



The health professional-sub-Saharan migrant relationship in the network of primary healthcare facilities in Morocco: “Case prefecture of Meknes”

*Rharib **Oussama**¹, Ababou **Mohammed**²

¹Sociology and Psychology Laboratory, Faculty of Letters and Human Sciences Dhar El Mahraz, University Sidi Mohammed Ben Abdellah of FES, Morocco & Higher Institute of Nursing and Health Technology of Fes Annex of Meknes, Morocco.

²Sociology and Psychology Laboratory, Faculty of Letters and Human Sciences Dhar El Mahraz, University Sidi Mohammed Ben Abdellah of FES, Morocco

***Corresponding author:**

Oussama.rharib@usmba.ac.ma

Abstract:

Given its geographical position, Morocco has become a crossroad of migratory flows for sub-Saharan migrants. This recent phenomenon has taken several forms over the last decade. Among others, certain migrants take the risk in difficult conditions and find themselves at the end of their African trajectory, stopped in the north of the continent due to restrictive measures taken by the European Union. Most of them are forced to stay in Morocco, where these sub-Saharan migrants face all sorts of health precariousness and difficulties in accessing healthcare, as well as subhuman conditions of social and family isolation, and economic and administrative vulnerability. The study aims to take a sociological look at the specific context of the health of sub-Saharan migrants, which aims, through a quantitative and qualitative study, to analyse the relationship between health professionals and sub-Saharan migrants. The survey took place in primary healthcare facilities in the prefecture of Meknes. The results obtained reveal that despite the efforts made by the Moroccan Ministry of Health to facilitate migrants' access to health services, the "cultural diversity" dimension in the field of health has remained a hindrance. This is

evident in the misunderstanding between the health professional and the Sub-Saharan migrants, which has influenced the quality of healthcare delivery in that it has sometimes put the health professional in "cultural shocks" on the one hand, and the Sub-Saharan migrants in difficulties to easily benefit from culturally congruent healthcare on the other hand. This said, health professionals need training on the cultural diversity of Sub-Saharan communities to ensure culturally sensitive and competent transcultural healthcare.

Keywords: *health professional; sub-Saharan migrant; migrant health professional-patient relationship; transcultural care.*

Introduction

Today, Morocco is experiencing a wave of migration from Sub-Saharan Africa due to vulnerability (Faleh et al., 2009). These migrants are a relatively young people (more than eight out of ten of them are aged 15-44), the majority of whom come from West African countries (El Arabi, 2023). According to the High Commission for Planning, in its national survey on forced migration in Morocco (2021), more than one-third of migrants (39.1%) left their country of origin mainly for reasons related to war, insecurity, search for employment (36.7%) and acquisition of skills (14.1%). This population of sub-Saharan migrants (44.5%) has experienced several difficulties during migration; these include lack of money (17.7%), physical exhaustion due to walking, hunger and thirst (17.5%), physical and psychological violence (13.7%), sexual harassment or rape sexual harassment or rape (7.8%, 17.7% among women and 1.7% among men), arrest and detention (7.7%), refoulement, expulsion and deportation (6%).

Finally, it should be noted that (4.3%) of women get pregnant or bear children during the journey. In addition to these embarrassments, the struggles of migrants to fit in and cope with a new environment leave much to be desired: they have to start from scratch in an unfamiliar environment, relearn everyday gestures, find a suitable job, adapt to it, and their body system tries to get used to new weather conditions (Gerbes et al., 2015).

The Moroccan government, in its report on the national immigration and asylum policy (2019), revealed that these sub-Saharan migrants, particularly those in an irregular situation, are most often in a situation of vulnerability and exteriority in relation to the social and health programs in Morocco: migrants are most often subject to the same difficulties as the indigenous population, but their vulnerability is more apparent and the difficulties encountered have a particular impact on them (Berriane et al., 2015). In some situations, this is accompanied by the

stigmatisation of sub-Saharan migrants who are believed to be the source of epidemics (Linard, 2017).

This observation shows that despite Morocco's efforts, via the extension of medical coverage through the medical assistance scheme for the economically deprived (RAMED) and the free services offered to regular and irregular migrants via a network of 27,000 basic health facilities, the cultural diversity dimension in the field of health remains scantily studied in the healthcare relationship (National Strategic Plan for Health and Immigration, 2021). Linguistic and cultural barriers limit migrants' capacity to orient themselves to primary healthcare facilities and their authorised access to these services, which are essentially intended for the prevention and promotion of their health (P. Iqbal et al., 2022). These health services are particularly affected by the effects of migration. Thus, the diversity of ethnic groups and the multiplicity of cultural backgrounds of migrants raise several questions at the time of service provision (Kotobi, 2000). On the one hand, there is a need to provide services to migrants 'with a diverse cultural backgrounds and, on the other hand, to address the communication limitations that arise, particularly in a clinical context (Farber, 2019). In this respect, several questions arise:

What factors are associated with the relationship between health professionals and sub-Saharan

migrants in primary healthcare facilities in the Meknes prefecture? Can we talk about the transcultural care of health professionals towards sub-Saharan migrants at the level of primary healthcare institutions in the prefecture of Meknes?

In this framework, the present study argues that the cultural differences between the health professionals and the care receivers who are the sub-Saharan migrants at primary healthcare facilities have not been given the requisite attention. This diversity basically resulted from differences in language and notions of space and time, which have constituted relationship barriers between health professionals and sub-Saharan migrants. These factors determine the quality of care the migrants receive in that it, on the one hand, puts the health professional in cultural shocks and, on the other hand, makes it difficult for the sub-Saharan migrants to easily benefit from culturally congruent care.

Theoretical frameworks

This study fits into interactionist sociology (or symbolic interactionism). It is a current that analyses society as a result of the interaction between its individuals. This current was developed in the United States in the middle of the 20th century from the work of the University of Chicago and subsequent work in Europe, which attempted to explain the phenomenon of migration, its determinants and its impact on the redefinition of

migrants' cultural practices and sociability networks (Coulon, 2020). Subsequently, studies on migration over the last decades have largely found factors such as the need to escape dangerous situations and the search for a better environment as the major reasons for migration. For sociology, migration depends on positive factors that characterise the places of destination and negative factors in the places of departure (Lee, 1966). For science, the presence of cultural factors is well established: migration changes the value system and the culture of the communities from which people migrate (Massey et al., 1993). Thus, migrants are looking for links with support networks (housing, employment, education, health, etc.) to alleviate the ills of migration and to improve their "Capabilities" in Amartya Sen's language, especially for the vulnerable migrant population.

