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Abstract

The Covid-19 pandemic has put the Moroccan healthcare system to the test. Although the government of Morocco has successfully contained an exponential spread of cases thus far in comparison to neighbouring Europe, the health emergency highlighted the country's own 'pandemic': a crumbling public sector, poor human resources, regional and class-based inequalities, poor governance and corruption. Based on the analysis of press articles, key documents, policy measures, and royal discourses, this paper aims to provide a timely review of healthcare in Morocco and assess Covid-19's impact on it. Moving from the opportunities and barriers to the right to health, we explore the social and political implications of the pandemic. We find that the Palace strengthened its role by capitalising on its credibility and well-established networks, while other political actors appear increasingly detached from people's everyday challenges. Furthermore, by securitising the health threat, the regime abdicates its responsibilities and further infringes on other rights, like press freedom.

Keywords: Morocco; Covid-19; Health Care; Rights and Freedoms; Authoritarianism

Introduction

The Covid-19 pandemic has been challenging much more than healthcare systems around the world. Through them, it is testing governments' ability to face unexpected crises and guarantee the safety of citizens by securing the right to health and access to healthcare. In this regard, the global pandemic put social rights enjoyment centre-stage. In a way, it acted as a reminder of the importance of ensuring lasting progress with respect to them, particularly through the development of working, universal public health services. Not unlike other countries, Morocco's Covid-19 crisis ruthlessly put the spotlight on existing criticalities, particularly the shortcomings in healthcare provision, further exacerbated by geographical and social class divides. In doing so, it highlights the many hurdles in relation to the right to health and the extent to which its realisation on the ground is far from being universal or consistent with the required standards or the opportunities

foreseen on paper. Despite the efforts made, improving key health indicators in the last decades[1] and the rising share of national budget devoted to the reform of the health sector, Covid-19 highlighted Morocco's own 'epidemics' : Poor human resources, a crumbling public sector, regional and class-based inequalities, poor governance and corruption.

In this article, we argue that the pandemic also strengthened traditional power dynamics, with the Palace capitalising on its credibility, well-established networks and resources to monitor all initiatives while other players lagged behind or later jumped on the bandwagon. Lastly, emergency measures securitised press freedom by grabbing the consensus over restrictive provisions under the guise of combating Covid-19.

The current study proceeds as follows: it first highlights how the real chain of power more markedly unveiled itself in this multifaceted crisis, making evident the king's leadership and that of his ministers at the detriment, for instance, of an unpopular and troubled Ministry like that of Health. Secondly, it zooms in on the opportunities and shortcomings of the main public health insurance mechanisms, as well as on the fragility of the health system in terms of infrastructure and personnel. The article then illustrates the chaotic situation at public hospitals in stark contrast to the 'surprise' of many politicians, dangerously detached from common people's daily problems or perfectly aware of them but able to circumvent those obstacles by resorting to private clinics or other privileges. It finally concludes with a reflection on the new blows to press freedom with the excuse of the pandemic and in regards to the royal discursive framing of the threat.

Navigating the Health Emergency: Balance of Power to the Test

In the first wave of Covid-19 globally, Morocco had successfully contained the outbreak of a major contagion. Nevertheless, numbers have incredibly soared since July 2019. As of 7 December 2020, the country has officially recorded around 379,657 cases and 6,245 deaths.[2] After more than three months of strict lockdown following the declaration of national medical state emergency on 20 March, authorities reintroduced partial lockdown measures in many cities, like Fez, Meknes, Tangier, Tetouan and Marrakech over the summer. As countries around the world are facing the second wave of Covid-19, with a worrying uptick of cases, Morocco continues to monitor the evolution of the situation, with selective lockdown and curfew depending on the zone. This section revolves around the following questions: Who are those primarily responsible for the measures enacted to curb the spread of the pandemic? How are they implemented? In fact, looking at how a basic right such as the right to health is enjoyed, and particularly in times of crisis, is highly indicative of the functioning of a given society.

