

Gender-Based Violence and Access to Sexual and Reproductive Healthcare for Migrant Women in Morocco: A Qualitative Study

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ABSTRACT

Introduction: Migrant women face multiple vulnerabilities during their journey and in host countries, particularly regarding access to sexual and reproductive health services. In Morocco, migrant women are exposed to gender-based violence due to administrative irregularities, economic precariousness, and social exclusion. This violence negatively impacts their health and limits their access to essential care.

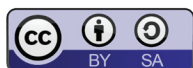
Methods: A qualitative study was conducted in July 2024 in Rabat and Casablanca, two regions with a high concentration of migrants. Focus group discussions were carried out with 48 participants, including women and men from sub-Saharan African countries. Participants were selected based on their experience with health services and their willingness to share their experiences. The data were manually transcribed and analysed thematically.

Results: The study included 48 participants, mainly from Côte d'Ivoire (60%), with an average age of 30 (range: 18-49). Most participants (92%) had irregular migration status, with an average duration of stay in Morocco of 2.5 years. Only 6% had medical coverage and 33% reported experiencing gender-based violence, mainly among women. Barriers to accessing care include a lack of information, language difficulties, social stigma, discrimination, and administrative obstacles. Despite these challenges, access was facilitated by support from NGOs such as Caritas, Médecins du Monde, and the Moroccan Association for the Fight Against AIDS (ALCS), as well as awareness campaigns focused on family planning, HIV/STI prevention, and gender-based violence.

Conclusion: Gender-based violence remains a significant barrier to accessing health services for migrant women in Morocco. Improving access requires better health information, multilingual support, and anti-discrimination measures to ensure equitable care for all women, regardless of their migration status.

Key words: Gender based violence; Sexual and reproductive health services; Access to health care; Health services accessibility; Migrant women; Morocco

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INTRODUCTION

Migration is a global phenomenon affecting millions of individuals, particularly those fleeing political instability, poverty and structural violence.¹ According to the World Health Organisation (WHO) and the International Organisation for Migration (IOM), an estimated 281 million international migrants in 2020, representing 3.6% of the world's population, including 84 million forcibly displaced individuals.^{2,3} Throughout their migratory journey or in host countries, migrants face multiple challenges such as discrimination, marginalisation and various forms of violence, including sexual exploitation, making them particularly vulnerable populations.¹ Among these populations, women and girls constitute the most vulnerable group due to the intersection of gender inequalities, socio-economic precariousness, and migration-related hardships.⁴ Although gender-based violence (GBV) can affect anyone regardless of gender or age, studies indicate that women and girls are disproportionately affected.⁵ The United Nations High Commissioner for Refugees (UNHCR) estimates that one in three women worldwide will experience physical, sexual or psychological violence during their lifetime, making GBV a major public health issue and a violation of fundamental human rights.⁴

According to the United Nations (UN), GBV encompasses « any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life ». ⁶ Beyond its immediate consequences, GBV leads to poor sexual and reproductive health (SRH) and mental health, exposing them to unwanted pregnancies, sexually transmitted infections and psychological trauma.⁷ Women and girls in migratory contexts are particularly at risk due to precarious living conditions, lack of social protection and limited access to health services.¹ To grasp the complexity of migrant women's vulnerabilities in Morocco, an intersectional approach is essential one that integrates overlapping factors such as legal status, ethnic origin, language, and economic precarity. Irregular sub-Saharan migrant women, for instance, often face compounded challenges related to racial discrimination, social exclusion, and administrative insecurity.^{8,9} These intersecting factors heighten their exposure to sexual violence, health risks, and institutional barriers to care.^{10,11} In Rabat and Casablanca, a Médecins Sans Frontières study reported that one in three migrant women had experienced sexual violence during their migration journey.¹⁰ Moreover, restrictive migration policies, the lack of tailored healthcare mechanisms, and insufficient training of health professionals further exacerbate these inequalities.^{8,12} Although Morocco adopted the National Strategy for Immigration and Asylum in 2013, its implementation remains fragmented particularly concerning effective access to healthcare for migrant women.⁸ A systemic understanding of these dynamics is therefore crucial to inform more inclusive and equitable health policies.