In the context of healthcare and intercultural care, it is essential that healthcare professionals take into account social and cultural factors in their care plans in order to adjust as much as possible to the particularities of foreign users (Brach & Fraserirector, 2000). In order to provide culturally competent care, health professionals have different transcultural models at their disposal, which include the following: the intercultural approach to the helping process specifies that care is a helping process based on the respect of the person, his or her worldview, value system

and needs. These terms of approach and attitude can be broken down into three steps: a) decentration to better understand one's own socio-cultural identity; b) penetration of the other's reference system; and finally c) negotiation and mediation (Cohen-Émerique, 1993). Leininger's Theory (Sunrise Model) remains a better alternative for providing culturally congruent care. Adaptation helps people from a given culture to achieve satisfactory therapeutic outcomes, while restructuring care helps people rearrange, transform or change their lifestyle and develop habits more appropriate to their healthcare needs (Hwang, 2011). Purnell's Transcultural Model is an opportunity for better care of culturally diverse patients and requires a particular cultural competence on the part of healthcare professionals to adapt to the needs of people from other cultures. Cultural competence is a conscious process that is always part of a continuum (Coutu Wakulczyk, 2003).

Population and Methods

This sociological study sought to shed light, using a quantitative and qualitative deductive approach, on the mechanisms and processes at work in the relationship between health professionals and the patients of sub-Saharan migrants. The study is part of an analytical perspective of a range of situations in the care relationship between health professionals working in primary healthcare establishments on the one hand and sub-Saharan migrants on the other hand.

1- Sub-Saharan migrant population

Sub-Saharan migrants constitute an important population among the population

treated at the primary healthcare facilities in the prefecture of Meknes, numbering 756 migrants in 2019.

Table 1: Migrants consulting at primary healthcare facilities in the prefecture of Meknes during 2019

<i>Indicators</i>		<i>Number</i>
Age	<i>Less than 5 years</i>	57
	<i>From 5 to 18 years</i>	120
	<i>From 18 to 65 years old</i>	707
	<i>Over 65 years</i>	41
	<i>Total</i>	925
Gender	<i>Male</i>	556
	<i>Female</i>	369
Source	<i>Sub-Saharanans</i>	756
	<i>Syrians</i>	143
	<i>Other</i>	26
Situation	<i>Regular</i>	625
	<i>Irregular</i>	300

Source: Meknes Prefecture Health Facilities Network Service, year 2019

This network of primary healthcare facilities is designed to act on the health conditions of the inhabitants, of which migrants are an integral part. It constitutes the first interface between the population and the healthcare system. Through this network, the strategy of covering the population with basic health services (health promotion, prevention, essential care, etc.) is developed. This network

comprises a set of so-called basic healthcare establishments which are intended to provide primary healthcare (maternal and child health (MCH), family planning (FP), vaccination, prevention and control of endemic diseases, treatment of endemic diseases and injuries, education, sanitation, supply of essential drugs, etc.).

Table 2: Number of migrants benefiting from health programs offered at primary healthcare facilities in the prefecture of Meknes:

<i>Health programmes</i>			<i>Number</i>	
<i>Number of migrants who received curative consultation</i>			533	
Overall number of migrants benefiting from health programmes	<i>PSGA (Pregnancy and childbirth follow-up Programme)</i>	<i>Women in ANC (antenatal consultation)</i>	16	
		<i>Women CpoN</i>	9	
		<i>Delivery</i>	0	
	<i>PF (Family planning)</i>	<i>Women followed up for FP</i>		25
		<i>NIP (National Immunisation Programme)</i>		32
	<i>Parasitic disease control programmes</i>			00
	<i>STIS/AIDS</i>			50
	<i>LAT (Tuberculosis Control)</i>			8
	<i>Diseases chronicles</i>	<i>Diabetes</i>		42
		<i>HTA (High blood pressure)</i>		33
<i>Other to be specified</i>		00		
<i>References</i>			03	
<i>CAP for residence card</i>			324	

Source: Meknes Prefecture Health Facilities Network Service, year 2019.

The sample selection criterion was to maximise the diversity of profiles in relation to the problem studied, taking into account gender, origin and type of medical coverage. The participants in the study are as follows: five women and five men aged between 18 and 39. They come from six countries: Senegal, Cameroon, Nigeria, Comoros, Ivory Coast, and Mali. Their stay in Morocco ranged between seven months and four years. Four participants are in a regular situation, two of whom have (RAMED) coverage, and six in an irregular situation. Six participants are unemployed, and two are in higher education. Five people speak French, three

speak English, and two speak French with great difficulty. By diversifying the profiles as much as possible, there is a good chance of gathering varied and contrasting responses. The content of the responses, as the data collection progressed, reached saturation point, and the last interviews provided practically nothing compared to the previous respondents. At this point of saturation, it was necessary to legitimately put an end to the interviews and to consider that the sample of migrants chosen is valid, although not strictly representative. (10 sub-Saharan migrants).

