migrant women in hiding clandestine abortion in morocco
index

1 Justification and project methodology
2 Migrant women and abortion in Morocco
3 Morocco and its obligations under International Law
4 Case study: Tangier
This publication has been possible thanks to the financial support of the Oak Foundation (the opinions expressed in this publication represent the opinion of the authors, and in no manner do they represent the official opinion of the Oak Foundation).

This report was prepared by a Women’s Link consultant who resides in Morocco and by a team of attorneys at Women’s Link Worldwide who are experts in sexual and reproductive rights and the rights of migrant women. Leiyla Hessini and Laura Villa of the organization IPAS* also provided comments and assisted with revisions.

Pictures courtesy of Elena Maleno Garzón.

* IPAS is a global non-governmental organization dedicated to ending preventable deaths and disabilities from unsafe abortion. Through local, national and global partnerships, IPAS works to ensure that women can obtain safe, respectful and comprehensive abortion care, including counseling and contraception to prevent future unintended pregnancies. For more information, visit: [http://www.ipas.org](http://www.ipas.org).
FACT SHEET 1  ■  justification and project methodology
In February of 2009, Women’s Link Worldwide published *Migrant Women’s Rights: An Invisible Reality*, the first in a series of reports that sought to document the experiences of migrant women and human rights violations they suffer during the migration process.

In this new report, *Migrant Women in Hiding: Clandestine Abortion in Morocco*, Women’s Link unites two lines of work: migrant women’s human rights and sexual and reproductive rights. By considering these issues together, particularly how the realities of migrant women’s lives affect their sexual and reproductive rights, this investigation documents a hidden reality that must be brought to light.

Morocco is a transit country for migrant women who have left Sub-Saharan African and are headed for Europe. In recent years, in conjunction with the militarization of European migration policies, migration populations that pass through this country have tended to include more and more women. These women are generally young, sometimes minors of childbearing age, and in most cases, they rely on prostitution as a means of survival; alternatively, they are women who have been trafficked for sexual exploitation. These women are also frequently victims of sexual violence and rape, both in their countries of origin and during the migration process. Accordingly, two types of secrecy characterize the experiences of migrant women living in Morocco. On the one hand, a secrecy that results from their irregular legal status and, on the other hand, one that arises out of the complexities associated with accessing health services, such as abortion, in the context of Morocco’s restrictive abortion laws.
In the report *Migrant Women’s Rights: An Invisible Reality*, Women’s Link confirmed that a high number of abortions are performed in clandestine and unsafe conditions in Morocco. Given this reality, the specific objectives of this investigation are the following:

- Highlight the abortion situation for migrant populations which have difficulty accessing sexual and reproductive health services in the context of restrictive laws.
- Identify the social, political, legal and religious movements in the Kingdom of Morocco that address abortion.
- Compile the rights afforded to migrant women according to distinct international treaties and agreements that are binding upon Morocco, as well as the recommendations made by the international human rights community for Morocco regarding migrant women and abortion. These recommendations are legal requirements and include the Concluding Observations of Committees that monitor compliance with international human rights treaties.
This study includes the results of a field investigation of migrant women and abortion in five Moroccan cities where most of the migrant population resides: Rabat, Casablanca, Oujda, Tangier and El Aaiún.4

The field work is complemented by an analysis of the migration context in Morocco, the national legislation and the current debates surrounding abortion within the country. This is supplemented by an analysis of the right to legal and safe abortion and an analysis of the rights that protect migrant women under international law, in accordance with the recommendations made to Morocco by the Committees that oversee the implementation of the United Nations’ international treaties.

The report relied upon the following sources of information:

- Case studies: From November of 2008 through May of 2010, we tracked the abortions that were performed on a sample population in the city of Tangier. We also investigated how the abortions were performed and pre and postabortion care. We obtained this information directly from women who had recently had an abortion.
- Interviews with seven Moroccan organizations connected to legal and social work around abortion.
- Interviews with nine Moroccan and international social organizations that work with migrant women and, in some cases, work on sexual and reproductive health.
- Interviews with six group leaders from distinct migrant communities.
Two focus groups:

1/ Ten French-speaking women of different nationalities (Congolese, Ivorians and Cameroonian) living in Rabat. Among them were women recognized as refugees by the United Nations High Commissioner for Refugees (UNHCR-Morocco).

2/ Ten women of Nigerian nationality living in Tangier. All of these women were victims of trafficking and either traveled through Algeria or Libya to arrive in Morocco.

NOTES


2 The country has become one of the main entry points for the continent of Europe and a part of the route used by migrants. The country’s northwestern coast is a point of departure for the Canary Islands, the north coast is part of the route used by migrants to access the coast of Spain’s peninsula by sea, and the country provides access to the European continent by land through the Spanish territories of Ceuta and Melilla. Some reports have estimated that close to 10,000 Sub-Saharan immigrants with irregular status live in Morocco in conditions of extreme vulnerability, violence and discrimination. The number of female migrants is increasing and they are exposed to additional risks, including sexual violence, gender discrimination, lack of access to sexual and reproductive health services and involvement in trafficking networks. See: http://www.redasociativa.org/dosorillas/modules.php?name=News&file=print&sid=2041 [last accessed on November 20, 2010].


4 El Aaiún is a city in Western Sahara that is under Moroccan jurisdiction. Sub-Saharan migrant women that pass through this city sometimes find themselves under the control of Moroccan authorities and bound by the country’s laws.
FACT SHEET 2 ■ migrant women and abortion in Morocco
The majority of migrant women we came into contact with in Morocco came from Nigeria and the Democratic Republic of Congo, though we also met women from Ivory Coast, Cameroon, Senegal and Guinea. They survived by begging or engaging in prostitution, and in some cases they relied on other survival strategies, such as finding a “husband” or a “journey husband”\textsuperscript{1} who would provide protection and security.

Our field work indicates that a significant number of Nigerian women are involved in trafficking networks\textsuperscript{2} and traffickers have begun to establish networks from other countries, such as Congo, Senegal and Guinea. The number of minors who are involved in these networks has also increased in recent years. Migrant women leave their countries of origin for various reasons, ranging from armed conflicts and poverty to various forms of gender discrimination. Throughout the migration process, women are exposed to physical and sexual assaults, detentions without due process protections, trafficking networks, sexual and labor exploitation, inadequate health care services, no access to justice, domestic violence and xenophobia, among other hardships. The reality and profile of these women vary according to the cities they live in and distinct contexts of their lives.

The majority of French-speaking migrants from Nigeria who are involved in trafficking networks are located in \textit{Tangier}. Confidential sources report that the percentage of trafficked women ranges between 30\% and 40\% of the migrant population.
They live on the outskirts of rural neighborhoods in dwellings which are 4 by 6 square meters, and in poor sanitary conditions. In recent years, the number of women with children has increased (each woman has an average of 1 to 2 children). The children range from 0 to 3 years of age, with a few children over the age of 4. The school-age children do not attend school due to the fact that they lack documentation, though many of them have the birth certificates that are provided by the hospitals. Even when children have birth certificates, the Administration refuses to enter the majority of them into the civil registry, and without this documentation they cannot access public or private education.

Migrant women also suffer racial discrimination, sexual abuse and rape by the local population. Moroccan authorities frequently subject these women to abuse. With regard to access to sexual and reproductive health services, the women report that they cannot receive care through the public health system and that they suffer mistreatment in the hospitals. Access to health care is difficult and, as a result, limited. For the most part, migrant women are only able to access care when civil society organizations intervene in the process.

There is less political pressure in non-border cities, such as Casablanca and Rabat. In Casablanca, women account for 40% to 45% of the migrant population. These women live on the outskirts of urban neighborhoods and mostly come from Nigeria, Congo, Senegal, Ivory Coast and Guinea. The most common means of survival are begging and prostitution.

In Rabat, women’s living conditions are similar to those of women living in Casablanca. The majority of the migrant women who are refugees live in Rabat, which is due to the fact that the United Nations High Commissioner for Refugees (UNHCR) office is located in that city. Women who come from the Democratic Republic of Congo make up the highest percentage of women refugees.

In Oujda, a city that borders Algeria and serves as the point of entry for many women coming to Morocco, there is a high incidence of violence against women and few social organizations provide this population with protection and assistance. It is also an area where the Moroccan government carries out the largest number of deportations without due process protections, failing to comply with international or bilateral agreements and the country’s own Moroccan Immigration Law 02/03.

The women live in informal camps on the border or on either side of the border. The camps are called “calm places,” ghettos comprised of dwellings made out of plastic and branches. These camps can be either mobile or stable, depending on the location. The mobile camps are typically found on the outskirts of the university campus, while the stable camps are located in forests or in peripheral neighborhoods. There is one settlement which is located on the university campus in Oujda.
The percentage of women who live in Oujda fluctuates, ranging from 5% to 20% in the past. Minor girls who left their countries intending to emigrate to another country represent between 5% and 7% of the population of migrant women. Ninety percent of the women and girls are of Nigerian nationality, although there are some women from Cameroon and the Democratic Republic of Congo.

**El Aaiún** is a city that serves as a point of transit to Spain for those passing through the Canary Islands. The road that connects the city to Mauritania has also been converted into a point of passage for migrations from West Africa to Morocco. The conflict in Western Sahara has militarized the area. This city has the only official detention center for immigrants. Many women are either hidden in the desert, waiting to travel to Europe, or in the detention center, waiting to be deported.

