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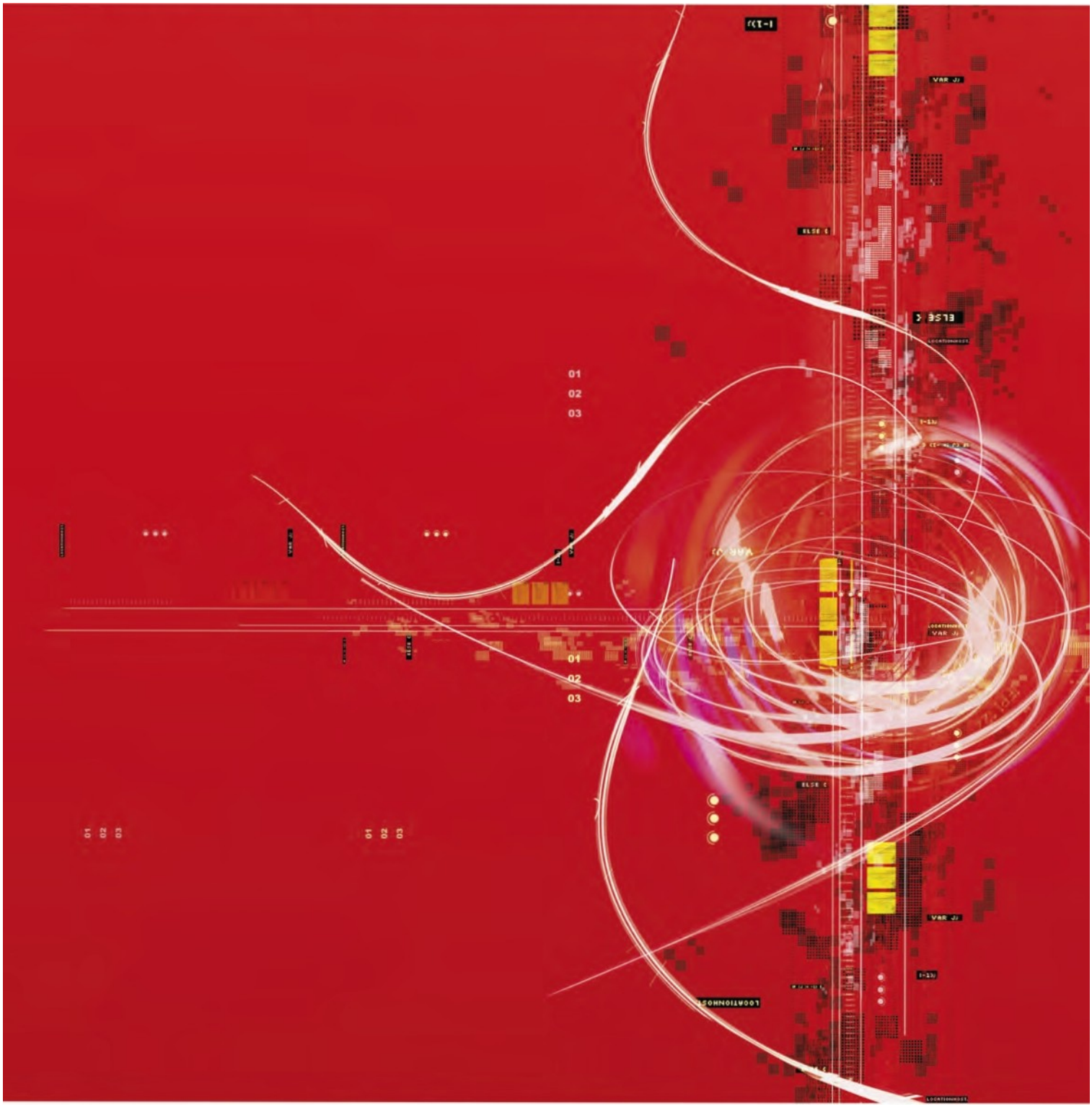
National Observatory on Drugs and Addiction

Annual report
of the National Observatory on Drugs and Addiction

2014



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Observatoire National des Drogues et Addictions

2014 Annual Report of the National Observatory on Drugs and Addiction

MOROCCO

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Contents

Foreword:

"A review of the state of the nation offers us the opportunity to assess the extent of the progress made, using all known mechanisms for measuring that progress." Speech from the Throne, 2014.

For some years, the Kingdom of Morocco has demonstrated a clear political will to address drug use issues in a proactive and pragmatic manner. No one can hope to deal effectively and efficiently with this problem without having an understanding of its nature and magnitude, which presupposes an accurate scientific evaluation of the phenomenon, carried out on a regular basis. You can only deal with what you know, and what you know is what you have measured.

This evaluation is the main task of the National Observatory on Drugs and Addiction (*Observatoire National des Drogues et Addictions* - ONDA). The annual report is its outcome. Through the use of well-established scientific mechanisms, the successive annual reports will help in future to make a detailed assessment of developments in our country and, in so doing, provide reliable data for the drawing up of appropriate custom-made programmes for improved management of addiction issues.

In keeping with the wishes of the Kingdom of Morocco, an evidence-based approach was the overriding consideration in the setting up of ONDA, an instrument for data collection, analysis and reporting, serving politicians and institutional decision-makers; ultimately, ONDA is the outcome of a responsible, realistic and objective policy.

ONDA's mission is to help policy-makers, and all those involved in this field, to have access to reliable, up-to-date information so that they can take context-specific action in the various areas connected with drug use, namely prevention, treatment, harm reduction and rehabilitation.

To succeed in its mission, ONDA works with the different departments involved in both demand and supply reduction. Data collection covers the epidemiological characteristics of treatment requests, conditions secondary to use, use in the general population and certain specific population groups, associated morbidity and mortality, trafficking and seizures. The indicators compiled meet well-known scientific requirements and are consistent with those of international observatories, in particular the European Monitoring Centre for Drugs and Drug Addiction.

This first report, effectively ONDA's founding act, is the result of data sharing by the Ministries of Health, Justice and the Interior, via the Directorate-General of National Security, and the Customs and Indirect Taxation Authority. It carries the endorsement of an independent scientific committee known for its scientific credibility.

ONDA's mission also includes communicating, as appropriate, in connection with this report and acting as a discussion partner for the various political, community, institutional and civil society players.

ONDA is the reflection of a pragmatic policy in a rights-based country which is adopting a head-on, holistic approach to the problem of drug use, not only in the interests of its citizens suffering from drug abuse and dependence, but also for the purpose of taking targeted preventive measures for the well-being of those not yet affected by this scourge.

It goes without saying that this first report cannot be exhaustive. In future it will require additions and further information. But it has the merit of being an initial working document and compilation of data offering a more or less accurate picture of the current drug use situation. However, only a study of trends based on subsequent reports will provide a clear view of how the phenomenon is developing.

Although the report focuses mainly on illegal drugs, the fact remains that tobacco is still the most harmful and costly drug in public health terms. It is also the drug which arouses least interest in terms of prevention. Our hope is to see one day a comprehensive and forceful programme against tobacco use in our country.

Lastly, this report aspires to bring all the departments concerned together around the idea of data sharing to ensure improved pooling of information. Access to information, the sole guarantee of pragmatic, enlightened policies, is a right which undoubtedly reflects the progress of democracy in our country.

Prof Jallal Toufiq
Director

Preamble:

Morocco is faced with a number of risk factors which could contribute to a worsening of the drug use situation in the years ahead. Morocco also has assets and protective factors which will need to be consolidated and preserved. Here is a brief analysis of the current situation:

Brief analysis of the drug situation in Morocco:

- **Strengths:**

1. Clear political will.
2. A free environment respectful of patients' rights in a rights-based country.
3. Existence of specific programmes and tools for managing drug use, especially in the fields of demand reduction and treatment: a national mental health and drug addiction programme together with an ambitious, holistic national action plan clearly affirming the right of dependent users to proper treatment.
4. Relatively good knowledge of the epidemiological aspects of drug use in Morocco.
5. Highly qualified human resources: existence of university diplomas in addictology at the Faculty of Medicine and Pharmacy in Rabat, in Casablanca and, soon, in Marrakesh; existence of a national addictology association.
6. Existence of a favourable working environment respecting the rights of citizens suffering from drug dependence and advocating drug-related harm reduction as a priority.
7. Existence of a fairly respectable care system with a gradual expansion and diversification of treatment provision.
8. The experience and expertise accumulated over the last thirty years, which make Morocco a pioneering country in the region.
9. Involvement of users themselves through the setting up of their own associations.
10. First timid signs of civil society involvement.
11. Great openness of Morocco to international expertise and opportunities for co-operation with specialised governmental and non-governmental organisations.
12. Clear will to continue to reduce cannabis growing.

- **Weaknesses:**

1. Definite delay in responding to the phenomenon, which impacts negatively on current efforts, mainly in the care provision and prevention fields.
2. Qualified human resources still in short supply, especially in the research and prevention fields.

3. Limited material resources in the research field.
4. Limited range of care, with difficulties of access in some parts of the country.
5. Legislation allowing mandatory treatment for drug users unclear and not always used.
6. Limited prevention programmes, often lacking valid scientific support and socio-culturally inappropriate.
7. Rehabilitation programmes virtually non-existent.
8. Still no programmes dealing specifically with substance-free addictions (pathological gambling etc.).
9. Stigma surrounding drug use, which impacts negatively on access to treatment.
10. Much less cannabis grown in the north of the country than in the past, but production continues, with easy access for young people, who are significantly exposed.
11. Timid and ambivalent policy on tobacco, the most widely used drug in the world and the leading cause of death.
12. Legislation still too harsh on drug users caught in possession of drugs for their own personal use.

- **Opportunities:**

1. Environment respectful of human rights and favourable to any initiative to provide treatment for people who are suffering.
2. Good research environment.
3. Good knowledge of the phenomenon.
4. Favourable attitude on the part of the public authorities, and in particular the Ministry of Health, towards faster expansion of treatment programmes.
5. Gradual improvement in society's perception of addiction.
6. Positive dynamics in treatment for drug users, encouraging competition and improvements to existing programmes.
7. Existence of the National Observatory on Drugs and Addiction as a data collection and situational analysis instrument for evidence-based programmes.
8. Willingness of international institutional partners to help Morocco (European Union, World Health Organisation, UNODC, etc.).
9. Morocco represented in the MedNET network since 2006.
10. Accession of Morocco to the Council of Europe's Pompidou Group (2011).
11. Readiness of the European Monitoring Centre for Drugs and Drug Addiction to co-operate with Morocco via ONDA.

- **Threats:**

These are all the factors that risk worsening the situation, namely:

1. A still young population, meaning that annual incidence rates are inflated by the mere fact of the size of the sub-population at risk of starting use and dependence, particularly in the 15-25 age group.
2. Easy and inexpensive access to cannabis.
3. Easy access for young people to tobacco and solvents.
4. Easy access to alcohol, especially for young people.
5. A perception of tobacco that minimises the risks involved and the lack of any real decision to implem a ban on its use in public places.
6. Difficulties of access to care, leading to an increase in cases of addiction and, above all, exacerbating its consequences, such as HIV or hepatitis C infection.
7. Morocco's position on international trafficking routes:
   - Closeness to southern Europe, a big market for cocaine;
   - Trafficking route for benzodiazepines coming from the East;
   - Trafficking route for cocaine originating from Latin America, transiting via Sub-Saharan Africa and crossing Morocco on its way to Europe.
   - Trafficking route for heroin originating from Afghanistan, transiting via the Horn of Africa and Sub-Saharan Africa and crossing Morocco on its way to Europe.
8. The great population mobility seen in Morocco (migrant populations, Moroccans living abroad and tourists).
9. Morocco's great accessibility via its long coastline, borders and entry points (airports, ports and overland routes).
10. Economic factors facilitating cash flow (percentage of the population holding a bank account, cash transactions etc.).

This analysis is clearly not exhaustive. It is merely a quick look at some risk factors and some protective factors. It is vital to reduce the former to a minimum and to strengthen the latter. Only a study of the trends in the situation, through the regular collection of data on demand and supply management, can guide us towards pragmatic and effective policies.

Part A. New developments and trends

1. Drug policy: legislation, strategies and economic analysis

1.1. Introduction

Faced with a worrying situation due to the growth of drug trafficking, combined with increasing needs in the areas of prevention, treatment and rehabilitation of drug users, Morocco has reiterated its determination to work in concert with all the states concerned to combat drugs and related crime and thus, in a spirit of shared responsibility, develop a comprehensive, balanced and co-ordinated response to the danger they represent for all societies.

1.1.1. Definitions

Moroccan law does not refer to drugs but to the concept of poisonous substances, drawing on the classifications contained in the 1961 Single Convention on Narcotic Drugs and the 1971 Vienna Convention. Three categories are recognised: toxic substances (Table A), narcotic substances (Table B) and dangerous substances (Table C).

In the Moroccan context, the word "drug" in the overall sense is used only by certain specialists and voluntary sector activists.

By convention, the term "drugs" (or psychoactive substances) as used in this report covers licit and illicit drugs and excludes substances not usually associated with problem use (coffee, chocolate, etc.).

Licit drugs include substances such as alcohol, tobacco and psychotropic medicines (especially hypnotics/anxiolytics). Illicit drugs comprise narcotic substances and certain substances not classified as narcotics but which are used for a purpose other than that for which they are normally intended (glues, solvents, etc.) or whose legal status is unclear (new synthetic substances).

The use of psychoactive substances varies in terms of its frequency. In this report, use will be described as experimental, use in the year, regular use or daily use:

- Experimental use: having used the substance at least once in one's lifetime. This concept is more illustrative of a substance's dissemination in society than of real levels of use;
- Use in the year means use at least once in the previous year;

- Regular use means 10 or more instances of use in the previous 30 days;
- Daily use means repeated use each day;
- Recent use means at least one instance of use in the previous 30 days;
- Prevalence rate: total number of cases across a given population at a given time regardless of the length of use. This is a "snapshot" of the population at a time t which can be repeated at a different time or in a different place to monitor trends in the parameters studied and allow comparisons to be made in time and space.

In terms of behaviour, two clinical diagnoses are currently distinguished: harmful behaviour (or abuse) and dependence. This distinction is generally accepted in international scientific circles and is based on medical definitions (the World Health Organisation's International Classification of Diseases (ICD 10) and the American Psychiatry Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV)):

- Harmful use (or abuse) is understood as use or behaviour which has, or may have, adverse health, social or legal consequences. These may depend on specific contexts (driving, pregnancy, etc.) and affect the user him/herself or a third party. By definition, the concepts of harmful use and abuse imply repetition of the behaviour.

- Dependence is understood as psychopathological behaviour having certain biological, psychological and social characteristics beyond mere physical dependence. The main criteria contributing to its definition are: compulsive desire for the substance, difficulty in controlling use, use of the substance to avoid withdrawal symptoms, the need to increase the dose to achieve the same effects as before, and the central place taken by the substance in the user's life.

These international definitions of abuse and dependence are generally hard to reflect in surveys. On the other hand, it is possible to incorporate short sequences of questions that can be used to detect persons suffering from problem use, i.e. "use likely to cause significant health and social damage to oneself or others".

1.1.2. Data collection tools

The main sources used are Moroccan legal texts relating to the use of narcotic drugs and official documents relating to the various international conventions.

1. 2. Legal framework and implementing instruments

1.2.1. History of Morocco's policy on narcotic drugs

The history of Morocco's policy on narcotic drugs, like that of its criminal policy, is bound up with the period of French colonisation.

The Moroccan Kif and Tobacco Company was set up in 1954 to control the marketing of kif, which had been identified by international law as a narcotic drug in 1952.

On becoming independent, Morocco was signatory to all the narcotics-related conventions signed by France during the protectorate (Hague Convention of 23 January 1912 on opium, Geneva Convention of 11 February 1925 on opium, Geneva Convention of 13 July 1931 to limit the manufacture and regulate the distribution of narcotic drugs, and Lake Success Protocol signed in New York on 11 December 1946, amending the previous conventions).

On the eve of independence, the French Protectorate secured the adoption of the Dahir of 24 April 1954 prohibiting kif hemp.

Moroccan legislation remained unchanged for some twenty years after independence.

After independence, Morocco ratified, on 22 November 1966, the Single Convention on Narcotic Drugs signed in New York on 30 March 1961, which was published by Royal Decree No. 236-66 of 22 October 1966. Morocco also ratified, by Dahir No. 1-97-98 of 3 April 2002, the Geneva Protocol signed on 25 March 1972, amending the 1961 Convention.

The Criminal Code, adopted on 26 November 1962, was independent Morocco's first piece of legislation. However, it contained no provisions relating to trafficking in, or the use of, narcotic drugs. These questions continued to be governed by the Dahir of 2 December 1922 regulating the import of, trade in, and possession and use of poisonous substances, and by the Dahir of 24 April 1954 prohibiting kif hemp.

The Dahir of 26 November 1962 did, however, establish some important principles, such as the principle of judicial placement in a treatment facility. This principle referred to the "placing under supervision, in an appropriate facility, by decision of a trial court, of a person found guilty, as perpetrator, co-perpetrator or accomplice, of a crime or misdemeanour, while in a state of intoxication caused by alcohol or drugs, where the offence committed appears related to that intoxication" (Article 80).

1.2.2. Legal framework governing the sale and consumption of alcohol

Two Moroccan legal instruments refer to alcohol, both dating back to 1967. The first is an order issued by the Director General of the **Royal Cabinet** on 17 July 1967 regulating the sale of alcoholic and alcoholised beverages. The second is the **Royal Decree** of 14 November of the same year.

- Order of the Director General of the **Royal Cabinet** of 17.7.67 regulating the sale of alcoholic and alcoholised beverages:

- ***Article 28***: It is forbidden to anyone operating a licensed establishment to sell alcoholic or alcoholised beverages, or provide them free of charge, to Moroccan muslims.
- **Article 29**: Admission to drinking establishments is forbidden to juveniles under the age of 16 not accompanied by their father, mother or any other person having responsibility for them.
- ***Article 30***: It is forbidden to anyone operating a licensed establishment to sell alcoholic or alcoholised beverages, or provide them free of charge, to juveniles under the age of 16.
- ***Article 31***: Anyone who induces a juvenile under the age of 16 to drink to a state of drunkenness shall be punished with a prison sentence of 6 months or a fine of 100 to 1 000 DH.
- ***Article 32***: Operators of drinking establishments who serve drinks to persons who are manifestly drunk or admit them to their establishments shall be punished with a fine of 150 to 500 DH.

- ***Royal Decree*** No. 724-66 of 11 Sha'aban1387 (14 November 1967) containing the Law on the Suppression of Public Drunkenness.