Table 3: Socio-demographic data of sub-Saharan migrants

<i>Pseudonym</i>	<i>Gender</i>	<i>Age</i>	<i>Country of origin</i>	<i>Level of education</i>	<i>Family status</i>	<i>Migratory status</i>	<i>Year of immigration</i>	<i>Economic situation</i>	<i>Housing</i>	<i>Medical coverage</i>
Henri	H	39	Sénégal	Primary	Single	Not regularised	2016	Begging	Rented flat	NO
Patrick	H	35	Cameroun	Primary	Single	Not regularised	2016	Begging	Rented bachelor flat	NO
Ngozi	F	22	Nigeria	Primary	Married	Not regularised	2018	Begging	Rented bachelor flat	NO
Med	H	19	Iles Comores	University	Single	Regularised	2017	scholarship holder	Rented flat	insurance
Emma	F	18	Cote d'ivoire	University	Single	Regularised	2018	scholarship holder	Rented flat	insurance
Kaschka	F	32	Mali	Primary	Married	Regularised	2015	Household	Rented flat	RAMED
Eric	H	38	Cameroun	Primary	Married	Regularised	2016	Mason	Rented flat	RAMED
Amina	F	23	Cameroun	Primary	Single	Not regularised	2017	Begging	Bachelor apartment rented	NO
Anam	F	23	Nigeria	Illiterate	Married	Not regularised	2018	Begging	Bachelor apartment rented	NO
Alex	H	29	Nigéria	Illiterate	Married	Not regularised	2018	Begging	Bachelor apartment rented	NO
<i>Pseudonym</i>	<i>Gender</i>	<i>Age</i>	<i>Country of origin</i>	<i>Level of education</i>	<i>Family status</i>	<i>Migratory status</i>	<i>Year of immigration</i>	<i>Economic situation</i>	<i>Housing</i>	<i>Medical coverage</i>
Henri	H	39	Sénégal	Primary	Single	Not regularised	2016	Begging	Rented flat	NO
Patrick	H	35	Cameroun	Primary	Single	Not regularised	2016	Begging	Rented bachelor flat	NO
Ngozi	F	22	Nigeria	Primary	Married	Not regularised	2018	Begging	Rented bachelor flat	NO
Med	H	19	Iles Comores	University	Single	Regularised	2017	scholarship holder	Rented flat	insurance
Emma	F	18	Cote d'ivoire	University	Single	Regularised	2018	scholarship holder	Rented flat	insurance
Kaschka	F	32	Mali	Primary	Married	Regularised	2015	Household	Rented flat	RAMED
Eric	H	38	Cameroun	Primary	Married	Regularised	2016	Mason	Rented flat	RAMED

During data collection via an interview guide designed in French and English, all necessary provisions to protect the rights and freedoms of sub-Saharan migrants were taken into consideration by all investigators. At the time of the interview, it was essential to make sure that the migrant understood the objective of the process and that he or she still agreed to the interview. In some situations where the migrants did not speak English or French perfectly, it was necessary to use interpreters who belonged to the same community as the migrants in the study (friends, family members, etc.) after the consent of the respondents in the study. In addition, in order to conduct the interviews in strict compliance with ethical rules, the measures taken were as follows: a) the migrant was informed in advance of the objectives and procedures of the survey via an information sheet; b) the migrant's agreement was requested orally or by signing the consent form; c) the creation of a friendly and relaxed atmosphere; d) reminders at all times that participation remains voluntary and the possibility for migrants to avoid answering certain questions that they found uncomfortable; e) the right to withdraw at any time without having to justify their decision; f) the physical safety and psychological well-being of the respondents were largely respected.

The appointments, duration and places of the interviews were fixed in consultation with the migrant at the primary healthcare

facilities in the Meknes prefecture: consultation office, rest room or meeting room, available, safe, comfortable, without the presence of a third party guaranteeing full respect for his or her privacy, dignity and confidentiality.

The study used a semi-structured interview guide as a data collection tool. Most of the data was collected from transcripts (the interviews), as the material was often difficult to use in its raw state, i.e. directly from the field diary or the interview recordings. In addition, following the large amount of data collected during the interviews with sub-Saharan migrants, it was necessary to answer the following question: How should all this information be presented in order to draw good conclusions? The "coding" technique was designed for this reason by referring to the "grounded theory". This method was developed by two American sociologists, Barney G. Glaser and Anselm L. Strauss, and set out in a book entitled *The Discovery of Grounded Theory: Strategies for Qualitative Research*, published in Chicago in 1967.

To encode the semi-directive interview, different coding phases (open, axial and selective) were validated. In this respect, a connection of the specific keywords identified with the respondents' answers was made. This was done in order to establish links between the different answers and to draw conclusions.

2- Health professionals' population:

Health professionals of all categories (medical framework and paramedical executive) practising in the network of primary healthcare establishments in 64 primary healthcare facilities, of which 31 are in rural areas, formed the population of this

study. The total number of health professionals working in the services urban area is 293. Consequently, the distribution of the health professionals studied by cadre and by care unit is presented in the following table:

Table 4: Number of health professionals working in urban primary healthcare facilities in the prefecture of Meknes

	<i>Medical framework</i>		<i>Paramedical executive</i>		<i>Total</i>	
	<i>Male</i>	<i>Feminine</i>	<i>Nurses and health technicians</i>			<i>Midwives</i>
			<i>Male</i>	<i>Feminine</i>		
<i>Level 1 Urban Health Center</i>	17	58	110	18	262	
<i>Level 2 Urban Health Center</i>	04	03	01	07	31	
<i>Total</i>	82		136		293	
<i>50% of the total population</i>	41		68		146.5	

Source: Regional Scheme for the Supply of Care SROS Fez Meknes 2016-2020

This study concerned health professionals who work exclusively in primary healthcare facilities in urban areas and who are in daily contact with sub-Saharan migrants. The RESSP in rural areas was excluded from the

study as almost all migrants are concentrated in the neighbourhoods and periphery of the city of Meknes. Therefore, the target population of this study was 293 health professionals from 33 urban health centres in

the prefecture of Meknes. Subsequently, given the impossibility of reaching all health professionals, the use of sampling techniques was necessary to obtain a sample that was as representative as possible of the target population. Thus, a stratified draw was chosen according to the healthcare facilities and the cadre of health professionals to ensure that all categories of personnel were represented in the sample. The first step consisted of developing a sampling plan that included an exhaustive and nominative list of health professionals. In the second stage, the target population was stratified according to each care unit and by cadre (medical and paramedical staff). In the third stage, a simple random selection of healthcare professionals was carried out to constitute our sample. At the level of each care unit, two nominative lists of professionals were drawn up for each medical and paramedical staff. The professionals were then numbered from 1 to the last number on each list of health professionals. The individuals were then drawn at random from a table of random numbers for the two lists and for each care unit.

The present study opted for a sample of 146 health professionals (50%) of the target population ($293/2=146, 5$). With a response rate of (69 %), the final sample consisted of 101 health professionals in all categories (34 Medical framework and 67Paramedical executive), with a predominance of women (75%). The majority of the participants in the

study were between 50 and 60 years of age (62%). The paramedical and medical staff represent (72%) and (28%) of the sample size respectively. Most of the participants (57%) have been in the job for between 10 and 20 years. This shows that this population has accumulated a relatively reasonable amount of experience.