Since the very beginning of the pandemic in the country, the real chain of command more markedly unveiled itself, as is not unusual in times of crisis. Notably, the Palace capitalised on its credibility, resources and well-established networks to monitor all initiatives while other stakeholders conveniently followed. The king Mohammed VI always appeared on the front line, surrounded by technocrats and his 'royal' ministers , namely those usually appointed outside political parties and imposed on the cabinet formation by the Palace. Unsurprisingly, *Abdelouafi*

Laftit, the Minister of Interior (MoI) - one of the so-called 'regalian' (royal) ministries [3]- took the lion's share. The head of government, Saad dine El Otmani from the Islamist Party of Justice and Development (PJD), just blessed the decisions taken, and almost saw the MoI take his place by becoming 'vizier instead of the vizier'.[4] Overall, government's action and political parties have been relegated to the background. Notably, Khalid Aït Taleb, the Minister of Health (MoH), was completely overshadowed by Mohamed El Youbi, the Director of Epidemiology at the same Ministry.

It is worth opening a parenthesis here about the MoH. Aït Taleb is a technocrat, and was appointed right before the Covid-19 crisis amidst a government reshuffle after the left-wing Party of Progress and Socialism (PPS) decided to withdraw from the governmental coalition.[5] He therefore replaced Anas Doukkali from the PPS (January 2018 - October 2019). Without partisan support, however minimal, or any political experience, Aït Taleb's appointment unintentionally facilitated the almost unilateral crisis management by the *makhzen*, Moroccan 'deep state' gravitating around the Palace. Traditionally, Moroccan (official) governments tend to be oversized and, secondly, always ensure the inclusion of at least a trustworthy party close to the *makhzen* – like the National Rally of Independents and the Party of Authenticity and Modernity – and technocrats, possibly in strategic departments that remain under the significant control of the monarchy. The Ministry of Health is not part of the abovementioned 'royal' ministries and it therefore has less prestige or relevance. Moreover, it is a 'troubled' portfolio, often unwanted by political parties because of the many challenges the related sector has. Suffice it to recall that a great deal of demonstrations and structural problems in Morocco concern education and health.

In the last three years (from 2017 to 2020), there have been three ministers of health including the current one, that means one minister each year on average. For instance, Houcine El Ouardi (January 2012 - October 2017), a doctor and another member of the PPS was dismissed by the king in the context of the demonstrations led by the People's Movement (*Hirak* for short) that rocked the northern Rif region in October 2016. Despite his dismissal, El Ouardi was widely appreciated by citizens for his fight against the pharmaceutical lobbies, which even earned him some death threats - an extremely rare circumstance for a Moroccan minister. He was sacked with other politicians held responsible for the delay in the implementation of Al-Hoceïma's urban development project 'Manarat al-Mutawassit' (the Mediterranean's Lighthouse). Launched in 2015, this 'package' of reforms should have seen the realisation of a number of infrastructures within the health sector, agriculture, mobility as well as cultural and touristic facilities aimed to boost the regional economy by 2019. On that occasion, many suspected that El Ouardi ended up as the scapegoat of the 'political earthquake' promised by Mohammed VI to stem off the discontent in the Rif.

By contrast, Minister of Agriculture and Fisheries Aziz Akhannouch, one of Morocco's richest men and leader of the pro-Palace National Rally of Independence, who could have been equally concerned by the scandal, remained in place. With regard to this, it is worth recalling that the Rif Hirak erupted over the death of Mouchine Fikri, a 31-year-old fishmonger who was crushed to death in the trash compactor he had jumped into to retrieve his merchandise previously confiscated

by police. The brutal episode - which immediately resembled what had happened to Mohamed Bouazizi, the Tunisian fruit-vendor who set himself on fire in December 2010 and whose death would become the catalyst for the Arab Uprisings - revealed the common practice of illegal fishing of swordfish by local inhabitants, who struggled to attain their livelihood when the time for fishing bans came; illegal fishing was a practice often tolerated by authorities. Recently, Afriquia Gas corporation, owned by the Akwa Group of Akhannouch, injected one billion MADs (approximately 91,56 million euros), with extensive coverage from private media he monopolises in the fund created by the king to face the pandemic.