- Whosoever is found in a state of manifest drunkenness on streets or paths or in cafés, cabarets or other public places or places open to the public shall be punished with a term of imprisonment of one to six months and a fine of 150 to 500 dirhams, or one of these two penalties only. These penalties may be doubled if the individual found drunk has caused a public disturbance.

- Anyone found in a state of public or manifest drunkenness shall be taken by the police, at their own expense, to the nearest police station and be held there until they have recovered their senses, for a period not exceeding that laid down in Article 68 of the Code of Criminal Procedure, before being brought before the competent court. These penalties may be doubled if the individual found drunk has caused a public disturbance.

1.2.3. Legal framework governing the sale and consumption of tobacco

Morocco signed the Framework Convention on Tobacco Control (FCTC) in 2004. The FCTC was the first WHO anti-tobacco treaty to come into force following the globalisation of the tobacco industry. This convention is based on a strategy of reducing tobacco demand and supply.

Law No. 15-91 on tobacco control was passed by the Moroccan Parliament on 23 July 2008 and was due to come into force in January 2010. Law No. 15-91 concerns the prohibition of tobacco use and advertising in public places and the sale of tobacco to minors. The law, which comprises 14 articles, lays down pecuniary penalties for all offences. For example, smoking a cigarette in a public place carries a fine of 100 DH, which is doubled in the event of a second offence. The fine is raised to 500 DH if the offender is a manager of the public place. Under the law, the term "public place" covers public institutions, government offices, school courtyards, cafés and restaurants with an area not exceeding 50 m2. It should be noted that cafés and restaurants covered by the law are allowed to provide smoking areas. They are, however, required to comply with certain criteria. Smoking areas must be well ventilated and completely separate from the rest of the premises.

The other penalties provided for concern tobacco advertising and the absence of a health warning on cigarette packets. In the latter case, the fine may be as much as 10 000 DH. The law authorises the criminal police, within the limits of their powers, to make findings that an offence has been committed. The law also specifies that half of the amount collected in fines will be paid over to municipal health offices and hospitals. The other half will be allocated to anti-tobacco associations.

The provisions relating to the sale of tobacco to minors state that it will henceforth be necessary to show valid ID in order to purchase a packet of cigarettes. Another measure introduced by the law is a fine of 2 000 DH for selling cigarettes to minors. In the event of a second offence, the fine is increased to 5 000 DH, and the tobacconist may have his licence withdrawn. There are also penalties for anyone caught offering cigarettes to juveniles under the age of 18.

The proposed amendments to the law banning smoking in public places strengthen the legal provisions relating to the prevention of smoking. They are also designed to fill a legal vacuum. It should be noted in this connection that the penalties imposed by Law 15-91 prohibiting smoking in public places were not dissuasive.

Indeed, smoking in a place where it was prohibited carried a fine of only 10 to 50 DH. The aims of the new text are to limit the harmful effects of smoking, generate additional financial resources and reduce tobacco advertising.
The non-application of the law in some places is due to the lack of implementing decrees.

1.2.4. Current overall context in Morocco

The current context is marked by the adoption of the new Constitution (2011), which emphasises citizens' rights, including the right to healthcare (Art.31), the introduction of legislative reforms, re-organisation of the healthcare system and the introduction of a medical assistance scheme for the economically disadvantaged (RAMED). This means, on the one hand, bringing existing health services up to standard and creating new healthcare and treatment facilities in accordance with a regulatory framework, while identifying specific branches of healthcare and making available sufficient numbers of trained staff; and, on the other, building management and co-ordination capacity at all levels, ensuring cross-sectoral co-operation and establishing partnerships with civil society.

Regarding mental health policy, the Ministry of Health has introduced a raft of reforms over the past ten years: decentralisation, the incorporation of mental healthcare into basic healthcare, and reduction of the number of beds in psychiatric hospitals, thus reducing the number of unsuitable facilities while improving access to care through referral to local community psychiatry. The aim is to reduce problems of access to, and continuity of, care and remedy the shortage of human resources and facilities. These policy directions are consistent with the recommendations recently made public in the National Human Rights Council's report on mental health.

1.2.5. Current legal framework

One of the most important legislative instruments relating to drugs in Morocco is the Dahir introducing Law No. 1-73-282 of 21 May 1974 on the suppression of drug addiction. The law identifies three categories of offences: trafficking, incitement and use. It therefore punishes both the possession and use of substances or plants classified as narcotics and the fact of facilitating the use of these substances or plants by any means.

Article 8 of the law takes account of drug users' interests since it accords importance to the treatment and monitoring of drug users. This article provides that "criminal proceedings will not be instituted if the offender consents, after a medical examination carried out by order of the Crown Prosecutor, to submit to detoxification treatment for the period necessary to cure him or her […]" and that "the investigating judge may, following an opinion from the Crown Prosecutor, order the person concerned to undergo this treatment". Article 8 also states that it is possible in exceptional cases where minors are involved to "treat the offenders in the family environment in accordance with the conditions laid down in an order issued by the Minister of Justice after consulting the Ministry of Health".

In practice, however, the provisions of Article 8 are only very rarely applied.

The Dahir of 3 October 1977 (amended by no. 1993/52) set up the National Commission on Narcotic Drugs. This commission is composed of various ministerial departments responsible mainly for the medical and social fields and law enforcement. Its mission is to control licit psychoactive substances, suppress the cultivation of, and trade and trafficking in, illicit drugs and put in place a drug use prevention policy.

Morocco's adherence to international law on narcotics control continued with the country's accession on 7 November 1979 to the Vienna Convention on Psychotropic Substances, signed on 21 February 1971. On 9 October 1992 it ratified the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, signed in Vienna on 20 December 1988. By Dahir No. 1-97-98 of 3 April 2002, Morocco also adopted the Protocol amending the 1961 Single Convention on Narcotic Drugs, adopted in Geneva on 25 March 1972.

1.2.6. Drug use

The provisions of the Criminal Code that deal with narcotic drugs are Articles 80 (Placement in a treatment facility), 571 (Handling) and 89 (Confiscation). In addition to this, an Order of the Minister of Public Health (last amended in 1997) lists all licit and illicit drugs.

With regard to the penalties for drug-related offences, these are punishable by up to 30 years' imprisonment, together with a fine of up to 60 000€ (665 458.72 MAD). On average, however, drug traffickers receive sentences of 8-10 years.

According to figures supplied by the Moroccan authorities for the year 2010, approximately 29% of the prison population had been charged with drug-related offences ranging from personal use to trafficking as part of an organised gang.

Drug use remains a criminal offence, which sometimes leads to a feeling of stigmatisation on the part of users. According to a 2011 survey commissioned by the Directorate-General of Prison Administration and Rehabilitation, half of the 300 drug users questioned felt that they had been treated by medical personnel in a way that "infringed their fundamental rights", and 87% said they had been subjected to violence by the police. When asked to specify the kind of ill-treatment they had suffered, 83% mentioned harassment and 65% "illegal practices".

1.2.7. Drug trafficking and money laundering

Moroccan law provides for a maximum prison sentence of 30 years for drug offences and fines ranging from 20 000 dollars (174 000 MAD) to 80 000 dollars (670 000 MAD) for offences related to illegal drugs. Ten to fifteen years' imprisonment remains the typical sentence for big drug traffickers convicted in Morocco.

Under government policy, Morocco also firmly condemns the production and distribution of drugs and laundering of the proceeds from illegal drug transactions. Since 2003, Morocco has adopted a series of measures to step up enforcement of anti-money laundering legislation, including the bringing into force of a law against money laundering in May 2007 and the setting up of a financial intelligence unit in Rabat. This law makes it obligatory to report suspicious financial transactions carried out by anyone in a position of responsibility in the public or private sector who, as part of his/her duties, executes or facilitates movements of funds potentially linked to drug trafficking, human trafficking, arms trafficking, corruption, terrorism, tax evasion or counterfeiting.

In the late 2000s, the Moroccan government set up a Central Authority for the Prevention of Corruption. In 2010, the government launched a two-year programme to promote the integrity and transparency of public services, strengthen internal administrative supervision and reform anti-corruption law. In 2011, with the adoption of the new Moroccan Constitution, the Central Authority for the Prevention of Corruption changed status to become an independent agency, thus gaining increased powers.

In Rabat in July 2013, the Council of Europe launched the process of reviewing Morocco's legal and institutional framework against corruption. This process, based on the GRECO methodology, is led by an on-site team of experts appointed by the Council of Europe and the Moroccan authorities. A draft report will then be discussed with the Central Authority for the Prevention of Corruption, other relevant public bodies and representatives of civil society. The results of this review will help to ensure that the anti-corruption and anti-money laundering activities implemented in the second phase of the South Programme are better targeted.

More recently, in September and October 2013, the team of experts undertook an on–site visit to Morocco as part of the EU/Council of Europe programme on "Strengthening democratic reform in the southern neighbourhood" (South Programme). The visit was conducted in the context of the review of Morocco's legal and institutional framework against corruption.

The experts had discussions and exchanges with national stakeholders, including representatives of the government, law enforcement agencies, parliament and civil society.

To combat money laundering, the Moroccan government also set up a Financial Intelligence Unit in 2009 to collect, process and disseminate financial intelligence and co-ordinate the operations of investigating authorities, public agencies and other public-law bodies. Law No. 43-05, enacted and implemented in 2007, strengthened the national regulatory framework against activities linked to drug trafficking. The unit can exchange financial intelligence on money laundering and the financing of terrorism with equivalent agencies in other countries. In this context, between October 2009 and December 2012, the unit received 184 requests for financial intelligence from 10 foreign financial intelligence units, and issued 28 requests.

In February 2010, Morocco made a high-level political commitment to work with the Financial Action Task Force (FATF) and the Middle East and North Africa Financial Action Task Force (MENAFATF) to remedy the gaps in its strategy for combating money laundering and the financing of terrorism. Since then, Morocco has improved its AML/CFT strategy, notably by adopting legislative amendments widening the scope of the crimes of money laundering and financing terrorism, extending the obligation to exercise customer due diligence and taking steps to render the Financial Intelligence Unit fully operational. However, the FATF noted that a number of shortcomings remain in Morocco's AML/CFT strategy. Morocco should continue to implement its action plan so as to remedy these shortcomings, notably by criminalising the financing of terrorism in a satisfactory manner.

In February 2013, the FATF reported a few gaps in Morocco's strategy to combat money laundering and the financing of terrorism. The FATF is not yet satisfied that Morocco has made sufficient progress in correcting the most significant gap, namely that pertaining to the financing of terrorism. Morocco has successfully implemented all other elements of its action plan, but should co-operate with the FATF and MENAFATF to remedy this shortcoming by passing the necessary laws.

In April 2013, the Moroccan parliament accordingly adopted a draft law on combating money laundering which also extends to the financing of terrorist activities. This draft law consists of two articles:

- The first refines the definition of what constitutes an act of terrorism. Thus, the financing of terrorism is an act of terrorism, even if committed outside Morocco.
- The second defines income as "all tangible and intangible assets, movable or immovable, separate or joint, as well as legal documents attesting to ownership of those assets or of the rights attaching to them".

The draft law extends the scope of prohibited activities to include all aspects of the financing of terrorism and strengthens the powers and competences of the Moroccan judiciary to punish money laundering committed within the national jurisdiction or in a foreign jurisdiction.

1.2.8. Legal framework governing harm reduction

The increase in injecting drug use and the reporting of cases of HIV and hepatitis B and C contamination among IDUs, particularly in the Tangier-Tetouan and eastern regions, prompted the introduction of appropriate preventive measures to deal with the spread of these epidemics in Morocco.

The Harm Reduction Programme for Injecting Drug Users (IDUs) began in Tangier in 2008 and was then extended to Tetouan, Nador, Oujda and El Hoceima. The range of services includes awareness raising and education in the places frequented, distribution of injection kits and condoms, needle collection, social support and self-help.

Substitution treatment is one of the therapeutic options offered to opioid-dependent persons. It involves prescribing medicines based on morphine derivatives which have a similar pharmacological action to that of the psychoactive substance responsible for the addiction. Substitution treatment is regarded as an effective means of reducing opioid use, problem use of other drugs, criminal activity and the mortality rate. It has also proved its worth in reducing risky behaviour related to injecting drug use, particularly behaviour which poses a risk of transmitting the human immunodeficiency virus (HIV), the hepatitis C virus (HCV) and sexually transmitted diseases (STDs).

The opioid substitution treatment (OST) programme in Morocco thus forms part of the machinery for reducing the risks of infection associated with injecting drug use.

A unanimous consensus on this point among health professionals and addiction specialists led to the setting up of a substitution pilot project. The factors taken into account in the choice of methadone were international experience and the Moroccan context (cost, care facilities, prevalence and the places where drug users are concentrated).

Methadone obtained marketing approval in 2009 and was placed on the Health Ministry's list of essential medicines.

Methadone substitution treatment was introduced on a trial basis in June 2010, the intention being that 100 opioid users at three sites (Tangier, Salé and Casablanca) should benefit from it. The aim was to help bring about an improvement in the physical and mental health of IDUs, prevent HIV and hepatitis B and C contamination among them and facilitate their social reintegration. A policy document on opioid substitution treatment was drawn up by the Ministry of Health.

A decisive impetus was given by His Majesty King Mohammed VI, who launched the introduction of methadone in Oukacha prison in Casablanca. Harm reduction measures are supported by the Mohammed V Foundation for Solidarity under an agreement with the Ministry of Health and the Ministry of the Interior for the construction of 7 harm reduction centres across the country.

An evaluation of the harm reduction programme and the pilot programme on methadone substitution treatment was carried out at the end of 2011. It showed the relevance of the work done in the Moroccan context, with teams gaining experience in the practice of harm reduction and substitution treatment, thus permitting an extension and scaling up of the programmes across the territory.

The Strategic Plan for Combating AIDS 2012-2016 therefore provided for the strengthening and extension of the harm reduction programme for IDUs, including the provision of methadone substitution treatment in the main places of use, including prisons.

1.3. National Action Plan: strategy and evaluation

1.3.1. Background to the action plans on mental health and drug addiction

In the last thirty years, Morocco has seen use of other drugs develop alongside traditional cannabis use, and patterns of use have become more varied. The factors underlying the spread of these new drugs in Morocco and the diversification of patterns of use seem to be related to Morocco's geographical proximity to Europe and the manifold interactions that come about as a result of migration flows.

Alarmed by the drug use phenomenon in the country, the Moroccan authorities carried out an analysis of the epidemiological situation with regard to drug use in Morocco on the basis of quantitative and qualitative surveys. The findings, which were submitted to the responsible authorities in mid-2006, brought out the full scale of problem drug use in Morocco. Initial data showed a transition from traditional drug use (cannabis) to other drugs, problems relating to injecting drug use, and practices posing a risk of infection.

The Health Ministry's first Strategic Plan on Mental Health dates back to 1990. There have been plans covering the years 1990-1995, 1996-2001, 2002-2006, 2007-2011 (revised in 2008 to become the plan 2008-2011) and 2012-2016 (current plan).

Before 2006, the Strategic Plan on Mental Health included an "addiction" section, which was geared mainly to demand reduction.

One of the new features in 2007 was a National Strategic Plan against Addiction based on prevention, treatment and rehabilitation.

The first Action Plan on Harm Reduction among Injecting Drug Users covered the years 2008-2012.

The alert over trends in drug use patterns resulted in rapid evaluations of the drug use situation and the risks involved (in line with the National Plan for Combating AIDS among At-Risk Populations).

The Ministry of Health conducted several rapid evaluations in 2006 and 2008 (phase 1: 4 sites; phase 2: 4 other sites), with support from UNODC and UNAIDS.

Taking account of the context, patients' needs and proposals from mental health and addiction professionals and experts, the government decided to implement a first national action plan to address this situation and its consequences for health.

While pursuing its policy of decentralising psychiatric care to local level, adopted in line with WHO recommendations, the Ministry of Health embarked in 2006 on a national process of consultation with a view to revising and updating the country's strategies against mental illness and drug addiction.

The aims of the first National Action Plan 2008-2012 against drug addiction were to:

- Warn young people about the dangers of psychoactive substance use;
- Improve the quality of care for drug users;
- Improve access to facilities;
- Build the capacity of those involved in providing specific care and treatment for persons suffering from addiction disorders ;
- Encourage partnerships with specialist NGOs and local authorities to set up rehabilitation facilities.

The first National Action Plan 2008-2012 provided for a number of actions to be taken.

Table 1.1: Actions provided for under the National Action Plan 2008-2012 on Mental Health and Drug Addiction

Action 132: Reducing demand	- Implementation of a social communication strategy.
Action 133: Reducing HIV and hepatitis C risks among injecting drug users	- Marketing approval for methadone.
Action 134: Treating and rehabilitating drug users (2008 priority)	- Creation of 16 detoxification units for drug users in psychiatric facilities; - Creation of 16 medico-psychological centres offering preventive and counselling services for drug users; - Creation of 16 "low-threshold" units for harm reduction among injecting drug users, linked with the medico-psychological centres.
Action 135: Carrying out epidemiological studies and surveys	- Rapid evaluations of the drug use situation in relation to HIV risks: 4 sites studied each year.
Action 136: Reinforcing human resources, recruiting and providing initial and further training for mental health workers.	- Recruitment of qualified interdisciplinary professionals; - Curriculum development and improvement in the Ministry of Health: occupational therapists; - Initial and further training courses for mental health professionals in prevention and treatment for drug users.

1.3.2. National Action Plan against Addiction 2012-2016

Taking account of the context, drug users' needs and proposals from mental health and addiction professionals and experts, the aims of the National Action Plan against Addiction are to:

- Warn young people about the dangers of psychoactive substance use;
- Improve the quality of care for drug users;
- Improve access to facilities;
- Build the capacity of those involved in providing specific care and treatment for persons suffering from addiction disorders ;
- Encourage partnerships with specialist NGOs and local authorities to set up rehabilitation facilities;
- And reduce the risks associated with drug use, particularly injecting drug use.

The perspective adopted in the National Action Plan against Addiction 2012-2016 is based on 4 strategic objectives:

- **Objective 1: Reducing demand by:**
  - Implementing a social communication strategy through campaigns to raise awareness of individual and socio-cultural risk factors, the promotion of early detection, etc.;
  - Implementing programmes and developing modules and guides on primary preventive care (teachers and parents);
  - Using trained peers to provide support;
  - Involving non-governmental organisations.

- **Objective 2: Treating persons suffering from addiction**

  The treatment of persons suffering from addiction calls for the development of treatment facilities and the training of human resources qualified in addictology.