The study used a face-to-face questionnaire as a data collection instrument, and the drafting of the final version was dependent on a pre-test of the questionnaire. A total of 14 questions were developed according to the research questions of the study. These questions include the following items: a) identification of health professionals (age, gender, location, level of education); b) professional situation (cadre, function, seniority, work position); c) basic and continuous training: basic knowledge in terms of culture and cultural diversity; d) care practice vis-à-vis sub-Saharan migrants; e) care limits of the relationship between health professionals and sub-Saharan migrants; f) suggestions and recommendations of health professionals for successful cross-cultural care. Then, after validation of the research subject and authorisation of access to the study area by the health authorities at the medical prefecture of Meknes, data were collected from 101 out of 146 health professionals, i.e. a participation rate of (69%). All ethical conditions were respected, namely: a) anonymity and confidentiality of data; b) free

and informed consent; c) respect for the freedom to participate and to withdraw at any time.

The data processing and analysis phase was preceded by a stage of purification and verification of the responses, and then a coding of the questions and responses was carried out to facilitate the exploitation of the questionnaire. In the second stage, a descriptive analysis of the responses was carried out for each of the questions by identifying the numbers and proportions in favour of the responses selected using Excel software. Subsequently, tables and graphs were drawn up to better highlight the results obtained.

Results

1- Results of interviews with sub-Saharan migrants

In successive waves of migration in Africa, thousands of sub-Saharan Africans have come to Morocco in search of a better life, either as a transit country to Europe and/or as a country of settlement (Faleh et al., 2009). Thus, living in a new context can have an influence on the physical and mental health of sub-Saharan migrants, especially within the period of their arrival in the host or transit country (Edurne & Anoso, 2021). In view of this situation, taking into consideration the challenges of sub-Saharan migrants, regardless of their migration status (regular or irregular), should be included in all strategies of

political, economic, technical, linguistic, religious and social institutions (Bertrand, 1986).

It is in this context that the Ministry of Health in Morocco has undertaken several initiatives aimed at guaranteeing migrants the right to access health services. Indeed, the primary healthcare services studied do not exclude any person presenting themselves to the establishment. However, despite these efforts to ensure better proximity of migrants to health facilities, certain cultural limitations were revealed by the present study, which influences, in one way or another, the relationship between health professionals and sub-Saharan migrants, regardless of their migratory status.

1-1- Sub-Saharan migrants' more or less limited access to primary healthcare facility networks

The report on the national immigration and asylum policy in 2019 states that the care of sub-Saharan migrants in Morocco currently remains one of the priorities of the strategic plan of the Ministry of Health in Morocco in order to enable them to benefit from medical services under the same conditions as the natives and to remove the obstacles encountered or felt through: a) the integration of regular migrants and refugees into the medical coverage programme for the most disadvantaged; b) the organisation of awareness-raising

sessions, informing migrants of their right to access health services; c) the training of health professional staff on the care of migrants; d) the designation of focal points for the information and orientation of migrants in health structures; e) the integration of migrants and refugees into public health programmes.

Despite these efforts, many migrants under-utilise healthcare resources and face multiple barriers to accessing appropriate healthcare services (Wang, 2014): fear of stigma, cultural limitations and divergent religious practices and customs represent barriers to accessing healthcare and providing appropriate care to migrants (De Vito; De Waure et al., 2016). In this sense, some migrants state¹that they have never been to health centres, as Emma points out:

No idea, I don't visit health centres, there is an association that looks after us, sometimes if I have a health problem, I go directly to the private sector... I don't know about health centres.

For Alex:

I can't go to the health centres; it's complicated; we have to put up with the pain, we have to put up with the suffering, we try to use some traditional practices, our children

are no longer protected, it's our destiny, we have to accept these difficult conditions... but before you talk to me about health, you must know, sir, that we live in the dirt without a fixed abode, we don't have any money to buy food, and I don't always manage to ask for money at the roundabout.

Other migrants report limited access to health centres, which is often limited to certificates of physical fitness to obtain a residence permit. Other services in the network of primary healthcare facilities are underused, particularly for cases of "sexually transmitted infections", "pregnancy and childbirth follow-up", and "child vaccination". Ngozi has this to say in this regard:

I benefited with my family from STI/AIDS screening and treatment for a genital infection; it went very well despite some stigmatising attitudes of some health professionals that I did not accept as if we were AIDS carriers. It is true that in some African countries, sexuality is almost free and unprotected, but not the actions of health professionals [which] I find exaggerated and disrespectful.

Anam, on his part, states:

The last time I visited the health

¹The testimonies expressed are spoken by the respondents and without correction

centre was during my pregnancy, and I had bad memories because of some discriminatory behaviour of the health professionals. I decided not to come back, and I passed the end of my pregnancy...so it was very hard for me.

However, Kaschka's testimony shows a certain satisfaction with his experience at the health centre:

Yes, I go to the health centre periodically for my daughter's vaccination, and I am satisfied with their performance, their welcome, and their advice; my daughter was well taken care of even when I was pregnant, and the centre respected the appointment, and for the examinations, it was, fortunately, our association that took care of that.

Other migrants are no longer concerned about their state of health, despite its deterioration, as they are always on the move and plan to leave Morocco as soon as possible, especially during the months of July and August, as is the case for Alex:

We try to get money from roundabouts and by collecting rubbish in the popular neighbourhoods to take turns to join our friends in Tangier and Tetouan and leave Morocco in July and August.

These migrants regardless of their regular or irregular status and regardless of their objective in relation to their stay in Morocco (country of transit or country of

settlement), poverty and precariousness remain a particular characteristic of this type of migration, which is upstream of their accessibility to healthcare. And if the question of economic and physical accessibility to healthcare seems easy to capture, it seems from the verbatim statements of the participants in the study that the nature of the care provided by the health professionals lacks contextualisation of the knowledge and means available to them and ignores the relevant cultural factors to be taken into account when dealing with the migrants. While the nature of the illness of migrants and the attendant discrimination have constituted the socio-cultural constraints on their access to healthcare, it could be eradicated by dealing with a language barrier and enhancing the relationship between these migrants and the healthcare givers.