In recent decades, Morocco has emerged as a key migratory corridor between Africa and Europe due to its geographical position on the Strait of Gibraltar.¹³ Initially considered a transit country, Morocco has increasingly become a destination country for migrants, particularly from sub-Saharan Africa.¹⁴ Migrant women in Morocco are exposed to multiple vulnerabilities linked to administrative irregularities, economic insecurity, and difficult access to health and legal services, these factors

exacerbate their exposure to GBV and limit their access to SRH services.¹⁵

Recognising these challenges, Moroccan has undertaken several efforts to improve the living conditions of migrants through the adoption of the Global Compact for Migration¹⁶ and the implementation of the National Strategy on Immigration and Asylum (SNIA) in 2018.¹⁷ Additionally, law 103-13 on combating violence against women, which applies to all women residing in Morocco, including migrants.¹⁸ In 2022, the Office of the High Commissioner for Planning (HCP) worked with the UNHCR and non-governmental organisations (NGOs) to improve the protection of migrants against GBV.¹⁹ However, despite these advances, migrant women's access to SRH services remains insufficient, largely due to language barriers, lack of information, fear of stigma and structural obstacles.

The aim of this study is to explore the impact of GBV on access to SRH services among migrant women living in Morocco. By adopting a qualitative approach, this research aims to identify the types of violence experienced by participants, the barriers and facilitating factors influencing access to care, and the specific challenges faced by migrant women who are victims of GBV. The results of this study seek to provide practical recommendations for improving access to health services and to inform public policies and programmes targeting vulnerable migrant populations.

METHODS

Study design

A qualitative study was conducted using focus group discussions (FGDs) with migrants (men and women) who had been living in Morocco for at least three months and who had experience with Moroccan public health services. This research focuses on GBV as a factor influencing access to healthcare, particularly SRH services. The study was conducted in July 2024 in two regions of Morocco (Rabat and Casablanca) with a high concentration of migrants.

Eligibility criteria and population

This study included migrant women aged 18 to 49 years and men aged 18 or older, with a wife, a sister, or a daughter with experience in healthcare facilities. Participants had to have lived in Morocco for at least three months and have accessed SRH services and/or healthcare related to GBV. Fluency in French was required to ensure effective participation in FGDs. This linguistic criterion was selected for two main reasons: firstly, French is the most commonly spoken language among sub-Saharan migrants in Morocco, particularly in urban areas such as Rabat and Casablanca. Secondly, the research team lacked the resources to provide professional interpreters during the data collection phase, which could have compromised the quality and consistency of the discussions.

Migrants who had been in Morocco for less than three months, non-French speakers, individuals who had never attended Moroccan healthcare facilities, and minors under 18 were not eligible to participate. Exclusion criteria included voluntary withdrawal of participants at any time before or during the FGDs

and inability to participate actively due to a physical or psychological health condition.

Data collection and analysis

Participant recruitment was conducted methodically, in collaboration with healthcare professionals and local NGOs that work directly with migrant women, such as Caritas and Médecins du Monde. Information about the study was shared through information sessions and posters in community centres and NGO offices. This approach followed predefined inclusion and exclusion criteria to ensure diversity in participant profiles and strict adherence to ethical research principles. However, as recruitment was mainly through NGOs and health facilities, women who are less connected to these networks may have been underrepresented, potentially introducing selection bias.

FGDs were conducted by trained researchers using a participatory approach to capture diverse perspectives on GBV and its impact on access to SRH services. This method highlighted the voices of migrant communities, especially women survivors. Given the sensitive nature of GBV, discussions took place in a safe, non-judgmental environment to encourage open dialogue. Each region hosted two FGDs (one for women, one for men) in French, the predominant language among sub-Saharan migrants in Morocco. The absence of professional interpreters required selecting French-speaking participants to ensure effective communication.

A total of four FGDs were conducted across the two regions, with 48 participants (24 women, 24 men), providing diverse insights into the intersection of GBV and SRH services in the context of migration in Morocco. A semi-structured interview guide was developed to explore key issues related to SRH services and GBV, including the types of violence experienced, the impact of GBV on health-seeking behaviours, barriers to accessing care after experiencing violence, the responsiveness of SRH services to GBV survivors, and the role of stigma and discrimination in healthcare settings. On average, each FGDs lasted between 100 and 120 minutes. Audio recordings were made to ensure accurate data collection, then transcribed and analysed manually. Each audio recording has been transcribed to preserve the authenticity of the exchanges. The notes taken have also been recorded in French for analysis purposes and translated into English. During transcription, the names of the participants were removed and replaced with an assigned identifier to maintain their confidentiality.