  - **Developing treatment facilities for drug users by:**
    - Providing facilities at local level: outpatient addictology centres (medico-psychological prevention and harm reduction services);
    - Setting up consultation units and units integrated with hospital facilities, particularly for detoxification;
    - Setting up rehabilitation facilities, with the need to develop partnerships.

Table 1.2: Current situation regarding addictology centres in Morocco

Existing local addictology centres	Planned sites
Outpatient centres: • Rabat • Tangier • Tetouan • Nador • Al Hoceima • Oujda • Marrakesh	• Agadir • Fes • Lak ar El Kebir • Assilah • Chefchaouen • Larache • Berkane • Tangier
Residential centres: • Salé • Casablanca	

◆ Training human resources qualified in addictology through:

- The setting up on a lasting basis of diploma courses in addictology;
- In-service training for general practitioners and nurses on early diagnosis and treatment of addiction disorders ;
- Training in addictology for other parties involved: teachers, parents, social players, NGOs, etc.

- **Objective 3: Reducing the risks associated with injecting drug use (see National Action Plan for Harm Reduction 2012-2016)**

- **Objective 4: Monitoring and evaluating the National Action Plan against Addiction 2012-2016**

  The National Action Plan against Addiction 2012-2016 will be monitored and evaluated by a number of bodies, including a National Programme Monitoring Committee, the National Commission against Narcotic Drugs and the National Observatory on Drugs and Addiction (ONDA).

ONDA, considered as a centre of expertise on operational strategies in the field of addictology, is tasked with collecting, analysing and interpreting data, producing factual information as an aid to policy-making in the field of addictology, disseminating reports, carrying out studies and research in the addiction field, and performing a watchdog function.

1.3.3. National Action Plan for Harm Reduction

1.3.3.1. History of harm reduction policy in Morocco

Harm reduction policy in Morocco is the outcome of a long process of preparation and consultation among decision-makers, professionals in the addiction care and HIV/AIDS prevention and care fields, specialist associations, representatives of civil society and drug users themselves.

In 2005, the Ministry of Health embarked on the process of developing a national strategy against addiction in co-operation with UNAIDS, UNODC and the Global Fund. A rapid assessment of the situation regarding HIV/AIDS risks associated with injecting drug use was carried out at 4 sites (Rabat-Salé, Casablanca, Tangier and Tetouan). The findings of the study, published in early 2006, pinpointed the urgent need to pursue a consistent HIV prevention policy within this group by introducing a "harm reduction" element among injecting drug users.

This process, which involved all stakeholders in the mental health and addiction field, provided the opportunity to articulate the difficulties facing professionals, persons involved in other departments, and users and their families. The strategy was then revised in the light of epidemiological data and the demographic, cultural and socio-economic characteristics of the Moroccan population.

The aims of the new strategy were to:

- Consolidate primary and secondary prevention as part of a local community approach, with the focus on ways of reducing risk factors and on demand reduction;
- Implement an action plan for the reduction of HIV and hepatitis C risks among drug users;
- Improve the treatment provided to this population by developing rehabilitation and reintegration techniques;
- Monitor the situation in order to gain a better qualitative and quantitative knowledge of the problem.

Reducing risks of infection was one of the three main thrusts of the National Strategy against Drug Addiction 2006-2010, aimed at bringing active users into the care and prevention system without cessation of drug use being a precondition. There were two aspects to this:

- Preventing infectious diseases in a hard-to-reach segment, namely marginalised injecting drug users;
- And acting as a "bridge" to treatment.

The National Action Plan 2008-2011 for reducing HIV risks among injecting drug users had as its main aim "to secure access for drug users to prevention, HIV screening and good-quality treatment and care services". This aim was reflected in the field in the stepping up of prevention activities meeting the needs of IDUs exposed to the risk of HIV and HCV infection; ensuring access for identified IDUs to appropriate screening, treatment and care; stimulating community responses to drug users in the fight against HIV/AIDS; and, lastly, establishing national steering of the harm reduction system.

Three working priorities were set: systematic targeting of hard-to-reach populations (outreach work and needle exchange programmes); putting in place substitution (methadone) maintenance programmes; and encouraging the development of self-help groups among drug users.

Over the four years of the plan (2008-2011), it was possible to carry out a large number of risk reduction activities. Among the most important, the following may be mentioned:

- Designing prevention aids for IDUs;
- Setting up and expanding methadone substitution programmes at three trial sites (Tangier, Salé and Casablanca) ;
- Establishing the first drug users' self-help group, which participates actively in prevention activities aimed at IDUs, in particular via its newsletter written entirely by users for their peers ;
- Launching vocational rehabilitation projects with the help of a Catalan association (Casal Del Infante);

- Training dozens of professionals in harm reduction measures and methadone prescription;
- Repeatedly advocating harm reduction and the human rights of users;
- Conducting numerous surveys, rapid situational analyses and RDS studies;
- Conducting prevention and peer education activities in many Moroccan prisons;
- And setting up a national committee to manage harm reduction.

This first National Action Plan for reducing HIV risks among injecting drug users (2008-2011) was evaluated, making it possible to document the significant actions carried out in the field since 2008. Thanks to the Health Ministry's co-operation programme with the Global Fund to fight AIDS, Tuberculosis and Malaria, it was possible to support the functioning and funding of specialist NGOs, provide training and acquire, among other things, injection kits and methadone.

Support from UNAIDS, UNODC and other partners made it possible to implement various components of the plan, and in particular to carry out studies, develop stakeholder capacity and build networks.

In the space of 4 years, the experience gained by Morocco in carrying out the main activities of the plan made the country a model for the entire MENA region.

The evaluation also brought out the shortcomings in this first National Action Plan for harm reduction, highlighting the difficulties and obstacles which hindered the implementation of some activities and suggesting possible ways of remedying them. The activities which it was not possible to carry out include activities on the following topics : female IDUs, work with pharmacists at all sites, management of hepatitis C, psychosocial support and the setting up of a standardised national system for monitoring all partnership activities and arrangements.

1.3.3.2. National Action Plan 2012-2016 for reducing HIV risks among injecting drug users

The main aim of the National Action Plan 2012-2016 for reducing HIV risks among injecting drug users is to reduce new HIV infections among injecting drug users by 50% by 2016.

The specific aims are as follows:

- To ensure access for IDUs at all priority sites to regular high-quality combined prevention activities delivered by local teams;
- To ensure access for IDUs to opioid substitution treatment at all priority sites to prevent drug injection;
- To ensure access for IDUs to comprehensive combined medical and psychosocial treatment services;
- To optimise co-ordination and management of the risk reduction system at national and local level.

The National Action Plan 2012-2016 for reducing HIV risks among injecting drug users puts the emphasis on a "combined prevention" approach comprising 7 components:

1. Access to the equipment needed to inject, smoke or inhale drugs with minimum risk of contamination;
2. Prescription of substitution treatment to as many heroin users as possible;
3. Access to screening and to antiretroviral treatment for HIV and HCV positive persons in need of treatment;
4. Actions to change individual behaviour using written and audiovisual aids;
5. Actions to change norms in the subculture through "inside" action, community involvement and self-help;
6. Psychosocial support, integration and vocational rehabilitation;
7. Action to combat social stigmatisation and discrimination and protect fundamental human rights.

Table n°1.3: Targets for combined prevention coverage of injecting drug users and current "active" injectors

	Base values (2011)	2012	2013	2014	2015	2016
Number of IDUs (heroin and/or cocaine/crack), all routes of administration combined, benefiting under the DDR programme	1700	1700	2200	2700	3200	4000
Number of active injectors benefiting under the DDR programme	ND	600	1000	1300	1600	2000

The operational arrangements of the National Action Plan 2012-2016 for reducing HIV risks among injecting drug users include:

- The setting up of low-threshold harm reduction centres and addiction treatment centres (Mohammed V Foundation for Solidarity), involving the provision of specialist consultations with referral and follow up, fixed and mobile risk prevention units (specialist NGOs), the involvement of multidisciplinary teams, capacity building for persons working with IDUs, the establishment of functional links with HIV screening services and networking with local players (occupational integration programmes, legal protection, etc.);

- The introduction of needle exchange programmes;

- Support for self-help;

- And development of the opioid substitution (methadone) programme.

The main challenges of the current plan include:

- Establishing a multisectoral strategy for the prevention of drug use, particularly among young people;

- Developing rehabilitation facilities and social reintegration arrangements for drug users;

- Expanding treatment services in general and harm reduction services for highly vulnerable groups: women, prisoners, all disadvantaged groups, etc.;

- Improving access for drug users to health services (methadone substitution treatment, antiretroviral treatment, treatment for tuberculosis, etc.);

- Building the capacity of NGOs and involving drug users in projects;

- Mobilising the media and the education system, inter alia to combat stigmatisation;

- Ensuring the sustainability of programmes: specialised human resources and trained local operators;

- And ascertaining trends in the drug use situation by conducting evaluations and studies.

1.4. National and international co-ordination

1.4.1. National co-ordination and the National Observatory on Drugs and Addiction (ONDA)

Conscious of the need for a comprehensive, integrated approach, Morocco bases its action against drugs on a strategy geared to reducing supply, suppressing both trafficking and demand and putting in place measures to promote alternative development.

On an institutional level, Morocco set up an Anti-Drug Co-ordination Unit (UCLAD) in 1996, in an effort to co-ordinate the different departments responsible for law enforcement, and a National Commission on Narcotic Drugs.

Since 2005, a national anti-drug strategy has been implemented, calling for efforts to be concerted to ensure co-ordination both on an institutional level and in terms of the implementation of multidimensional actions common to several sectors.

For example, as part of the comprehensive approach adopted in the field of supply reduction, eradication operations are combined with a broader approach encouraging alternative development and replacement crops.

Major, overarching projects are accompanied by other projects aimed at combating poverty and hardship and promoting human development in the overall context of the National Human Development Initiative (INDH).

This combined strategy of control and prevention has enabled the Moroccan authorities to reduce the areas on which cannabis is grown by 65%, from 134 000 hectares in 2003 to 47 500 in 2010 (in 2010, 9 400 hectares were eradicated).

The implementation of large-scale eradication and anti-drug trafficking campaigns has necessitated the investment of substantial financial, material and human resources.

Since 2009, the Moroccan government has implemented an integrated alternative development programme, with a budget of 900 MDH, in the country's northern provinces. Several socio-economic and environmental development projects have been launched, targeting 74 rural communities.

Regarding the availability of data, the Moroccan authorities have conducted several surveys and studies which allow trends to be identified, inter alia in terms of prevalence, demand and drug use at school. These studies and surveys are mainly the responsibility of the Ministries of Health, Justice and Education and, depending on their aims, are conducted on different scales. For example, "capture-recapture" studies carried out by the Ministry of Health in the north of the country and the main urban areas have provided a clearer picture of the (medical and social) treatment of drug users.

The Ministry of Justice has also provided data on drug use in prisons. Several surveys were in progress in January 2013, inter alia on the purity and price of drugs and on the proportion of prison sentences related to drug use or trafficking.

The main areas in which data are lacking are those relating to the consequences of drug use, such as data on drug-related morbidity and mortality.

In order to centralise existing information and data on drugs and addiction and collect new data to fill the gaps, Morocco established its National Observatory on Drugs and Addiction (ONDA) in 2011. ONDA was officially launched on 11 June 2013.

ONDA is an independent body which provides decision-makers with objective, reliable and comparable factual information on drug use and drug addiction, and their consequences. ONDA specialises in collecting, analysing and interpreting data in order to produce information as an aid to decision-making in the area of drugs and drug addiction.

ONDA is also responsible for the scientific aspects and accuracy of reports and publications.

ONDA's missions are:

- To supply information deemed essential for formulating policies and organising services related to drugs;
- To provide information on questions of general interest related to drug use;
- To collect and produce the information needed to meet reporting obligations under national and international drug monitoring and control programmes.

ONDA's functions are:

- Collecting data and observations at national level;
- Analysing and interpreting the information collected;
- Producing reports and disseminating findings;
- Publishing each year a national report or, at the very least, up-to-date information on the national situation;
- Producing specific studies and other reports on request.

ONDA's strategies are:

- Adopting international reference instruments;
- Establishing or adopting a national reference framework for the drawing up of reports;
- Obtaining data and finding experts to interpret them;
- Structuring identified sources of information into a coherent system;
- Creating and gradually developing a national data collection network.

1.4.2. International co-ordination and co-operation

Faced with a worrying situation due to the growth in drug trafficking, compounded by increasing needs in the areas of prevention, treatment and rehabilitation of drug users, Morocco has reiterated its will to work in concert with all the states concerned to fight drugs and the related crime and, in a spirit of shared responsibility, provide a comprehensive, balanced and co-ordinated response to the threat that this scourge poses to all societies.

Morocco is a signatory to the various United Nations conventions on narcotic drugs and psychotropic substances (1961, 1971 and 1988) and to the United Nations Convention against Transnational Organised Crime (2000).

Morocco has many legal instruments regulating all aspects of drugs (cultivation, trafficking and use). The national legislative arsenal against activities related to drug trafficking was further strengthened by Law 43-05 on money laundering enacted in 2007.

In the context of judicial co-operation, Morocco co-operates fully with its partners to combat drug trafficking, particularly in the context of extradition requests, but reciprocity is not always possible with some European countries which tolerate the possession and use of certain drugs, which also encourages trafficking.

As early as 1977, acting on UN recommendations, Morocco established an institutional framework to co-ordinate measures against drug trafficking and drug abuse, by setting up the National Commission on Narcotic Drugs.

UNODC's participation in cannabis surveys in Morocco is a sign of Morocco's desire to involve the international community and funding agencies in its anti-drug efforts.

Morocco maintains close relations with the International Narcotics Control Board (INCB), whose reports emphasise the efforts made by Morocco and the progress made in eradicating cannabis growing and fighting drugs.

Morocco also co-operates closely with the MedNET network (the Pompidou Group's co-operation network on drugs and addiction in the Mediterranean region), whose aim is to promote co-operation, exchange and two-way knowledge transfer between countries of the southern Mediterranean and European countries (North-South and South-South exchange). The MedNET network, which Morocco joined from its inception in 2006, works to promote mutual co-operation and carries out numerous activities related to drug use management (training, study visits, creation of university diplomas in addictology in Rabat and Casablanca, carrying out of national MedSPAD surveys concerning the prevalence of drug use in schools, production of prevention materials, etc.).

Its constructive relationship with the MedNET network prompted Morocco to apply for membership of the Council of Europe's Pompidou Group on 1 July 2011. Morocco's accession to the Pompidou Group testifies to the country's credibility and constitutes clear recognition of its efforts in the human rights field, one of the pillars on which the Council of Europe's Statute is based. Morocco was the first non-European country to become a full member of the Pompidou Group. The already exemplary co-operation between the MedNET network and the PG calls for further consolidation.

The Kingdom of Morocco works in close co-operation with other countries of the Mediterranean region on drugs issues. The Ministry of Foreign Affairs and Co-operation has also reiterated Morocco's strong support for and commitment to preserving the stability, security and unity of the Gulf states, re-affirming the Kingdom's determination to continue co-operating with its partners in the fight against terrorism, drug and arms trafficking, money laundering and transnational crime.

The period 2008-2009 was marked by the setting up of a joint anti-drug committee between Morocco and Spain and by the Kingdom's accession to the Co-ordination Centre for Anti-Drug Enforcement in the Western Mediterranean Basin (CECLAD-M).

Morocco also holds observer status with the Maritime Analysis Operational Centre (MAOC-N). The Interior Ministers of Spain and Morocco have put in place a strategy for detecting drugs not only at airports but also in the Straits of Gibraltar.

Morocco works in close co-operation with various US agencies, such as the Federal Bureau of Investigation (FBI), the Drug Enforcement Administration (DEA) and the Department of Homeland Security (DHS). Furthermore, the Department of State's Bureau of International Narcotics and Law Enforcement Affairs and Diplomatic Security maintains a working relationship with relevant Moroccan government agencies.

Morocco accordingly maintains effective partnerships with European countries, the United States and African countries with the aim of stepping up co-ordination and the fight against international drug trafficking networks while establishing mechanisms to better counter the transit of drugs across its borders.

Since ONDA was set up, Morocco has received spontaneous and proactive technical support from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The EMCDDA has shown a clear willingness to help ONDA in its tasks and establish lasting co-operative relations. A close co-operation framework is currently under discussion between the two parties. ONDA adopts the same instruments and indicators as the EMCDDA and proposes to act as a link between the EMCDDA and other observatories being set up in the MENA region.

2. Drug use in the general population and in specific groups

Several general and specific population surveys have been carried out in the last ten years and have provided a picture of the drug use situation in relation to HIV infection.

Starting in the early 1990s, Morocco launched a series of epidemiological studies which provided a better knowledge of the phenomenon and led to the setting up of large-scale strategic plans tailored to the reality of the figures and actual trends in drug use. The first epidemiological studies on drug use in Morocco date back to 1993-1995 (survey of street children and surveys in psychiatric settings).

2.1. Drug use in the general population

2.1.1. National survey on the prevalence of mental disorders and drug addiction

This, the first general population survey by the Ministry of Health on the prevalence of mental disorders and drug addiction, was carried out with the support of the WHO and in co-operation with the university psychiatric centres of Salé and Casablanca.

The results of the national survey on mental health and drug addiction, carried out between September and December 2003 among a sample of 6 000 people aged 15 and over selected as being representative of the Moroccan population, showed that:

- Lifetime prevalence of psychoactive substance use was 4.8%.
- The prevalence of alcohol abuse was 2%, with 1.4% dependent on alcohol.
- The prevalence of substance abuse was 3.3 %, while dependence stood at 2.8 %, all substances and routes of administration combined.
- Substance abuse and dependence, including alcohol, was predominant among men, to the tune of one woman for every 10 men.
- Substance abuse was more a feature of rural areas than of urban areas, whereas alcohol abuse and dependence were an urban phenomenon.

-The prevalence of drug use in the previous 12 months showed that cannabis was the most used drug. Sedatives, which came second, accounted for only 0.18% of the population, followed by cocaine with 0.05%, solvents with 0.04% and, lastly, opioids with 0.02%. It should be noted, however, that the survey methodology did not facilitate identification of substances with a very low prevalence in the general population, such as cocaine and heroin in Morocco.

2.2. Drug use in schools

Morocco focuses particular attention on the prevalence of drug use in the school environment. It was against this background that MedSPAD (Mediterranean School Survey Project on Alcohol and other Drugs) surveys were carried out in 2006, 2009 and 2013.

MedSPAD is an adaptation to the Mediterranean context of the ESPAD survey (European School Survey Project on Alcohol and other Drugs) and forms part of the activities of the MedNET network.

