in-fact been shut down by the government in the past because it provides free reproductive healthcare services to migrants, refugees, and poor Moroccan women. It is doing great work and Dr. Lahna works extensively to train midwives throughout rural regions in Morocco to improve maternal child health outcomes. Unfortunately because of his extensive work he is not able to keep the clinic functioning throughout the year. Like the HIV specific-services I believe that this small clinic being geared towards reproductive health for specific populations is a slight step in the right direction.

Shame and Violence

Isolation from Moroccan Society

Syrian refugee women are navigating a different cultural terrain in Morocco. Although their Muslim identity is a pillar in the lives of the five women I interviewed, the fact that these women live together in extended family units within the same neighborhood allows them to minimally engage with larger Moroccan society. I learned that Oulfa, the neighborhood my interviewees live in, was home to over 40 Syrian families during my interviews. In Oulfa displaced Syrians have formed a small diasporic community that continues to grow as many try to help their families enter Morocco. These women are also not held up to Moroccan ideals of shame and respectability because they do not carry histories in neighborhoods where intergenerational gossip and surveillance take place. When I asked four of the five interviewees if they would marry Moroccans they laughed and said “no”. They let my mother and I know that

many still marry cousins within families or people their families know such as in-laws. Although displaced, this practice enables Syrian refugee women to protect their own culture and heritage while subverting expectations that may be placed on them if they married into Moroccan society.

Journey to Morocco and Carrying Violence/Trauma

The shame and violence these women carry is understandably different. Displacement, economic destitution, and removal from land, shape the violence they face. A lack of citizenship also impedes the potential of any future material realities or civil rights for them and their children. Additionally their physical journeys, violence and trauma manifested in their bodies, participants located their new illnesses in their displacement from Syria. Loubna believed her issues were rooted in her refugeeness, saying “... since leaving home I have gotten illnesses, diabetes and blood pressure.” Soltana felt similarly that her eye problems manifested once she left Syria. Four of the five women similarly reflected on their lives before the road as part of farm owning families. Two of the older women, Loubna and Khaliti Aicha, adamantly identified hesitation and fear of Assad. When I offered to stop and re-iterated that the interviews had to be consensual they said it was okay and used kind affirmations in Arabic. Regardless, even in Morocco their embodied experiences of fear, surveillance and trauma linger.

In Morocco they live in tiny overcrowded apartments with no way to grow their own food or generate income in the ways they know. This was especially poignant when the women in Soltana’s living room asked about my education, age, and marital status. They were troubled by how, as a 25 year old woman, I was unmarried and in school and looked for answers. I then

asked about their levels of education and Khalti explained “we had our land, we were farmers, that is all we needed, we did not need school okay.” All of the women prayed for my mother that I would get married.

Gendered Subjugation in Society as Social Inequity

As aforementioned, all of the women were never formally educated and this manifested in different ways throughout the interview. The women in this group were particularly surprised when I asked them the question “How could healthcare for women like you in Morocco be improved?” They seemed surprised that I wanted their insight. Zaman, the youngest interviewee of the group who was nine months pregnant at the time of her interview responded by saying “what can I say? What do I know?” Despite thinking critically and displaying a natural aptitude for interacting intelligently, she would look to others for assurance or simply defer to their opinion, particularly her husband, often saying "ask my husband" or "tell my husband." She was not the only interviewee in this group to centre a patriarch for knowledge. As aforementioned, both Soltana and Louba had men present at their interviews, in fact they would even look to them for insight and almost permission to share their thoughts at times. Soltana’s husband and Loubna’s nephew would provide parts of the interview and chime in. Although the men did not sit right next to us for the entirety of the interview or for the entire set of questions (my grandfather distracted them for as long as he could), they were always present. I attempted to interview the other three women, Zaman, Sanaa, and Khalti Aicha, in a private setting, however, I was unable to, as they wanted to be in a living room near the other women.

The Syrian women I spoke to have to rely on men in a way that is unique and different

than the Moroccan women I spoke to. Men in their lives not only hold the remaining documents they possess, they are also the only members of their families who can read, write, fill out documentation, and speak confidently with Moroccan authorities. As a result of a lack of literacy the women did struggle to answer some of the questions. All of the Syrian women interviewed were illiterate. At the same time, some questions prodded them to want to learn more. For instance, when asked question nine, which reads “Do you know the signs of breast cancer?” although every woman interviewed did not know any, they did proceed to ask. They were eager to learn about signs they should be concerned about, and of breast cancer in general.

CHAPTER SEVEN: CONCLUSION

Throughout my research, despite the diversity of backgrounds and viewpoints expressed, a number of cross-cutting themes emerged. The commonalities shared amongst the groups included: experiences of violence, desire for gendered services access, possible solutions and interventions. This research produced new findings. Here, I acknowledge its limitations, and suggest further avenues for exploration and additional research questions.

Cross-cutting Shame and Violence

A common theme amongst all four categories of women I interviewed was experiences of violence throughout their lives. Violence is experienced in a multitude of ways and is a public health issue (Rutherford, Ziwi, Grove, & Butchart, 2007). The forms of violence the women I interviewed witnessed were as diversified and distinct as the women themselves, yet there were

innumerable parallels. Throughout the interviews incidents of structural, systemic, and symbolic violence materialized. Interpersonal and collective violence were disclosed by the women I interviewed through their retelling of encounters where they faced gender-based violence, sexual violence, intimate partner violence, terrorism, child maltreatment, domestic violence, family violence, workplace violence, structural violence, new wars, complex emergencies, armed conflict, and genocide. Of the eighteen forms of violence outlined by Alison Rutherford, Anthony Ziwi, Natalie Grove, and Alexander Butchart (2007), fifteen were identifiable throughout the interviews I conducted. The Syrian women I interviewed as well as the two HIV positive refugees, from Congo and CAR respectively, experienced some very distinct forms of violence as compared to the Moroccan women. For instance, displacement and armed conflict are themes that have shaped their lives and detrimentally impacted their health. Comparatively, although the Moroccan women were not survivors of armed conflict, they experienced violent encounters and were governed by standards that were culturally specific and resulted in violence. One salient example is the violence that ensues when a Moroccan woman is an unwed mother. Non-Moroccan women who are unwed mothers are not held to the same strict standards. The interview with Justine, the HIV positive refugee from CAR, helps support this. As an unwed mother and non-Muslim, Justine never felt that she was impacted by societal standards to the same degree.