The transcripts were analysed by grouping the data collected by theme. This analysis was carried out methodically, following essential steps to ensure the reliability and rigour of the results. The transcripts were then read several times identify key findings. Open coding was conducted manually by independent researchers to identify significant segments of text related to the participants' experiences of GBV and their access to SRH services. This manual stage also allowed for in-depth familiarisation with the data while preserving the authenticity of the participants' voices. Once all transcripts were coded, similar codes were grouped into broader categories that represented the main issues discussed during the FGDs. These categories made it possible to organise the data in a structured way and to identify common patterns across the different groups. The main categories that emerged were; types of violence experienced by migrant women, barriers to accessing SRH services following GBV and

factors facilitating access to care. To ensure the reliability of the results, the analysis was conducted independently by members of the research team. Differences in coding were discussed and final categories were agreed upon by all researchers.

The full transcription of interviews was independently performed by the authors (A CH, M C, and H K). Thematic analysis began with initial manual coding conducted separately by A CH and F HA. Any discrepancies were reviewed collectively, with arbitration by H K if necessary.

Ethics/Approval

This study was approved by the institutional ethics committee of the Mohammed VI University of Sciences and Health /Casablanca. All participants will be asked for their authorisation and consent, informed of the general aim of the study and committed to respecting the anonymity and confidentiality of the data collected throughout the study, as well as respecting their individual choice of whether or not to participate. To guarantee the anonymity of the data, a unique identification number will be assigned to each participant. In this way, data analysis will be based on a totally unidentified database. Authorisation to access the selected primary care centres will be requested from the Ministry of Health, as well as from the relevant provincial health delegation.

RESULTS

Demographic and socio-economic characteristics of participants (Table A1 in annex)

This study involved a sample of 48 participants, made up of 24 female and 24 male migrants, mainly from sub-Saharan African countries. The majority of participants came from Côte d'Ivoire (60%), followed by Cameroon (14%), Mali (10%) and other sub-Saharan African countries. The average age of participants was 30, with the majority aged between 18 and 34 (61%). In terms of level of education, most participants had a high school education or had attended university (60%). Some 92% of the participants had irregular migratory status, which limits their access to healthcare services. In terms of employment, the most common occupations were domestic and informal, with 23% declaring that they had a source of income. Of all participants, 66.67% ($n = 32$) reported no violence at all, while 33.33% ($n = 16$) said they had experienced some form of VBG, particularly women. Regarding access to healthcare services, only 6% of participants had medical coverage, making access to care difficult. Public hospitals and health centres were among the most frequented establishments. Participants also stressed their dependence on associations and NGOs for access to healthcare.

Manifestations and experiences of gender-based violence among migrant women

The participants described a variety of manifestations of GBV, bearing witness to forms of abuse in their lives, often accentuated by their migratory status. Migrant women highlighted physical, verbal, sexual and psychological violence, experienced in contexts of heightened vulnerability for various reasons (migratory status or social or economic isolation). This violence manifests itself not only in

personal relationships, but also through institutional abuse and discrimination in access to health or justice services. We will now list some of the types of violence identified in the FGDs:

Table A1. Demographic and socio-economic characteristics of migrant in Morocco (Ra-bat/Casablanca)