The MedSPAD surveys in Morocco were conducted by two joint teams from the Ministry of Education and Higher Education and Ar-razi university psychiatric hospital in Salé. The first MedSPAD survey, in 2006, targeted children in the Rabat-Salé area. Two further MedSPAD surveys were subsequently carried out in 2009 and 2013 on a nationwide basis. These surveys mainly target children aged 15-17 and are repeated every 3-4 years in order assess the trends in drug use in this age group.

Similar MedSPAD surveys are carried out in countries around the Mediterranean, including other Arab or North African countries such as Tunisia, Algeria and Lebanon. These surveys will permit comparisons of data, given the geographical and cultural proximity of the countries concerned.

The MedSPAD survey, derived from the ESPAD survey, was fully reviewed to adapt it to Moroccan culture and render it operational. The teams from the Ministry of Education and Ar-razi university psychiatric hospital in Salé held several preliminary working meetings at which the entire survey methodology was discussed point by point and optimal implementation strategies were agreed.

The MedSPAD surveys pursue a variety of aims: determining the age of first use of psychoactive substances, bringing out the factors that may be predictive of drug use among students, gaining a better understanding of the opinions and behaviour of this population group and obtaining information that can be used as a basis for drawing up recommendations and taking preventive action against the use of psychoactive substances in the school environment.

2.2.1. MedSPAD survey 2006

The survey took place in February 2006. It was based on an anonymous 57-item self-questionnaire translated into Arabic.

The sample consisted of 2 139 students aged 14-23. The 15-17 age group accounted for 52.2% of the sample.

Females slightly predominated among the students aged 15-17 (59% of the sample). Prevalence rates for drug use increased with age and were gender dependent. Drug preferences differed significantly according to gender (p=0.000).

The prevalence curves suggested that drug use was largely experimental.

In terms of lifetime use, tobacco was the substance most used by both sexes in the 15-17 age group (boys 19.5%, girls 10.2%).

Among the boys, lifetime prevalence of alcohol use was 16.6%. The figure for cannabis was 12.5%. Psychotropic substances came last with 9.5%.

8.4% of the girls reported lifetime use of psychotropic substances. The figure for alcohol was 4.7%. Cannabis came last with 1.5%.

1.4% of the students reported lifetime use of other drugs, such as cocaine, opioid derivatives, organic solvents and ecstasy.

40% of the students aged 15-17 had experimented with more than one drug. As many as two out of every five substance-using students had a family member or friend who used the same substance.

The age of first use of psychoactive substances was early among the youngest students. Absences from school, running away from home, below-average marks and unsatisfactory relations with parents were linked to drug use in a statistically significant way.

2.2.2. MedSPAD survey 2009

Table 2.1. sets out the main findings of the MedSPAD survey 2009.

Table2.1: Prevalence of psychoactive substance use (MedSPAD survey 2009) (in %)

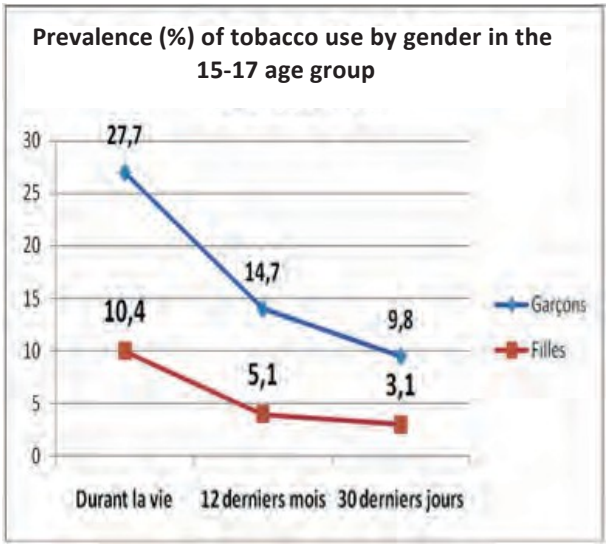
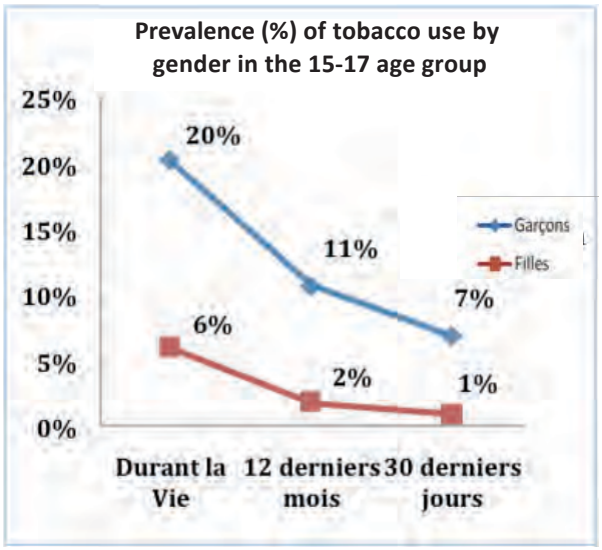
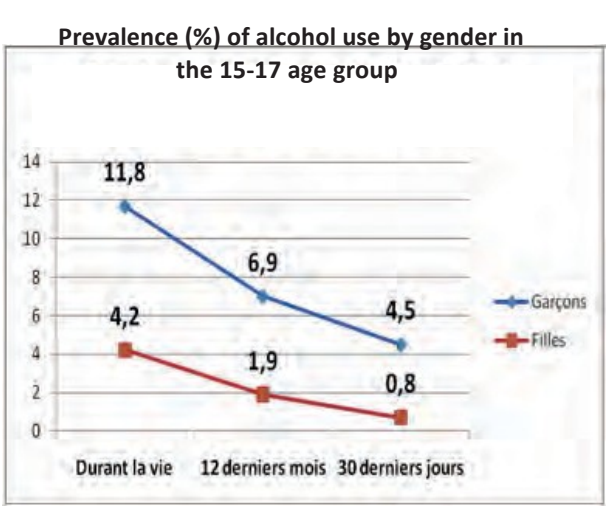
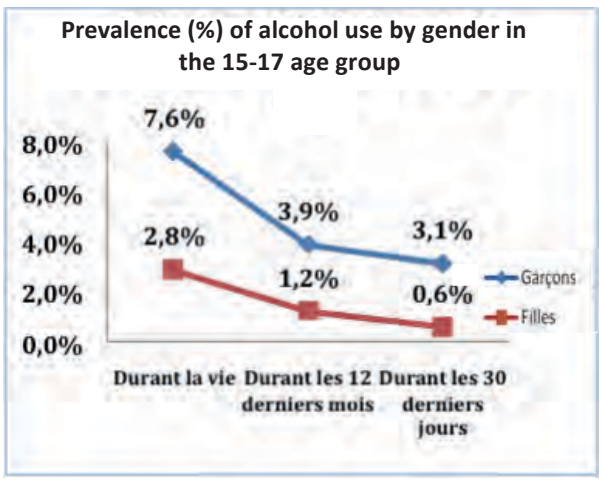
Substances	Population	Lifetime	In the previous 12 months	In the previous 30 days
Tobacco	Overall	20.4	10.7	7.6
	age 15-17	18.5	9.3	4.3
Shisha	Overall	22.3		
	age 15-17	18.9		
Alcohol	Overall	10	5.8	3.6
	age 15-17	7.7	4.2	2.5
Cannabis	Overall	9.3	6.3	4.2
	age 15-17	7.2	4.6	2.6
Psychotropic substances	Overall age 15-	4.3 4	2.4 2.2	1.7 1.3
Cocaine	Overall	1.5	0.9	0.6
	age 15-17	1.2	0.7	0.4
Crack	Overall	0.9	0.5	0.5
	age 15-17	0.6	0.3	0.3
Others	Overall	7.4		
	age 15-17	5.8		

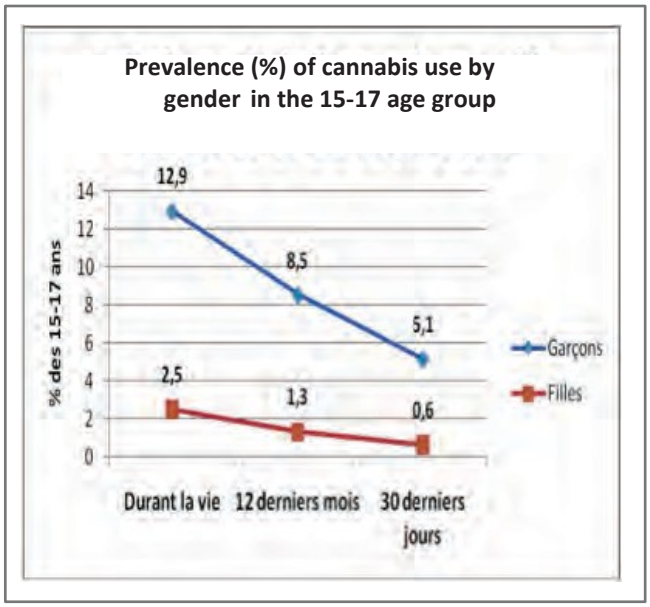
2.2.3. MedSPAD survey 2013

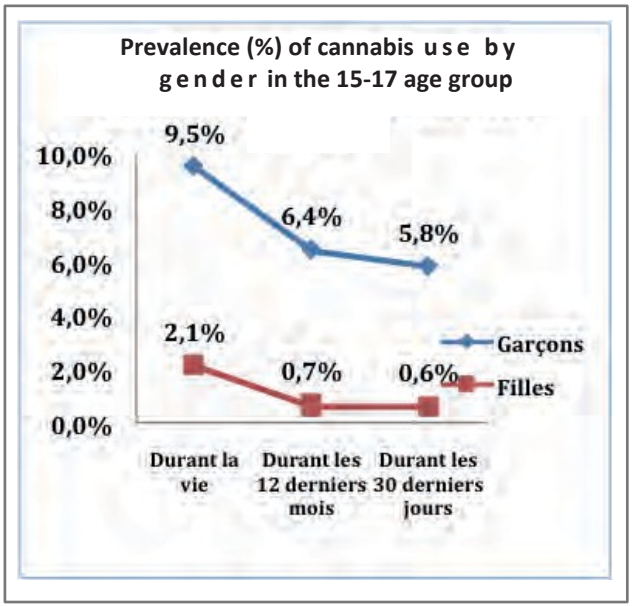
Two joint teams from the Ministry of Education and Ar-razi university psychiatric hospital in Salé were entrusted with carrying out the nationwide MedSPAD survey 2013. This large-scale survey was motivated by a common political will on the part of the Ministries of Education and Health to assess the problem of drug use in schools on a national level and draw up suitable recommendations for addressing this problem.

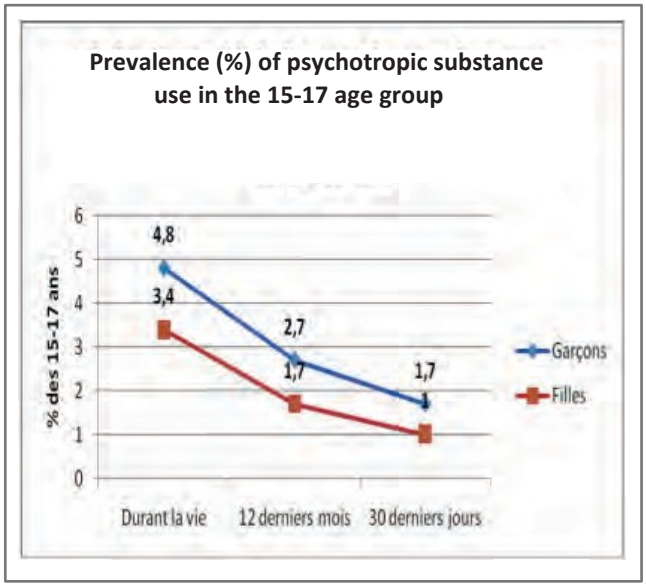
Comparisons with the MedSPAD survey 2009 show a decline in the prevalence rates for tobacco, alcohol and cannabis in the 15-17 age group. The figures for psychotropic substance appear to have increased in relation to those recorded in 2009.

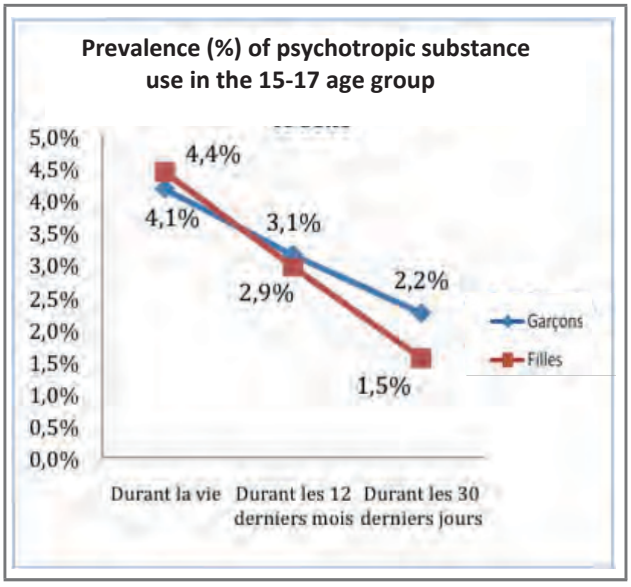
Table 2.2: Comparison between MedSPAD 2009 and MedSPAD

2013 MedSPAD 2009	*MedSPAD 2013*
	
	









Overall analysis of drug use among Moroccan secondary school students reveals a number of risk factors, including three which are crucial:

- Ease of access to drugs, which are sometimes sold in the vicinity of schools;
- A perception of drug use which minimises the risks involved.
- The lack of consistent nationwide prevention programmes that are evaluated and adapted.

3. Prevention

3.1. Introduction

Drug use prevention policy is implemented on different levels in Morocco. Its guiding principles are to prevent, or at least delay, first use and prevent or reduce abuses. In the school environment, the overall framework for action is the prevention of addictive behaviour, which falls into the wider context of education for health.

The ministries involved in prevention are the Ministries of Health, Education and Vocational Training, the Interior, Justice and Freedoms, Youth and Sport, Higher Education, Habous and Islamic Affairs, Solidarity, Women, the Family and Social Development, and Employment and Social Affairs.

Many voluntary associations also supplement the government's work at local level by being present at the grassroots and organising activities in the context of drug use prevention.

School surveys have been carried out to gain a better knowledge of the target group and make a better diagnosis: national school survey 1994; survey on the prevalence of mental disorders and drug addiction in 2003; MedSPAD surveys in 2006, 2009 and 2013.

The setting up of "citizenship clubs" marks the beginnings of a national prevention campaign. Clubs dealing with health, the media, theatre and other leisure activities have been set up in schools to provide students with structures and explain to them the serious dangers of drugs. Some state schools have considered building higher walls to keep dealers out. Counselling units also run by teachers have been set up to raise awareness and find solutions to the most serious cases.

The Ministry of Health put in place a "social communication strategy for drug use prevention" for the period 2008-2012. The aims of the programme were to:

- Prevent drug addiction among young people and vulnerable groups and promote mental health.
- Increase the quantity of care available to drug us

- Reduce risks of HIV/AIDS and hepatitis C infection among injecting drug users.
- Treat drug addiction and rehabilitate drug users.
- Combat the stigmatisation of drug users.

The Ministry of Health put in place a new national drug prevention strategy via an action plan covering the period 2012-2014.

This plan includes targeted actions aimed at young people, adults and vulnerable groups. The prevention of addictive behaviour is combined with the promotion of healthy lifestyles, in particular through the implementation of a social communication strategy. To increase the effectiveness of preventive measures, the Ministry plans to develop collaborative relations and partnerships. Indeed, if preventive measures are to be effective and important, they must be implemented as part of an integrated, cross-sectoral policy.

Some Moroccan voluntary associations are also involved in drug use prevention.

One example is the "Moroccan Association against Tobacco and Drugs", which carried out a number of nationwide prevention campaigns in the course of the year to make Moroccans aware of the risks they run by using these illicit substances. The association raises awareness among citizens by holding open days, inviting specialists to give talks, doing door-to-door work and organising sports events.

An awareness-raising campaign was launched in March 2012, in partnership with the Association of Life and Earth Science Teachers of Morocco (AESVT), in 10 private and state schools in Marrakesh. Students in all subjects were given the opportunity to participate in a competition on the theme of drugs. The AESVT also does work in some schools as part of its "education for health in schools" activities. To mark World Anti-Smoking Day, the Nador section of the AESVT organised an anti-smoking awareness evening on 31 May 2013 in co-operation with the Farkhana school clubs.

Similarly, the Directorate-General of National Security (DGSN) organised an awareness-raising campaign over the school year (from September 2013 to 27 April 2014) for children attending state and private schools, to warn them about the dangers of drug use, and in particular the dangers of psychotropic pills. The campaign reached 777 631 pupils in 5 646 schools.

In the absence of a proper monitoring system in Morocco, there is little evaluation of how drug use prevention practices are implemented. But some ideas now seem to have acquired widespread currency: the limits of an approach based exclusively on information and the importance of developing psychosocial skills, an interactive approach and parents' role in prevention.

3.2. General context and main players

The actions taken are mainly dictated by a universal prevention approach and, for the most part, are taken within the context of secondary education, where the educational community is extensively involved in their co-ordination and implementation.

There are three broad categories of players who work with young people in this field: school staff (teachers and health and social workers); members of associations specialising in prevention or education for health; and specially trained police and gendarmes.

3.3. Monitoring and data

There is no national system for monitoring prevention activities across the main sectors active in this field.

As a result, few data are available concerning the coverage of prevention activities in schools.

To gain an overview of preventive responses in Morocco, it is necessary to consult institutional players in the healthcare field, and assessments of action taken in the field are based on piecemeal feedback.

3.4. Legislative framework

There are relatively few legal instruments dealing with drug use prevention. Where tobacco and alcohol are concerned, there is a large body of legislation relating to advertising, accessibility and use in public places, and taxation designed to limit their use.

3.5. National co-ordination

Policies for the prevention of licit and illicit drug use are set out in government plans, and in particular in a national drug prevention strategy produced by the Health Ministry's Directorate of Epidemiology and Disease Control.

3.6. Addiction prevention policy – Strategic vision and action plan 2012-2016

Prevention is a major component of the national strategy against addiction. The Moroccan action plan against addiction describes it as a priority requiring the implementation of relevant actions, optimisation of resources and a comprehensive, multi-factor approach.