Shame and all of its iterations in Morocco were present for all of the women I interviewed. *7ashuma* and *aaib* were words that I heard regularly, during my interviews and outside of my interviews. I hear the words here in Canada too, from my mom and my aunts. I believe Moroccan women from all social locations, even in diaspora, are governed by multiple

versions of shame. It is important to note that patriarchal notions of shame persist globally to paint specific women in certain ways and set a baseline for “respectable” womanhood. The poles of shame and respectability shift based on time and space. As aforementioned, in a Moroccan context *7ashuma* presents a shame that Moroccans and those navigating Morocco understand. Searching through Moroccan women’s experiences of sexual health, sex education, and healthcare and *7ashuma* I only found one article that overtly discussed any links that was written by Moroccans. The article titled *Sexuality in Morocco: Women sexologist's point of view* by Nadia Kadri, Khadija Mchichi Alami, and Soumia Berrada (2016) is an overview of stud that examine women’s sexuality and reproductive health. Kadri, Mchichi Almi and Berrada (2016) write “[s]ex-education focuses on ‘hashouma’⁸ (a mixture of shame and interdicts) and on upholding virginity” (p. 20). They also observe that 98.8% of the 800 women they surveyed in Casablanca believed that “... preserving one’s virginity is considered to be a social duty” and the majority of participants believed “adultery is considered to be forgivable for men, but not for women” (p. 21). My own work also resonates with Kadri, Mchichi Almi and Berrada’s (2016) findings; shame plagues and sculpts the lives women can have, it limits their potential and their possibilities and is inherently gendered.

Despite differences, some of the ordeals the women experienced, such as domestic violence and family violence, were experienced by all groups. Through the interviews and thematic analysis, it is clear that women across all four groups faced multiple barriers and subsequently were unable to assert their human rights. The results are alarming. The resulting

⁸ The same word as *7ashuma* just direct spelling from the authors.

injustice from the aforementioned forms of violence drastically frame the healthcare experiences of these women.

Gendered Service Access

Revealed through my research was a major difference between one group and the other three. The group of women who were HIV positive had surprisingly positive encounters with their specialized health services. All of the HIV positive women who used OPALS, also used what was described as a HIV/AIDS specific wing at Suisse, the major hospital all of the women from Rabat used. The HIV/AIDS specific pavilion at the hospital extraordinarily improved the healthcare experiences of the HIV positive women participants. According to OPALS staff, this intervention of a hospital wing that was geared towards HIV/AIDS patients has phenomenally changed the lives of those experiencing the illness. Every interviewee I spoke with who used the services praised the physician and staff in the unit, they also noted the free medication in this wing - something that is usually withheld unless staff are bribed in general hospital units. As witnessed through the interviews with women who were HIV positive, their experiences when accessing the neighborhood hospital were filled with stigma and shame. The pavilion and OPALS combined are in fact so successful that sisters Fatima and Zahra travel hours on various forms of transit from their village to receive care at those facilities.

Surprisingly, the positive reception to these services by the women I spoke to experiencing HIV/AIDS is remarkable given the fact that the disease is globally stigmatized on three different levels: individual, environmental, and political (Nyblade, Stangl, Weiss, & Ashburn, 2009). Undoubtedly the experiences of the HIV positive women I interviewed are

influenced by the fact that they are able to find services tailored to them and their illness, driven by a mandate to provide comprehensive stigma free HIV/AIDS services to ensure survival and prevention. Dr. Attoussi, the OPALS staff psychologist and executive director has long been part of efforts to destigmatize HIV/AIDS in the Middle East and North Africa, especially throughout Morocco. He emphasized the need for more sexual health education indicating that the success OPALS has experienced is due to government support and funding of its mission. The vast differences in support between the small group of HIV positive clients I interviewed from the other three groups of women I spoke to are corroborated by research that speaks to the importance of gender and illness specific services (Nyblade, Stangl, Weiss, & Ashburn, 2009; Teunissen, Rotink, & Lagro-Janssen, 2016, p. 6).

The other three groups of women I interviewed, Syrian refugees, sex workers, and unwed mothers, all expressed desires for stigma free services that met their needs. While Syrian refugees opted for private care by going to stop lights and begging for money or borrowing within their community, sex workers on the other hand specified that their abhorrent treatment in public healthcare settings had driven them to avoid care when they were ill to the point where they would wait until they were extremely ill. This fear is in addition to a financial hurdle that forces most sex workers to save up or borrow money when they did access private healthcare. While both groups expressed their preference to go to private care, Syrian women only accessed and experienced private care since their arrival in Morocco; sex workers, being Moroccan, had experienced and witnessed both the private and public healthcare systems in Morocco and made their decisions based on financial constraints and lived experience, inevitably avoiding care when they lacked any money or resources leading to detrimental health outcomes for themselves

and their children. The remaining group, unwed mothers, were all able to readily identify that private healthcare was significantly better, but being the youngest group of women I interviewed, they are isolated and shunned from family and community support and they were rarely if ever able to access private care.

In brief, based on my interviews from the small study I conducted, unwed mothers faced exorbitantly poor healthcare treatment whether it be when they were pregnant, during labour, or after labour. It is unconscionable that unwed mothers, the most socially isolated group face some of their worst criticisms from healthcare providers while they access care and are in labour. Some even reported that the tremendous stigma they faced went beyond a long wait at the hospital, and included being left alone for hours and being fingerprinted by police moments after they give birth. Some disclosed that the first hospitals they went to refused to help them when the women did not produce paperwork from an organization or the name of a husband and did not let them enter the hospital to give birth. Other women who did not have this experience knew of unwed mothers who experienced such circumstances.

Unwed mothers were the only group of women I interviewed who divulged dreadful and damaging experiences even when they accessed specialized supports through organizations for unwed mothers. Arguably the worst experiences amongst the women I interviewed were from the unwed mothers. In final analysis, there is no doubt that ideally, accessible stigma-free services responsive to the unique needs of women are essential and necessary to ensure positive and respectful healthcare experiences. These findings from my small-scale study are supported by larger studies illustrating that in order “[t]o optimize patients’ assessments of hospital care,

women require more gender-sensitive nursing care, more privacy, and better pain management than they receive at present” (Teunissen, Rotink, & Lagro-Janssen, 2016, p. 1).