Migrant women’s presence in **Dakhla**, another city in Western Sahara, however, has increased. We have documented that the number of women who come from Mauritania to have abortions in the private health centers in El Aaiún and Dakhla is also increasing.

**MIGRATIONS AND ASYLUM IN FIGURES**

**Global**

- The International Organization for Migration estimated the total number of international migrants worldwide to be 214 million persons in 2010.
- Globally, female migrants constitute almost half of all migrants. In developed countries, the number of female migrants exceeds the number of male migrants.
- It is estimated that between 10 and 15% of the world’s migrants are in an irregular administrative situation. Most of these foreigners enter the country legally but overstay their authorizations.
- Europe is estimated to host almost 70 million international migrants, one-third of the global total. Asia hosts the second largest migrant population (61 million), followed by Northern America (50 million), Africa (19 million), Latin America and the Caribbean (7 million) and Oceania (6 million).
- Nearly 6 out of every 10 international migrants, 112 million people, live in high-income economies.
- In 2009, women represented 40% of asylum-seekers.
- According to the United Nations High Commissioner for Refugees (UNHCR), by the end of 2010, there were 43.7 million forcibly displaced people worldwide, the highest number in 15 years.
- In 2010, women constituted 47% of refugees worldwide.
Morocco

In recent years, the number of foreigners arriving in Morocco has increased and the migrant population has become more visible in the streets and cities of the country. Morocco has gone from being considered only a “country of transit” through which migrants attempt to access Europe, to being considered a destination option for people coming from not only the continent of Africa, but also countries in Asia such as Bangladesh, India or Pakistan. Its geographic location and political stability make it a country that is considered to be an attractive destination for the migrant population.

Estimates by government sources and independent researchers indicate that some 10,000 irregular migrants of Sub-Saharan origin may currently be residing in the country.\(^\text{18}\)

According to the Moroccan Association for Migration Studies (AMERM), women from Nigeria represent the largest group of female migrants in Morocco, accounting for 37% of all migrant women, followed by women who come from the Congo, Mali, Cameroon, Sierra Leone, Senegal, Ivory Coast and Liberia.\(^\text{19}\)

According to figures provided by the Moroccan government, almost 8,700 migrants were involuntarily repatriated to their countries of origin between 2004 and 2008.\(^\text{20}\)

According to the figures of the UNHCR office in Morocco,\(^\text{21}\) by the end of July 2010, the active refugee population consisted of 771 Moroccan refugees. Within this population, it is estimated that 205 are minors, who account for more than 25% of the total refugee population. 133 of these refugees are adult women, who represent 17% of the total refugee population.\(^\text{22}\)
The World Health Organization (WHO) defines abortion as the termination of a pregnancy before the fetus has attained viability. To better understand the difficulties associated with migrant women’s access to safe abortion in Morocco, we first present an analysis of the country’s abortion regulations, and the various debates surrounding this issue.

2.1. NATIONAL LEGISLATION REGARDING WOMEN AND ABORTION

In Morocco, a transit country for many African women who decide to emigrate to the European continent, abortion is prohibited unless it is necessary in order to protect the life or health of the woman. This section provides an analysis of the Moroccan legislation regulating criminal punishment for the performance of an abortion. We also include the regulation that protects doctor-patient confidentiality, given the fact that a health care professional’s obligation and the right to “preserve absolute confidentiality on all he knows about his patient, even after the patient has died” is a fundamental part of creating and maintaining trust in the patient-doctor relationship. This is necessary to protect the life and personal integrity of the patient during the provision of all health care services, including safe abortion.
In the Moroccan Criminal Code of 1962, abortion is addressed in the chapter on crimes “against family order and public morality.” According to article 449:

*anyone who induces or attempts to induce the abortion of a pregnant woman, using food, beverages, medication, maneuvers, violence or any other means, whether she has given her consent thereto or not, shall be punished with imprisonment for a term of one to five years and a fine of 200 to 500 dirhams.* If death results therefrom, the penalty shall be imprisonment for a term of ten to twenty years.

Article 454 states that a woman who resorts to abortion will be punished with imprisonment for a term of up to two years and a fine of 120 to 500 dirhams. Nonetheless, article 453, amended by Royal Decree No. 181-66 of 1967, establishes an exception when an abortion is necessary to protect the health of the mother, provided it is performed by a physician or surgeon and the husband gives his consent. If there is no husband or the husband refuses or is prevented from giving his consent, the physician or surgeon should obtain the written permission of the chief medical officer of the province or prefecture. If the physician believes that the woman’s life is in jeopardy, consent is not required, although the physician must give his opinion to the chief medical officer.

Although it is not explicitly stated in national legislation, during a meeting with the UN Human Rights Committee in 1999, the Moroccan government stated that it was obvious that “rape can have devastating consequences on mental health” and, as a result, induced abortion should not be considered illegal when it is necessary to preserve the health of the woman.

With regard to doctor-patient confidentiality, article 446 of the Criminal Code establishes that:

*doctors, surgeons, and other health care works, as well as pharmacists, midwives and any other individuals who, given their profession or function, whether permanent or temporary, should protect confidential communications, or who reveal confidential information when they are not obligated or authorized to act as reporters, shall be punished with imprisonment for a term of one to six months and a fine of 200 to 1000 dirhams.*

This article establishes an exception to doctor-patient confidentiality where health care workers know of cases of abortion, violence between spouses or gender-based violence:
However, the abovementioned individuals will not be subject to the punishments listed in the previous paragraph:

1. When, without being obligated, they report cases of abortion that they learned of in the course of their profession.

2. When they report any acts of violence or mistreatment inflicted on children and women within or outside the family home to judicial or administrative authorities and they learned of these acts in the course of their profession.

When summoned by the judicial authorities regarding the abovementioned offenses, these individuals are free to provide or not to provide their testimony.

In conclusion, abortion in Morocco is permitted only when necessary to preserve the physical or mental health of the woman, provided it is performed with the consent of the husband or the local medical authority. Abortion is permitted in cases of rape under the exception that allows for an abortion when necessary to preserve the mental health of the woman. Under no circumstance does doctor-patient confidentiality extend to induced abortion.
2.2. PERFORMING ABORTIONS IN REALITY

The Moroccan Association against Clandestine Abortion (AMLAC) calculates that between 650 and 800 abortions are performed under the supervision of physicians on a daily basis, while an additional 200 abortions are performed under clandestine conditions. The number of abortions increases in cities where there is a high rate of sex tourism, according to one of the organizations interviewed.31

Clandestine abortions cost between 150 and 1500 euros. Doctor Chraïbi, president of AMLAC, states that “Even among those that are performed in medical settings, some are done without anesthesia, without the necessary sterilization, without limits as to the age of the fetus. If you have money in Morocco, you can access this type of abortion. If you are poor, you are left with sharp objects, ingesting products that cause abortions and result in liver failure, poisons, and many suicides...”

2.3. DISCOURSSES AND ACTIONS IN SUPPORT OF THE LIBERALIZATION OF ABORTION

The social and political debate

Women’s social organizations, working on sexual and reproductive health or human rights, were the first to engage in a public debate surrounding abortion in Morocco. The first organization to work specifically on abortion, the Moroccan Association against Clandestine Abortion (AMLAC), was founded on September 20, 2008. The organization’s goals include influencing the national debate on abortion, raising public awareness of the consequences of clandestine abortion, promoting the prevention of unwanted pregnancies and reforming abortion laws in order to reflect current medical and social realities.32 According to AMLAC, 13% of maternal deaths are caused by unsafe abortions.33 AMLAC also proposes that legal abortion should be available in cases of rape, incest, fetal malformations, pregnant minors, pregnant women over 45 years of age, pregnancies that put the life or the physical or mental health of the woman at risk, and social vulnerability.

The Moroccan Association of Family Planning (AMPF) has been providing sexual and reproductive health services since 1971 and has a presence throughout the Kingdom. In November of 2008, AMPF published an exploratory study on unsafe abortion.34

Women’s organizations, however, have adopted a discourse that goes beyond public health and maternal mortality. These organizations understand women’s individual liberty encompasses the decision to have an abortion, and they emphasize the need to reform the criminal code so that women no longer need to obtain their husbands’ consent before having abortions. In 2010,
the group “Printemps de la Dignité” brought together twenty associations which defend women’s human rights. The group’s goal is penal reform that promotes equality among men and women, particularly in the areas of domestic violence and spousal rape, sexual relations outside of marriage, abortion and trafficking.

In the political context, the Islamist Justice and Development Party (PJD) facilitated a discussion around clandestine abortion in the Moroccan Parliament in 2008. The PJD has recognized that clandestine abortion is a problem that contributes to maternal mortality rates. The facilitators also indicated that they would submit the recommendations which came out of the discussion to the Moroccan Parliament, the Secretary General of the government and the Royal Palace.

The legal debate

In reality, the abortion debate surrounds the current interpretation of article 453, which establishes the exception for abortions when the woman’s life or health is in danger. A large part of the debate involves the interpretation of the concept of danger to the health of the woman as recognized by the Criminal Code, and whether that concept encompasses both physical and mental health. One of the strongest arguments in favor of such an interpretation is that, according to the World Health Organization, health is defined not only as the absence of disease or infirmity, but also as a state of complete physical, mental, and social well-being. The Convention on Economic, Social and Cultural Rights, moreover, which was ratified by Morocco in 1979, also recognizes that health implies the highest attainable standard of physical and mental health. Accordingly, it should be clear that abortion is legal when the risks to a woman’s health go beyond merely her physical health.