The concept of structured multi-factor comprehensive prevention means:

- Sharing reliable knowledge;
  Promoting healthy lifestyles;
- Educating for health;
- Building life skills;
- And putting in place a framework of laws and regulations.

This prevention policy seeks to reach all the target groups in their various life settings:

- The general public ;
- Schools and universities;
- Recreational and sports facilities;
- The workplace ;
- And vulnerable groups.

3.6.1. Strategic objectives of the action plan 2012-2016

- **Objective 1: Preventing addictive behaviour and promoting healthy lifestyles**

  ◆ **Measure 1: Putting in place a social communication strategy**

  - **Action 1**: designing and disseminating information and communication tools based on scientific data in order to build knowledge among the general public (TV and radio advertisements, films, handbooks, posters etc.), with the production of a "policy document on communication for drug use prevention among young people".

  - **Action 2**: developing and implementing effective awareness-raising programmes aimed at teachers and pupils (incorporated into the curriculum).

  - **Action 3**: producing guides and handbooks to assist and advise NGOs, parents, teachers, etc. A guide for NGOs working with young people (WHO support and co-operation with Ar-razi hospital in Salé) and an educational module for teachers (WHO support and co-operation with Ibn Rochd university hospital in Casablanca) have been produced for this purpose.

  - **Action 4**: developing and implementing effective assistance and awareness-raising programmes aimed at parents.

- **Objective 2: Early detection and diagnosis of addictive disorders**

  ◆ **Measure 1: Incorporating the prevention of addictive behaviour among young people into basic healthcare at all community healthcare facilities (youth health services)**

  - **Action 1**: incorporating drug use prevention into the activities of addictology centres.

  - **Action 2**: encouraging the inclusion of drug use prevention in regional health plans and the setting up of multidisciplinary units as part of basic healthcare.

◆ **Measure 2: Building the skills of health professionals and other players in the field of addictology**

- Action 1: training 30 general practitioners and psychiatrists in addictology every 2 years (addictology diplomas from the university hospitals of Rabat-Salé and Casablanca)

Action 2: training personnel (nurses, doctors and others) working in basic healthcare.

- Action 3: providing further training for basic healthcare professionals by organising (in 2013) and scheduling (for 2014-2015) training workshops in brief intervention techniques (WHO support, co-operation with Ar-razi hospital).

- **Objective 3: Co-operation, partnership and multisectoral approach**

  - **Actions:**
    - Advocating the need for effective prevention measures and the importance of integrated cross-sectoral policies.
    - Putting in place cross-sectoral programmes.
    - Putting in place specific co-operation programmes.
    - "Media pacts", etc.

  - **Co-operation with the following partners in the health sector:**
    - Directorate of Population – School Health: producing handbooks and guides on youth and adolescent health, producing a guide for schoolteachers and making available a webpage for young people and adolescents.
    - Healthy Lifestyles Unit (DELM): anti-smoking campaign.
    - National Commission on Narcotic Drugs.

  - **Multisectoral approach involving:**
    - The Ministry of Higher Education – University Health, through the production of information leaflets;
    - The holding in 2013 of a multisectoral consultation workshop for the implementation of a multisectoral policy on mental health, including drug use prevention;
    - The Directorate General of National Security, with the holding in 2012 of a study day on the drug use problem and another in December 2013 on a multisectoral policy for the prevention of drug use and addiction.

- **Partnership with NGOs and international organisations:**

- Annual proposals for action plans on drug use prevention among young people.
- Partnership with UNESCO: organisation in 2012 of a study day on "preventing drug use in schools: current situation and strategies for action".
- Partnership with MedNET/Pompidou Group.
- Partnership with UNODC.

- **Objective 4: Monitoring, evaluation and research**

  - **Measure 1: Setting up a National Steering Committee on Addiction Prevention**

  - **Measure 2: Setting up a National Observatory on Drugs and Addiction (ONDA)**

  Several roles were assigned to ONDA:

  - research and trend monitoring;
  - sharing information and expertise;
  - support for planning;
  - and designing and validating tools for action.

  - **Measure 3: Promoting action research on preventing psychoactive substance use**

- **Future stages and recommendations of the action plan 2012-2016**
  - **Consolidating the partnership with NGOs by:**
    - Sharing information;
    - Increasing technical and financial support for NGOs and providing a frame for prevention activities;
    - Making available validated tools (web training workshops, etc.);
    - Implementing capacity building activities;
    - Taking stock of the situation and listing associations working in the field of addiction prevention.
  - **Adopting one or more standardised operating models at national level based on a national consensus.**
  - **Devising a multisectoral strategy.**
  - **Promoting ONDA as a mediator playing a part in increasing international exchanges.**

4. Problem drug use

4.1. Specific context of problem drug use in Morocco

Growing concern on the part of the public authorities, health professionals and civil society organisations has led to major changes in Morocco's policy against AIDS in the light of drug use phenomena.

In 2003, the Ministry of Health conducted the first nationwide general population survey on mental health (data collected from a representative sample of six thousand people); this survey, whose findings were released in 2006-2007, included a section on "addiction" aimed at assessing the prevalence of substance use, abuse and dependence among Moroccans over the age of 15.

The findings constituted a first national knowledge base on the scale of psychoactive substance use.

For example, 4.8 % of those surveyed reported psychoactive substance use in the previous 12 months; 3 % and 2.8 % respectively were abusing or dependent on these substances.

These findings prompted the Moroccan authorities to look more closely into the scale of drug use in the country. A survey devoted to the theme of drug users was accordingly designed. This survey, entitled "rapid evaluation of the situation regarding the risk of HIV infection related to injecting drug use and problem drug use in Morocco", was carried out in 2005, and the results were published in 2006.

It gave a precise idea of the profile of these drug users and their patterns of use. Injecting drug use was also documented, this having been one of the aims of the survey: 3 out of every 4 users had taken drugs by injection and half had re-used syringes.

Morocco therefore possessed a first knowledge base on the drug users and use patterns (substances, methods of use, etc.) potentially amenable to approaches of the demand reduction type.

This first knowledge base paved the way for a national action plan on demand reduction, which covered the period 2008-2011 and targeted injecting drug users.

The main thrusts of the action plan included setting up local demand reduction programmes in partnership with NGOs (with access to sterile injecting equipment) and introducing opioid substitution treatment (OST).

The first local demand reduction scheme in Morocco, including a needle exchange programme (NEP), was started up in Tangier by the Support Association for the Hasnouna Medico-Psychological Centre, an association dedicated to demand reduction and established on the basis of the Hasnouna centre (which subsequently, in June 2010, became one of the first three pilot sites for the methadone maintenance treatment programme).

The Association against AIDS (ALCS) launched the second programme in 2009 in and around the city of Tetouan. The "*RDR Maroc*" (demand reduction Morocco) team then launched the third in 2010 in and around the city of Nador.

Concurrently with the implementation of the demand reduction plan, a second evaluation was conducted in November and December 2008 at four other sites designated as priorities in the action plan: Nador, Al Hoceima, Oujda and Fes.

Unlike the first in 2005, this second evaluation also included a biological component (capillary blood samples taken on blotting paper) to help calculate a national estimate of HIV and HCV seroprevalence among drug users (information which was essential for the national strategy against AIDS and which had previously been lacking).

This second component was only implemented in Nador and Al Hoceima.

The two rapid evaluations were carried out using the "snowball sampling" technique for the recruitment of survey respondents.

Heroin was the most used substance (77 %), particularly in Nador (100 %) and Al Hoceima (97 %). 60 % had used the injection method at least once in their lifetime, with a frequency ranging from 98 % in Nador to 3 % in Fes. A source of concern from the point of view of demand reduction was that the rate of needle sharing among injecting users was 73%, an increase on the rate found in the first evaluation.

While the risk of HIV transmission through needle sharing was well identified for nine respondents out of ten, the same did not apply to the sharing of other injecting equipment, and, above all, the risk of HCV transmission was much less fully and clearly understood. The consequences of these high-risk use practices combined with poor knowledge are reflected in the results of the biological component : an HIV seropositivity rate of 38% among the drug users tested in Nador (no HIV seropositivity detected in Al Hoceima); and HCV seropositivity rates of 89 % and 9 % respectively among the drug users tested in Nador and Al Hoceima.

The second rapid evaluation of the risk of HIV infection among drug users in Morocco made it possible to establish a clear link between injecting drug use and anti-AIDS strategy, despite the methodological limitations of these surveys (based on the recruitment of drug users). For this reason, those responsible for combating AIDS and reducing demand for drugs in Morocco wished, as part of national steering of the action plan on demand reduction, to gain a more detailed knowledge of the phenomena associated with injecting drug use: it was decided to launch a series of surveys using the RDS (Respondent Driven Sampling*)* method at five priority sites, including Tangier, Nador and Tetouan. This new series of surveys, which targets injecting drug users, should make it possible to:

- Determine the scale of injecting drug use and estimate the size of this population;
- Describe the socio-demographic characteristics of injecting drug users and their practices posing a risk of infection;
- Help calculate a national estimate of HIV and HCV seroprevalence among drug users;
- Identify users' needs in terms of HIV and HCV prevention and addiction care.

Tangier was chosen as a test site for this method and the survey was carried out there between October 2010 and February 2011. The survey in Nador was carried out in November and December 2011. In less than 10 years, Morocco has been able to refine its knowledge of phenomena associated with drug use and, above all, gradually clarify the nature of the interactions between drug use and the dynamics of the HIV/AIDS epidemic, thus paving the way for a focus on actions targeting IDUs in strategies against HIV/AIDS.

As part of this development, it was natural, therefore, that associations working to combat AIDS should be fully involved in these actions and, more generally, in actions concerning drug users in Morocco.

4.2. Results of the main surveys carried out

4.2.1. Rapid evaluation of HIV risks among IDUs (phase I: 2005-2006)

The rapid evaluation of the situation regarding the risk of HIV infection related to injecting and problem drug use was carried out in 2005-2006 among a sample of 495 heroin, cocaine and psychotropic drug users, mainly injectors.

The aims of the survey were to determine the scale of injecting drug use, estimate the prevalence of use of these drugs and practices posing a risk of infection in this group. 70% of the participants were recruited in the street, 25% in prisons and 5% in hospitals. 36% were recruited in Tangier, 24% in Tetouan and in Casablanca, and 16% in Rabat-Salé.

The survey is not representative of drug use as a whole in Morocco because it targeted mainly injecting users, or persons taking substances that can be used by intravenous injection, and was confined to a small number of sites.

The sample consisted of 347 men (84.14%) and 77 women (15.59%). The most represented age group was the 25-35 year olds, who accounted for 63.7%.

Six out of every ten respondents (58.6%) described themselves as unmarried, while one in five (18.6%) said they were married. Four out of every ten respondents were unemployed and only one in four was in gainful employment at the time of the survey. A little less than one in four had their own home (23.2%). The others lived with their parents (54.1%) or other close family members (8.9%) and a small minority (3.2%) described themselves as “of no fixed abode”.

The socio-demographic characteristics of the drug users surveyed (age, marital status, education, occupation and place of residence) showed no significant variations from one site to another.

- Substance use:

In the previous 12 months, 9 out of every 10 respondents (89.9%) had used cannabis, 8 in 10 had mainly used non-opiate psychotropic drugs (75.9%), 7 in 10 (69%) heroin, 6 in 10 (60.4%) cocaine and 5 in 10 (54.9%) alcohol.

- Injections:

74% of those surveyed said they had injected a drug at least once in their lifetime. In the sample, injectors accounted for 50% among the 25-34 year olds and a third of the 35-44 year olds. Heroin and cocaine were the two most injected substances (one out of every two had used heroin and one in three cocaine).

- Risky practices:

Among the injectors, nearly one out of every two said they had shared a needle with another user. Two-thirds of users injected drugs at home, as compared with one-third in the street. Nearly 50% of the injectors said they had used needles that had already been used. Although 3 out of every 4 claimed to "disinfect" the used needles, most of them did so with water. Most had an insufficient or unclear knowledge of how HIV and HCV are transmitted and the means of protection when drugs are administered by the intravenous, nasal or pulmonary routes.

50% of the men and 70% of the women had multiple sexual partners, whereas only 10% of the men and 22% of the women regularly used condoms.

Three out of every four women (74%) said they had had sex in return for money or drugs. The female injecting drug users shared proportionally more needles with other injectors than the males (70.6% versus 62.8%). The survey also showed that the women in the sample were younger, used heroin less often, injected drugs less often, were more rarely screened for viral diseases and, lastly, had access less easily to detoxification treatments.

- Mobility and periods spent in Europe:

Nearly 47% of those surveyed had spent time abroad, particularly in Europe (94%). These were mainly users from the north of Morocco. There is a similarity between the substances used during the time spent in Europe and those currently used in Morocco. Among those who had spent time abroad, a little less than seven out of every ten had used heroin (66%) and/or cocaine/crack (also 66%).

- Imprisonment:

Nearly half the users consulted had been arrested for a drug-related problem. The main drugs used by imprisoned users are, in descending order: heroin, cocaine and psychotropic drugs. Around one out of every five of those who had used drugs in prison said they had taken them intravenously. 60% of those who had injected drugs in prison had shared their needle with others.

- HIV and HCV prevalence:

A minority of the respondents had been tested for hepatitis C and AIDS (14.4% and 14.2% respectively). The prevalence of HIV and HCV among the respondents who had been tested and knew the result was 7% (4/58) and 18% (13/71) respectively. Although, nationwide, injecting drug users accounted for 4% of AIDS cases reported since 1986, the figure was 10% for the Tangier-Tetouan region. All the HIV tests carried out in 2006 and 2007 under the sentinel surveillance system proved negative. The results should be interpreted with caution, however, because these tests were carried out in one city (Tangier) on a fairly limited number of injectors (around a hundred a year). They are not representative of the national situation as a whole.

4.2.2. Bio-behavioural / RDS surveys Tangier 2009 and Nador 2011

RDS surveys are surveys based on respondent-driven sampling. According to the bio-behavioural RDS surveys carried out in Tangier in 2010 and Nador in 2011, the prevalence rates for HIV and HCV at the two sites were as follows:

- Tangier: HIV 0.4% and HCV 41% ;
- Nador: HIV 22%.

67 % of IDUs said they had used sterile injecting equipment for the last injection. 30% said they had used a condom the last time they had had sex. Only 11% had been tested for HIV in the previous 12 months and knew the result.

4.2.3. Determinants of HIV/AIDS and HCV vulnerability among drug users

The main determinants of vulnerability to HIV/AIDS and HCV infection among drug users in Morocco are of two kinds: individual and societal/social.

4.2.3.1. Individual behavioural determinants of HIV and HCV vulnerability among IDUs

Behaviour posing a risk of infection is very widespread, especially where the sharing of injecting equipment is concerned:

- Sharing of the spoon used for preparing the drug, with each user drawing off part of the liquid;
- Use of the syringe as a measuring instrument;
- Sharing of the syringe itself;
- Re-use of a syringe abandoned or hidden by another user;
- Re-use of one's own syringe;
- Sharing of water used for preparation and rinsing;
- Sharing of straws to smoke heroine or base cocaine (crack).

4.2.3.2. Societal/social determinants

- Dependence on the substance: the effects of the substance and drug market conditions – finding the necessary money and then the substance take up a lot of energy, mentally and physically. Concerns relating to health are often replaced by concerns about obtaining drugs and/or using them. This applies in particular to injecting drug users, and especially heroin users.

- Material conditions of survival: the typical active user generally invests most of his/her resources and income in procuring the substances needed for his/her daily use. Ex-users often have no training or job and also lack sufficient resources.

- The social organisation and culture of IDUs: the social organisation of active drug users revolves mainly around the drug market. The relations between dealers, sellers and users depend on the conditions imposed by the market. At any time, each of these protagonists may be a danger to the others. The clandestine nature of drug users' activities results in human relations that are dominated by mutual distrust and, often, a lack of solidarity.

- The great mobility of Moroccan drug users between Morocco and the countries of southern Europe where there is a very high prevalence of HIV and HCV entails a risk of spreading the HIV/AIDs and HCV epidemics to users living in Morocco.

5. Treatment: demand and supply

5.1. General description

5.1.1. Addiction treatment policy and strategy

Among the Maghreb countries, Morocco has been a pioneer in the treatment of drug users, having carried out, since the late 1980s, a series of epidemiological surveys concerned with the nature and scale of the problem.

The provision of addiction care is hampered by the lack of sufficient human resources and facilities to meet the needs of a population in which demand in relation to the suffering caused by addiction and its social and familial consequences is increasing constantly.

Treatment for drug users in Morocco, including detoxification, after-care and rehabilitation, is dispensed by facilities specialising in addictology, including both outpatient and residential facilities.

Care provision includes residential addictology centres in Salé and Casablanca, medico-psychological centres (CMP) in Rabat, Tangier, Tetouan, Oujda, Nador and Marrakesh operating on an outpatient basis, and harm reduction centres. In towns and cities lacking dedicated addictology facilities, hospitals and psychiatry departments are the places where drug users receive detoxification treatment and follow-up care.

The Moroccan Ministry of Health has adopted a national strategy to address the issue of drug use and has announced the setting up of 14 addiction treatment units by 2020 in the regions faced with an upsurge in this phenomenon.

The Ministry's strategy for dealing with addiction is based on improving medical provision for drug users, setting up specialist consultation units in the various regions, strengthening the treatment network, creating specialist mobile units in the university hospitals and promoting youth health services offering psychiatric consultations in Rabat, Beni Mellal, Marrakesh and Casablanca.

Furthermore, the methadone substitution programme began in 2010 at three pilot sites (Tangier, Salé and Casablanca), with support from the Pompidou Group's MedNET network for the training of medical personnel. This type of treatment forms part of the national harm reduction programme in Morocco. There was a national consensus on the choice of methadone and no specific legislative basis was needed for this because methadone is included on Morocco's list of essential medicines for public health.

This substitution programme received a very positive evaluation in 2011. The Moroccan government therefore approved its extension to another seven towns and cities (Oujda, Rabat, Marrakesh, Tetouan, Nador, Al Hoceima and Agadir).

The accessibility of addictology services seems quite limited in relation to the prevalence of drug dependence. In 2012, the preliminary report by the National Human Rights Council on mental health and human rights described them as being "inadequate […] and virtually beyond the reach of the low incomes of drug addicts, who find neither the resources nor the facilities" to combat their addiction.

The national action plan 2012-2016 for combating addiction provides for the opening of hospital units specialising in addictology in Berrechid, Kenitra, El Kelâa Sraghna and Agadir.