Possible Solutions and Interventions

In brief, from my findings I understand that women accessing healthcare in Morocco are forced to acquiesce to their current situations. This is a result of interlocking oppressions including systemic and structural oppression. There is a complex web of reasons why care is so varied between women, some of which have been identified throughout this paper. The situation for marginalized women accessing health services in Morocco is far from ideal. There are however possible solutions. As illustrated through my findings, there are positive healthcare experiences in Morocco for some marginalized women. As has been noted, there is an urgency for unwed mothers to receive improved care, as they are particularly vulnerable and forced to be in healthcare situations that are undignified.

There are a number of potential interventions that could be implemented. Despite women from every group having both negative and positive experiences, there was a clear trend that people who accessed private care received better care than those who accessed public healthcare experiences. However, just as important is the overwhelming positive experiences the HIV positive women I interviewed had at the public HIV specific pavilion. As has been noted, this small-scale wing has radically improved the experiences of the women I interviewed. If such a model were to proliferate in hospitals and be tailored to other marginalized groups it could prove effective. Targeted wings are not enough alone. As illustrated through the example, OPALS training for staff and community outreach also matters. Training not only results in more

purposeful care, it also ensures empathy and stigma free services responsive to the needs of women. Arguably this would require policy level changes on a national scale.

An additional avenue for potential intervention is the introduction of full-spectrum birthing assistants and doulas throughout Morocco, but especially in rural areas. A deficit that women pointed out in their birthing and other healthcare experiences was treatment by hospital staff. A doula could serve marginalized women in a number of ways including acting as an advocate and a guide. Doulas could also assist in other elements of healthcare far beyond pregnancy and birth, especially if they are full-spectrum. One contentious issue in Morocco that was a thread throughout my interviews was contraceptives. There was a range of understanding of contraceptives and women had varied experiences getting contraceptives, although there is no need for a prescription for birth control in Morocco. In Morocco,

... most brides are socially conditioned not to question the authority of their husbands, they are often unable to use contraception or to plan their families. The combined effect of these factors may also make brides more likely to tolerate partner violence and not leave abusive husbands (Sabbe et al., 2013).

Full-spectrum doulas, designated public health advocates who worked holistically in communities, or social workers could help address the aforementioned issues. More than one woman I spoke to mentioned not being able to use condoms regularly because their husband disliked them. More than five told me they did not know what the birth control pill was when they first started having sex. More than ten women I spoke to did not know any definitive signs of breast cancer, they did not even know a lump or cyst is a potential sign. Lastly, over 15 of the women I interviewed did not definitively know what a pap smear was although all of them were

sexually active. Surely this signals a fundamental need for a full-spectrum doula or a community health educator and advocate in communities and hospitals.

It is known that,

[e]lements that affect the functionality of health systems—human-resource capacity, health-facility infrastructure, supply systems, financial resources, government stewardship, district-level management, and monitoring—will also impinge on efforts to scale up packages for health of mothers, neonates, and children within the continuum. (Kerber et al., 2007)

In Morocco all of the aforementioned elements that impact the functioning of a health system for women and their children, especially during birth, were mentioned during my interviews. Ideally, a reproductive justice approach to women's health could be utilized, informed by the voices and needs of marginalized women accessing health care services in Morocco. Although physical infrastructure and resources are an issue, one of the most striking findings was the lack of social support for women navigating healthcare systems. Arguably, social supports should be prioritized as they seem to be the most needed element. To reiterate, this intervention could be in the form of a doula, birthing assistant, social worker, or a community based health advocate who accompanies patients. There is proven success in other parts of the world with such interventions, the World Health Organization (2004) writes:

... giving social support during and after delivery, either as a birth companion — for example, acting as a doula (a South African term for a specially trained woman providing social support to women in labour) — or by supporting the household while the woman is away for childbirth informing the skilled attendant about women who have become pregnant in the community so that the skilled attendant can make direct contact with them serving as a link between families, communities and local authorities

and the reproductive health services encouraging.” Not only does this fill a gaping hole in Morocco’s current healthcare system, it ensures safer pregnancies and healthcare interactions for women (World Health Organization, 2004).

Lastly, it is well known that a mother’s level of education is correlated to quality of life, that of hers and her child’s. My own findings also revealed such a correlation. Paul Glewwe (1999) used data in 1991 from 1990-91 Moroccan Enquete Nationale des Niveaux de Vie des Menages (ENNVN) analogous to the Census to evaluate women’s health in Morocco. Through his work Glewwe (1999) determined,

[t]hree major conclusions can be drawn from the empirical work in this paper. First, health knowledge appears to be the most important skill that mothers (indirectly) obtain from their schooling that prepares them to provide for their children's health. Second, estimating the impact of health knowledge on child health could suffer from substantial endogeneity bias that can underestimate its true impact if one does not instrument the health knowledge variable. Third, the analysis suggests that schooling contributes to mother's health knowledge in Morocco only indirectly health knowledge is not directly learned in school but instead is learned using literacy and numeracy skills acquired in school (p. 154)

In 2017 I would argue that literacy is still a major issue detrimentally impacting women’s health in Morocco. As I mentioned through my writing, educational barriers were evident throughout my research. At times I had to break down questions and some questions turned into educational moments in and of themselves. This was particularly true for the questions regarding breast cancer, birth control, and pap smears. I also found through my interviews that some women did indeed impact their children’s health due to their lack of health knowledge and literacy skills, corroborating Glewwe’s (1999) findings.

Presently, women are forced to capitulate to multiple systems and oppressive structures that detrimentally lead to poor healthcare experiences and subsequent outcomes. It is important to note that it is not the healthcare system alone that affects women's health in Morocco, as illustrated a number of social forces impede on women's ability to navigate healthcare. Additionally, policy and administrative issues such as change in address impact women's ability to have their RAMED cards, stripping them of the free care they are guaranteed living under the poverty line. Although healthcare may be at the nexus the experiences shared with me from the four groups of women manifest into a web of issues women in Morocco must negotiate and traverse.

New Findings and Strengths

Though research and writing about women's health in Morocco is not a new phenomenon, my study did offer some unique and supplementary findings to add to a diverse growing body of work in the field. My research is the first body of research to compare these particular four groups of women in a cross-cutting way. There is nuance in the findings for a number of reasons. One may be my own heritage. Much of the literature in the field that is presently in English has been written by non-Moroccans. There is also some geographic diversity in my work and there were a number of recruitment methods employed generating unique findings.