Participant ID (CI) Code	Country of origin	Age years old	Level of education	Migration status in Morocco	Type of medical coverage in Morocco	Employment in Morocco	History and type of violence	Health establishment visited during the stay in Morocco					
								Public hospitals	Health Centres	Clinical	Private medical practices	Laboratories	Other
FGF201	Ivory Coast	41	No	Irregular	No	No	No	No	Yes	Yes	Yes	No	No
FGF202	Mali	36	No	Irregular	No	No	Yes	Yes	Yes	No	No	Yes	No
FGF203	Ivory Coast	34	No	Irregular	No	Not	Yes	Yes	Yes	No	Yes	No	Association
FGF204	Ivory Coast	28	1 Primary	Irregular	No	No	No	No	Yes	No	No	No	No
FGF205	Ivory Coast	32	3rd middle school	Irregular	No	No	No	Yes	Yes	Yes	Yes	Yes	No
FGF206	Ivory Coast	35	No	Regular	Not	Not	No	Yes	Yes	No	No	No	No
FGF207	Ivory Coast	23	Third grade	Irregular	Not	No	Yes	Yes	Yes	No	Not	Not	Not
FGF208	Ivory Coast	24	2 Primary	Irregular	Not	Not	No	Yes	Yes	No	No	No	No
FGE209	Ivory Coast	57	No	Irregular	No	Maid	No	Yes	No	No	No	No	Pharmacy
FGF210	Ivory Coast	22	3rd middle school	Irregular	No	Maid	Yes	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGF211	Ivory Coast	29	2nd year bachelor's degree	Irregular	No	Maid	No	No	No	Yes	No	No	No
FGF212	Ivory Coast	23	1 Primary	Irregular	No	No	No	Yes	Yes	No	No	No	No
FGH201	Guinea	27	Baccalaureate +4 years (Master's)	Irregular	No	No	No	Yes	Yes	No	No	No	No
FGH202	Guinea	18	2nd year middle school	Irregular	No	No	No	No	No	Yes	Yes	No	No
FGH203	Ivory Coast	32	No	Irregular	No	No	No	Yes	Yes	No	No	Yes	No
FGH204	Sierra Leon	18	6th high school	Irregular	No	No	No	No	Yes	No	Yes	No	No
FGH205	Guinea Conakry	25	Baccalaureate	Irregular	No	No	No	No	Yes	Yes	No	Yes	No
FGH206	Ivory Coast	35	Fifth grade	Irregular	No	No	No	Yes	Yes	Yes	No	No	No
FGH207	Ivory Coast	25	1st middle school	Irregular	No	No	Yes	Yes	No	No	No	Yes	No
FGH208	Ivory Coast	18	Baccalaureate	Irregular	No	No	Yes	Yes	No	No	No	Yes	No
FGH209	Ivory Coast	35	Baccalaureate	Irregular	No	No	No	Yes	Yes	Yes	No	No	No
FGH210	Guinea Conakry	30	Bachelor's level	Irregular	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No
FGH211	Burkina Faso	21	Technical Diploma (Electricity)	Irregular	No	No	No	Yes	Yes	Yes	Yes	Yes	No
FGH212	Ivory Coast	19	5th high school	Irregular	No	No	No	Yes	Yes	Yes	Yes	Yes	No
FGF401	Ivory Coast	49	Fifth grade	Irregular	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGF402	Cameron	34	2nd primary	Irregular	No	No	No	Yes	Yes	No	Yes	Yes	Pharmacy/AMPF
FGF403	Ivory Coast	34	Baccalaureate	Irregular	Yes (CNSS)	No	No	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGF404	Ivory Coast	40	Fifth grade	Irregular	No	Hair-dresser	No	Yes	No	Yes	Yes	No	Pharmacy
FGF405	Mali	49	3 Emme College	Irregular	No	No	No	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGF406	Mali	45	Koranic school	Irregular	No	Beautician	No	Yes	Yes	No	No	Yes	Pharmacy/AMPF
FGF407	Ivory Coast	36	No	Irregular	No	No	No	No	No	No	No	No	Pharmacy
FGF408	Mali	25	1 Primary	Irregular	No	Maid	No	No	No	Not	Not	Not	Pharmacy
FGF409	Ivory Coast	24	BTS Technical Diploma in Communication	Irregular	No	No	Yes	Yes	Yes	Yes	Not	Yes	Pharmacy
FGF410	Ivory Coast	34	4th primary	Irregular	No	No	No	No	No	No	No	No	No
FGE411	Cameron	40	2nd year high school	Irregular	No	No	Yes	No	No	No	No	No	AMPF
FGF412	Central Africa	40	1st year high school	Irregular	No	No	Yes	Yes	Yes	No	No	Yes	AMPF
FGH401	Congo Brazzaville	48 years old	Baccalaureate +3	Irregular	No	Yes	Yes	No	No	No	No	No	Pharmacy
FGH402	Cameron	30 years	Baccalaureate	Irregular	No	No	No	Yes	Yes	No	No	No	Pharmacy/ONG

Table A1. (continued).