Table 5.1: Budget planning for the setting up of addictology facilities

Domaines	Budget par année en Millions de Dhs									
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Construction des hôpitaux	25	50	50							
Construction de services intégrés	18	13.5	9	13.5	-	13.5	-	13.5	-	-
Création d'unités de pédopsychiatrie (CHU)	4.5	4.5	4.5	4.5						
Création d'unités d'addictologie	4.5		4.5		4.5		4.5		4.5	
Aménagement et réhabilitation		25								
Total	52	78	68	18	4.5	13.5	4.5	13.5	4.5	-

5.1.1. Main areas of activity of addictology centres in Morocco:

The main areas of activity of addictology centres in Morocco are:

- Treatment of drug users, outpatient consultations for addiction problems, follow-up treatment and referral to hospital and detoxification facilities;
- Demand reduction based essentially on information, awareness-raising and education;
- Reducing risks of HIV, HCV and tuberculosis contamination related to injecting drug use via "low threshold" and mobile units;
- Psychosocial counselling and community support for drug users.

5.2. Current provision in terms of addiction care

5.2.1. Facilities:

Psychoactive substance users experiencing difficulties with their drug use can seek help from various health professionals. First of all, there are specialised facilities, namely addictology centres, whose main function is to receive these patients and provide them with residential or outpatient treatment.

In addition to these specialised facilities, patients may also be received in psychiatric hospitals.

The facilities for treating addiction currently comprise:

- **Outpatient centres**:

- Marrakesh Addictology Centre, Rue Ben Qaddama, Prefecture of Marrakesh Menara ;
- Nador Addictology Centre, Cité El-Matar, Province of Nador ;
- Hasnouna Medico-Psychological Centre, Quartier Marchane, Prefecture of Tangier-Asilah, Tangier municipality;
- Oujda Addictology Centre, Hay El-Irfane, Oujda;
- Rabat Addictology Centre, Cité Yacoub-Elmansour, Rabat;
- Tetouan Addictology Centre, Quartier Lahmama, Province of Tetouan.

- **Residential centres:**

- Addictology Department, Ar-razi University Psychiatric Hospital, Ibn Sina Hospital, Rabat-Salé;
- Addictology Department, Ibn-Rochd Hospital, Casablanca.

5.2.1 Human resources:

As of 1 April 2014, the human resources trained in addictology consisted of:

- 6 teams trained in prevention and intervention at local level (health professionals and members of NGOs working in the addiction field) located in Tangier, Rabat, Tetouan, Nador, Al Hoceima and Oujda.
- 53 addictologists trained at the Faculties of Medicine of Casablanca and Rabat (two-year inter-university diploma course in addictology, leading to a qualification).
- 12 psychiatrists, 22 nurses and 9 general practitioners working in treatment facilities for drug users.

5.2.1. Residential treatment programmes for drug users:

5.2.3.1 National Centre for Addiction Treatment, Prevention and Research (CNTPRA) at Ar-razi hospital in Salé

The National Centre for Addiction Treatment, Prevention and Research (CNTPRA) at Ar-razi hospital is open to all persons with problem drug use, whatever their geographical origin. Admission is decided by a specialist medical team. An admission interview provides the opportunity for an overall assessment (motivation, addictive behaviour, psychiatric and somatic state, family and social circumstances).

Each patient is bound to the care team by a therapeutic contract based on trust, which will enable him/her to receive during his/her stay:

- Regular medical assistance together with appropriate treatment;
- Psychotherapy sessions (motivational therapy, cognitive therapy, group counselling, body and relaxation therapy, management and relapse prevention techniques, etc.);
- Information and education sessions (information about addiction, the harm caused by the various drugs, the risks related to injecting drug use – AIDS/hepatitis B and C -, relapse prevention, etc.);
- Occupational therapy and social integration sessions (projection of videos, sporting and educational activities, music, writing and drawing workshops, etc.);
- Psychosocial support and rehabilitation measures, family support and post-hospitalisation monitoring.

Following the initial assessment to evaluate the severity of the addictive behaviour and the possible existence of psychiatric and/or somatic comorbidity, drug users join a "residential detoxification programme" which last between 5 and 10 days and requires a toxicological and biological exam, as well as medical care to manage the symptoms of withdrawal. Treatment is individualised based on the psychoactive substances to which the patient is addicted and on any comorbid psychiatric and/or physical symptoms. The patient is then, following a second evaluation, supported through post-hospitalisation care which includes therapy focused on the prevention of relapses and on occupational therapy, all delivered in accordance with a well-established roadmap. The duration of this second phase is 3 months, and it is renewable on the advice of the healthcare team. The centre remains open year round and guarantees its patients complete confidentiality.

The men's unit has 4 inpatient beds and 12 beds for post-rehabilitation outpatients. The women's unit has 2 inpatient beds and 4 post-rehabilitation outpatient beds.

5.2.3.2. The addictology department at Ibn Rochd university hospital in Casablanca

The addictology department at Ibn Rochd university hospital in Casablanca offers treatment for addiction disorders on an outpatient or inpatient basis. On average, this centre sees 40 patients a day with nearly 12 new cases every day.

The hospital welcomes patients of all ages. They are generally between the ages of 14 and 50, and 28 on average. Patients are school students, university students, the employed and unemployed alike, and persons on the edge of society. Those requiring inpatient care are admitted to a rehabilitation unit. However, the unit's capacity is limited to ten patients, two patients in each room. The unit is equipped with facilities for occupational therapy, sports, reading and leisure activities. Patients have access to a variety of sports and leisure activities. Patients are kept apart from their friends, families and anything that is a reminder of their past habits.

The length of hospitalisation varies between 1 and 3 months depending on the progress of the treatment, the degree of addiction and the nature of the drugs used. This is a period of complete abstinence during which patients promise not to use drugs.

S.2.4. The Opioid Substitution Treatment (OST) programme in Morocco

The OST programme in Morocco is part of the national programme for reducing risks related to drug use, particularly injecting drug use.

There was a national consensus on the choice of methadone as the substitution substance, based on the cost effectiveness and other advantages offered by this substance.

The programme's main aims are to prevent viral contamination (HIV, hepatitis and other infectious diseases) among injecting drug users, ensure the availability of better medical treatment, encourage a reduction in illicit drug use and provide this group with better opportunities for social integration.

The introduction of maintenance-oriented opioid substitution treatment in Morocco was the subject of full-scale consultations between stakeholders. This concerted approach also led to the drawing up of "practical recommendations for promoting the implementation of the substitution treatment programme". On the basis of these recommendations, three pilot programmes (Salé, Tangier and Casablanca) were given permission in June 2010 to prescribe this substance to opioid-dependent users on a "high safety threshold" basis.

Under the national protocol, the pilot phase was governed by two key principles: daily on-site dispensation and supervised taking. This rigour was justified by major concerns relating to the social acceptability of methadone at the time of its introduction. But the protocol also allowed for a move towards more flexible dispensation procedures (dispensation in small doses taken at home), provided patients were stabilised and the methadone programme was well established socially and politically.

The evaluation of methadone use as part of the review of the Action Plan for Harm Reduction 2008-2011 shows clearly that, in terms of technical content and professional practices, Morocco now possesses a solid bedrock of knowledge enabling it to look ahead confidently to an upscaling of access to methadone substitution treatment.

To upscale the programme at national level, i.e. increase the number of patients receiving methadone from 120 to 2 000 by 2016, the following two measures have been applied:

• Authorisation for methadone to be dispensed by instalments (once a week, or every two weeks for those living a long way from the centre). This has enabled the existing centres to include new users who were on a waiting list without necessarily having to increase the number of staff responsible for prescribing and dispensing methadone.

• Training for physicians from other medical specialisms in prescribing substitution treatment. The fact is that Morocco does not have enough psychiatrists for national upscaling as planned. Whatever the profiles of the future teams, it will be necessary to ensure that they have all acquired a minimum core of knowledge in the treatment of addiction and demand reduction approaches. General practitioners and paramedical staff working in basic health centres can contribute greatly to the success of this critical upscaling process. Theoretical and practical training for these health workers is provided by means of the university diploma courses in addictology run by the Faculties of Medicine of Rabat and Casablanca. Both universities already train some forty general practitioners and psychiatrists every year.

In addition to the two mentioned above, the upscaling process calls for the following additional measures:

- Establishment of a partnership with hospitals: encouragement should be given to the setting up of official partnerships between methadone centres and the hospitals treating patients on methadone for other conditions. The idea would be to ensure that the quantity of methadone corresponding to the required daily doses is available during the period of hospitalisation; the methadone would be kept by the hospital care team and distributed to patients on a daily basis.

- Introduction of buprenorphine: the national protocol prioritised methadone for the introduction of opioid substitution treatment largely for cost-efficiency reasons. While it might have been legitimate to take account of the drawbacks of buprenorphine (particularly in the event of misuse) in deciding to exclude it when OST was introduced in Morocco, the public authorities and professionals can now, based on the success of the pilot phase, contemplate introducing buprenorphine, particularly for the patients whose profile matches its indications most closely. Buprenorphine could be introduced initially in the first three pilot centres, whose teams are trained in prescribing it, before being extended to other prescribers.

Where prisons are concerned, it is recommended that the first step should be to guarantee continuity of care for persons given substitution treatment before imprisonment and to contemplate the initiation of substitution treatment in prison while ensuring continuity after release.

His Majesty King Mohammed VI inaugurated the first methadone centre in a prison in Morocco in Casablanca in 2011. Oukacha prison is the country's largest, with a capacity of up to 8000 inmates.

Consultations were carried out in 2012 with a view to developing a model for methadone prescription in prisons and producing a guide on this subject. The report that emerged from these consultations estimates that nearly 10% of drug users are in prison. Based on the planned coverage at national level (2000 people on substitution treatment in 2016), and bearing in mind that 10% of OSTs (i.e. 200 in 2016) will be administered in prisons, the report proposes phasing admission to the prison methadone programme as follows:

Table 5.2: Phasing of admission to the prison methadone programme

Year	2012	2013	2014	2015	2016
Number of IDUs on methadone in prison	0	75	100	150	200

Imprisoned opioid users will have access to OST according to the following main admission criteria:

1. The prisoner is a new arrival and comes forward because he was already in a programme outside prison or in another Moroccan prison;
2. The prisoner is a new arrival and comes forward because he was already in a programme in another country (in or outside prison);
3. The prisoner is a new arrival but did not come forward. His presence is noticed thanks to the weekly exchange of active patient lists between specialised centres and prisons;
4. The prisoner is recognised as an injecting drug user by the general practitioner during a consultation. HIV-positive patients are always given priority;
5. The prisoner comes forward spontaneously as a heroin addict and asks for help.

To this end, a tripartite agreement will be signed between the Ministry of Health, the Directorate-General of Prison Administration and Rehabilitation and the non-governmental organisations operating in prisons. Its purpose will be to ensure continuity of care for those arriving in prison (who were receiving substitution treatment before their imprisonment) and for those leaving prison (who were receiving substitution treatment while in prison).

S.2.S. Prospects for the methadone programme in Morocco

The prospects for the methadone programme in Morocco are as follows:

- Setting up of addictology units integrated with the new psychiatric hospitals planned in the regions, for hospital treatment: Oujda, El Kelaâ des Sraghna, Kenitra and Agadir;

- Setting up at each priority site of at least one specialised treatment centre for women (drug users and mothers, sisters and wives of drug users) focusing on reproductive health (contraception, pregnancy, caring for children) and the violence and stigmatisation faced by women. Such centres should develop and promote methods of intervention/treatment suited to the country's social and cultural conditions and train health professionals in gender-specific care and interventions;

- Provision of community reintegration services for young drug users together with all the necessary facilities (accommodation, vocational training workshops, etc.) to help the young beneficiaries to become reintegrated more quickly;

- Setting up of a coherent, integrated data collection system meeting all needs, those of the facilities themselves and those of the ministries and national and international partners in the field of drug demand reduction.

Table 5.3: Prospects for the methadone programme in Morocco

	2012	2013	2014	2015	2016
1. Authorise dispensation of methadone by instalments for stabilised patients.	X				
2. – Test "care sharing" in Tangier	X				
- Extend "care sharing" to the whole country.		X	X	X	X
3. Develop a short intensive theoretical and practical training module for future prescribing GPs, common to the three existing methadone centres	X				
4. - Determine the arrangements for remunerating prescribing GPs and nurses who provide on-call services	X				
- Apply these arrangements to all members of the scheme.		X			
5. – Test high-dose buprenorphine in the three existing centres prescribing substitution treatment.		X			
- Extend high-dose buprenorphine prescription to the whole country.			X	X	X
- Draw up and test a protocol to ensure continuity of care for patients on methadone hospitalised for other conditions		X			
- Send this protocol to all hospital departments likely to receive such patients			X		
Develop a model and produce a handbook for prescribing substitution treatment in prisons	X				
Test and evaluate arrangements for continuity of substitution treatment for persons imprisoned in Tangier, Nador and Casablanca		X	X		
Extend to all priority sites the contract between methadone centres and the prison administration to ensure continuity of care for those receiving it prior to imprisonment				X	X

6. Health consequences of drug use

6.1. Analysis of the epidemiological situation of infectious diseases related to drug use in Morocco

According to sentinel surveillance (2014 National Report on the Implementation of the Policy Declaration on HIV/AIDS of the Ministry of Health), HIV prevalence in Morocco remains low and relatively stable in the general population (around 0.14%) and among pregnant women (0.1%). However, it is much higher in the key groups most exposed to risks of HIV infection, such as sex workers (2.0%), men who have sexual relations with other men (4.5%), injecting drug users (14%) and migrants (4.5%). High prevalences were also recorded among certain vulnerable groups such as prisoners (0.3-1%) and seasonal workers (0.4-1%).

According to the report, injecting drug users and their partners account for 6.5% of new infections in the country. These overall figures hide a situation which is in fact very varied. Surveys among users since 2005 show a highly contrasting situation as regard intravenous injection use and the prevalence of HIV and HCV.

The north of Morocco, and especially towns on or close to the Mediterranean coast, seems to be the focal point both for heroin use and for intravenous injection use. There are four main sites: Tangier, Tetouan, Nador and Al Hoceima. By “site” we mean the main town and the surrounding communities. The mobility of drug users between (especially southern) Europe and northern Morocco is no doubt an important factor for understanding the spread of heroin, cocaine, injecting drug use, HIV and HCV in this part of the Kingdom.

HIV prevalence in the four sites in northern Morocco is quite varied. While it is zero in Al Hoceima (no cases in 2008) and low in Tangier (0.4% in 2010), a prevalence rate of 25% was found in Nador (2011). In the absence of appropriate bio-behavioural studies, the situation in Tetouan is not precisely known, but evidence suggests the existence of an epidemic centre whose scale is unknown. Voluntary screening carried out by the ALCS in December 2011 in a non-custodial environment revealed a seroprevalence rate of 18% (6 HIV-positive out of 34 tested).

HCV prevalence was 9.3% in Al Hoceima (2008), 45.4% in Tangier (2010) and 73% in Nador (2011). A number of these people would seem to have been contaminated in the first few months or years of intravenous injection use.

Other pockets of injecting drug use were identified in Berkane (eastern region) and Casablanca.

The majority of injecting drug users are in socio-economic situations which tend to place them among the disadvantaged or disaffiliated social categories. Typically, they are single men aged 30-35 with little or no education who have never worked or work on an occasional basis, and who still live at the family home or live with friends or relatives.

Risky practices related to injecting drug use are both numerous and very widespread in this group. The most commonly reported ways in which injecting equipment is shared are:

- Needle sharing: two or more users share the same syringe after some perfunctory cleaning, with cold or, at best, hot water;
- Sharing the spoon used for preparing the substance, with each user drawing off part of the liquid;
- Using the syringe as a measuring instrument: all the liquid is drawn off into the same syringe. The graduated scale on the syringe is used to determine each user's share; the other user's share is put back in the spoon. He/she then uses his/her own syringe to draw off the liquid from the shared spoon;
- Re-using a syringe abandoned or hidden by another user. Out of fear of the police and/or the family, some users hide their syringes at their usual places of use. When an injector runs out of syringes, he/she can find ones that others have hidden. In so doing, he/she takes the risk of using a syringe without knowing its owner and, *a fortiori*, the person's HIV and HCV serological status. There are added risks in re-using one's own syringe and sharing water used for preparation and rinsing.

In the RDS survey held in Tangier (2010), the sharing rate in the previous month was 33.1% for needles, 35.9% for water used for preparation, 35.1% for water used for rinsing, 35.2% for spoons and 32.3% for cotton/filters. In the RDS survey held in Nador (2011), the sharing rate in the previous month was 36.2% for needles, 44.5% for water used for preparation, 41.8% for water used for rinsing, 40.0% for spoons and 31.1% for cotton/filters.

In addition to the sharing of injecting equipment, other practices pose a risk of HIV and/or HCV contamination: 84.1% in Tangier and 83.1% in Nador had re-used their needles in the previous month and 35.9% et 29.9% respectively had used already used needles the last time they had injected drugs.

Although nearly all respondents (98.2% in Tangier and 99.2% in Nador) said they “always” or “sometimes” disinfected the needle prior to re-use and/or sharing, 96.5% in Tangier and 89.3% in Nador used water for this purpose. One in every two users (Tangier 45.9%; Nador 5.8%) had injected for the last time in the street, where the risk of sharing injecting equipment is high.

This risk-taking is particularly worrying when it is combined with a lack of knowledge about how HIV/HCV is transmitted. In this group, it is as if practices posing risks and knowledge of those risks came in reverse order: the former are frequent and numerous while the latter tends to be sketchy and/or totally erroneous.

Whether it is sketchy, wrong or right, knowledge of the risks differs considerably according to the virus (HIV or HVC), but also, where the same virus is concerned, according to the equipment available.

For example, knowledge about how HCV is transmitted when injecting equipment is shared is more confused than in the case of HIV. Many respondents consider that HCV is less likely to be transmitted that HCV when injecting equipment is shared. This is obviously at variance with the scientific data available on the virulence of these two viruses. These examples show a real ignorance about HCV transmission and, to a lesser extent, HIV transmission. This ignorance is all the more serious when one considers that many of them are seropositive to this virus and that some of them were contaminated from the start of their injecting drug use, probably in the first few months.

Where sexual risk-taking is concerned, of those who had had sexual relations in the previous 12 months:

- 58.2% in Tangier and 75% in Nador had never or rarely used a condom;
- A little under one in four (Tangier 23.9%; Nador 24.7%) had not used a condom the last time they had had sex;
- 18.0% et 24.4% respectively had had sex for money (prostitution) ;
- 24.4% in Tangier and 18.8% in Nador had had sex other than with their regular partner in the previous 12 months.