One such finding was lateral violence I witnessed between and within groups of women. A notable one occurred during my interviews at the Amane women's shelter. Although all of the women are in dire situations living in a shelter that is far from what we would consider a shelter in Canada, they had issues amongst them. This was mentioned to me by two of the social workers who said that they let

the women “work them out.” I did not understand how social stigmas followed the women into the shelter nor did I think the issues would ever be rooted in the women’s situations which brought them to the shelter. I assumed that the women would have empathy for one another and the situations the social workers mentioned were more so about beds, cleaning, or other issues. As I interviewed a woman who was divorced she casually said in her interview “yes, I’m not a slut like some of the women up there.” She did this gesturing to the upper floor where the unwed mothers slept, a space she also slept. While in Casablanca at ASF, I asked why only unwed mothers were admitted into their three-year program. I thought the program could be useful to women from a number of marginalized backgrounds. I was then told that ASF used to help divorced women and widows, as all lacked a male in their lives and were detrimentally impacted. However, this was halted when the divorced women and widows began sexually shaming the unwed mothers. This is similar to the comments I heard at the shelter from the divorced woman I met. Although all of these women are in the same financial situation and live at the margins of society, the emphasized shame and stigma towards unwed mothers is evident.

Limitations

Although the study boasted a number of strengths, as with any study there were also a number of limitations and some setbacks. Firstly, it was a small scale study with definitive time limitations. Despite the fact that some of my interviewees could give me a generous amount of time that was not the case for all of them. One limitation was a result of the nature of snowball sampling and rushed opportunities to interview individuals in between appointments. For instance in some cases I was referred to women with limited amounts of time before they had to be picked up, take a train, or go to work. Subsequently, some interviews were tightly structured and there was no room for extensive sub questions or flexibility to go beyond my fifteen pre-determined questions.

An additional limitation which exists in this study is the relationship limit. My relationship with each group of women I interviewed was inherently different. Further, my relationship to each interviewee is distinct and dynamic. The settings and circumstances I interviewed women in, the way they were referred, their agenda for the day, and other people such as social workers or family members prompting my interviewees to finish were added limitations. For instance, three women declined to be interviewed by me for a reason that I would consider an issue based on the interviewee relationship to me. The three women who declined interviews were unwed mothers whose interviews had been arranged by social workers at organizations. One social worker mentioned prior to my interviews, “the girls will not like speaking to you because you’re young, you’re close to their age, it hurts their feelings.” This was evident when two of the unwed mothers saw me and then decided not to speak to me. Granting all this, my relationships to the women in some scenarios was also an asset. For instance, some of the unwed mothers at ASF became familiar with me over the course of my internship and wanted to actively participate in my work. They were at ease and knew me to a certain extent after seeing me in the kitchen, at the daycare, at their literacy class, getting my hair washed at the salon, and eating at the restaurant daily. There is also a need to mention power dynamics, specifically with Syrian women. I am still attempting to navigate power, and perhaps this is part of community-based research that I will always be troubled by. The way the women perceived my mother and I comes out at points in the interviews and their ongoing interactions afterwards. This surely could have influenced their responses, there were points in this specific set of interviews where the women requested specific things and deviated from the interview questions, one poignant example is asking for a refrigerator. The ethics of getting to leave an apartment, one with no fridge where people sleep on thin floor mats, with stories is one that I will continue to process.

As previously mentioned this study was a small scale study, an additional limitation was the short period of study. The wide geographic and demographic range I attempted to capture compounded by the fact that I interviewed a wide range of women with diverse healthcare situations also acted as a limitation. A more comprehensive study could have been achieved if I focused on one group of women in depth, conducting only interviews with them. Lastly, this study examining health care access across four groups of women in Morocco is the first of its kind. Entering new territory, the preliminary nature of this study was admittedly a limitation. Regardless of this disadvantage the findings of this study can surely serve as a foundation for further research in addition to acting as foundational discoveries to build on in the future.

Implications for Future Research

As previously mentioned this was the first study of this kind. Although this is a notable limitation it also probed new research questions and has implications for future research in a number of fields. This research amongst the four groups of women illustrated notable comparative differential access and outcomes amongst different groups of women. This could be explored more in-depth through multiple interviews with the same women, observation through accompaniment, or additional methods. As a result of interviewing four groups, one noteworthy finding was that unwed mothers appeared to have the worst healthcare experiences. This has been illustrated in previous research, although no one has examined all four of these groups there is research and writing on unwed mothers and sex workers. As Morocco experiences shifts in cultural attitudes there is optimism for more organizations like ASF and OPALS but at the same time it should be noted that some cultural attitudes are becoming more conservative, made evident by the exile of sex workers in Ain Leuh. As Bordat and Kouzzi (2010) write,

“... a local NGO in this town describes how some residents do not support and even oppose its work because they consider that by working with unwed mothers, the NGO is encouraging prostitution” (p. 189). This illustrates that unwed mothers continue to be targeted and shamed, even their services are stigmatized and under attack.

A supplementary finding was the fact that the curiously favourable experiences of the group of HIV positive women, a globally stigmatized group, who accessed the HIV pavilion at Suisse and OPALS could serve as a micro example of a pocket of services in public health that are doing well. This could serve as a beacon for what healthcare services that are tailored could be in Morocco, with a noted urgency for a specialized service for unwed mothers. Violence was a pervasive theme that undercut across all of the groups, examining the role healthcare workers could play in addressing intimate partner violence in Morocco could be an avenue to explore in future research. Chibber and Krishnan (2011) illustrate that there have been attempts to integrate awareness of intimate partner violence in the healthcare sector to assess and build capacity to address intimate partner violence at both the primary and secondary level.

Future research could involve developing a pilot program at a few of the *jamayats* that already serve unwed mothers. This pilot program could implement adding a birth support advocate and resources at some *jamayats*. This could be a full-spectrum doula, a social worker who goes with the woman instead of the current model which just sends women with paperwork, or a supportive birth attendant. All of the benefits of such an intervention have been previously discussed.