The religious debate

The organizations in Morocco which were interviewed highlight the importance of introducing religion into the debate on abortion, given the fact that the country is strongly influenced by Muslim legal schools of thought. According to the majority of Muslim legal scholars, if the fetus is in the first stage of formation (up until day 40 of a pregnancy), and if it might be possible to avoid a problem, abortion is permissible.

Morocco’s official religion is Sunni Islam and the country follows the Maliki school of thought, one of the most conservative schools of thought with regard to abortion. Within the Sunni branch, the largest branch of Islam, there is no unified position regarding abortion. Some schools of thought are more permissive and have indicated that the termination of a pregnancy is permissible under certain circumstances. The four legal-religious schools of Sunni thought agree that abortion is prohibited after the “ensoulment” of
the fetus, which occurs at four months or 120 days of gestation.\textsuperscript{44} Nonetheless, an exception to this principle makes it permissible to terminate a pregnancy when the woman’s life is in danger.\textsuperscript{45} Each school of thought, however, has a different view of when the performance of an abortion is acceptable:

- In the case of the Hanafi school of thought, some permit abortion until the limbs of the embryo have formed during the first four months of a pregnancy, even without a specific reason for the abortion. Others, however, disagree and state that abortion is not permitted during the first four months of a pregnancy.\textsuperscript{46}
- Those of the Maliki school of thought consider abortion to be reprehensible, though not prohibited, during the first 40 days of a pregnancy and prohibit abortion after the moment of “ensoulment.”\textsuperscript{47}
- The Shafi’i school of thought has three views on the subject. The first considers abortion to be prohibited from the time the sperm enters the uterus, the second permits abortion up until the point that the fetus begins to take a human form (40 days) and the third permits abortion until the moment of “ensoulment” (120 days).\textsuperscript{48}
- In the case of the Hanbali school of thought, some state that it is permissible to perform an abortion during the first 40 days of the pregnancy, while others permit abortions through the first 120 days of the pregnancy.\textsuperscript{49}

In conclusion, all of the schools of thought agree that abortion is prohibited after 120 days of gestation but disagree as to when abortion is permissible.
2.4. ABORTION RATES

Global
- Abortion rates, in general, are fairly similar in 4 of the 6 largest regions of the world: 31 per 1,000 women in Latin American and the Caribbean, 29 per 1,000 women in Africa and Asia, and 28 per 1,000 women in Europe.\(^{50}\)
- The number of abortions worldwide fell from an estimated 45.5 million in 1995 to 41.6 million in 2003. The estimated number of unsafe abortions changed little during this period – from 19.9 million in 1995 to 19.7 million in 2003.\(^{51}\)
- The number of unsafe abortions which took place worldwide increased from 19.7 million in 2003 to 21.6 million in 2008. Almost all of these abortions occurred in developing countries.\(^{52}\)
- Restrictive abortion laws do not necessarily result in low abortion rates, just as permitting abortion on broad grounds does not necessarily result in high abortion rates. The legal status of abortion, however, affects whether or not it is provided in a safe manner.\(^{53}\)
- In 2008, the percentage of maternal deaths due to unsafe abortion was 13%.\(^{54}\)

Africa
- In Africa, 5.5 million unsafe abortions were performed in 2003 and 6.2 million in 2008.\(^{55}\)
- In 2008, 28 per 1,000 women aged 15-44 years had an unsafe abortion.\(^{56}\)
- In 2008, unsafe abortion caused 14% of the maternal deaths in Africa.\(^{57}\)
- In 2008, there were 29,000 maternal deaths due to unsafe abortion,\(^{58}\) approximately 460 deaths per 100,000 unsafe abortions.\(^{59}\)

North Africa
- In 2008, approximately 900,000 unsafe abortions were performed in North Africa. The rate of unsafe abortion was approximately 18 per 1,000 women aged 15-44 years.\(^{60}\)
- In 2008, the estimated number of maternal deaths due to unsafe abortion in North Africa was 170 per 100,000 unsafe abortions. It is estimated that approximately 1,500 women died as the result of unsafe abortion in that year.\(^{61}\)

Morocco
- Between 600 and 800 clandestine abortions are performed each day. Of these, between 150 and 200 abortions are performed in risky and unsafe conditions.\(^{62}\)
- In Morocco, of 4553 women between 15 and 49 years of age, 10% of those who are married have had an abortion, while 75% of those who are single have thought about terminating a pregnancy.\(^{63}\)
access to sexual and reproductive health services, including safe abortion, for migrant women\textsuperscript{64}
The field work carried out as part of this investigation highlights the context in which migrant women have abortions in Morocco. This context is characterized by the level of sexual violence women are exposed to, which is more severe for victims of trafficking, as well as the migrant population’s use of misoprostol, also known by the commercial brand name Cytotec, as a method of abortion. The following section summarizes the principal observations of our field work.

3. 1. MIGRANT WOMEN’S RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH RECEIVE VERY LITTLE PROTECTION

Migrant women’s rights are afforded limited protection and are systematically violated because of the following difficulties associated with accessing sexual and reproductive health care:

The clandestine situation
For the most part, migrant women who come from Sub-Saharan Africa are forced to live in hiding in Morocco. Given the fact that they do not have legal permission to reside in the country, identification by the Moroccan authorities leads to detention and expulsion from the country in most cases. Women can also be detained when they seek care at a hospital. In addition, because the majority of these women are involved in trafficking networks, we cannot underestimate the ability of these networks to control migrant women and limit their freedom of movement.

The position of women who have been granted refugee status by the United Nations High Commissioner for Refugees (UNHCR) is not much better, as Morocco does not believe that the UNHCR has the authority to process and grant requests for asylum. Consequently, Morocco does not give residential or labor permits to individuals who have been granted asylum.

These factors affect migrant women’s ability to move, since women fear the possible consequences of encounters with the authorities or other third parties. Although civil society organizations, such as Doctors Without Borders, have made efforts to improve access to health care among migrant women, their lack of legal status makes it difficult to ensure that they will receive adequate care or that their right to health will be sufficiently protected. The fact that migrant women live in secrecy makes it difficult to ensure access to primary health care services and even harder to ensure access to sexual and reproductive health services, including safe abortion. When a woman is given refugee status, access to sexual and reproductive health services improves, but this does not mean that she will always be able to access safe abortion services when it is necessary for her to terminate a pregnancy.
Classe des mères
Health care workers: difficulties and context

Our report *Migrant Women’s Rights: An Invisible Reality* documents the constant violation of migrant women’s rights in Morocco. In addition to their precarious living situation, migrant women face discrimination from institutions and the local population, and lack the necessary legal status to reside in Morocco. Given these factors, failure to recognize these women’s most basic human rights, such as the right to health, is inevitable.

Migrant women, however, do not only face barriers to health care resulting from their lack of documentation and resources. They are also faced with a public health system which is not sufficiently developed to adequately serve the needs of the population relying on it for health care services. It also is important to note that migrant women are in a situation of extreme vulnerability and are unable to complete the steps required in order to access free health care.

However, there is a loophole in the regulation of migrant population’s access to public health. This means that access to health for this population is arbitrary and, in most cases, depends on the specific policy followed by each of the regional Health Delegations. There is a general lack of awareness among health care workers about the rights of the migrant population. Consequently, it is not uncommon for migrant women to encounter difficulties in their interactions with sexual and reproductive health care providers, even once they have successfully accessed an institution which has, in theory, an obligation to protect their right to health, as recognized at the national and international levels.

In practice, when Health Delegations are aware of these issues, the Delegate should intervene in individual cases and ensure that migrant women receive care within the public system. Nonetheless, in recent years, civil society organizations have made great efforts to facilitate access to health, particularly in the areas of monitoring women’s pregnancies and vaccinating migrant women within the public health system.

Many of the challenges associated with accessing sexual and reproductive health care involve health care workers:

- Health care workers’ lack of awareness of migrants, including the right to primary health care regardless of a migrant’s legal status or whether an individual provider agrees with the Health Centers’ internal practices.
- The difficulties associated with language comprehension, particularly among women from French-speaking countries, who tend to be the least autonomous regarding sexual health because many of them remain under the control of trafficking networks.
The corruption that is present within the public health system, despite various actions taken by the Moroccan Ministry of Health to address this problem.

Authorities’ repressive conduct in hospitals, which not only causes the migrant population to fear accessing health care services but also leads to confusion among health care workers as to whether it is permissible to provide care to this population.

**Lack of economic resources**

If accessing sexual and reproductive health services and safe abortion is difficult for migrant women within the public health system, receiving care in private hospitals is impossible, given the extreme lack of resources among this population.

Migrant women, many of whom are pregnant or have children who are under 3 years of age, rely on begging or the assistance of social organizations in order to survive. Despite efforts to modernize the system, Morocco’s public health system is deficient. Hospitals fail to provide assistance covering one hundred percent of a sick person’s needs, from medicine to other services that a patient should receive reimbursement for under all circumstances.

The public health system’s lack of resources has led to extensive privatization of health care in Morocco, where the cost of care is disproportionately high when compared to the income of the local population. A private specialized consultation costs 200 dirhams, and a consultation with a
family physician costs between 150 and 100 dirhams. Hospitalization, analysis, x-rays and surgical interventions increase the cost to the point that is it essentially prohibitive for the majority of the population. As a result, pharmacies function as heath centers and a large part of the population, including migrant women, avoid having to pay for these medical expenses by seeking medical advice and buying medicines directly from pharmacists, without first going to a hospital or health center.