1-2- **The lack of respect for cultural diversity frequently marks the health professional-patient relationship of sub-Saharan migrants**

In the health system, as in society in general, the health professional comes into contact with people who do not come from the same cultural background: norms, values, and frames of reference differ, as do preferences, health needs, ways of using healthcare and, finally, ways of caring for oneself. This state of affairs calls for the assessment of the particularities, the

respect of the norms of the person to be cared for, as well as those of the health professional and the institution in order to provide appropriate and quality care (Vissandjée & Dupère, 2000). In parallel, Mohamed emphasises:

There are nurses and doctors who say to us, 'We know it's different in your country, and we're looking for what you're doing about it.' When they say that, we feel a bit reassured, and we're happy that they're interested in our way of doing things.

He adds that it is important for health professionals to take care of us globally and not to isolate the cultural aspect. However, the majority of the migrants participating in the study state that their culture of origin is more or not respected and not well integrated by health professionals. They add that they have problems understanding the language and its content. They are not able to say everything that is important to them, as Anam's report confirms:

I don't only have difficulties with medical language but with language in general ...etc. It's not the same as speaking my mother tongue.

For Amina, going to the health centre to seek the services of health professionals is a very serious problem:

What I have noticed personally is the same for the others, that the doctors examine us very quickly,

they have very little time ... and it seems that they want to get rid of us as soon as possible because we can no longer understand each other.

Ngozi, on his part, also confirms this lack of cultural sensitivity among health professionals:

The health professionals have no idea about our culture, and I can't say everything I want to in my heart... sometimes I get stuck; they have to look for a solution for us; we are fragile.

The same situation had occurred with Alex, who states in this sense:

I speak in English, and no one at the health centre can speak to me; my girlfriend accompanies me and tries to translate for me, but it's not enough. Despite the non-verbal explanations of the nurses and doctors, I don't understand, and I don't know what to do.

These findings reveal the one-sided nature of the health system, which is embedded in institutional and organisational frameworks that are not always familiar to sub-Saharan migrants. And despite the efforts made by some health professionals, the cared-for sub-Saharan migrants complain about the loneliness they have felt in primary healthcare facilities and the communication difficulties they have experienced with the

teams. Care does not always respect traditional means of protection, and care practices can potentially be experienced as indecent, violent, or even traumatic with the serious occurrence of a sense of intrusion.

Securing an environment conducive to culturally congruent care and respect for migrants from other cultural backgrounds is not the sole responsibility of the healthcare unit. It thus requires a certain adaptation of migrants' view of care in the context of his or her culture (Lemaitre, 2015). Migrants requesting health services are therefore expected, in parallel with the healthcare system, to select and use cultural traits according to their interests and the constraints of the situation: "Culture is indeed a place for staging oneself and others" (Abdallah-Pretceille, 2013, p.17).

1-3- Racism and discriminatory behaviour mark some care relationships at the level of primary healthcare facilities

Despite the adaptation efforts of the health professionals, the sub-Saharan migrants in the study often felt discriminated against in certain care units. This may be due to a certain racism on the part of the health professional, to too many demands from foreigners or to a lack of understanding on the part of these two social actors (Hamed et al., 2022). In this sense, the sub-Saharan migrants affirm that their status as

migrants did not play a role or was not an advantage. In this sense, they complained of difficulties of varying intensity during visits to a health centre linked in particular to their migrant status. Among the testimonies, Patrick, a Cameroonian, expressed his dissatisfaction:

We are human beings in great suffering, uprooted; we are strangers in these health structures with a different culture, without resources, nor help, nor anything.

The migrants' perceptions of the health centres were strongly determined by the reception conditions, the way in which the premises were located, and the care and information dimension. In this respect, Amina said:

The reception, the reception I expect a lot, when I get to the health centre, I find myself confused. I don't know what to do, and there is no guidance to make it easier for me to access the services.

Other migrants add that they have experiences of injustice, rejection and discrimination (stereotypes, prejudices, etc.), which result in a strong feeling of exclusion among migrants, given their negative impact on their psychological adaptation and mental health: low self-esteem, feelings of powerlessness, loneliness, depression, stress, disruptive behaviour and conduct disorders. Anam, a Nigerian respondent, complains about this situation of great suffering, which is evident in her tears and

tone of voice:

I feel uncomfortable with the looks of the health professionals, and I am not satisfied; they call us Africans as if they are not also Africans and not by our own names; it is really traumatic.

Eric also confirms this with great nervousness:

I managed to understand Arabic, and during a visit, a health professional asked his colleague to 'go and see what this black man wants'. They have to be physically and psychologically available to welcome us, and with a lot of respect; we are not animals.

Sub-Saharan migrants, especially those who are not regularised, are more likely to be stigmatised and discriminated against at healthcare facilities because of their origin, their migratory status and their ignorance of medical jargon. And, being identified as African or by skin colour seems to be enough to categorise them as otherness (Kotobi, 2000). This research reveals the problem of racism in some healthcare institutions and the mistrust that marks the healthcare relationship. The migrants in the

study often feel discriminated against in healthcare facilities. This reflects the existing problem around cultural differences in the health system and highlights the cultural mistrust and dissatisfaction of sub-Saharan migrants with regard to health services and provision (Liot et al., 2020). In this sense, data from the quarterly reports of the network of primary healthcare facilities further justify the under-utilisation of the services of these health facilities (see table n°2). Cultural factors are often mentioned to explain this under-use of health services by sub-Saharan migrants. According to Bertrand (1986), they represent an "ethnocultural barrier" associated with the values, attitudes, perceptions, expectations, social norms, beliefs and practices related to the use of services in the country of origin. This migrant population arrives with their own experience of healthcare, and this influences their expectation and reactions to the Moroccan health system. Thus, the lack of knowledge of services and the different expectations of health professionals are factors that explain why their use of services is very different from that of natives.