Lastly, it is my understanding that academic work connecting multiple categories of women in Morocco is rare. Further, as aforementioned, work from a Moroccan perspective has yet to proliferate the field. I strongly believe that there is desire and capacity to build a reproductive health framework in

Morocco that is informed by the lived experiences of Moroccan women and women living in Morocco. I hope in future work I can explore what building bridges across marginalization, working towards solidarity building versus the existing service silos and lateral violence would look like. This work has helped me start to imagine what reproductive health justice could look like in Morocco and I hope it helps others imagine such futures.

Discussion

As a Moroccan woman I am troubled by the history of extractive and voyeuristic research in Morocco. One space, where I interviewed women on two occasions, Amane, had signs all over in French, English and German indicating that taking photos was not allowed with prominent red caution symbols and Xes superimposed on images of cameras. Although the majority of women at the shelter could not read or write, these posters cover the walls. When I arrived for the first time the two Moroccan social workers mentioned, “the signs are up for the tourists, we mean the white people who come here to see the women and babies you know.”

The second time I went to Amane and met the executive director, Madame Najat, she mentioned the signs were for “white people from *karriege*.” Although the word *karriege* indicates an outsider, a label which I have worn in many circumstances in Morocco, the term in this instance was not meant for me. Madame Najat explained that “white people from outside post photos on social media – like facebook, they don’t understand that these women’s husbands can find them here and follow them.” These are parts of the stories I heard that I did not find in the literature I reviewed before travelling to Morocco or while writing this paper. This sentiment was not only present at the Amane center – every Moroccan person I spoke to who was a

researcher or employee at a *jamayat* discussed or mentioned the ethics of Western researchers. While I spent my two weeks at ASF I witnessed firsthand the entitlement and procurement of specific stories that fit a white researcher's desires for her narratives of unwed mothers in Morocco. She avoided obtaining rich, thick, whole stories, and instead focused on damage and deficit.

In 1994, Valerie Staats reflected on her experience living in Morocco for two years and writing to her friends who wanted to hear about the lives of Moroccan women. Staats described Morocco in 1994 as “[b]oth traditional and modern, Morocco has a complex society which cannot be generalized” (p.1). Today, I believe this statement still holds true. I chose to use semi-structured interviews and weave narratives intentionally in order to avoid gross generalizations I sometimes witness of my motherland and other countries and peoples that are researched. Throughout my research I found differences and inconsistencies with some existing literature on the lives of Moroccan women. I hope that my contributions will act in a way to proliferate these dominant narratives and perhaps thicken them as they challenge them.

In my research and writing I did not want to focus on what is absent in existing literature, I do not want to fixate on viewing my community as damaged and subsequently exhaust time combatting narratives that were not created nor informed by Moroccan women/women living in Morocco in authentic ways. I am invested in counter storying, re-storying, and re-searching the stories of women navigating gender and health in Morocco. My work, social location and understanding disrupts previous and contemporary writing on women in Morocco. One example is Analiza Adeline Grabowski's research conducted in 2016 and titled *Cultural Constructions of Gendered Health in Morocco from a United States' Perspective: How Gendered Tashuma*

(Shame) Shapes and Enables Women's Health in this area of the World. In the recent paper she also discusses 7ashuma, however her understandings of Morocco and Moroccan women's health seem to perpetuate Western understandings of Morocco and exhibit gaps which skew the lives of Moroccan women. Grabowski (2016) writes of cultural shame for women, stating:

[t]his is especially true of toilet paper use during menstruation. ... In the 7emaam beldi, there is an extra hose where you cleanse yourself after going to the bathroom, instead of using toilet paper. This ritualistic method of cleaning oneself is in alignment with 7ashuma culture, so that women are pressured into maintaining a certain level of vaginal "cleanliness" so as to avoid shame.

Admittedly, as Moroccan diaspora and a Muslim this was an amusing observation. The observation is indisputably one of an outsider that did not further investigate cultural and religious practices and instead painted them as misogynistic. If Grabowski's (2016) argument about women was correct, men would also not use a water hose following fiqh, Islamic jurisprudence hygiene. In fact, Grabowski would find out with a simple search that the water hose is not inherently Moroccan or regulated to 7emaam beldi, the hoses exist throughout washrooms in Muslim countries and are also found in many Muslim households in the West. None of this is linked to pressuring women or sexual shaming. If Grabowski had spoken to more Moroccan women or men or even searched Muslim toilette etiquette she would have found that washing with water is part of Islamic jurisprudence. She would have also realized that toilette paper is not avoided to shame women and force vaginal cleanliness, toilette paper is considered a luxury in Morocco and is indicative of social class.

So although Grabowski and I both examined *7ashuma*, shame and women's reproductive health in Morocco, our social locations translated into very different understandings. In consideration of the foregoing example it is imperative to recognize that Grabowski is not the only person to conduct research in Morocco and report inaccuracies that skew and misrepresent cultural and religious practices. A number of misrepresentations stem from orientalism and are rooted in Western stereotypes of Morocco and its people. This is why this research project was so important to me. As Gracia Anzaldúa, exclaims, "[i]t is not enough to stand on the opposite river bank shouting questions, challenging patriarchal white conventions" (1997, p. 270). Although I noted my limitations as an outsider above, I also believe that this project helped me trace my way back through my heritage as I had the honor to listen to women's stories, be invited into their households, and lives.

References

- Abdesslam, B. (2011). Social determinants of reproductive health in Morocco. *African Journal of Reproductive Health*, 15(2), 57-66.
- [AFP News Agency]. (2014, August 15). *Unwed mothers in Morocco struggle against harsh judgement* [Video File]. Retrieved from <https://www.youtube.com/watch?v=y1xprRV-qAA>
- Alami, A. (2015, June. 3). Moroccan Film About Prostitution Creates Uproar. *The New York Times*. Retrieved from <https://www.nytimes.com/2015/06/04/arts/international/moroccan-film-about-prostitution-creates-uproar.html?mcubz=3>
- Anzaldúa, G. (1997). La conciencia de la mestiza: Towards a new consciousness. *AM Garcia, Chicana feminist thought: The basic historical writings*, 270-274.
- Aksit, E. E. (2011). The women's quarters in the historical hammam. *Gender, Place and Culture*, 18(02), 277-293.
- Basty, F. (2011, January 10) Moroccan Government Releases Extensive Gender-Based Violence Study. Retrieved July 05, 2017 from

<http://www.unwomen.org/en/news/stories/2011/1/moroccan-government-releases-extensive-gender-based-violence-study>

Bordat, S., & Kouzzi, S. (2009). Legal Empowerment of Unwed Mothers: Experiences of Moroccan NGOs. *Web.* < http://www.wluml.org/sites/wluml.org/files/LEWP_BordatKouzzi.> *Pdf.*

Bordat, S. W., & Kouzzi, S. (2010). Legal empowerment of unwed mothers: Experiences of Moroccan NGOs. *Legal Empowerment: Practitioners Perspectives.*

Brown, L. A., & Strega, S. (2005). *Research as resistance: Critical, indigenous and anti-oppressive approaches.* Canadian Scholars' Press.