As discussed in this section, under these conditions, migrant women are unable to receive abortions through the inaccessible private health system. In the majority of cases, they have no choice but to terminate their pregnancies in secrecy. When there are complications, some women visit an emergency room for postabortion care or directly consult the pharmacy which prescribed the medication.

Lack of awareness of sexual and reproductive rights
The majority of migrant women in transit that find themselves in Morocco have low to medium levels of education, which means that many of them do not have access to information regarding their sexual and reproductive health, including information about sexual education, use of contraceptives, safe motherhood and safe abortion. Women with higher levels of education may have access to sexual and reproductive health care but that access is often impeded by the high levels of violence they suffer, both inside and outside their respective communities.

Moreover, it is important to highlight that there are few opportunities to access education regarding sexual and reproductive rights in Morocco. This education is generally provided by development cooperation projects led by international organizations.
Frequent sexual violence
In Fact Sheet 1, as well as the first part of this section, we discussed the high levels of violence, particularly sexual violence, that affect migrant women in Morocco and often lead to unwanted pregnancies. Given the context of migrant women’s lives in Morocco, where there is little access to health care in general and practically no access among the migrant population, frequent sexual violence aggravates their already vulnerable situation. This sexual violence interferes with the implementation of protocols intended to prevent unintended pregnancies and the practice of unsafe abortion. For example, emergency contraception is inaccessible for these women, either because they are unaware of its availability or because it is unsustainable to take it every time they suffer sexual violence, which is may be as frequent as on a daily basis.

Although migrant women are under the constant threat of raids, deportations and detentions, one recent campaign led by social organizations attempted to raise awareness among Moroccan authorities that a woman’s status as a victim of sexual violence trumps her status as an irregular migrant. This campaign is fairly new and, ultimately, it seeks to ensure that migrant women have access to the sexual violence centers which are opening in public hospitals. According to Doctors Without Borders, in 2010 they provided one hundred consultations relating to episodes of sexual violence that had occurred not only in Morocco, but also at some point during the migration process.73

Negation of sexual and reproductive autonomy
Men, whether they are “boyfriends,” “husbands” or “connection men,” making decisions on behalf of women in the area of sexual and reproductive health is another form of violence. For women who are victims of trafficking, decisions as to whether or not they take contraception or whether they will have an abortion or bring the pregnancy to term are always made by the network in accordance with its own interests.

Importance of collaboration
The social organizations in Morocco that specialize in sexual and reproductive health or human rights, work primarily with the local population. The majority of organizations working with the migrant population, however, do not have clearly defined strategies to help migrant women access abortions. The lack of collaboration and coordination among these organizations makes it difficult for migrant women to access to sexual and reproductive health services, but this could be resolved if these organizations began working more closely together.
3.2. ACCESS TO ABORTION SERVICES AMONG MIGRANT WOMEN

Migrant women in Morocco use various methods to terminate unwanted pregnancies, all of which take place in secrecy, particularly the use of misoprostol. The following section presents what we observed on the ground:

Methods used to abort

The majority of migrant women in Morocco take misoprostol to terminate their unwanted pregnancies. The migrant population in Morocco refers to misoprostol as Cytotec, one of the commercial brand names for misoprostol. Although many countries have only listed one approved use of the drug on the national register, the prevention or treatment of gastric ulcers, the drug also causes uterine contraction, which can cause an abortion. Misoprostol can be administered in a number of ways, including oral, vaginal, buccal (between the cheek and the gum), rectal or sublingual administration. However, the medication is generally administered vaginally or orally. When administered correctly, the medicine serves as an effective means of safely terminating a pregnancy. A much smaller percentage of women use homemade methods, such as onbelé, a plant that has abortion-inducing effects.

According to the International Federation of Gynecology and Obstetrics, the dosage needed to safely induce an abortion during the first trimester is 800 milligrams administered vaginally every 12 hours, until 3 doses have been completed. To induce a pregnancy during the second trimester, a dosage of 400 milligrams administered vaginally is recommended every three hours, until 5 doses have been completed. The Latin American Federation of Obstetrics and Gynecology (FLASOG) recommends, as an alternative to vaginal administration, sublingual (under the tongue) administration of an 800 milligram dosage every 3 or 4 hours, until 3 doses have been completed, up until the ninth week of pregnancy. In all cases, it is recommended that women have access to emergency services in the event that there complications or the method does not result in a complete abortion.

Despite the fact that most migrant women in Morocco take misoprostol to terminate their unwanted pregnancies, they generally do not know how to use it properly. As a result, it is administered in high doses, mixed with other medicines, or at advanced gestational ages, including up until the sixth month of a pregnancy. The use of misoprostol without following scientific recommendations for safe use causes women to suffer from hemorrhages, infections resulting from the retention of the placenta, subsequent deformities resulting from abortions that were not successfully completed, and deaths due to complications in cases where women use it at advanced gestational ages. Hospitals, however, record these deaths as deaths due to cardiac arrest.
Access to misoprostol among migrant women

Migrant women in Morocco generally use misoprostol that comes from Spain, where it is legal to use it to induce abortions, and it is available on the black market in Morocco. Trafficking networks provide the medication to migrant women who are victims of trafficking, while other migrant women and refugees obtain the medication from fellow migrants.77

Abortions among women who are victims of trafficking

The report Migrant Women’s Rights: An Invisible Reality highlighted the very high number of migrant women in Morocco who are victims of trafficking. Of the 71 women who were interviewed in Morocco, 49% were victims of trafficking. It should be mentioned that of the 63 women from Nigeria who were interviewed, 100% were victims of trafficking.78

To be a victim of trafficking means that your body belongs to the trafficking network and that the network makes all decisions pertaining to both your body and your life, as well as your sexual and reproductive health. The “connection men” rape these women, or decide who can rape them. At the same time, the same “connection men” decide whether the women will carry their pregnancies to term or terminate them, in accordance with the interests of the network and in consideration of the fact that, upon birth, the baby will become “property” of the network. As a result, is it the traffickers who provide a woman who is the victim of trafficking with misoprostol and determine the dosage that she should take, in spite of the fact that the traffickers are often unaware of the recommendations for safe use.

Abortions in border areas

The pressure that authorities place on migrants is much more severe in border areas, making it more likely that migrant women’s already limited rights will be violated at the border than in other parts of Morocco. In these areas, police forces have greater control over certain services, such as health care services. These women, moreover, sacrifice access to sexual and reproductive health care in order to avoid detentions and deportations.

Groups of migrant women also feel like their freedom is more limited in these areas, whether due to objective actions or the subjective fear of raids or control by authorities. It is noteworthy that migrant women experience heightened anxiety and fear in border areas because they are in a better position to imagine arriving in Europe when they are living near a border.
For groups of migrant women who are in the “tranquilos,” access to health care services is nonexistent. During this time, which can last anywhere from a few weeks to months, they are controlled by groups of individuals who will help them cross the border. Many abortions, moreover, are performed under these circumstances and in the absence of any type of health care services. It is, therefore, important to keep in mind that some of the women who arrive in Spain by boat have received incomplete abortions in these “tranquilos.”

3.3. POSTABORTION CARE IS NOT GUARANTEED EVEN THOUGH IT IS CONSIDERED TO BE EMERGENCY MEDICAL CARE

Postabortion care refers to the care provided after the termination of a pregnancy and includes a range of essential reproductive health services. Postabortion care is widely recognized within the field of medicine as an intervention with broad potential to save women’s lives, improve the quality of their lives, and empower women to take control of their reproductive health. In 1994, the International Conference on Population and Development in Cairo identified postabortion care as an efficient means of addressing the health risks associated with abortions that are performed under risky conditions.

In practice, there is no guarantee that the migrant population in Morocco will receive this kind of care, even though it is available to the rest of the Moroccan population. Migrant women are afraid to request postabortion care in public hospitals, given the fact that they may be detained due to their migration status and may later face deportation. As a result, migrant women only receive postabortion care when a social organization is involved and serves as a mediator between the woman and the hospital.
<table>
<thead>
<tr>
<th>GEOGRAPHIC CONTEXT</th>
<th>MIGRATION SITUATION</th>
<th>ACCESS TO HEALTH</th>
<th>ACCESS TO MISOPROSTOL</th>
<th>POSTABORTION CARE</th>
<th>ACCESS TO ILLEGAL BUT SAFE ABORTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CASABLANCA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic and business center. The city is located on the coast of the Atlantic Ocean.</td>
<td>Women make up 40% of the migrant population. For various reasons, almost all services that were once provided to migrants are no longer available.</td>
<td>Public hospitals are accessible but they do not provide services to migrant women and migrant community leaders.</td>
<td>On the black market. Women purchase it from other migrant women.</td>
<td>Provided in public hospitals. Access improves when social organizations intervene.</td>
<td>Physicians provide abortions but they are expensive, between 150 and 2,000 euros. Sometimes women request assistance from NGOs. Because this is a crime, it is uncommon.</td>
</tr>
<tr>
<td><strong>EL AAIÚN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital of Western Sahara under the control of Morocco.</td>
<td>A low percentage of migrants are women. The majority of the women remain under the control of the authorities in the detention center. The percentage of women using this route as a means of entering Morocco from West Africa is rising.</td>
<td>The authorities must intervene for women in the detention center to access the public hospitals.</td>
<td>Organizations are not aware that this drug can be used as a method of abortion.</td>
<td>Public hospitals provide this care to the local population. It is less likely that the migrant population will receive this care.</td>
<td>Physicians provide abortions but they are expensive. An abortion costs between 150 and 2,000 euros, depending on the stage of the pregnancy.</td>
</tr>
<tr>
<td>GEOGRAPHIC CONTEXT</td>
<td>MIGRATION SITUATION</td>
<td>ACCESS TO HEALTH</td>
<td>ACCESS TO MISOPROSTOL</td>
<td>POSTABORTION CARE</td>
<td>ACCESS TO ILLEGAL BUT SAFE ABORTION</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td><strong>OUJDA</strong></td>
<td>Capital of the Oriental Region. Located close to the Morocco-Algeria border, which has been closed since 1994.</td>
<td>Access to health is fairly limited. The women depend on MSF’s intervention and they do not have other means of accessing care, due to their fear of being detained and the fact that their status as undocumented immigrants takes priority over their right to health in the border areas.</td>
<td>The women obtain the drug from others within their own migrant communities, who in turn find it on the Moroccan black market.</td>
<td>It is necessary for an accredited social organization to intervene.</td>
<td>Physicians provide abortions but they are expensive, between 150 and 2,000 euros. Cytotec is sold by migrants. Given the scarcity of gynecologists, the procedure is performed by generalist physicians.</td>
</tr>
<tr>
<td><strong>RABAT</strong></td>
<td>A high percentage of the women are refugees, which is due to the fact that the UNHCR office is located in this city.</td>
<td>With regard to the UNHCR, it has an agreement with Urgent Access. Various social organizations must intervene to ensure that migrants have access to health care.</td>
<td>On the black market. Women purchase it from other migrant women. It costs between 300 and 400 dirhams.</td>
<td>Provided in public hospitals. Access improves when social organizations intervene.</td>
<td>Physicians provide abortions but they are expensive, between 150 and 2,000 euros. Sometimes women request assistance from NGOs. Because this is a crime, it is uncommon.</td>
</tr>
</tbody>
</table>
### Tangier