Among the sites for which reliable data are available, the situation in Nador is unquestionably the most worrying in terms of the HIV and HCV epidemics. Although the causes of the development of this concentrated focal point of the HIV and HCV epidemics cannot be determined from the data available, it is at least possible to identify three factors which would seem to have interacted:

- The first is related to Nador's geographical location on the border of the Spanish enclave of Melilla. Together, Melilla and Nador form a "common market" for drugs and, at the same time, a "drug use scene" common to users from both urban areas. It is perhaps no coincidence that most injecting drug users are concentrated within a radius of 15-20 km around the enclave;

- The second factor is related to the mobility of drug users in this region between Morocco and Spain. Spain was and still is the first country of destination for immigration to Europe from the Nador region. In the 1980s and 1990s, HIV prevalence in Spain was among the highest in Europe. It is highly probable that the mobility of drug users between Spain and Morocco, combined with the mingling of injecting heroin addicts on the Nador-Melilla drug scene, contributed jointly to the transfer of the HIV epidemic from Spain to this region.

- The third factor is related to the shortage of sterile needles due to difficulties of access to pharmacies.

6.2. National response to the spread of the HIV and HCV epidemics

The national response to the spread of the HIV and HCV epidemics among injecting drug users is exemplary in many respects. The key factors behind this success are three in number:

- A desire from the outset to give political support at the highest level to a coherent risk reduction strategy based on actual local conditions but enriched with the latest international advances in this field. This political support was an important lever for initiating and speeding up the implementation of the risk reduction policy.

- The ability to mobilise national and international resources to implement this policy and ensure the sustainability of actions taken. For example, support from the Global Fund to fight AIDS, Tuberculosis and Malaria (Round 6) was instrumental in launching activities in the field in Tangier and Nador. Thanks to the tangible results achieved, this support was even a catalyst in mobilising resources from other sources, such as the INDH and DROSOS. The technical assistance received from UNAIDS and other partners for implementation of the various components of the policy also helped ensure high-quality supervision owing to the involvement of international consultants.

- The mobilisation of professionals and civil society players who, putting aside all rivalries and conflicts of interest, were able to design in record time and implement all the necessary or planned actions. During this period, the main players active in this field were able to organise into associations and form a network, and thus establish strategic links with other partners in order to maximise efficiency.

Moroccan harm reduction policy has as its main aim “to secure access for drug users to prevention, HIV screening and good-quality treatment and care services”. This aim was reflected in the field in (1) the stepping up of prevention activities meeting the needs of IDUs exposed to the risk of HIV and HCV infection; (2) ensuring access for identified IDUs to appropriate screening, treatment and care; (3) stimulating community responses to drug users in the fight against HIV/AIDS; and (4) establishing national steering of the harm reduction system in order to guarantee the complementarity and coherence of the whole.

To achieve this aim, three working priorities were set: systematic targeting of hard-to-reach populations (outreach work and needle exchange programmes); putting in place substitution (methadone) maintenance programmes; and encouraging the development of self-help groups among drug users.

Although they have different purposes, these three priorities complement one another in terms of their end goal: the systematic targeting of hard-to-reach populations seeks to change individual behaviour; methadone dispensation programmes seek to change lifestyles and, in particular, bring drug users out of clandestinity; self-help seeks to change norms in the drug sub-culture through "inside" action. These three priorities interacted to produce unarguably satisfying results.

Over the four years of the plan (2008-2011), it was possible to carry out a large number of risk reduction activities. Among the most important, the following may be mentioned:

- Designing prevention aids for IDUs;
- Implementing local prevention activities for the most hard-to-reach IDUs, including a fixed centre in Tangier and three mobile units in Tangier, Nador and Tetouan, staffed by over 20 paid employees;
- Access to HIV and HCV testing at the fixed centre in Tangier;
- Setting up and expanding methadone substitution programmes at three trial sites (Tangier, Salé and Casablanca) ;
- Establishing the first drug users' self-help group, which participates actively in prevention activities aimed at IDUs, in particular via its newsletter written entirely by users for their peers ;
- Launching vocational rehabilitation projects with the help of a Catalan association (Casal Del Infante);

- Training dozens of professionals in harm reduction measures and methadone prescription;
- Repeatedly advocating harm reduction and the human rights of users;
- Conducting numerous surveys, rapid situational analyses and RDS studies;
- Conducting prevention and peer education activities in many Moroccan prisons;
- And setting up a national steering committee in charge of harm reduction.

At the end of 2011, the following projects were operational:

- Three local harm reduction schemes were operational and had experience (Tangier, Tetouan and Nador);
- Over the period as a whole, some 3300 IDUs were reached by prevention activities at the three sites;
- Over the period, 278 000 needles were distributed, with a 40% return rate for used needles.
- Another two local harm reduction schemes were taking shape at the end of the programme (Rabat and Casablanca), without a needle exchange programme.

6.3. Mortality related to drug use and mortality among drug users

Data on the harm caused by illicit drugs are much harder to come by than in the case of licit substances. In particular, little is known about the long-term effects of chronic use because of the relatively recent nature of this phenomenon and the, by definition, more hidden and clandestine nature of use of these substances. Comparisons of mortality data must take particular account of this problem.

At present there is no national register containing data relating specifically to mortality related to drug use and mortality among drug users.

7. Harm reduction and social reintegration of drug users

7.1. National Strategic Plan against AIDS 2012-2016

The primary aim is to reduce new HIV infections among injecting drug users by 50% by 2016.

This aim forms part of the implementation of the aims of the Policy Declaration on HIV/AIDS adopted in the wake of the high-level meeting in June 2011 and the "three zeros" of eliminating HIV/AIDS: zero new infections, zero deaths and zero discrimination.

To achieve this primary aim, the National Strategic Plan against AIDS 2012-2016 sets four specific objectives:

- IDUs at all priority sites to have access to regular, high-quality combined prevention activities delivered by local teams;
- IDUs at all priority sites to have access to opioid substitution treatment to prevent drug injection;
- IDUs to be provided with combined, comprehensive medical and psychosocial treatment;
- Co-ordination and management of demand reduction arrangements to be optimised at national and local level.

Table 7.1: Targets for coverage by the demand reduction programme of IDUs and current "active" injectors

	Base values (2011)	2012	2013	2014	2015	2016
Number of IDUs (heroin and/or cocaine/crack), all routes of administration combined, who have benefited under the programme	1700	2000	2400	2700	3200	4000
Number of active injectors who have benefited under the programme	ND	600	1000	1300	1600	2000

HIV prevention among drug users is part of the first expected outcome of the National Strategic Plan 2012-2016: "50% reduction in new HIV infections by 2016". The expected outcome is to extend harm reduction measures for IDUs to reach 4000 IDUs with local prevention programmes and 2000 with methadone substitution treatment by 2016. Annual coverage targets have been set together with monitoring and evaluation indicators, including the indicators of the policy declaration. The plan's objectives and targets have been adjusted for the regions where injecting drug use is prevalent, under regional strategic plans launched in 2012.

The demand reduction programme, in place in Tangier since 2008, has been consolidated and extended to Tetouan and Nador under a partnership between the Ministry of Health, AHSUD (Hasnouna Support Association for Drug Users), the Association *RDR/Maroc* and the ALCS.

A new national plan for harm reduction among IDUs was drawn up for the period 2012-2016 based on a participatory approach involving all stakeholders. The availability of a range of services is guaranteed in all the geographical areas concerned, including local awareness-raising and educational activities, distribution of injection kits and condoms, collection of used needles, social support, self-help and methadone substitution treatment.

This period has seen the consolidation of the methadone substitution programme in place in Tangier, Salé and Casablanca since June 2010, the recruitment of new IDUs to the programme, which has continued at the three centres, reaching 300 at the CMP in Tangier, 42 at the Ibn Rochd addictology centre in Casablanca and 26 at Ar-razi hospital in Salé. The programme has also been extended in Tetouan and Nador.

Furthermore, with a view to introducing substitution treatment in prisons, rules and procedures for methadone prescription and dispensation in prisons have been drawn up in the form of guidelines and a handbook.

A bio-behavioural RDS survey carried out among IDUs in Tetouan provided updated data on IDUs and strategic information for strengthening the demand reduction programme.

A 52-minute documentary entitled "*Ceux de M'sallah*", filmed in the M'sallah district of Tangier with the assistance of AHSUD, was broadcast on the national TV channel 2M on 1 December 2013. This film highlights the work done by the Ministry of Health and Civil Society, which has led to a reduction in injecting drug use in Tangier and in HIV transmission among injecting drug users.

On the strength of the expertise acquired through its work in the field, AHSUD set up a resource and training centre on drug-related harm reduction in 2013. This centre is designed to meet not only the capacity building needs of national stakeholders, but also, on request, those of other countries of the Maghreb and French-speaking Africa.

2 231 injecting and non-injecting drug users were covered by the programme in 2012 and 2 839 in 2013. The average number of needles received by injecting drug user by year was 75 in 2012 and 68 in 2013. The number of IDUs on methadone substitution treatment was 367 at the end of 2013.

7.2. Introduction of methadone substitution treatment in prisons

The National Strategic Plan against AIDS 2012-2016 provides for the strengthening and expansion of the harm reduction programme for IDUs, including the provision of methadone substitution treatment at the main places of use, including prisons.

A decisive impetus was given by His Majesty King Mohammed VI, who launched the introduction of methadone in Oukacha prison in Casablanca. Harm reduction measures are supported by the Mohammed V Foundation for Solidarity under an agreement with the Ministry of Health and the Ministry of the Interior for the construction of 7 harm reduction centres across the country.

An evaluation of the harm reduction programme and the pilot programme on methadone substitution treatment was carried out at the end of 2011. It showed the relevance of the work done in the Moroccan context, with teams gaining experience in the practice of harm reduction and substitution treatment, thus permitting an extension and upscaling of the programmes across the territory.

For this purpose, Morocco drew on international technical assistance, involving close co-operation with the Mental Health Department, which runs the methadone programme, the steering committee of the methadone programme, the National Anti-AIDS Programme, the Directorate-General of Prisons, UNAIDS, UNODC and the Global Fund's management unit, to support the process of introducing the methadone substitution programme in prisons in Morocco.

This co-operation gave rise to an operational model for introducing a substitution programme adapted to the prison context in Morocco.

The model includes inter alia the following components:

- A stocktaking and needs analysis relating to the introduction of the substitution programme in prisons;
- Recommendations for the implementation of the programme and the various stages in this process;
- Criteria for admission to the substitution programme in prisons for persons already on substitution treatment prior to their imprisonment and those requiring substitution treatment ;
- Procedures for dispensing methadone in prisons: places and times of dispensation, amounts to be dispensed, dosing of methadone and urine testing;

- Organisation and management of dispensing teams, and necessary equipment;
- Methods of planning and managing methadone stocks;
- Organisational aspects of the programme, including: referencing and cross-referencing systems, management and co-ordination with external services dispensing methadone substitution treatment;
- Availability and use of other means of prevention, including needles, syringes and condoms;
- Supporting measures to be implemented;
- The information and monitoring system to be put in place.

The coverage target is 10% of beneficiaries of the OST programme (200 in 2016) in Moroccan prisons.

7.3. Social reintegration of drug users

In a discriminatory legal and socio-cultural context, drug addiction inevitably leads users to marginalisation, growing isolation and precarious living conditions.

Many Moroccan voluntary associations are working to help drug users with their social reintegration.

Of these, the National Association for Drug Harm Reduction (*RDR-Maroc*) was set up on 18 July 2008 to act as an umbrella for the different harm reduction activities for drug users and to encourage the setting up of dedicated associations at national level and the development of civil society's skills in the field of drug-related harm reduction.

RdR-Maroc is a Moroccan not-for-profit organisation working to prevent, treat and reduce the risks associated with addiction in general and psychoactive substance use in particular.

Its members include not only health professionals and other relevant professionals/stakeholders, but also parents and friends of users or former users. It has 5 regional sections, in Nador, Al Hoceima, Oujda, Rabat and Marrakesh, and 3 preparatory committees, in Tangier, Larache and Casablanca.

Its missions are to:

- Raise awareness of, and prevent, the social and health risks associated with drug use;
- Support drug users so that they become active labour force participants and agents of development;
- Assist drug users with their rehabilitation and reintegration;
- Defend the rights of drug users as full citizens;
- Combat the stigmatisation and social exclusion of drug users;
- Foster and support research into harm reduction for drug users;
- Mobilise and bring together players involved in drug harm reduction in order to combine thei efforts at regional level.

At present, measures for the rehabilitation and reintegration of drug users are still limited and depend on partnerships and networking between different Ministries (Health, Youth and Sport, Employment and Social Affairs, etc.).

8. Drug-related crime and prisons

8.1. National policy against drug abuse and drug trafficking

8.1.1. Morocco's comprehensive approach to the fight against drugs

Conscious of the need for a comprehensive, integrated approach to drugs, Morocco bases its action against drugs on a strategy geared to reducing supply, suppressing both trafficking and demand and putting in place measures to promote alternative development.

In concrete terms, this strategy puts the emphasis on police operations, eradication of cannabis cultivation, particularly through programmes to develop alternative crops, and demand reduction, which depends on economic development, to slow down cannabis production in the country's northern regions.

On an institutional level, Morocco set up an Anti-Drug Co-ordination Unit (UCLAD) in 1996, in an effort to improve co-ordination between the different departments responsible for law enforcement, and a National Commission on Narcotic Drugs.

Since 2005, a national anti-drug strategy has been implemented, calling for efforts to be concerted to ensure co-ordination both on an institutional level and in terms of the implementation of multidimensional actions common to several sectors.

For example, as part of the comprehensive approach adopted in the field of supply reduction, eradication operations are combined with a broader approach encouraging alternative development and replacement crops.

Major, overarching projects are accompanied by other projects aimed at combating poverty and hardship and promoting human development in the overall context of the National Human Development Initiative (INDH).

This strategy of control and prevention has enabled the Moroccan authorities to reduce the areas on which cannabis is grown by 65%, from 134 000 hectares in 2003 to 47 500 in 2010 (in 2010, 9 400 hectares were eradicated).

The implementation of large-scale eradication and anti-drug trafficking campaigns has necessitated the investment of substantial financial, material and human resources.

Since 2009, the Moroccan government has implemented an integrated alternative development programme, with a budget of 900 MDH, in the country's northern provinces. Several socio-

economic and environmental development projects have been launched, targeting 74 rural communities.

8.1.2. Efforts to suppress drug trafficking

Morocco's efforts in this field have been focused mainly on setting up specialist units, stepping up controls and modernising facilities at sea, land and air borders. The total quantities of narcotic drugs seized by customs have been on the rise since 2004.

The government has increased the police presence in the Rif mountains and northern coastal areas to intercept drug shipments and man drug control posts. The Moroccan navy conducts the usual sea patrols. Moroccan government forces now use helicopters, planes, fast boats, mobile X-ray scanners, ultra-sound devices and satellites in their fight against drugs.

Under Moroccan law, the maximum prison sentence allowed for drug trafficking offences is 30 years and fines for illegal drug-related offences range from 20 000 to 80 000 dollars. Ten to fifteen years' imprisonment remains the typical sentence for big drug traffickers convicted in Morocco.

8.1.3. Cannabis cultivation and production / Eradication of cannabis crops

Along with Mexico and Afghanistan, Morocco remains a major producing country. However, cannabis production is falling constantly as the area under cultivation decreases. The Moroccan government has achieved a significant reduction in the production of cannabis and cannabis resin in the last few years. The total area under cultivation had gone down to approximately 47 000 hectares in 2013 (UNODC 2013 World Drug Report).

On the other hand, indoor cultivation in Europe, the United States and Oceania remains a problem. To give an idea of the scale of the problem, the DEA estimated the quantity of cannabis grown in the USA in 2012 at nearly 4 400 000 plants. A major eradication campaign was mounted in 2013.

Morocco's efforts to combat illicit cannabis cultivation, production and trafficking led to the eradication of 9 400 hectares of illicit cannabis crops in 2010. The total area used for illicit cannabis cultivation fell accordingly from 134 000 hectares in 2003 to less than 47 500 hectares in 2012.

Moroccan policy on detecting and preventing drug offences is based on an overall strategy of alternative development and a programme for promoting replacement crops whose cost is estimated at 116 million dollars. These initiatives have made it possible to undertake socio-economic and environmental development projects in 74 rural communities.

8.1.4. Movement / transit of drugs

Because of its closeness to Morocco, Spain represents a transfer point for Moroccan-produced cannabis entering Europe. From Spain it can be shipped on to most other destinations in western Europe. France, Belgium, the Netherlands and Italy are major countries of destination for cannabis from Morocco.

Most large illicit shipments of cannabis to Spain are carried by sea on fast boats which can do the round trip in about an hour. Other means are also employed, such as fishing boats, yachts and other outboard vessels. Drug smugglers continue to bring cannabis across the Straits of Gibraltar by lorry and car, via the Spanish enclaves of Ceuta and Melilla and the port of Tangier.

Spain's deployment of a network of fixed and modular radar, infrared and video sensors around the Straits of Gibraltar starting in 1999, known as SIVE (Integrated External Surveillance System), forced Moroccan smugglers to take longer and more dangerous routes.

Over the last few years, drug organisations based in Latin America have started to use well-established Moroccan cannabis routes for smuggling cocaine and heroin into Europe. Although the main African redistribution centres for cocaine from Latin America are still sub-Saharan countries such as Ghana, Guinea, Guinea-Bissau and Nigeria, Morocco is increasingly used as a transit country. There is a risk of increased activity in future along the desert route leading to Morocco.

The last UNODC report on the drug use situation (2013) mentions a possible decline in cannabis production in Morocco.

8.2. Drug-related convictions

The provisions of the Criminal Code that deal with drugs are Articles 80 (Placement in a treatment facility), 571 (Handling) and 89 (Confiscation). In addition to this, an Order of the Minister of Public Health (last amended in 1997) lists all licit and illicit drugs.

With regard to the penalties for drug-related offences, these are punishable by up to 30 years' imprisonment, together with a fine of up to 60 000€ On average, however, drug traffickers receive sentences of 8-10 years.

According to figures supplied by the Moroccan authorities for the year 2011, approximately 25% of the prison population had been charged with drug-related offences ranging from personal use to trafficking as part of an organised gang.

Drug use remains a criminal offence, which sometimes leads to a feeling of stigmatisation on the part of users. According to a 2011 survey commissioned by the Directorate-General of Prison Administration and Rehabilitation, half of the 300 drug users questioned felt that they had been treated by medical personnel in a way that "infringed their fundamental rights", and 87% said they had been subjected to violence by the police. When asked to specify the kind of ill-treatment they had suffered, 83% mentioned harassment and 65% "illegal practices".