Bouhmouch, N. (2013). 475. *Documentary film (60 minutes).*

Charrad, M. (2001). *States and women's rights: The making of postcolonial Tunisia, Algeria, and Morocco.* Univ of California Press.

Chibber, K. S., & Krishnan, S. (2011). Confronting intimate partner violence: A global health priority. *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine*, 78(3), 449-457.

- Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.
- d'Adesky, A. C. (2006). *Moving mountains: the race to treat global AIDS*. Verso.
- Dageid, W., & Duckert, F. (2008). Balancing between normality and social death: Black, rural, South African women coping with HIV/AIDS. *Qualitative Health Research*, 18(2), 182-195.
- Daley, S. (2012, Oct. 29). Villagers in Morocco Drive Out Prostitutes. *The New York Times*. Retrieved from <http://www.nytimes.com/2012/10/30/world/africa/moroccan-villages-war-on-prostitution-draws-critics.html>
- Davis, S. S. (1978). Working women in a Moroccan village. *Women in the Muslim World*.
- De Châtel, F. (2014). The role of drought and climate change in the Syrian uprising: Untangling the triggers of the revolution. *Middle Eastern Studies*, 50(4), 521-535.
- Dennerlein, B. (2012). Remembering Violence, Negotiating Change The Moroccan Equity and Reconciliation Commission and the Politics of Gender. *Journal of Middle East Women's Studies*, 8(1), 10-36.

- Edwards, C. (2012). *Advocacy Strategies for Marginalized Women in Morocco*. *Journal of New Media Studies*, (1):1-15.
- Eisenberg, A. M. (2011). Law on the Books vs. Law in Action: Under-Enforcement of Morocco's Reformed 2004 Family Law, the Moudawana. *Cornell Int'l LJ*, 44, 693.
- El Masaiti, A.. (2017, July 23). Access to AIDS Treatment in Morocco Increased by 32% Between 2010-2016. *Morocco World News*. Retrieved from <https://www.moroccoworldnews.com/2017/07/224061/access-aids-treatment-morocco-increased-32-2010-2016/>
- Elmir, E., Nadia, S., Ouafae, B., Rajae, M., Amina, S., & Rajae, E. A. (2002). HIV epidemiology in Morocco: a nine-year survey (1991–1999). *International journal of STD & AIDS*, 13(12), 839-842
- Elouazi, S. (2017, November 23). 22,000 Moroccans Live with HIV: UNAIDS. *Morocco World News*. Retrieved from <https://www.moroccoworldnews.com/2017/11/234643/moroccans-hiv-unaid-aid-morocco/>
- Evrard, A. Y. (2014). *The Moroccan women's rights movement*. Syracuse University Press.
- Fernea, E. W. (1998). In Search of Islamic Feminism: One Woman's Global Journey.

Glewwe, P. (1999). Why does mother's schooling raise child health in developing countries?

Evidence from Morocco. *Journal of human resources*, 124-159.

Gnes, D. (2013). Maghnia: Crossing the Uncrossable Border. *Euro-Mediterranean Human*

Rights Network (EMHRN).

Grove, N. J., & Zwi, A. B. (2006). Our health and theirs: forced migration, othering, and public

health. *Social science & medicine*, 62(8), 1931-1942.

Gökengin, D., Doroudi, F., Tohme, J., Collins, B., & Madani, N. (2016). HIV/AIDS: trends in

the Middle East and North Africa region. *International Journal of Infectious*

Diseases, 44, 66-73.

Grabowski, A. A. (2016). Cultural Constructions of Gendered Health in Morocco from a United

States' Perspective: How Gendered *7ashuma* (Shame) Shapes and Enables

Women's Health in this area of the World.

Graiouid, S. (2004). Communication and the social production of space: the hammam, the public

sphere and Moroccan women. *The Journal of North African Studies*, 9(1), 104-130.

- Hanafi, L. (2013). The implementation of Morocco's 2004 Family Code Moudawana: stock-taking & recommendations. *The Danish Center for Research and Information on Gender, Equality and Diversity KVINFO*.
- Harrak, F. (2009). The history and significance of the New Moroccan family code. *Institute for the Study of Islamic Thought in Africa (ISITA), Working Paper Series*.
- Hartwell, A. (2013). Understanding Health and Medicine: A Critical Examination of Governance, Surveillance and Control within Contemporary Culture. *Behavioural Sciences Undergraduate Journal*, 1(1), 25-38.
- Hasnain, M. (2005). Cultural approach to HIV/AIDS harm reduction in Muslim countries. *Harm reduction journal*, 2(1), 23.
- High Commissioner of Planning/Haut-Commissariat Au Plan. (2012). National Survey Prevalence of Violence Against Women in Morocco/Enquête Nationale sur la Prévalence de la Violence à l'égard des Femmes au Maroc. Kingdom of Morocco/Royaume de Maroc.
- Hill, D. M., & Kurtz, D. L. (2008). The effects of stigma on Aboriginal women living with HIV/AIDS. *Canadian Journal of Community Based HIV/AIDS Research, Supplement Edition*, 5-15.

Jay, C. (2013). Acting up: performance and the politics of womanhood in contemporary Morocco. *Journal of African Cultural Studies*, 25(3), 305-318.

Kadri, N., Mchichi Alami, K., & Berrada, S. (2010). Sexuality in morocco: Women sexologist's point of view. *Sexologies*, 19(1), 20-23. doi:10.1016/j.sexol.2009.03.005

Kerber, K. J., de Graft-Johnson, J. E., Bhutta, Z. A., Okong, P., Starrs, A., & Lawn, J. E. (2007). Continuum of care for maternal, newborn, and child health: from slogan to service delivery. *The Lancet*, 370(9595), 1358-1369.