Participant ID (CI) Code	Country of origin	Age years old	Level of education	Migration status in Morocco	Type of medical coverage in Morocco	Employment in Morocco	History and type of violence	Health establishment visited during the stay in Morocco					
								Public hospitals	Health Centres	Clinical	Private medical practices	Laboratories	Other
FGH403	Cameron	24 years old	No	Irregular	No	No	Yes	No	No	No	No	No	Pharmacy
FGH404	Cameron	21 years old	3rd year of secondary school	Irregular	No	No	Yes	Yes	Yes	No	No	Yes	Pharmacy
FGH405	Cameron	45 years old	Baccalaureate +2	Regular	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Pharmacy/ONG
FGH406	Ivory Coast	21 years old	Baccalaureate	Irregular	No	No	No	No	No	Yes	Yes	No	Pharmacy
FGH407	Ivory Coast	27 years old	Baccalaureate	Regular	No	No	No	No	Yes	No	Yes	No	Pharmacy
FGH408	Ivory Coast	38 years old	Baccalaureate +4	Irregular	No	Yes	Yes	No	No	Yes	Yes	Yes	Pharmacy
FGH409	Ivory Coast	43 years old	BTS Technical Diploma in Communication	Irregular	No	No	No	No	No	Yes	No	No	Pharmacy
FGH410	Ivory Coast	32 years old	Baccalaureate +2	Regular	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGH411	Ivory Coast	37 years old	Baccalaureate +2	Irregular	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Pharmacy
FGH412	Mali	41 years old	Baccalaureate +1	Irregular	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Pharmacy

Physical violence

Physical violence is an act with the intention or consequence of causing pain and/or physical injury (20). It includes beatings, sexual assault and attempted murder.²⁰ One participant described concrete acts of physical violence that caused visible injury:

« I've seen violence in Dakhla, I've had juice poured in my face, I've been hit. My face was swollen, but thank God people intervened. »

Another participant described a direct assault when she was pregnant:

« In 2019, in Hay Nada, a motorbike and he slapped me with eight months of pregnancy, I cried. »

Another participant said that her boss had slapped and beaten her, showing that physical violence in the domestic workplace has a direct impact on the victim's professional life.

« For me, it's my boss, we had an argument and she hit me and we went to the police and I had to leave work. »

Sexual violence

Sexual violence covers situations in which a person imposes on another person one or more behaviours, one or more comments (oral or written) of a sexual nature.²¹ Participants described acts of non-consensual, humiliating sexual assault and racial discrimination:

«Sometimes we walk along and the young Moroccans behave inappropriately, slapping us on the back as we pass.»

«I have experienced harassment in the street. Once, a Moroccan man slapped my bottom as I walked past. I confronted him, asking if he would do the same to his sisters. Because we're foreigners, they think they can do what they want.»

Institutional violence

Institutional violence can lead to moral harassment of a staff member and result in actions on the part of professionals, such as verbal, physical and psychological violence (22). One participant highlighted the lack of follow-up to the complaint by the police, showing an institutional failure to provide protection or justice to the victim:

«I too have already been assaulted; it was the son who lived in my neighbourhood and I filed a complaint with the police and they told me we were going to go before the prosecutor but until today they haven't called me.»

Another participant described the requirement for papers to intervene, which prevents undocumented migrants from obtaining justice or protection:

«I've seen migrants fighting and if they go to the police, they're asked to show papers. There's nothing we can do.»

One participant highlighted the ineffectiveness of the police response to the violence suffered by women:

«One participant highlighted the ineffectiveness of the police response to the violence suffered by women»

Barriers to accessing SRH services, including GBV services in Morocco

Analysis of the data collected during the FGDs in the two regions of Rabat and Casablanca enabled us to identify five major obstacles that migrants face in accessing health services in Morocco, including services responsible for dealing with all types of violence. These obstacles are: lack of information and education, stigmatisation and discrimination, difficulties linked to geographical access, linguistic and cultural barriers, and administrative and documentary obstacles.

Lack of information and education

Lack of information about the services available to deal with violence is one of the main obstacles to accessing healthcare. The majority of participants stressed the lack of such information and the importance of knowing about it in order to facilitate access to services. Some participants expressed

the lack of precise information on how to deal with all types of violence:

«We're not aware of any services that deal with this kind of thing.»