2) Results of the self-administered questionnaire to healthcare workers in the network of primary healthcare facilities in the prefecture of Meknes

2-1- Health professionals' knowledge of cultural diversity and care

Figure 1: The components of culture according to health professionals' with sub-Saharan migrants

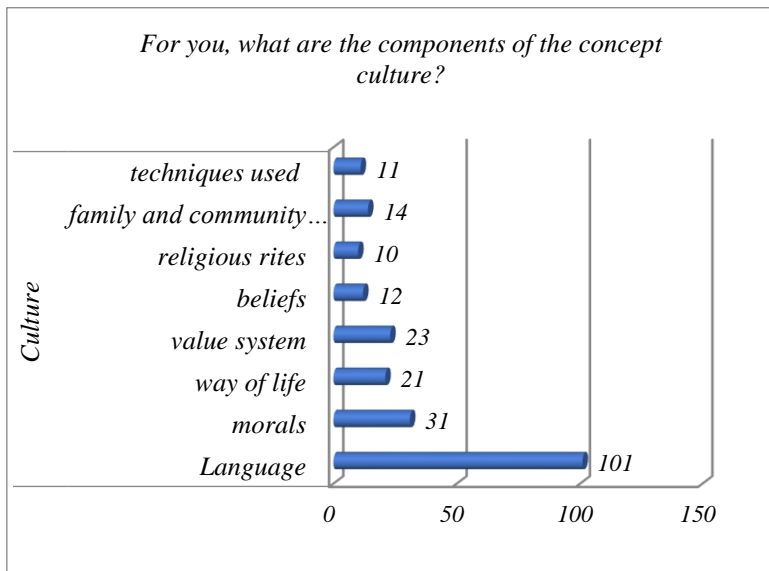
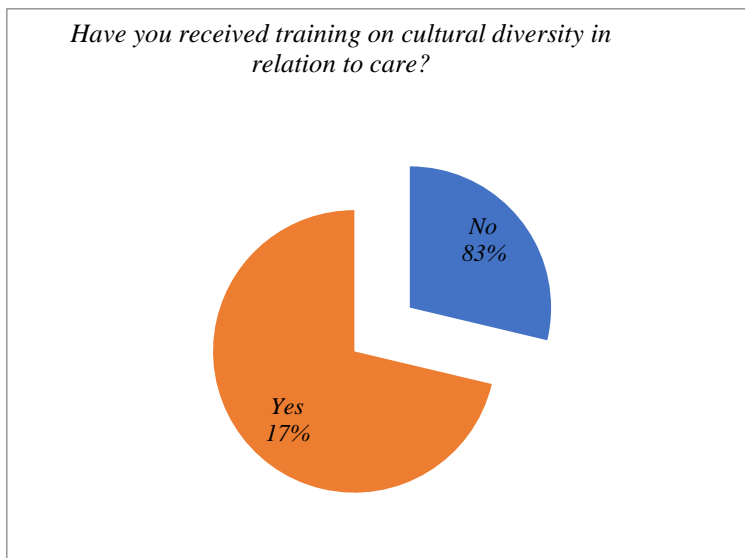


Figure 2: Training of health-care workers on cultural diversity in the health-care context



According to the health professionals' responses, almost all of them (101/101) reduce the concept of culture exclusively to language as an essential component. However, the other components of culture are only timidly considered by the

respondents. Similarly, a large proportion of the health professionals stated that they had not received any training on cultural diversity (83%). While only (17%) of the health professionals stated that they had received sufficient training on the importance of cultural diversity in the care relationship

2-2- Cultural diversity and care practice

Figure 3: Difficulties encountered in adapting to new care situations according to health professionals

Do you find it difficult to adapt to new care situations with sub-Saharan migrants?

■ Always ■ Sometimes ■ Rarely ■ Never

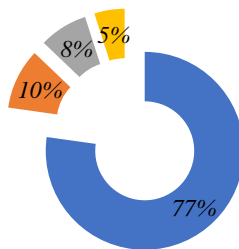
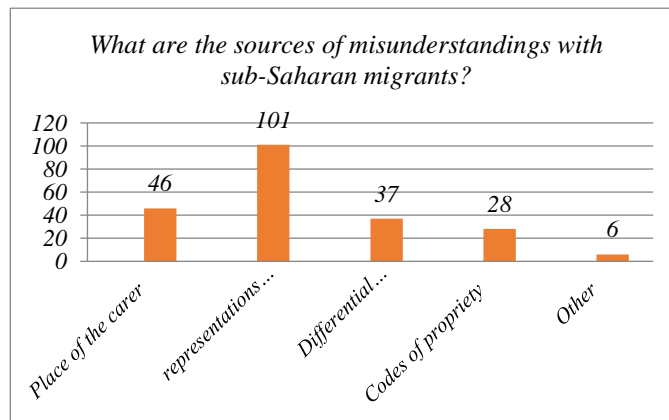


Figure 4: Sources of areas of misunderstanding with sub-Saharan migrants according to health professionals



In the light of this graph, 77% of health professionals stated that they still had difficulties adapting to new healthcare situations involving sub-Saharan migrants. Thus, the majority of health professionals admitted that they felt vulnerable when

faced with situations of migrants' healthcare, given that they lack orientation about the migrants (101/101), the place of the health professional (46/101) and the differential notion of space (37/101

Figure 5: Understanding of migrants in complex care situations according to carers

Do you feel you are able to understand sub-Saharan migrants from different cultures in order to resolve complex situations?

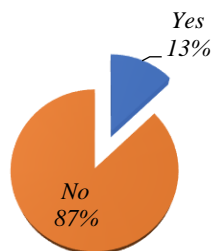


Figure 6: Behaviours adopted by carers in complex care situations

How do you deal with complex care situations?



This graph shows that 87% of health workers do not try to adapt their practices to the

culture of the sub-Saharan migrants they give care to, while only 36% resort to

problem-solving. Also, the majority of health professionals do not know what to do in complex healthcare situations and only find

non-verbal communication as their main solution. However, other techniques are commonly used by health professionals.