King, E. M., & Mason, A. D. (2001). Engendering development through gender equality in rights resources and voice. Summary.

Kreutzberger, K. (2008). Single mothers and children born out of wedlock in the Kingdom of Morocco. *YB Islamic & Middle EL*, 14, 49.

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The lancet*, 360(9339), 1083-1088.

Levy, J. (2006). Using a Metaperspective to Clarify the Structural-Narrative Debate in Family Therapy. *Family Process Journal*, 45(1), 55-73.

Lindsey, U. (2017, June 28). Morocco's Rebellious Mountains Rise Up Again. Retrieved July 05, 2017 from

<https://www.nytimes.com/2017/06/28/opinion/morocco-protest-monarchy.html>

MacDonald, G., Kingsbury, R., & Shaw, S. (2005). Adding insult to injury: Socialsomatic pain theory and response to social exclusion. *The social outcast, Psychology Press, New York.*

Maddy-Weitzman, B. (2005). Women, Islam, and the Moroccan state: The struggle over the personal status law. *The Middle East Journal*, 59(3), 393-410.

Maghraoui, A. (2001). Political authority in crisis: Mohammed VI's Morocco. *Middle East Report*, (218), 12-17.

Maher, V. (1974). *Women and property in Morocco: their changing relation to the process of social stratification in the Middle Atlas* (No. 10). CUP Archive

McKanders, K. M. (2014). Anatomy of an Uprising: Women, Democracy, and the Moroccan Feminist Spring. *BU Int'l LJ*, 32, 147.

Morocco World News. (2015, May 27). Study Claims 19,333 Prostitutes 'Work' in Four Major Moroccan Cities. *Morocco World News*. Retrieved from

<https://www.morocoworldnews.com/2015/05/159485/study-claims-19333-prostitutes-work-in-four-major-moroccan-cities/>

Moss, C. (2015, October 9). *Airbnb owners in Morocco face fines if guests are unmarried.*

Retrieved from

<http://www.telegraph.co.uk/travel/destinations/africa/morocco/articles/Airbnb-owners-in-Morocco-face-fines-if-guests-are-unmarried/>

Nyblade, L., Stangl, A., Weiss, E., & Ashburn, K. (2009). Combating HIV stigma in health care settings: what works?. *Journal of the international AIDS Society*, 12(1), 15.

Mutlu, C. E., & Leite, C. C. (2012). Dark side of the rock: borders, exceptionalism, and the Precarious Case of Ceuta and Melilla. *Eurasia Border Review*, 3(2), 21-39.

[PBS NewsHour]. (2011, December 21). *In Morocco, 20,000 Imams Trained to Teach HIV/Aids Awareness, Compassion* [Video File]. Retrieved from <https://www.youtube.com/watch?v=XQVD8CyQcx4>

Pellegrino, E. D. (1986). Rationing health care: the ethics of medical gatekeeping. *J. Contemp. Health L. & Policy*, 2, 23.

<http://heinonline.org/HOL/LandingPage?handle=hein.journals/jchlp2&div=6&id=&page=>

- Rutherford, A., Zwi, A. B., Grove, N. J., & Butchart, A. (2007). Violence: a glossary. *Journal of Epidemiology & Community Health, 61*(8), 676-680.
- Tamanna, N. (2008). Personal status laws in Morocco and Tunisia: A comparative exploration of the possibilities for equality-enhancing reform in Bangladesh. *Feminist legal studies, 16*(3), 323.
- Teunissen, T. A. M., Rotink, M. E., & Lagro-Janssen, A. L. M. (2016). Gender differences in quality of care experiences during hospital stay: A contribution to patient-centered healthcare for both men and women. *Patient education and counseling, 99*(4), 631-637.
- Timmermans, S. (1998). Social death as self-fulfilling prophecy: David Sudnow's Passing On revisited. *The Sociological Quarterly, 39*(3), 453-472.
- Wuerth, O. (2005). The Reform of the Moudawana: the role of women's civil society organizations in changing the personal status code in Morocco. *Hawwa, 3*(3), 309-333.
- Saba, H. F., Kouyoumjian, S. P., Mumtaz, G. R., & Abu-Raddad, L. J. (2013). Characterising the progress in HIV/AIDS research in the Middle East and North Africa. *Sex Transm Infect, 89*(Suppl 3), iii5-iii9.

- Sabbe, A., Oulami, H., Zekraoui, W., Hikmat, H., Temmerman, M., & Leye, E. (2013). Determinants of child and forced marriage in Morocco: stakeholder perspectives on health, policies and human rights. *BMC international health and human rights*, *13*(1), 43.
- Sharara, S. L., & Kanj, S. S. (2014). War and infectious diseases: challenges of the Syrian civil war. *PLoS pathogens*, *10*(11), e1004438.
- Staats, V. (1994). Ritual, strategy, or convention: Social meanings in the traditional women's baths in Morocco. *Frontiers: A Journal of Women Studies*, *14*(3), 1-18.
- Staszak, J. F. (2014). Planning prostitution in colonial Morocco: Bousbir, Casablanca's quartier réservé.
- UNHCR. (2015). Morocco update information note on Syrians applying for asylum in Morocco. <http://www.undp.org/content/dam/unct/morocco/docs/UNCT-MA-Information%20Note%20on%20Syrians%20Applying%20for%20Asylum%20Morocco-%20September%202015.pdf>

Venema, B., & Bakker, J. (2004). A Permissive Zone for Prostitution in the Middle Atlas of Morocco. *Ethnology*, 43(1), 51-64. doi:10.2307/3773855

Zoglin, K. (2009). Morocco's family code: Improving equality for women. *Human Rights Quarterly*, 31(4), 964-984.

Zvan-Elliott, K. (2009). Reforming the Moroccan personal status code: a revolution for whom?. *Mediterranean Politics*, 14(2), 213-227.

Appendices

Appendix A: Semi- Structured Interview Guide English

Thank you for being here with me today, and thank you for sharing your knowledge with me. My name is Nashwa Khan and I am currently doing a project looking at how women navigate health care in Morocco. I really appreciate any insight you can give me.