«We don't know, there's a lack of communication.»

Another participant spoke of the barrier linked to access to information and the skills of the people responsible for passing it on:

«It depends on the person receiving the information. If they're well-informed, they'll give the right advice, but if they're not, if it's someone who has nothing, they won't give the right advice.»

Stigmatisation and discrimination

Stigma and discrimination in healthcare were identified as major obstacles to accessing care. Many participants reported experiences of discrimination, particularly because of their migrant status and ethnic origin. One participant pointed out that the presidents of her community harbour racial prejudices, believing that black people are not suited to living with Moroccans:

«When I spoke to the presidents of our community about it, he told me that blacks don't used to live with Moroccans. So, they're not used to living together. So, it's difficult to say, sometimes it's better to let them go.»

One migrant also described how, although migrant women are given a certain priority in hospital, they face stigmatisation because of their migrant status:

«Here, all the women who come here know that they have priority, but there's a bit of a stigma attached to them in hospital. But as soon as you're a migrant, the doctors may look at you differently.»

Geographical difficulties of access

Distance and lack of transport have made access to health facilities difficult, as one participant put it:

«It's hard to get to hospital because you don't always have the money to pay for transport. Sometimes you have to wait days for cheap transport.»

Language and cultural barriers

Participants, particularly those who do not speak Arabic (Darija) or French well, often find it difficult to interact with healthcare staff. Some participants shared their experiences:

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

«We have the language problem, it's a bit difficult, we have the language barrier because a lot of people don't speak French very well.»

«When I go to hospital, the staff don't speak my language. I only speak a little Arabic, so it's difficult to understand the medical advice.»

Administrative or documentary barriers

Participants described other major barriers to accessing healthcare, including administrative and documentary barriers. Undocumented or irregular migrants are often afraid to go to hospital or to report violence, as some migrants reported:

«Without a residence permit, we can't lodge a complaint. Most of us are here illegally, so we're afraid. Those with legal documents receive help, like my sister who was bitten by a dog in Casablanca. But for those without papers, the police don't take care of us.»

Another report:

«Judicial authorities don't always follow the right procedures. A sub-Saharan woman suffered violence from her employer. The employer lodged the complaint, and the police asked the victim to sign a document she didn't understand. She refused until they translated it into French. It took two hours, and they tried to convince her to drop the charges. What would have happened if she had signed without understanding?»

Factors facilitating access to SRH, including GBV services in Morocco

Factors facilitating access to GBV services mainly include the existence of legal aid, the presence of migrant associations and non-governmental organisations (NGOs) that raise awareness and provide guidance, and awareness campaigns that enable migrant women to better understand their rights. One participant described the importance of help from associations:

«Thanks to the association, I learned that there were services for women like me. They helped me make an appointment at the hospital and explained how to make a complaint.»

Other participant explained how a doctor supported her after she had been a victim of violence:

«The doctor I met was very understanding. He listened to me and referred me to an association that helps women who are victims of violence. It was a great relief to know that someone understood me.»

The ease of access to free or subsidised healthcare in some regions has also facilitated access to services for some migrants, as one participant pointed out:

«I managed to access care because there was a free health campaign in my town. That allowed me to consult without having to pay.»

DISCUSSION

This study provides an in-depth analysis of the demographic, socio-economic, and health challenges faced by sub-Saharan migrant populations in Morocco, with a particular focus on GBV and barriers to accessing SRH services. Our findings corroborate previous research indicating that irregular migration status significantly exacerbates vulnerabilities, limiting access to fundamental rights, including healthcare and justice. The conclusions of this study highlight the critical intersection between migration, gender, and structural inequalities, which collectively contribute to the precariousness of migrant women.