Coming back to the monarchy-led containment efforts against the spread of the virus, it is not to be forgotten that all measures initially implemented - e.g., borders lockdown, blanket bans on public gatherings and restrictions on domestic travels, school and business closures, suspended group prayers in mosques - mirrored the royal roadmap. Indeed, the famous meeting held in Casablanca between the king and key civil, security and military officials spread the idea that the situation was managed by the royal Palace.[6]

Indeed, Morocco (read it the monarchy) showcased an impressive ability to enforce lockdown and mobilise resources in the mid-term. Firstly, the king urged the creation of a solidarity emergency fund starting from ten billion dirhams (about one billion dollars), which has since more than tripled.[7] Secondly, provisional infrastructures were set up at the king's initiative as well. As the Commander in Chief of the armed forces, Mohammed VI ordered the military to create and equip new medical facilities in various regions of the country to deal with the Covid-19 outbreak.[8] Moreover, part of the country's manufacturing infrastructure switched to begin producing vital medical equipment such as ventilators[9] and masks[10] so as to reach self-sufficiency in record time. Without disregarding these meritorious efforts and positive achievements, the pandemic exacerbated already glaring problems in relation to a fair and sound access to healthcare.

Realising the Right to Health in Morocco: Access and Barriers

In Morocco, the right to health care is officially enshrined in Article 31 of the 2011 Constitution.[11] Law No. 65-00 of 2002 on basic medical coverage, established two main public health insurance mechanisms. Firstly, a basic medical scheme known as Compulsory Health Insurance (AMO, *Assurance Maladie Obligatoire*) for public and private employees has been working since 2005. In 2016, this mandatory health insurance was expanded to also include higher education students. Secondly, the Medical Assistance Regime (*Régime d'assistance médicale*, RAMED) program is designed to support the poorest and most vulnerable strata of society, as it targets low-income citizens and includes coverage schemes for workers in the informal sector.[12] First tested locally in 2008, it was then extended to the national scale in 2012.

The promised universal coverage, however, is yet to come. Only sixty-two per cent of Moroccans are given access to free publicly available services, covered at thirty-four per cent and twenty-eight per cent by AMO and RAMED respectively.[13] In April 2018, the Moroccan government launched the '2025 Health Plan' to restore the health sector and address the

constitutional provisions foreseeing a universal access to healthcare.[14] Composed of three pillars, twenty-five axes and 125 actions, the main objective of this plan is the generalisation of medical coverage but its effects have yet to be assessed. This year, on the occasion of his annual Throne Day speech,[15] king Mohamed VI announced a roadmap for the generalisation of medical coverage by the next five years and acknowledged the urgent need to modernise the social protection system, not unlike the speech he delivered in 2018. Yet for nearly twenty years, the kingdom has been reforming its welfare and social security system, yet reforms are far from tangible and mostly stay on paper.[16]

It is undeniable that Moroccan health indicators have improved steadily in recent years, and that there have been many government plans to improve access to care and expand the hospital network, as well as *ad hoc* policies like price-cuts across medicines. According to prime minister El Othmani, the budget devoted to the health sector has improved in an unprecedented manner in the last twelve years. In particular, his government raised the budget of the health sector to $1.6 billion in 2019, namely a sixteen per cent increase compared to 2016.[17] But, if compared with other North African countries, Morocco's health expenditure as a share of GDP (5.8 per cent) is the lowest with the exception of Egypt.[18] In the framework of the 2020 financial law, the Minister of Health announced a further increase to 7.72 per cent of the total budget.[19] And yet, health services are still below expectations. As recently highlighted by the Minister of Health, the bulk of problems lies within the governance of the sector, and undoubtedly the gap between what is on paper and citizens' everyday life catches the eye.