1. How you are doing health-wise right now?
2. When was the last time you went to a clinic or saw a physician? What was that like? Who did you see? How did they treat you? How did you pay?
3. Do you experience any trouble while accessing women's health or gendered healthcare services? How do you overcome? Who helps you?
4. Have you ever avoided going to get healthcare when you were not feeling well? Why? What was that like?
5. Do you know what healthcare services you are allowed to have?
6. Have you given birth? What was your experience like?
 - a) Where did you give birth
 - b) Who supported you
 - c) Were there any challenges
 - d) What was pre-natal and post-natal care like
7. If you've taken birth control how did you get it? What was that like?
8. If you were experiencing heavy vaginal bleeding what would going to the doctor look like? (Or Ovarian Cyst, irregular period, needed birth control, prenatal care, pap-smear, breast exams, yeast infection etc.)
9. Do you know the signs of breast cancer?
10. Have you ever got a pap smear? If you have when was the last time you got one?

11. Can you tell me about a story memorable experience you have had when seeking healthcare?
12. How could healthcare for women like you in Morocco be improved?
13. Do you think your experience as a "widow/divorcee/single mom/refugee" is different from other women accessing healthcare? how? why do you think that is?
14. How does your community plays a role in your health and well-being? How does community help you access and understand healthcare? (i.e the women around you or from same community group)
15. Is there anything I am missing that you would like to tell me or is there anything important for me to know?

(If above questions are very close ended with answers can capture a moment with this last question)

Reminder: get clarification to ensure understood what the person is saying in the moment

End of interview probe(s):

If client had answers different from other interviews in same substrata/the literature

Q: I am happy to hear about your experiences and appreciate you sharing them with me. I have read and heard very different experiences from other women in similar situations, do you mind reflecting on why you think your experiences are different? How that happened? Or reflecting on this difference?

Appendix B**Demographic Sheet:**

Place of meeting/source of referral: _____

Date of birth/Age: _____

Where were you born (in Morocco)/Where did you relocate from/What citizenship do you hold?:
_____What type of healthcare do you access? (CNSS, Mutuelle, RAMED, pay out of pocket):

Ethnicity: _____

Religion: _____

Marital Status: What is your marital status?

- Single, never married
- Married or domestic partnership
- Widowed
- Divorced
- Separated

Do you have children? _ yes _ no

If yes, how many children? _____ ages and gender _____

Employment Status: _____

When is the last time you were hungry or missed a meal because you could not afford it?

What is your house like? Or describe the place you live? _____

Appendix C: Demographic Tables

Table 1: Names of Interviewees and Demographic Information (Unwed Mothers in Morocco)

Name	Citizenship-	Age	Marital Status	Healthcare	Education Completed	Gravidity & parity
Eman	Moroccan	16	Unwed; engaged to 26 year-old	Public	Grade 8	Pregnant at time of interview
Laila	Moroccan		Unwed	Public but had to pay	Grade School	1 child (2)
Fatima	Moroccan	22	Unwed	Public	Literacy School	1 child (1 yr 3 months)
H.T.	Moroccan	27	Unwed	RAMED	Grade School	3 children (6, 3, 6 month)
Khansat	Moroccan	20	Unwed	RAMED	Some College	1 child (1)
Meriyem	Moroccan	27	Unwed	Public but had to pay	Some high school	2 children (3, 7)
Jamila	Moroccan	28	Unwed	Public but had to pay	Grade School	1 child (5) + preg. During interview
Meriem	Moroccan	21	Unwed	Public but had to pay	Grade School	2 children (12-15); different fathers ; unwed mother.
Rachida	Moroccan	21	Unwed/Father of baby died	Public but had to pay	Grade School	1 child

Table 2: Names of Interviewees and Demographic Information (Women living with HIV/AIDs in Morocco)

Name	Citizenship-	Age	Marital Status	Healthcare	Education Completed	Gravidity & parity
Malika	Moroccan	36	Married; separated 4-5 months	Pay out of pocket	Grade 3	4 children (20, 14, 10, 2) + preg. at time of interview
Hassna	Moroccan	39	Currently married, second marriage	RAMED	Grade 12	2 children (15, 9); 6 pregnancies
Zahra	Moroccan	54	Divorced first husband, widow of second	RAMED	Never went to school	Sterile - could not get pregnant
Hanane	Moroccan	27	Married in 2006 at 16 to 36-year-old man	RAMED	Grade 8	3 children (6, 3, 6 month)
Fatima	Moroccan	59	Widowed	RAMED	Never went to school	2 stillborn births
Emilia	Congo - lives in Rabat since 2016	36	Divorced in 2009	CARITAS	Some high school	Experienced a miscarriage
Justine	CAR – lives in Rabat since 2016	36	Single - never married - unwed mother and refugee	UNHCR card	Some college	2 children (12-15); different fathers ; unwed mother.

Table 3: Names of Interviewees and Demographic Information (Women living with HIV/AIDS in Morocco)

Name	Citizenship-	Age	Marital Status	Healthcare	Education Completed	Gravidity & parity
Khadija	Moroccan	42	Divorced	Public/Private when able	Grade 34	Experienced a miscarriage
Mourabit	Moroccan	29	Single	Public/Private when able	Grade 9	Has never been pregnant
Ruby	Moroccan	30s	Divorced	RAMED/OPALS	College	3 children
Huda	Moroccan	36	Divorced	Public/OPALS	Some Grade 12/College	Experienced an Abortion
Hannan	Moroccan	34	Divorced	OPALS/Private when able	Grade 5	2 children Experienced a miscarriage recently
Salwa	Moroccan	34	Divorced	OPALS	High School	Did not want to disclose

Table 4: Names of Interviewees and Demographic Information (Syrian Refugee Women in Morocco)

Name	Citizenship-	Age	Marital Status	Healthcare	Education Completed	Gravidity & parity
Soltana	Syrian	25	Married since age 15	Pay out of pocket	Never went to school	4 children (12, 7, 3, 3)
Khalti Aicha	Syrian	Did not know	Widow, Married before 15 years old	Pay out of pocket	Grade 12	11 children (various ages, not sure)
Zaman Nassan Karakan	Syrian	19	Married since age 18	Pay out of pocket	Never went to school	1 child (met her at 9 th month of pregnancy and with newborn)
Sanaa	Syrian	35	Married before 15 years old	Pay out of pocket	Grade 8	7 children (22, 20,18, 4.5, others unknown)
Loubna	Syrian	43	Widowed, Married before 15	Pay out of pocket	Never went to school	4 children (ages 18-25)