<table>
<thead>
<tr>
<th>Geographic Context</th>
<th>Migration Situation</th>
<th>Access to Health</th>
<th>Access to Misoprostol</th>
<th>Postabortion Care</th>
<th>Access to Illegal but Safe Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern city that is located 14 km from Spain.</td>
<td>A high percentage of women are victims of trafficking and live in neighborhoods on the outskirts of the city.</td>
<td>Access to hospitals is not guaranteed. Access to public hospitals improves when social organizations intervene. Women report being mistreated in the hospitals.</td>
<td>On the black market. Women who are involved in trafficking networks obtain it from their respective networks.</td>
<td>Provided in public hospitals.</td>
<td>Physicians provide abortions but they are expensive. An abortion costs between 150 and 2,000 euros, depending on the stage of the pregnancy.</td>
</tr>
</tbody>
</table>
## GLOSSARY

**Induced abortion.** The termination of a pregnancy through a deliberate intervention.\(^85\)

**Incomplete abortion.** Although the fetus is expelled, part or all of the placenta is retained.\(^86\)

**Unsafe abortion.** A procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.\(^87\)

**Medical methods of abortion.** The use of pharmacological drugs to terminate a pregnancy. Sometimes the term “non-surgical abortion” is also used.\(^88\)

**Emergency contraception (EC).** Emergency contraception refers to back-up methods for contraceptive emergencies which women can use within the first few days after unprotected intercourse to prevent an unwanted pregnancy. Emergency contraceptives are not suitable for regular use.\(^89\)

**Postabortion care (PAC).** A term coined in the early 1990s, it refers to a package of critical reproductive health care services. Its three elements are:

1. Emergency treatment for complications of spontaneous or unsafely-induced abortion.
2. Postabortion family planning counseling and services.
3. Links between these services and other elements of comprehensive reproductive health care.

Postabortion care is widely recognized as an intervention with broad potential to save women’s lives, improve the quality of their lives, and empower women to take control of their reproductive health.\(^90\)

**Sexually Transmitted Infections (STI).** Infections that are spread primarily through person-to-person sexual contact. There are more than 30 different sexually transmissible bacteria, viruses and parasites. Several, in particular HIV and syphilis, can also be transmitted from mother to child during pregnancy and childbirth, and through blood products and tissue transfer.\(^91\)
**Journey husband.** A companion who a woman meets during the journey. Hierarchically, a “journey husband” is ranked higher than “boyfriend” and lower than a “connection man.”

**Forced migration.** A migratory movement of a person in which an element of coercion exists, in particular as a result of or in order to avoid the effects of armed conflicts, situations of generalized violence, violations of human rights or natural or human-made disasters. This term applies to the movements of refugees and internally displaced persons.92

**Irregular migration.** The movement of a person to a new place of residence or transit that involves the use of irregular or illegal means, without valid documentation or using fraudulent documentation. This term also includes the smuggling of migrants.93

**Economic migrant.** A person leaving his or her habitual place of residence to settle outside his or her country of origin in order to improve his or her quality of life. This term may be used to refer to persons attempting to enter a country without legal permission and/or by using asylum procedures without bona fide cause. It also applies to persons settling outside their country of origin for the duration of an agricultural season, appropriately called “seasonal workers.”94

**Irregular migrant.** The term is used to describe someone who, owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country’s transit or admission rules; people who intend to obtain asylum without a just cause; and any other person not authorized to remain in the host country. These people are also called “undocumented migrants,” “clandestine migrants,” or “illegal migrants.”95

**Connection man.** The leader of a trafficking network in Morocco. According to information compiled in the field, the “connection man” should have knowledge of everything that happens to a woman who is a victim of trafficking, especially if it concerns her health.

**Repatriation.** A subcategory of return migration that refers to refugees who return to their countries of origin, prisoners of war under the Geneva Convention of 1949, civil detainees during times of war, and diplomatic envoys in times of crisis, in conformance with the Vienna Convention on Diplomatic Relations of 1961 and the Vienna Convention on Consular Relations of 1963.96

**Reproductive health.** A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so.97
### Sexual health
A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.\(^9^8\)

### Smuggling of migrants
The procurement, in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry of a person into a State Party of which the person is not a national or a permanent resident.\(^9^9\)

### Trafficking in persons
The recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs.\(^1^0^0\)

### Asylum seeker
A person who has crossed an international border and has not received a decision on their application for protection as a refugee. This term may refer to someone who has submitted his or her application for refugee status or awaits a decision on the application for refugee status. The asylum seeker cannot be returned to his or her country of origin until a final decision has been made on the application for refugee status. Not all asylum seekers are given refugee status.\(^1^0^1\)

### Refugee
A person who, in conformance with the Convention on the Status of Refugees of 1951, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country. In 1969, the Organization of African Unity (now the African Union) adopted a broader definition that applies to every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence. Upon adopting the 1984 Cartagena Declaration on Refugees, Latin American governments include among refugees persons who have fled their country because their lives, safety or freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violation of human rights or other circumstances which have seriously disturbed public order.\(^1^0^2\)
NOTES

1 See Glossary for the definition.
2 See Glossary for the definition.
3 The UNHCR has limited mobility in Morocco. Refugee women carry an identity card that has been granted to them by the UNHCR, but not by the government. The advantage is that the card provides access to health care services. The most recent mass deportation that included refugees occurred in 2006. Refugees’ freedom of movement is also limited in Rabat and Casablanca.

5 As a result of the conflict in Western Sahara the border between Morocco and Algeria has been closed since 1994.
8 Students provide protection to the migrant population.
9 Migrants are held in detention centers while they wait to be deported to Mauritania, or transferred to Oujda, where they are deported to Algeria. Individuals are provided with basic services while they are held in these centers.
11 Trends in International Migrant Stock [on-line]: the 2008 Revision. United Nations, 2008. Page: 1. http://www.un.org/esa/population/migration/UN_MigStock_2008.pdf. In Europe, 52.3% of migrants are women. The number of female migrants exceeds the number of male migrants in Oceania (51.2%) and in Latin America, the Caribbean and North America (50.1%). Female migrants are underrepresented by wide margins in Asia (44%), Africa (46.8%) and, in particular, the Gulf Cooperation Council countries, where they represent 29% of the migrant population. In countries where the migrant population is comprised primarily of contract workers, the proportion of women is generally low. United Nations, Department of Economic and Social Affairs, Population Division (2009).
14 United Nations General Assembly [on-line]: International migration and development. United Nations, May of 2006. Paragraph: 47. Available at: http://www.queensu.ca/samp/migrationresources/reports/Report%20of%20the%20SG_June%202006_English.pdf. These high-income countries include 22 developing countries, including Bahrain, Brunei Darussalam, Kuwait, Qatar, the Republic of Korea, Saudi Arabia, Singapore and the United Arab Emirates.
17 Ibid. Page 3.
19 Interview in the press (Le Matin) with the president of the Moroccan Association for Migration Studies (AMERIM). Available at: http://www.lematin.ma/Actualite/Journal/Article.asp?idr=110&sid=110326.
21 In the absence of a national asylum process, the UNHCR in Rabat oversees managing the registry, considering the conditions necessary for recognizing refugee status and providing documentation.
24 The World Health Organization has defined induced abortion as “the termination of a clinical pregnancy, by deliberate interference that takes place before 20 completed weeks of gestational age (18 weeks post fertilization) or, if gestational age is unknown, of an embryo/fetus of less than 400 grams.” WORLD HEALTH ORGANIZATION. Glossary on Assisted Reproductive Technologies (ART) Terminology. Revised and prepared for the International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization, 2009. Available at: http://www.icmartif.org/Glossary_2009_FertilSteril.pdf. Nonetheless, not all induced or voluntary abortions are safe. See the Glossary for the definition of induced abortion.
27 Dirham: a unit of currency in Morocco and in the United Arab Emirates. One euro is the equivalent to 10 dirhams.
28 Ibid.
30 Dirham: a unit of currency in Morocco and in the United Arab Emirates. One euro is equivalent to 10 dirhams.
31 The interviews were conducted between November of 2008 and May of 2010.
32 See the AMLAC website: http://www.amlac.org.ma.
33 Interview with the Director of the Moroccan Association of Family Planning, Mohamed Graigaa.
35 Spring of Dignity.
36 See: http://pandoras.periodismohumano.com/tag/printemps-de-la-dignite.
38 Interview with the Director of the Moroccan Association of Family Planning, Mohamed Graigaa.
39 World Health Organization Constitution. Preamble: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” Available at: http://www.who.int/governance/eb/who.constitution_en.pdf.
40 Article 12. Convention on Economic, Social and Cultural Rights: “1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”
41 NECCO, Elisabetta. Argumentos de Bioética en el Islam: Aborto, Planificación Familiar e Inseminación Artificial, Cuadernos de Almenara, Number 14.
42 Islam is divided into two branches: Sunni and Shia.
43 Although Tunisia also follows the Maliki school of thought, it does not criminalize abortion.
45 Ibid.
47 Ibid.
49 Ibid.
51 Ibid. P. 4.
Minimum wage is Morocco was 11.70 dirhams in November 2011.