In theory, RAMED should provide free coverage in hospitals to large segments of the population, but the reality on the ground is rather different. Transposed into practice, this scheme poses significant barriers to healthcare access, particularly with regard to the need to pay in advance before asking for reimbursement alongside the long waiting lists. Moreover, many other out-of-pocket expenses like transportation costs and accomodation must be added whenever the local medical centre is not able to offer the ad hoc service, an eventuality that becomes the rule.

In addition, its funding mechanism has never been fully implemented. As a result, RAMED mainly works by relying on the normal state subsidies that hospitals receive.[20] The generalisation of RAMED in 2012 led to an explosion in overall healthcare demand and put considerable pressure on public hospitals, unable to absorb it. According to RAMED operating procedures,[21] the patient-to-be shall first go to the nearest public health centre, the name of which is written on his/her beneficiary card. But very often, the closest centres lack the necessary equipment to take care of the patient and he/she is redirected to larger hospital centre, usually further away, such as university hospital centres (CHU) in big cities. Chérif-Alami rightfully points to the additional costs weighing on the patient and his/her family: [22] among others, the charges for transport and accommodation, if no relatives are able to host in the destination city so as to counterbalance the deficiencies of the system with traditional family-based solidarity networks.

A study carried out by the Italian NGO European Committee for Training and Agriculture (Cefa) as part of the *Reseau 31* project on the right to health for poor people,[23] points to a widespread dissatisfaction with the provision of medical and health services, poor at best if existent

at all.[24] Moreover, an alarming majority of respondents claim that they had to pay a bribe to be hospitalised.[25] Added to this is the corruption plaguing the ranks of officials who have an important role in granting the RAMED card and headed by the MoI; within hospitals and even up to the highest level. In 2017, for example, the Director General of the National Health Insurance Agency (ANAM) that presides over and manages both AMO and RAMED was involved in a big racketeering and corruption case in a procedure for awarding public contracts.[26] For the Moroccan Network for the Defense of the Right to Health, RAMED is a 'failure'.[27]

Beyond the shortcomings of these mechanisms, a number of heated issues equally and deeply affect the right to health on the ground. For years, Moroccan health professionals employed in the public system have been highly mobilising to protest against their dire working conditions. Low wages, congestion at hospitals and health-care centers, substandard infrastructures, and the uneven distribution of personnel and facilities across the country were among their main grievances. Since 2018, the country has been struck by a massive resignation of medical staff.

A rising discontent sparked among future physicians as well. In 2019, some 18,000 medical students went on strike for more than six months and massively boycotted classes, hospital internships and exams.[28] 'We invented the *gilets noirs*, long before the *gilets jaunes* in France' mocked El Mountadar Alaoui, secretary general of the independent labour union of physicians in the public sector (SIMSP) when describing the protest movements on the rise in the last years and their unmet demands.[29] Clad in black vests together with public sector doctors to symbolise death, they took to the streets nationwide, protesting against the government's decision to grant private medical school graduates access to public hospitals for training. Trapped in an unfair, perpetual competition with better-funded and better-equipped private medical faculties, they denounced the privatisation of medical education, the lack of training equipment and facilities, as well as the very low number of available positions in the competitive examination for interns and the high expenses they face during their course of study.

In addition, another phenomenon deeply affecting the situation is the massive exodus of Morocco's skilled doctors and para-medical staff abroad, particularly to Europe with France being the key destination. There, for instance, the adoption in 2017 of a decree for the temporary license to practice medicine,[30] dental surgery and pharmacy further encouraged this haemorrhage of qualified personnel from Morocco. The choice to leave is often driven and reinforced by uncomparable standards of working and financial conditions, to such an extent that it is almost impossible to compel them to return, as acknowledged by the MoH. SIMSP's secretary general Alaoui also explained that between 7,000 and 8,000 doctors migrated to France by the end of 2018.[31]