The data show that 60% of participants are from Côte d'Ivoire, with most being young adults (average age 30) and 92% in an irregular migratory status. Additionally, 23% work in precarious informal sector jobs. As Ashley-Norman et al. found, migrant and refugee women in Thailand face significant healthcare barriers due to their migratory status and economic vulnerability.²³ Among the 48 participants, 33.33% reported experiencing gender-based violence (GBV), while only 6% had medical coverage. This underscores their vulnerability to violence and healthcare access challenges, worsened by a lack of social protection. Goldenberg et al. highlight that systemic exclusion, driven by discrimination, racism, and lack of legal protection, exacerbates migrants' healthcare barriers.²⁴

Participants reported various forms of GBV, including physical, sexual, and institutional violence. Most described assaults in public spaces, workplaces, and homes, reflecting a normalization of violence against migrant women. Acharai et al. documented similar patterns in Morocco, where precarious migratory status exacerbates violence.²⁵ Institutional violence, such as discrimination by police and medical staff, was also reported. Samnani et al. found that Black migrant women with HIV in Canada face heightened stigmatization, limiting their access to care.²⁶ Cabieses et al. noted that exclusionary health policies reinforce violence against migrant women.²⁷ Additionally, Allen-Leap et al. highlighted that social isolation and financial dependence make migrant women particularly vulnerable to domestic violence.²⁸

Multiple barriers hinder access to SRH and GBV services in Morocco, including lack of information, racial and gender stigma, geographical constraints, language and cultural barriers, and administrative hurdles. These findings align with global trends where migrants face systemic healthcare barriers. Zaman et al. highlight that lack of identity documents and fear of detention or deportation prevent many migrant women from accessing care.²⁹ Similarly, Chavez et al., Musuka et al. and Amaghdour et al. show that migratory status negatively impacts healthcare access due to administrative barriers and lack of information.^{30–32} Rubini et al. and Hinman et al. emphasize that access to justice is critical; without legal assistance, GBV survivors are less likely to seek medical care, increasing their vulnerability.^{33,34} Language and cultural barriers further complicate interactions with healthcare providers. Casas et al. note that stereotypes among healthcare professionals reduce the quality of care for migrant women, as seen in Chile.³⁵

Despite these barriers, several factors facilitate access to care for migrant GBV survivors. First, NGOs and associations play a crucial role in providing medical and legal support, as highlighted by participants and supported by Chavez et al. and Koubri et al.^{30,36} Second, training healthcare professionals on GBV improves care quality, as noted by Musuka et al.³¹ Third, inclusive health policies, such as universal healthcare for migrants, reduce inequalities, as observed by Cabieses et al.²⁷ Finally, better monitoring of pregnant migrant GBV survivors is essential, as fear of judgment or rejection by healthcare providers often deters them from seeking care, underscoring the need for specialized training, as emphasized by Oram et al.³⁷

The study provides valuable, context-specific insights into the intersection of migration, gender-based violence, and healthcare access among sub-Saharan migrant women in Morocco, addressing a

significant research gap with a robust qualitative approach that captures nuanced lived experiences. The limited sample size and language constraints may affect the representativeness and depth of findings; future research should consider larger, more linguistically diverse samples and explore strategies to mitigate underreporting due to stigma and trauma.

To improve access to care for GBV survivors, the role of NGOs and associations should be strengthened to provide medical, legal, and administrative support. Training healthcare professionals on GBV and migrant care is crucial to ensure respectful and non-discriminatory treatment. Reducing administrative and legal barriers, including raising awareness among law enforcement and ensuring access to justice, is also essential. Multilingual information campaigns and psychological support services should be developed to provide comprehensive care for survivors.

CONCLUSION

The results of this study highlight the prevalence of GBV among migrants living in Morocco and its significant impact on access to SRH care. Physical, sexual and institutional violence are commonplace, often exacerbated by the victims' irregular migratory status. Stigmatisation, discrimination, administrative and language barriers and a lack of information limit access to care, making it difficult to treat victims of GBV.

However, certain factors facilitate access to services, including the support of associations or NGOs, legal assistance and awareness-raising campaigns. It is essential to strengthen these initiatives by incorporating a more inclusive approach that is adapted to the needs of migrants, in particular by providing better training for healthcare professionals in the care of survivors of GBV. Improving access to care, in particular through regularisation measures, better information and specific support systems, is a priority to ensure adequate and humanitarian care for migrants who are victims of violence.

Ethical Consideration

This study was approved by the Institutional Ethics Committee of Mohammed VI University of Health Sciences, Casablanca. Written informed consent was obtained from all participants before data collection. Participants' confidentiality and anonymity were strictly maintained throughout the study.

Conflict of Interest

The authors declare no conflict of interest.

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