Dirham: a unit of currency in Morocco and in the United Arab Emirates. One euro is equivalent to 10 dirhams.

Missoprostol is a registered drug in Spain. For information about its official registered use, see: http://www.vadencum.es/principios-activos-misoprostol-a02bb01.

More information, see: http://www.figo.org/files/figo-corp/Misoprostol_Poster_2.pdf.


The field work conducted in Oudja, Rabat and Casablanca made it possible to identify the areas in which women have access to misoprostol through other migrants.


Migrants in Morocco use this term to describe the safe places where they wait before crossing to Europe.

See Glossary for the definition.


The main reasons include lack of funding and the closure of the Evangelical Church’s office in Casablanca, which had provided services to migrants, due to the recent expulsion of Christians living in Morocco.

Action d’Urgence: A Moroccan organization that partners with the United Nations High Commissioner for Refugees to provide assistance to refugees and asylum seekers.


Ibid.

Ibid.

Ibid.

Ibid.


Ibid.


Ibid.

Ibid.
FACT SHEET 3 ▪ Morocco and its obligations under International Law

Cellule d’acceuil et d’orientation des enfants et femmes victimes de violence

خلية إستقبال وتوجيه الأطفال والنساء ضحايا العنف
The right to legal and safe abortion is protected by other fundamental rights, such as the right to life, health, security of person, be free from discrimination, information and education, the benefits of scientific progress and reproductive self-determination.

Under international human rights law, abortion has been recognized as a sexual and reproductive right. Sexual and reproductive rights rest “on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.”¹

These rights are expressed in a series of international treaties, which are monitored by specific Committees. Accordingly, the Human Rights Committee monitors the Covenant on Civil and Political Rights,² the Committee on Economic, Social and Cultural Rights monitors the Covenant on Economic, Social and Cultural Rights,³ and the Committee on the Elimination of Discrimination against Women monitors the Convention on the Elimination of All Forms of Discrimination against Women,⁴ among others. Each committee monitors the implementation of its respective treaty and periodically considers State parties’ reports to the committee. After considering these reports, the committees issue “Concluding Observations,” which constitute interpretations of the treaties, and both highlight the progress the State parties’ have made and provide suggestions for implementing the international treaties.⁵

General Observations or Recommendations also provide interpretations of a norm or specific right that is protected under the treaties. These interpretations are not directed towards a specific State in particular, and they function as interpretive guides for one or more rights. In the present investigation, for example, the Concluding Observations of the Committee on the Elimination of Discrimination against Women to Morocco in 2008 discuss the Committee’s General Recommendation No. 24, which addresses article 12’s right to health, in the following manner:

The Committee calls upon the State party to increase women’s access to primary health care services, including reproductive health care and means of family planning. In light of its general recommendation 24, the Committee also recommends that the State party increase awareness campaigns on the importance of health care, including information on the spread of sexually transmitted diseases and HIV/AIDS as well as on the prevention of unwanted pregnancies through family planning and sex education.⁶
General Recommendation No. 24 also references non-national women and girls, noting that:

18) States parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country.7

In General Recommendation No. 26, which addresses migrant workers, the Committee on the Elimination of Discrimination against Women has also noted the following:

Women migrant workers often suffer from inequalities that threaten their health. They may be unable to access health services, including reproductive health services, because insurance or national health schemes are not available to them, or they may have to pay unaffordable fees.8

Similarly, Recommendation No. 26 states that migrant workers face “lack of access to safe reproductive health and abortion services, when the health of the mother is at risk, or even following sexual assault.”9
In an effort to enhance the present investigation, international treaties and other documents that protect migrant women’s rights in the area of health, as well as the Committees’ Concluding Observations to Morocco that address safe abortion and migrant women, have been collected here.

The 1992 Constitution of the Kingdom of Morocco confirms the country’s consideration of the distinct international treaties and agreements, and establishes that:

_Aware of the need to incorporate its work within the frame of the international organisations of which it has become an active and dynamic member, the Kingdom of Morocco fully adheres to the principles, rights and obligations arising from the charters of such organisations, as it reaffirms its determination to abide by the universally recognised human rights._

International agreements and other documents that address women’s rights in the area of health include the following:

- Universal Declaration of Human Rights.
- Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (CAT): ratified by Morocco on June 21, 1993.
<table>
<thead>
<tr>
<th>RIGHT</th>
<th>NORM UNDER INTERNATIONAL LAW THAT PROTECTS THE RIGHT TO LEGAL AND SAFE ABORTION</th>
<th>NORM UNDER INTERNATIONAL LAW THAT SPECIFICALLY (BUT NOT EXCLUSIVELY) PROTECTS MIGRANT WOMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>International Covenant on Civil and Political Rights (Article 6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Convention on the Rights of the Child (Article 6)</td>
<td></td>
</tr>
<tr>
<td>Right to Security of Person</td>
<td>Universal Declaration of Human Rights (Article 3)</td>
<td>Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (Articles 3 and 13)</td>
</tr>
<tr>
<td></td>
<td>Covenant on Civil and Political Rights (Article 9 [1])</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Convention on the Rights of the Child (Article 19)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Convention on the Rights of the Child (Articles 9 [4], 11, 22 [Refugees] and 34 [Sexual exploitation])</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Convention on the Elimination of All Forms of Racial Discrimination (Article 5 [b])</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covenant on Civil and Political Rights (Article 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ILO Convention 182 on the Worst Forms of Child Labor (Article 7 [2])</td>
</tr>
<tr>
<td>RIGHT</td>
<td>NORM UNDER INTERNATIONAL LAW THAT PROTECTS THE RIGHT TO LEGAL AND SAFE ABORTION</td>
<td>NORM UNDER INTERNATIONAL LAW THAT SPECIFICALLY (BUT NOT EXCLUSIVELY) PROTECTS MIGRANT WOMEN</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Right to Health</td>
<td>Universal Declaration of Human Rights (Articles 25 [1] and 25 [2])</td>
<td></td>
</tr>
<tr>
<td></td>
<td>International Covenant on Economic, Social and Cultural Rights (Articles 10 [2], 12 and 15 [1] [b])</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (Articles 12 [1] and 12 [2])</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Convention on the Rights of the Child (Articles 24 [1], 24 [2] [d], 24 [2] [f] and 24 [3])</td>
<td></td>
</tr>
<tr>
<td>Right to be Free from Discrimination</td>
<td>Covenant on Civil and Political Rights (Article 2 [1])</td>
<td>Convention relating to the Status of Refugees (Article 16 [Access to the courts])</td>
</tr>
<tr>
<td></td>
<td>Covenant on Economic, Social and Cultural Rights (Article 2 [2])</td>
<td>Convention on the Elimination of All Forms of Racial Discrimination (Article 5 [f])</td>
</tr>
<tr>
<td></td>
<td>CEDAW (Article 1)</td>
<td>Covenant on Civil and Political Rights (Articles 13 [Due process] y 26)</td>
</tr>
<tr>
<td>Right to Reproductive Self-Determination</td>
<td>CEDAW (Articles 10 [h] y 16 [1] [e])</td>
<td></td>
</tr>
<tr>
<td>RIGHT</td>
<td>NORM UNDER INTERNATIONAL LAW THAT PROTECTS THE RIGHT TO LEGAL AND SAFE ABORTION</td>
<td>NORM UNDER INTERNATIONAL LAW THAT SPECIFICALLY (BUT NOT EXCLUSIVELY) PROTECTS MIGRANT WOMEN</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Right to Information and Education</td>
<td><strong>Universal Declaration of Human Rights</strong> (Articles 19 and 26)</td>
<td>ILO Convention 182 on the Worst Forms of Child Labor (Article 7 [2])</td>
</tr>
<tr>
<td></td>
<td><strong>Covenant on Civil and Political Rights</strong> (Article 19 [2])</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Covenant on Economic, Social and Cultural Rights</strong> (Article 13 [1])</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>International Convention on the Elimination of All Forms of Racial Discrimination</strong> (Article 5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CEDAW</strong> (Article 10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Convention on the Rights of the Child</strong> (Article 28 [1])</td>
<td></td>
</tr>
<tr>
<td>Right to the Benefits of Scientific Progress</td>
<td><strong>Universal Declaration of Human Rights</strong> (Article 27 [1])</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Covenant on Economic, Social and Cultural Rights</strong> (Article 15 [1])</td>
<td></td>
</tr>
<tr>
<td>INTERNATIONAL INSTRUMENT</td>
<td>RIGHT TO LEGAL AND SAFE ABORTION</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Covenant on Civil and Political Rights</strong></td>
<td>“The Committee notes with concern that the strict prohibition on abortion, even in cases of rape or incest, and the stigmatization of women who give birth to children outside marriage results in clandestine, unsafe abortions which contribute to a high rate of maternal mortality (…) The State party should ensure that women have full and equal access to family planning services and to contraception and that criminal sanctions are not applied in such a way as to increase the risk to life and health of women” (1999).10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“The Committee notes with concern that abortion is still a criminal offence under Moroccan law unless it is carried out to save the mother’s life. The State party should ensure that women are not forced to carry a pregnancy to full term where that would be incompatible with its obligations under the Covenant (arts. 6 and 7) and should relax the legislation relating to abortion” (2004).11</td>
<td></td>
</tr>
<tr>
<td><strong>International Covenant on Economic, Social and Cultural Rights</strong></td>
<td>In response to the country’s first report, presented by Morocco in May of 1996, the Committee on Economic, Social and Cultural Rights (CESCR) found that the difficulties impeding the implementation of the Covenant included disparities between rural and urban areas, as well as the unequal conditions between the male and female populations. CESCR also identified various provisions in the Code of Personal Status (mudawana), which is partly based on religious precepts, as another difficulty impeding the implementation of the Covenant. On this occasion, the Committee expressed its concern about the extent to which women enjoy equal remuneration for equal work and employment opportunities, access to education and the status of women in family, in accordance with articles 6, 7, 10 and 13 of the Covenant. In its recommendations, the Committee suggested that the State party adopt measures necessary to reduce existing disparities between the modern and traditional sectors of society and in particular between the rural and urban areas. In particular, the CESCR recommended both legislative measures and educational activities aimed at overcoming the negative influence of certain traditions and customs.12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In response to the country’s second report, discussed in November of 2000, the CESCR reiterated its concern that the persistence of traditional practices and attitudes with regard to women and children, which are deeply entrenched in Moroccan society, hamper the ability of the State party to protect and promote their economic, social and cultural rights. Accordingly, the Committee highlighted the persisting patterns of discrimination against women in national legislation, particularly in family and personal status law, as well as inheritance law. With regard to health, the CESCR</td>
<td></td>
</tr>
<tr>
<td>INTERNATIONAL INSTRUMENT</td>
<td>RIGHT TO LEGAL AND SAFE ABORTION</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| International Covenant on Economic, Social and Cultural Rights (continuation) | expressed its concern about the minimal health coverage provided by the State – 20% of the population – and the high rate of maternal and infant mortality. With regard to the right to education, the Committee observed the high rate of illiteracy within the female population and its increase to 65% for women in rural areas, as against 40% for men.  