In June 2020, data given by the Minister of Health accounted for around 14,000 Moroccan doctors working abroad.[32] By contrast, Morocco has a ratio of barely 7.2 doctors per 10,000 inhabitants while the WHO recommends a minimum of twenty-three doctors for the same share of inhabitants, that is less than one-third of the recommended doctors. Overall, the lack of doctors is estimated at 32,000 units, and that of nurses at 67,000.[33] These numbers sound even more gloomy if one considers the country's poor human resources, even more needed and precious in times of

crisis. When Moroccan-born Moncef Slaoui, virologist and former pharmaceutical manager, was appointed by US President Donald Trump to lead his administration's race to a Covid-19 vaccine,[34] MoH Aït Taleb released a statement by welcoming the international recognition of great skilled and talented Moroccan personnel abroad.[35] Pity that against the poor backdrop in Morocco, his declaration sounds anything but bitter words.

The Covid-19 pandemic risked to further worsen this lack of human resources. In response to the pandemic, many OECD countries enabled migrant health professionals to help meet the surge in demand for healthcare, a measure having an impact on their countries of origins, which usually already face severe shortages of skilled health workers.[36] Against the backdrop of the pandemic, in France, for instance, non-licensed foreign-trained health professionals could work as support staff in non-medical occupations. These kinds of initiatives further encourage and attract human resources, but have a high material cost in the home country.

Covid-19's Impact in Morocco and Politicians' Reaction

Before the arrival of Covid-19, it was already a difficult year for Morocco due to the hurdles it would have to overcome because of the drought and given its heavily weather-dependent agriculture. According to economic expert Najib Akesbi, the harvest will be halved by the end of the year, thus seriously affecting the economy.[37] This strong decline in agricultural production dangerously coupled with the sharp decline in exports and revenues from expatriates and tourism,[38] making the situation particularly tense.

As above mentioned, Covid-19 has not only exacerbated existing criticalities, but it has also unveiled rooted systems of inequalities in an intersectional manner: regional disparities, rural-urban cleavages, and above all, class-based discrimination. During the first wave of the pandemic, social media acted as an echo chamber of the extremely precarious conditions of some hospitals and of people's daily hardships, both medical staff and patients. Many videos posted on You Tube denounce a chaotic situation on the ground, with insufficient human and material resources to face the spread of the pandemic:[39] patients waiting for hours and no one coming to visit them, others replacing medical staff in order to assist more critical patients and many heatedly protesting by banging on doors and tables and shouting 'We are in prison!'.[40] As evidence of people's frustration with bureaucracy and authorities, other amateur videos show people throwing stones at a hospital administration, complaining about beating and threats by police, with the crowd inciting the struggle to the rallying cry 'Against the government! Against the authorities!'.[41]

The situation was particularly critical in large cities such as Casablanca, Tangier or even Marrakech.[42] For instance, last September, at the Ibn Rochd University hospital in Casablanca, the economic hub of the country, about eighty per cent of intensive care patients died, whereas the average cure rate nationwide was eighty per cent.[43] For the sake of clarity, when considering these numbers one has to take into account that this centre was devoted to the reception of the most critical patients. But in these circumstances, fatalities like what recently happened at the hospital

Mohamed V in El Jadida (in the Casablanca-Settat region) where six patients died because of the lack of oxygen in the intensive care unit are even more alarming.[44]

Evidence of social stress are the many episodes of protests that rocked the country for the detrimental effects of lockdown over the economy on the one hand, and to denounce physicians' dire working conditions under the crisis on the other hand. Despite the ban on gatherings, the confinement (total or partial, such as the curfew) and the socio-economic measures that accompanied it, part of the population has reacted against such imposition. In Casablanca for example, citizens demonstrated against the closure of the city.[45] Traders have also demonstrated in several 'peripheral' cities, such as Erfoud in the poor northwestern region bordering with Algeria, against the authorities' decision to close stores, other services and cafes from six pm.[46] As for the doctors, they reacted to protest against their situation, that the Covid-19 crisis made even harder.[47]