2-3- Sub-Saharan migrant health professional communication and the use of an interpreter

Figure 7: The use of an interpreter in a care situation according to health professionals

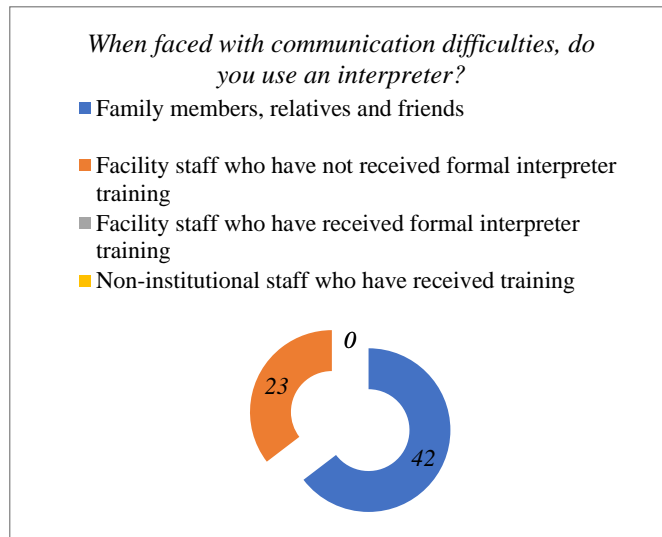
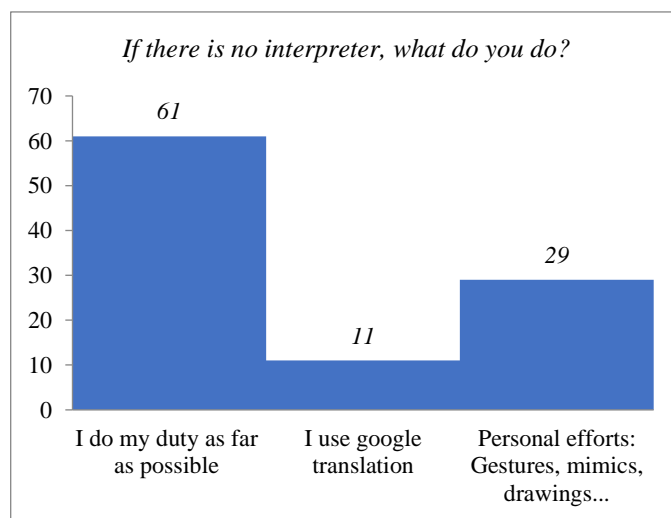


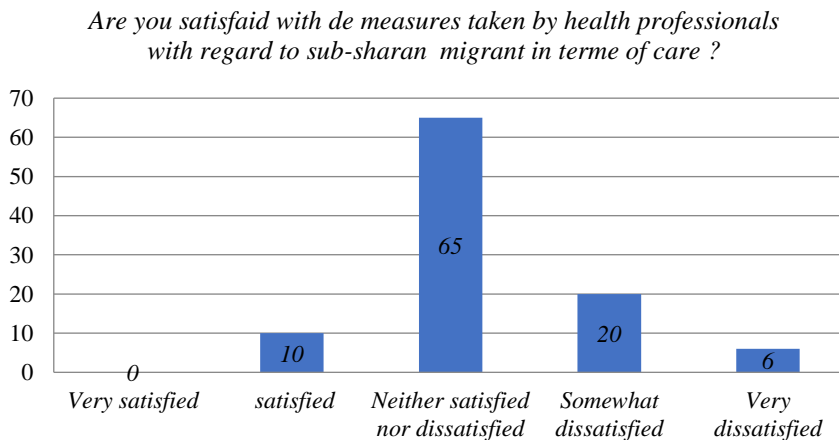
Figure 8: Actions taken by carers in the absence of an interpreter



The majority of healthcare professionals reported using an interpreter in healthcare situations. However, 74% of the study population relied exclusively on the "family members", "close friends", and "family friends" as interpreters to resolve communication problems. Faced with the absence of an interpreter, health

professionals try to find other alternatives to surmount the challenges they encounter while giving healthcare to sub-Saharan migrants. They achieve this through "personal effort within the limits of possibility", "gestures-mimics-drawings", and "smartphone-google translation".

Figure 9: Level of satisfaction with measures taken to address care



The majority of health professionals experienced dissatisfaction as a result of their inability to create an environment conducive to "culturally congruent care", given that they are unable to have efficient communication with sub-Saharan migrants.

Discussion

Drawing on the definition of culture by Tylor and many others, Kroeber and Kluck-hohn define it as a linked set of more or less formalised ways of thinking, feeling and

acting which, being learned and shared by many individuals, serve, in both an objective and symbolic way, to constitute these people into a particular and distinct collectivity (Journet, 2002). Culture contributes to the building of solid social structures for the present and the future. It is transferred from individual to individual and from generation to generation. To have a balanced view of culture, each culture must accept the differences between cultures (Ogocuwku, 2020).

In the context of care, culture has a strong influence on everyone's interpretation of and response to care activities. Each individual has the right to be respected for their uniqueness and cultural heritage, and when the patient's culture (lifestyle, mother tongue, beliefs and history) is alien to that of the health professional, a situation of mutual misunderstanding, anxiety and isolation can complicate the care relationship (Lemaitre, 2015). However, health professionals who adopt a person-centred approach to healthcare delivery through culturally competent care improve the quality of their care and can minimise harm and damage in their care relationship (Liot et al., 2020).

According to the responses of the health professionals, all of them reduce the concept of culture exclusively to language as an essential component (101/101). They have difficulties in giving the meaning of culture, spirituality and their relationship in healthcare practice. Thus, according to the participants in the study, the culture of ethnic minorities is not a priority in the basic and continuing education programs of doctors and nurses: the majority of the participants in the study stated that they had not received any training on cultural diversity (83%) while only 17% stated that they had received training in this area, specifically the head nurses and head doctors of the said healthcare institutions. This finding revealed the dissatisfaction of several health

professionals, especially those in charge of the "pregnancy and childbirth follow-up" and "maternal and child health" units, who are in perpetual contact with migrant women and require culturally adapted skills, given the strong influence on their interpretation of and responses to very specific and diversified care activities.

Amongst health professionals trained in this sense, the majority regularly experience uncertainty in caring for ethnically diverse patients, even after their training in cultural diversity and care. Such a situation can lead to hesitations that could contribute to inequalities in healthcare (White et al., 2019).

This may lead to situations of "culture shock", which results in the migrant missing his or her culture of origin, country, family and emotional environment. They will feel exiled within a care setting that is totally alien to them, with mostly negative emotions of anxiety, indignation, annoyance, depression, anger, psychological distress and others (Williams et al., 2019).