Table 8.1: Trends in the number of drug-related crimes from 2002 to 2013

Type of drug	Number of cases														
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total	Yearly average	Percentage
Kif	3800	2695	2626	2296	6809	4698	4788	3673	4172	4939	5476	9157	55129	4594	16%
Cannabis resin	17428	15712	13964	13696	11469	26725	20211	19770	22736	22876	26478	31964	243029	20252	69%
Cannabis oil	86	643	401	13	4	1	0	11	32	4	29	1	1225	102	0%
Cocaine	209	190	170	256	203	384	403	443	457	1099	433	310	4557	380	1%
Opiates	0	0	0	0	0	0	298	35	0	298	549	578	1758	147	0%
Heroin	305	261	247	348	253	364	432	571	614	347	440	400	4582	382	1%
Morphine	0	0	0	0	0	7	0	1	22	0	1	0	31	3	0%
Synthetic drugs	329	303	82	169	156	1890	93	229	307	204	155	274	4191	349	1%
Psychotropic drugs	207	380	287	171	163	87	268	229	358	513	308	425	3396	283	1%
Psychostimulants	652	1165	947	1937	1333	999	670	977	1355	991	1356	1608	13990	1166	4%
Solvents	899	948	800	940	1051	1260	1556	1103	868	1856	2129	2799	16209	1351	5%
Hallucinogenic gases	198	21	7	3	39	65	748	77	80	46	102	21	1407	117	0%
Maajoun	-	-	-	-	-	-	-	89	2	6	52	95	244	20	0%
Tobacco	-	-	-	-	-	-	-	216	393	2111	450	1733	4903	409	1%
Total	24113	22318	19531	19829	21480	36480	29467	27424	31396	35290	37958	49365	354651	29555	100%

Table 8.2: Trends in the number of persons prosecuted for drug-related crimes from 2002 to 2013

Type of drug	Number of persons prosecuted for drug-related crimes from 2002 to 2013														
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total	Yearly average	Percentage
Kif	4895	3078	3376	2878	12883	5957	7457	5070	5397	5692	6669	10539	73891	6158	16%
Cannabis resin	21973	21320	16234	15327	20312	32198	29816	29960	35150	28428	32837	39822	323377	26948	69%
Cannabis oil	100	651	523	24	6	1	0	11	32	4	35	1	1388	116	0%
Cocaine	233	225	226	359	319	547	601	578	564	1590	579	385	6206	517	1%
Opiates	0	0	0	0	0	0	564	188	0	340	595	591	2278	190	0%
Heroin	385	288	305	439	354	465	571	706	842	524	634	549	6062	505	1%
Morphine	0	0	0	0	0	8	0	1	33	0	1	0	43	4	0%
Synthetic drugs	583	387	82	200	163	2393	101	263	409	225	174	420	5400	450	1%
Psychotropic drugs	249	448	326	189	178	93	314	263	438	606	354	586	4044	337	1%
Psychostimulants	921	1341	1118	2099	1491	1007	764	1114	1628	1135	1648	2008	16274	1356	3%
Solvents	1016	1131	935	873	1157	1482	2150	1466	1007	2047	2382	4184	19830	1653	4%
Hallucinogenic	214	24	8	4	46	75	1308	89	93	53	125	21	2060	172	0%
Maajoun	-	-	-	-	-	-	-	89	3	14	68	101	275	23	0%
Tobacco	-	-	-	-	-	-	-	249	499	2204	1472	1959	6383	532	1%
Total	30569	28893	23133	22392	36909	44226	43646	40047	46095	42862	47573	61166	467511	38959	100%

8.3. Prisons

The total prison population on 1 January was 72 000, or 220 prisoners for every 100 000 inhabitants, whereas Morocco's prisons have a total capacity of 40 000 places.

In Africa, Morocco is ranked 6th for the ratio of prisoners to population. Of these prisoners, 1 152, or 1.6%, are minors.

According to figures provided by the Directorate-General of Prison Administration and Rehabilitation, 27.05% of those imprisoned, namely 19 476 persons, were convicted of drug trafficking offences. The Moroccan Observatory of Prisons reports a number of problems to do with the circulation of drugs – hallucinogenic pills and other prohibited substances – in prisons and the increased use of prohibited substances due to contacts which make it possible for drugs to be introduced into prisons and used as a medium of exchange. These practices are reportedly responsible for the spread of diseases among prisons and dangers to their health.

9. Drug supply data

9.1. ADI (Customs and Indirect Taxation Authority) data

The strategy of the Customs and Indirect Taxation Authority (ADI) follows the lines of the national strategy for reducing supply and demand. The Authority's action in this context in based on a compromise between the free flow of goods and persons and the effectiveness of controls.

In the light of the results achieved in 2013, this strategy had a deterrent effect on drug trafficking. Some relatively large seizures were recorded, on a similar scale to those effected in 2012, namely nearly 42 tonnes seized for a total of 395 recorded cases.

Cannabis resin accounts for the lion's share of the amounts seized.

Table 9.1: Quantities of drugs seized in 2012 and 2013

Type of drug	Quantities seized	
	2012	2013
Cannabis resin	41 tonnes 596 kg 986 gr	32 tonnes 104 kg
Leaf cannabis (kif)	13 tonnes 340 kg 823 gr	20 tonnes 703 kg 310 gr
Cocaine	24 kg 564 gr	14 kg 209 gr
Heroin	6 kg 628 gr	3 kg 132 gr
Psychotropic substances	67 091 units	411 024 units

Significant seizures made in 2013 include seizures of 2 981 kg of cannabis resin in Berkane and 2 048 kg in Fnideq, both in the north of Morocco.

Another significant fact worth pointing out is the use of scanners, which has contributed to the interception large quantities of cannabis resin, among others by the Regional Directorate of Tangier Med, where over 22 tonnes were seized, accounting for half of all seizures.

Similarly, a number of seizures were made of drugs transported in specially designed hiding places in vehicles driven by Moroccans resident abroad.

The beginning of 2014 was marked by increased checks on passengers at the various Moroccan airports in an effort to counter international drug trafficking. This made it possible to seize over 137 kg of cocaine originating from South America (trafficking based on the use of "mules" transiting through different airports).

Seizures of cannabis resin amounted to a little over 3 tonnes. The decline in seizures of this substance is thought to be due to increased controls at the various points of impact and the dismantling of trafficking networks.

9.2. The fight against illicit trafficking in drugs

In 2013, the police handled 18 447 cases related to illicit trafficking in drugs, resulting in the arrest of 20 898 persons.

9.3. The fight against drug abuse

In the fight against drug abuse, law enforcement handled 31 291 cases, arresting 37 770 users, including 724 minors, and seizing the following quantities of drugs:

Table 9.2: Quantities of drugs seized in the fight against drug abuse

Type of drug	Quantities seized in 2013
Cannabis resin	44 kg 12 gr
Leaf cannabis (kif)	67 kg 555 gr
Cocaine	61 gr
Heroin	11 gr
Psychotropic substances	1519 units

9.4. The fight against illicit drug trafficking and drug abuse around schools

Starting on 19 March 2008, the Directorate General of National Security (DGSN) introduced appropriate security measures to give effect to its policy of stepping up security and "cleaning up" the areas around schools and universities.

Since then, at the start of each school year, the DGSN has revitalised and optimised its strategy in order to counter the proliferation of anti-social behaviour and delinquency in the immediate vicinity of schools and universities.

An innovative approach combining prevention and punishment was adopted at the start of the 2013-2014 academic year.

The DGSN has also reactivated the joint units responsible for surveillance and protection in the areas around schools.

In the period from the start of the school year up to 15 July 2013, the police handled 810 cases, involving the arrest of 987 persons, including 866 users.

The work done by the police is especially significant in terms of drug seizures, particularly where cannabis resin is concerned, as shown in the table below:

Table 9.3: Quantities of drugs seized in 2013 in areas around schools

Type of drug	Quantities seized in 2013
Cannabis resin	08 kg 117 gr
Leaf cannabis (kif)	03 kg 969 gr
Maajoun	02 kg 109 gr
Cocaine	132 gr

10. The issue of the legalisation of cannabis for medical or industrial use

Introduction:

There has recently been a profusion of articles in the Moroccan press dealing with the issue of the legalisation of cannabis for medical or industrial use, a move advocated by some political parties and civil society movements. It was the vague and ambiguous nature of the language used by certain protagonists and journalists which prompted us to consider including this section in the report. The aim is to clarify concepts and offer some thoughts without taking any clear-cut position.

Defining the terms:

Several terms have been bandied about by the press and by some parties involved, creating doubt and confusion in the minds of readers and hence in the mind of the general public: legalisation, depenalisation, decriminalisation, legalisation of use, free sale of cannabis.

The depenalisation of cannabis means that its use is still a crime punishable by law but the punishment is waived in some circumstances (depending on the quantities involved or the number of times the person was apprehended).

Decriminalisation means that cannabis use is still prohibited but not punishable by law (personal use of cannabis). The aim is to focus judicial resources on the most serious crimes and reduce the costs involved in judicial proceedings on the condition that the resources allocated to prevention and treatment are increased. It brings the law closer to practical reality.

Legalisation means regulating cannabis use in a free market context, but with certain conditions (quantity permitted per year).

Debate in Morocco is currently focused mainly on the legalisation of cannabis production for medical and industrial use. Legalisation of cannabis use for “recreational” purposes is not on the agenda, or at any rate not yet. The debate in political circles and in society at large was not preceded by a clear campaign to explain the objectives.

The debate has engendered ambiguous and sometimes conflicting messages, creating confusion and problems of perception of the risk associated with the substance, especially among young people. “Legalising a substance for positive purposes” could be perceived as “attributing exclusively positive qualities to that substance”. After all, if a political leader advocates the legalisation of a substance, then it cannot be as harmful as all that. This is the impact the debate has on young people’s perceptions. In a country where very little preventive work is done among young people, one should not talk about legalising cannabis without making the aims very clear and without making any effort to educate the general public too. In the public health field, a message can have an emotional cost. This is when the impact of a message or idea on collective perceptions is much less favourable than the aim initially sought.

Moroccan society is relatively conservative. Any message that can be perceived as permissive or lax could have a negative emotional cost among the general public that would outweigh the expected benefits.

It is perfectly legitimate to consider legalising cannabis for medical and industrial use, but there are some major preconditions:

- clear and instructive information and communication campaigns
- a prevention programme targeting young people
- strict control of production and distribution channels.

Where this last point is concerned, different models have been adopted around the world for the legalisation of cannabis for medical or industrial purposes, involving different processes and pursuing different aims. The most common model is based on state control, with licences granted to private companies to harvest cannabis, undertake pharmacological or industrial processing and then distribute and sell it. The state collects taxes on this operation.

Some will say that it is sufficient to legislate. A law is a text, but it is also a practice and, above all, it has effects. Some questions arise:

- how will it be possible to control production and distribution in future if it is difficult to do so now to combat trafficking?
- how will it be possible to control prices on the illegal market given that there will always be "recreational" users of cannabis? In other words, what's the point of legalising cannabis at the entry point if you can't control trafficking through the back door?
- how will it be possible to control the type of plant, which is constantly changing (amount of THC vs. amount of CBD)?
- even assuming perfect control, how would it be possible to control the arrival on the market of cheap synthetic cannabis, a real global threat today, to make up for the shortage of cannabis on the illegal market?
- how would it be possible to counter the temptation of licensee companies to promote by-products, and what impact would that have on young people's perceptions?

There are countless questions. The answers form the basis for thinking about the preconditions for any initiative to legalise cannabis for medical or industrial use in Morocco. Whatever the scenario, no legalisation policy should be undertaken without serious measures to prepare the ground, such as sustained and appropriate prevention campaigns aimed at our young fellow citizens.

Part B. Summary and recommendations

Summary of the drug use situation in Morocco

Key facts:

(These facts are mainly based on the national household survey on mental disorders and drug use, 2006, MEDSPAD national surveys 1 and 2, 2009 and 2013, and the RDS surveys among injecting drug users in the northern region).

1. Tobacco is the most used drug in Morocco, followed by cannabis, alcohol, misused benzodiazepines, cocaine, heroin, solvents and other glues, then amphetamines.
2. No detailed study has been made of the prevalence of tobacco, amphetamines and other synthetic drugs in the general population.
3. The average prevalence of drug use, excluding tobacco, is between 4 and 5% of the adult population, in other words a minimum of 800 000 drug users (drug use does not necessarily mean abuse or dependence, for which more precise criteria are required).
4. Over 95% of these users are cannabis users, in other words over 750 000 Moroccans.
5. It is estimated that a minimum of between 50 000 and 70 000 Moroccans suffer from problem drug use.
6. At least 20 000 Moroccans are heroin users. At least two-thirds of these are injecting users.
7. Half of the injecting heroin users carry HIV or HCV.
8. At least 20 000 Moroccans are cocaine users.
9. At national level, one out of every five secondary school students has already smoked a cigarette and one out of ten has used cannabis in their lifetime. One out of every ten is a current tobacco user and around one in thirty is a current cannabis user.
10. Misuse (non-medical use) of benzodiazepines tends to be mainly confined to female secondary school students.
11. Half of Moroccan secondary school students have a perception of drug use that minimises the risks involved.
12. One out of every three secondary school students has been offered drugs at one time or another in the vicinity of the school (strong environmental exposure).
13. Use of solvents and glues is mainly confined to street children.
14. Use of amphetamines, especially ecstasy and MDMA, mainly occurs in nightclubs and other clubs (no detail data available).
15. Substance-free forms of addiction, especially pathological gambling in casinos and games of chance (lotteries, scratch cards, etc.), generate a growing demand for care.
16. No data available on the use of new psychoactive substances such as synthetic cannabinoids.

Recommendations:

Morocco has some obvious assets when it comes to overall management of the drug use problem, as regards both the demand and the supply side. The country can pride itself on the clear determination shown by its politicians to adopt a pragmatic, comprehensive, multidisciplinary and, above all, humanist approach to the problem.

At the same time, there are innumerable factors which risk worsening the situation. Only increased vigilance will help to curb the advance of the problem. To this end, some recommendations, mainly concerned with demand reduction, are set out below:

- Maintain and increase epidemiological knowledge and promote research;
- Continue to train qualified human resources;
- Speed up the programme for extending care provision to the whole country;
- Consolidate and expand the range of care available in the worst affected regions, in particular the north of the country;
- Set up specific programmes for prevention and treatment in the workplace (very high cost of the consequences of drug use in the workplace);
- Set up specific programmes for the prison environment;
- Set up counselling units in schools and universities;
- Step up harm reduction policies;
- Set up appropriate, especially community, rehabilitation programmes;
- Enforce and intensify the ban on smoking in public places (protect employees exposed to passive smoking: restaurants, nightclubs etc.);
- Raise the price of tobacco while countering the black market (an essential precondition), which would make it possible to allocate significant funds to prevention;
- Set up a varied and culturally appropriate national prevention programme, especially for young people and vulnerable groups;
- Pass legislation banning the sale of tobacco and drugs in areas around schools (designate drug-free zones);
- Intensify data collection and the development of a monitoring and alert system, including monitoring of new trends (ONDA);
- Combat the stigma associated with drug use and drug dependence by means of a national awareness-raising campaign;
- Promote the rights of drug-dependent patients to appropriate and accessible care;
- Maintain free care for the most needy among them;
- Encourage and support civil society initiatives;
- Strengthen ties and enhance co-operation between specialists, those who possess knowledge and technical expertise, civil society and political decision-makers.

Conclusions:

With a mean prevalence very slightly over 4% among the population at large, Morocco is close to the global average for drug use. However, there are many latent risk factors, be they demographic, environmental, economic or societal, which presage a worsening of the situation. Drug use among young people appears stable according to national surveys of secondary school students, but few figures are available for children not attending school and those living in precarious circumstances. A minimising perception of drug use among young people is a definite risk factor. The shortage of scientifically devised, culturally appropriate prevention programme adds to the risk, and it is further compounded by easy access to tobacco and cannabis.

Infections related to intravenous drug use and risky sexual behaviour under the influence of drugs generate significant public health costs and call for a strengthening of harm reduction and prevention programmes.

Other indicators needed for a proper assessment of the situation, such as treatment demand and drug-related morbidity and mortality, will be included in the next reports. Their introduction calls for human, technical and training resources which will need to be considered in future.

Morocco has made significant progress in managing drug use, in terms of demand reduction, and shows commendable political will. The programmes need to be speeded up as a matter of urgency.

An increase in ONDA's working resources is the sole guarantee of reliable and ongoing evaluation of the drug use situation and trends in that situation. This in turn is an essential precondition for the implementation of flexible, adaptable, pragmatic, effective and efficient policies for the good of the population.

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- Dahir introducing Law No. 1-73-282 of 28 Rabi' II 1394 (21 May1974) on the prevention of drug addiction, amending the Dahir of 12 Rabi' II 1341 (2 December 1922) regulating the importation of, trade in, and the possession and use of poisonous substances and the Dahir of 20 Sha'aban 1373 (24 April 1954) prohibiting kif hemp, as amplified or amended. Official Bulletin No. 3214 of 5 June 1974.

- Royal Decree No. 236-66 of 22 October 1966 ratifying and publishing the Single Convention on Narcotic Drugs adopted in New York on 30 March 1961. Official Bulletin No. 2640 bis of 5 June 1963.

III- Alphabetical list of useful data bases available on the Internet

Website of the National Observatory on Drugs and Addiction www.onda-drogues.com

IV- - List of acronyms and abbreviations used in the report

ALCS: *Association de Lutte Contre le Sida* (Association against AIDS)

ASCMPH: *Association de Soutien au CMP Hasnouna* (Hasnouna Support Association)

CBD: cannabidiol

CMP: *Centre Médico-Psychologique* (medico-psychological centre)

CNTPRA: *Centre National de Traitement, de Prévention et de Recherche en Addictions* (National Centre for Addiction Treatment, Prevention and Research)

EMCDDA: European Monitoring Centre for Drugs and Drug Addiction

HBV: hepatitis B virus

HCV: hepatitis C virus

HIV: human immunodeficiency virus

IDU: injecting drug user

MDMA: methylenedioxy-methamphetamine

MedNET: Pompidou Group's Mediterranean co-operation network on drugs and addiction

MedSPAD: Mediterranean School Survey Project on Alcohol and other Drugs

NEP: needle exchange programme

OST: opioid substitution treatment

POMPIDOU GROUP: Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs

THC: tetrahydrocannabinol

UNAIDS: Joint United Nations Programme on HIV/AIDS

UNODC: United Nations Office on Drugs and Crime

WHO: World Health Organisation