In response to the most recent report, considered in May of 2006, CESCR acknowledged Morocco’s progress in the area of legislative reform. This includes the new Family Code (2004), the new Labour Code and other institutional reforms. However, the Committee emphasized the traditions that continue to contribute to existing inequality and, again, the high rates of maternal mortality. The Committee also noted the lack of legal remedies available to individuals whose rights have been violated, and the persistence of conditions of disparity for women within the legal order. These disparities are reflected in the continued practice of polygamy, the regulation of inheritance and the lack of a specific provision making domestic violence a punishable offence. |
| Convention on the Elimination of All Forms of Discrimination against Women | “The Committee noted with concern the high rate of maternal mortality in Morocco, the high number of unattended births, the unavailability of safe abortion and the need to develop further reproductive and sexual health services, including family planning” and recommended “that the Government take special measures to reduce maternal mortality rates and protect women’s right to life by ensuring full and timely access of all women to emergency obstetric care” (1997).  

“The Committee is concerned about the high rate of infant and maternal mortality in the State party, limited access to health care services and family planning, and the incidence of clandestine abortions, which puts the women’s health at great risk” (2008).  

“The Committee calls upon the State party to increase women’s access to primary health care services, including reproductive health care and means of family planning. In light of its general recommendation 24, the Committee also recommends that the State party increase awareness campaigns on the importance of health care, including information on the spread of sexually transmitted diseases and HIV/AIDS as well as on the prevention of unwanted pregnancies through family planning and sex education” (2008). |
### International Committee on the Elimination of Racial Discrimination (CERD)

The Committee on the Elimination of Racial Discrimination considered the report presented in 1994 and observed that the State party has not implemented the provisions contained in article 4 of the Convention, which call for the adoption of specific penal legislation regarding racial discrimination. The Committee also notes the lack of information on the number of complaints of racial discrimination and suggests that necessary legislative measures be taken in order to give effect to the provisions of Article 4 of the Convention.

In 2003, the Committee on the Elimination of Racial Discrimination examined the reports submitted by Morocco for 1998, 2000 and 2002. The Committee reminded Morocco that the mere absence of complaints and legal action by victims of racial discrimination may be mainly an indication of the absence of relevant specific legislation, a lack of awareness of the availability of legal remedies, or insufficient will on the part of the authorities to prosecute. The Committee also recommended that the State “take into account the relevant parts of the Durban Declaration and Programme of Action when implementing the Convention in the domestic legal order, in particular in respect of articles 2 to 7 of the Convention.”

### Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment

The Concluding Observations do not explicitly reference migrant women. However, it is important to note that, according to its 2006 report, the Kingdom of Morocco does not make a distinction between persons based on their nationality in manifesting its respect for human rights and human dignity. The report also indicated that Morocco exempts certain individuals from deportation orders, including pregnant women, minors and any foreigner to a country where his or her life and liberty would be at risk or he or she would be subject to inhuman, cruel or degrading treatment.

### Convention on the Rights of the Child

Given the fact that Morocco is a transit country for many migrants trying to get to Europe, the national authorities noted the abandonment of children of would-be emigrants in the 2000 Report of the Special Rapporteur on the sale of children, child prostitution and child pornography, as well as their subsequent involvement in trafficking and use in various illegal and exploitative activities.

In the Concluding Observations issued in 2006, the Committee expressed its concern about “the difficult situation of certain groups of children, such as street children, working children, domestic maids, ‘petites bonnes,’ migrant and trafficked children, who are particularly vulnerable to all forms of exploitation.”


Ibid. Paragraph 18.


Morocco ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1993. Morocco made various reservations during ratification, including to articles 2, 9 (2), 15 (4), 16 and 29. Similarly, it did not sign the Optional Protocol to CEDAW. Nonetheless, though it has not made an official decision at this time, Morocco has indicated that it will withdraw its reservation regarding the right to family planning.


CASE STUDY  ■ Tangier
The goal of this case study is to establish the number of abortions performed during a specific timeframe for a sample population in Tangier. The field work began in November of 2008 and ended in May of 2011, spanning a period of one year and six months.

It is important to note that the number of migrant women living in Tangier between November 2008 and February 2010 ranged between 200 and 300 women. In March of 2010, as a result of the political pressure at Morocco’s border with Algeria, a large number of migrant women moved from Oujda (many of these women came from Libya) to Tangier, which caused the population to increase to 600 women.

We contacted women who had terminated a pregnancy, either on their own or with assistance, or sought postabortion care for complications, and the information they provided is included in this section. On average, three clandestine abortions were performed during each month of the study.

A key point to remember is that many of the pregnancies were the result of sexual violence and the decision to terminate the pregnancy was made by the traffickers who had sexually exploited the women. As a result some of the abortions, were involuntary.
COUNTRY OF ORIGIN. Of the 55 women involved in the case study, 53 were from Nigeria, one was from Ghana and one was from Cameroon. All of the Nigerian women came from Benin City, the capital of Edo State, and were all victims of trafficking.

Beauty told us: 1

“I left Benin a year and two months ago. I had spent a year in Tripoli. I came in through the desert of Niger. There, they raped my companions, but not me. In Tripoli, you aren’t free. You spend the day locked in a house with many more women. At night it is different, they take you out and you go to houses and you know what you have to do. My connection man decided to take me to Algeria and give me to another connection man, in Tripoli there were a lot of raids and we arrived at Oujda. There were four of us. I became pregnant in Tripoli. At first I didn’t want the pregnancy, my connection man said I have to keep it, then he said I have to get rid of it, that is what this connection man said and the sister 2 told me what I needed to take, up here and down there. “3

AGE. The women interviewed ranged from 14 to 31 years of age. The majority of the group, 36 women, was between 18 and 30 years of age, while 19 of the women were less than 18 years of age. However, four of the women claimed they were over the age of 18 but physically appeared much younger than 18. Only one woman said she was older than 30 years of age.

“I’m twenty years old.” Freedom breathed deeply and looked fearfully at the nurse.
“This girl is too narrow to give birth, she couldn’t give birth, she is a very small girl,” said the nurse.
“I have to say that I’m twenty years old,” Freedom finally confessed. “When I came to Spain, I had to say that I’m twenty years old. I left Nigeria when I was fourteen years old, we went in a group of sisters, there were eleven of us, more or less like me. Some of them are in Spain, others in Italy, they are with other sisters.”
“Is this your first pregnancy?” the nurse asked again.
“This I have done two times, the sisters did it to me, but today there was a lot of bloo,” stated Freedom.
**NUMBER OF CHILDREN.** The majority of women did not have any children. Thirteen of them had one or two children.