Each culture is shaped by a particular geographical, social and historical context. This is also true for proximity, which paradoxically contributes to cultural differentiation insofar as it leads to a desire to oppose, to distinguish, to be oneself for cultures in a neighbouring relationship. For this reason, Leininger (1991) has developed a theoretical model for culturally congruent

care that is based on adaptation to help people from a given culture achieve better therapeutics. And by restructuring care to assist people to redesign, transform or change their lifestyles and acquire habits more appropriate to their healthcare needs (Brunner et al., 2011).

According to the American Hospital Association (2020), cultural competence in healthcare refers to the predisposition of healthcare professionals to provide and adapt healthcare services for people with diverse values, beliefs and behaviours to meet their socio-cultural and linguistic needs. In fact, according to the participants in the study, 61% of the respondents stated that they regularly take care of sub-Saharan migrants, the majority of whom are in an irregular "undocumented" situation, originating from various countries, mainly Côte d'Ivoire, Cameroon, the Comoros Islands, Nigeria and Senegal. This explains the cultural mosaic of the Meknes prefecture. Nevertheless, a "cultural distance" has been observed separating sub-Saharan migrants and health professionals working in primary healthcare establishments in the prefecture of Meknes: they are increasingly faced with care situations marked on several occasions by a gap, misunderstandings that make care increasingly complex, marked by several areas of incomprehension, namely: a) representations of migrant 101/101; b) the health professional's place 46/101; c)

Differential notions of space 37/101; d)

Codes of propriety 28/101.

Cohen-Emerique (1993) states that care is a process of helping based on respect for the person, his or her worldview, value system and needs via three steps, namely a) decentration, b) penetration of the other's reference system, and c) negotiation and mediation. The results of the present study reveal that 64% of health professionals do not seek to adapt their practices to the culture of their sub-Saharan migrant patients, while only 36% resort to problem-solving adaptation. This situation reveals a lack of adaptation of health professionals to the values and behaviours of migrants and an inability to discern the beliefs, values and norms of migrants due to their strong ethnocentric tendencies: cultural dominance of the health system, the fact that health professionals impose their own orientation on migrants with culturally different beliefs, values and behaviours. They thus show insensitivity and risk attributing stereotypes, considering all sub-Saharan migrants to act in the same way. Furthermore, given the limits of clear and adequate institutional rules in this area and the deficits of training programmes on "cultural diversity and care", a minority (20%) of health professionals manage to find ways of getting by via "bricolage" in the language of Paul Pacson (1973), in order to perfect their care in a multi-ethnic context. It is a matter of letting migrants make their choices after having enlightened them.

Currently, societies are becoming increasingly culturally plural and heterogeneous, containing a myriad of migrant minority groups (Farber, 2019). Hence, the requirement to zoom in on changing the attitudes and behaviours of health professionals is likely to occur when cultural competence is strategically and qualitatively integrated into health science curricula and linked to learner values (Biles, 2020). This will lead to improved capacity of health facilities to provide appropriate care and services to diverse populations and to the reduction of disparities between migrants and the natives (Brach & Fraser, 2000).

Almost all health professionals (88%) believe that language is the main barrier to the relationship between health professionals and their patients (sub-Saharan migrants), especially with regard to dialects and the English language. However, ignorance of socio-cultural references and the language of the cared-for does not justify the denial of healthcare. (Zanchetta & Poureslami, 2006). The main cultural barriers to overcome are found in health institutions: the presence of professional interpreters at the reception of medical facilities establishes communication, promotes the establishment of a relationship of mutual trust and has a positive impact on the safety and quality of care in contrast to the use of untrained interpreters (Paradise et al., 2019). Moreover, it also contributes to a more equal relationship between the health professional, invested with knowledge and

power, and the cared-for person in need of help and support (Spitzer et al., 2019).

However, the use of an interpreter leads healthcare professionals to certain situations of ethical dilemmas. For instance, 34% of healthcare professionals indicated that they are obliged to ensure the confidentiality of data and to respect the privacy and autonomy of the person being cared for. Moreover, the use of an unprofessional interpreter is likely to lead to misleading interpretation with little fidelity, which influences the quality of care. Thus, the migrant risks not complying with treatments, care plans and monitoring visits.

In order to face these communication limitations and the absence of an interpreter on-site in certain situations of misunderstanding, 61 out of 101 health professionals try to do their homework as much as possible, 29 of 101 try to use gestures, mimics and drawings, while 11 of 101 use their smartphones to resolve the situation. However, it is very necessary to point out that despite these attempts, one should not neglect the meaning, which is paramount in any communication process and is at the centre of the linguistic quest (Uzoagba et al., 2022).

Notwithstanding these attempts, the majority of health professionals admit their inability to deal with an uncondusive environment, which is caused by ineffective

communication, just as it is a major hindrance to 'culturally congruent care. This is a cultural distance that further justifies the limitations of health programmes of which the information, education and communication component with the migrant is an integral part (Ahmed, 2018). The latter expresses a resistance to abandoning behaviours that make sense in their living environment. Moreover, in the case of sub-Saharan migrants, human relations are characterised more by a valorisation of the affective dimensions and interpersonal relations as obligatory components characterising social relations. Nevertheless, the attitude of the health professional, given several constraints (shortage of personnel, workload, etc.), is precisely characterised in certain situations by the desire to maintain an emotional distance and a minimum of formality in their relations with sub-Saharan migrants.

Conclusion

The originality of this study lies in the fact that it sociologically addresses the issue of cultural diversity of sub-Saharan migrants in a healthcare context. A certain insensitivity to the strategies of the Ministry of Health was observed in order to open up to an object that forcefully marks the relationship of health professional-care recipients of sub-Saharan migrants by focusing exclusively on economic and legal causal links. After identifying the different realities that determine the experiences of sub-Saharan migrants within the network of primary healthcare facilities, migrants are often vulnerable because of their health problems and also because they have to evolve in environments that are foreign to them. In order to live better in this unusual and sometimes difficult situation, the migrant needs to have a dialogue with the healthcare personnel, and the quality of this dialogue is crucial.

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Author Contribution

Oussama Rharib and Mohammed Ababou were responsible for the conceptualisation, definition of the methodology and the collection and analysis of quantitative and qualitative data for this research. Zoubida Sassioui and Salma Soulami provided assistance during the data collection period at the primary healthcare facilities. All the authors read and approved the final version of the manuscript.

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