Esther told us: "Having children here is a suffering. We brought the children only to suffer. I don’t want to have children, the majority of us don’t want to have children. The men don’t want to use condoms, I can’t take pills, we can’t take pills, if they deport you, you don’t take the pills. In the deportations, they also screw you, the soldiers on the border screw you, the black brothers screw you and after you know that you have a baby and you don’t want a baby, you don’t want the baby or you to suffer. How do you feed the baby? ... It is true that a baby will help you beg, but many times it is a problem, a suffering. But you don’t decide to have a baby, God decides, others decide."

**MARITAL STATUS.** It should be mentioned that when women use the term marital status in this study, they are referring to whether or not they have a connection to a man who serves as a protector and/or provider of security, and who shares a physical connection with them.

The previous report, *Migrant Women’s Rights: An Invisible Reality*, highlights the fact that this protection is not free and that "women have to have sex with their ‘husband’ and take care of domestic housework, including the preparation of food." Similarly, these connections can exist either inside or outside of a trafficking network. If a woman is "abandoned" by the network, is will be difficult for her to survive, having lost the support of a third person or of the group. The women who indicated that they were single were involved in trafficking networks but without a “husband” at the time of the interview. Among the women interviewed for the case study, 23 indicated that they had a “boyfriend,” 21 responded that they had a “husband,” four of the women indicated they were “single,” three of the women said they had a connection to a “connection man,” and two responded that they had been "abandoned."
Precious explained to us: "My husband is good, he behaves well. I met him during the journey. He is the father of one of my children. My connection man is not here, he is in Oujda. My sister doesn’t have a connection man, she doesn’t have a madame, nor a husband, they left her alone because she is sick. She also has two children. It is much harder if you don’t have a husband. There are husbands or boyfriends that aren’t good, they hit you, they don’t have money and they let you keep begging, those husbands are not good."

Beauty said: "I have been in Morocco seven years. I have two children. I had tuberculosis and I lost my chance to go to Spain. Having a madame means you can go to Spain. I’m single and it is very hard. I have tried to return to Nigeria through the office in Rabat, but now there are no flights to Nigeria, they say they have no money. I don’t know what to do with my life. My children have been to school, they go to church and there they teach them something."

Pat explained: "My connection man is my boyfriend. I didn’t want to have another boyfriend. I’m lucky he is my boyfriend. He takes care of me. I’m 15 years old. He took good care of me when they deported me and he went to find me quickly to protect me and make sure nobody screwed me, if they deport you the soldiers screw you and then you have babies. My sister had two babies, twins, from when they screwed her at the border. She couldn’t give birth to them and they performed an operation on her, now she doesn’t have a boyfriend because she has two babies, it is hard, but she of course has a connection man."
ABORTION AND HEALTH CARE SERVICES. Twenty-seven women indicated that they had had at least one abortion, twenty-one women had had two abortions, and six women had had three abortions. With regard to the method used to terminate the pregnancy, 53 of the women stated that they had used misoprostol, while two responded that they had taken “pills.” One of the women who used misoprostol said that she had taken it with alcohol. Women who are victims of trafficking and others who are not involved in trafficking all receive misoprostol from the same network: the Moroccan black market.

The women interviewed reported that they had not received any type of pre-abortion care, except for one Nigerian woman who reported having received care at a hospital in Nigeria. None of the women received adequate counseling regarding how to terminate a pregnancy.

Women received information about medical abortions from the individuals providing the medicine on the black market, as well as other migrant women who had already had abortions. Given the conditions under which the abortions were performed, these women neither received adequate information on how to use misoprostol nor had the capacity to choose to terminate a pregnancy under safe conditions.

Twenty-five percent of the women did not know how far their pregnancy had progressed at the time they had had the abortion. This figure emphasizes the fact that these women live in situations of extreme vulnerability, especially given the psychological harm they suffer as a result of the violence they are exposed to and the limited authority they have over their own bodies. Thirty percent of the women terminated their pregnancies during the third and fourth months of their pregnancy, at which point the use of misoprostol is no longer recommended. The remaining women terminated their pregnancies during the first and second months of their pregnancy.
Precious told us: “I don’t know how far along I am, I don’t know how long it’s been since I had my last period, I’m sorry, I’m very sorry, but I was deported and I feel disoriented. I think it was since I was deported that I started to miss my period, but sometimes my period doesn’t come and I’m not pregnant. I don’t really know, I’m sorry.”

Faith said: “My period didn’t come four times. I have taken five pills, three down there and two in my mouth. It hurts so much. I bled for three days but I haven’t seen anything, I haven’t seen anything, only blood. Is it alive? My stomach hurts so, so, so much.”
With regard to postabortion care, 41 women reported they had needed surgical care. All of these women underwent a dilation and curettage (D&C) procedure because the method they had used to terminate the pregnancy did not lead to a complete abortion. They presented with various symptoms, such as hemorrhage and fever. These women were able to receive postabortion care because a social organization had intervened and had been able to cover the costs of the care provided by the hospital. Five women received antibiotics after the abortion while eight did not receive any type of care or monitoring after the abortion.

Amina told us:

“I took the Cytotec in my mouth and down there. I bled after, I hurt so, so much. I bled a lot but was afraid of going to the hospital, I don’t have papers or anything. It had been four months since my last period. We were able to call a doctor who helped us and took us to the hospital. There, they told me that I had twins and I had taken the pills very late, that after four months I couldn’t take these pills because I could die too. They had to operate on me. I thought I died.”

And Blessing told us:

“I took the Cytotec in Oujda. I bled a lot, I was scared to go to the hospital. We called a doctor from Oujda but he was busy and I kept bleeding. I had a high fever, I was very hot and was vomiting. After I clenched, I had to shit, I shit on myself but everything else came out of my body too. One sister cleaned it all off, I didn’t want to look, I wanted to know if everything that I had inside had come out. I didn’t want anything inside. I was like crazy, tired, embarrassed, scared to death. I haven’t seen a doctor since. Sometimes my stomach hurts a lot, but I haven’t been able to control these pains. My stomach and head hurt and I’m afraid of what I’ve done.”
AUTONOMY. This section discusses whether the women made autonomous decisions to terminate their pregnancies or whether they were subjected to pressure from another person. For women who are the victims of trafficking, the decision to terminate a woman’s pregnancy can be made by a number of individuals, including a “connection man,” “husband,” “boyfriend” or other members of the trafficking network. If the woman is not part of a trafficking network, it is more likely that she will have the opportunity to make an autonomous decision. It is important to remember that a criminal network ultimately makes all of the decisions about the life processes of those individuals who belong to that network.

Of the 55 women who were interviewed, 29 indicated that they did not make the decision to terminate the pregnancy. Two women were unsure whether or not they had wanted to have the abortion, and ten did not know if they or others had made the decision. Eight stated that they made the personal decision to have the abortion, and seven women did not respond to the question. In the cases where it was clear to the women that the decision had been made by a third person, 18 women identified a “connection man” as the person who made that decision on her behalf. Twelve women responded that they had been pressured by the trafficking network, nine women by a “boyfriend,” and five women by a “husband.”

Sam told us:

“I don’t know… I suppose I wanted it too. Having a child here is very difficult, but I don’t have the solution, it is my boyfriend that has decided, I guess. I don’t know, I feel overwhelmed by the situation and I’m scared. I only know that it hurts me, it hurts me a lot and I want the pain to stop.”

Love explained:

“My connection man has called the sister on the phone, he is in Rabat and has said that I have to take Cytotec. I didn’t want to take it because I was scared, a companion had died in Oujda and another in Libya and I didn’t want to. At three in the morning, the sister and one of the ‘connection’ had woken me up and had forced me to take the pills, they gave them to me by force and gave me alcohol with them, I kicked but they made me swallow them. Afterwards, they tied me down do that I couldn’t vomit them up. I became very sick after but thanks to God I have not died.”
NOTES

1 All of the women’s testimonies were transcribed word-for-word from the conversations had with them. The language that appears here is the same language these women use when communicating with those individuals in the trafficking network who control them.

2 *Sister*: a person who someone shares a connection with, whether they come from the same neighborhood or extended family, are part of the same trafficking network, or have spent part of the journey together.

3 This is a reference to administering misoprostol through the mouth, either sublingually or orally, or through the vagina.

4 This statement demonstrates, for the reasons already discussed in this report, how difficult access to medicine can be for migrant women, especially when they are deported or detained in centers.


6 **Madame**: a woman who works for a human trafficking network and who is responsible for maintaining control over the women and ensuring that the women comply with orders they receive from the network.

7 **International Organization for Migration (IOM).**

8 A church led by evangelical Christians.

9 Cesarean section.

10 Misoprostol is a medicine that can be used to terminate a pregnancy. The migrant population in Morocco uses the commercial brand name Cytotec to refer to misoprostol.

11 **Dilation and curettage (D&C)**: is one of the different surgical treatments that can be used to terminate a pregnancy. It involves scrapping out the uterine lining.

12 She is referring to the fact that a surgeon came to perform the dilation and curettage (D&C) procedure.

13 She is referring to a social organization.

14 **Connection**: a man who works for the trafficking network and, within the network, is responsible for controlling, coercing and threatening the women to ensure that they will comply with the orders they are given.