Through a differentiated and preferential access to healthcare, the pandemic has also been a reminder of the disparity between the vast majority of people and the political élite. Indeed, the Covid-19 virus affected several politicians. Somehow ironically if not paradoxically, many of them seemed to discover, for the first time, the gloomy state of public health infrastructure and services in their constituencies. For example, MP Mohamed Hejira, also regional secretary of the Party of Authenticity and Modernity (PAM) in Fès-Meknes and Mayor of a small rural town in the Northern Taounate province, posted on his Facebook page: 'I have been subjected to neglect and indifference, I do not want that what happened to me may happen to other Moroccans'.[48] He complained about the total absence of the regional director and all those in charge, before promising that he would not be silent on the treatment reserved to the patients and on 'all the failures, fatal mistakes and indifference to innocent people's lives'. He concluded by drawing a terrifying observation, very rarely heard from the mouths of politicians: 'the sector is living in a complete coma'. On social media, many reacted to these criticisms with sarcasm: 'Welcome among us', 'You voted well on the health budget, didn't you?', 'Ah, when people protested what were you doing on your seat in parliament ?!'.

If Hejira finally went to a private clinic after 'discovering' the reality of public hospitals, other politicians preferred to resort to traditional herbal medicine, not always with better results. For instance, another MP, from the Marrakech Safi region, fearing to contract the Covid-19, was urgently admitted to a private clinic in the city, following the overuse of cloves infusion.[49] Traditional therapies including those of charlatans are still very popular in Morocco. Faced with the failure and poor reality of infrastructures, public authorities seem to turn a blind eye to the overrun of traditional, uncontrolled practices - which often takes advantage of the distress of the people - as well as to the visible damage to public health.

Not surprisingly, Aziz Rabbah, the Minister of Energy and Mines and Mayor of Kenitra, preferred to be treated at Cheikh Zayd Hospital in Rabat and not at the local hospital together with his wife and six members of the Kenitra municipal council. Indeed, citizens of Kenitra claimed on social media that their mayor, also a minister, should be treated as everyone else in the El Idrissi regional hospital commonly known as *Sbitar L'Ghaba*, the 'jungle hospital', a telling nickname.

Indeed, the ways in which politicians deal with public services is a very sensitive issue in the eyes of Moroccan citizens. Hence, their choices have a highly symbolic value. It is no coincidence that the king avoided getting treatment abroad during the period of the pandemic, although unrelated to the Covid-19 virus. On June 14, he underwent surgery in the local clinic of the royal Palace following 'the recurrence of the heart rhythm disorder', as specified by a press release from the Royal Palace.[50] In February 2018, the king had a similar surgery in France.[51] In fact, the monarch is usually treated, and has had surgery in, France on more than one occasion, including simple interventions, such as the surgery for a benign lesion (non-cancerous tumour of the eye) in September 2017. The last operation performed in Rabat says a lot about the attention with which the Palace manages the king's image, especially during crises, in order to show proximity with people. But it is also a message to reassure the population about the competence of Moroccan staff.

The king's state of health is causing concern to many citizens for the symbolism it embodies. The monarch is seen to be halfway between humanity and divinity. He therefore has two bodies, to recall the title of Ernst Kantorovitcz's famous essay, one referring to his human body and the other being the embodiment of the immortal and political body.[52] Indeed, on the pretext of Covid-19, the king refrained from making any official appearances as head of state for several months if not strictly necessary, but his state of health is somewhat delicate.[53]

Securitising the Pandemic (I): Who's Responsible for It?

In an attempt to sidestep or bypass an increasingly tiresome debate on whether threats are objective or subjective, the Copenhagen School focused instead on the ways in which a certain issue can be socially constructed as a threat through some 'speech acts'.[54] In this sense, the securitisation process dramatises politicised or non-politicised issues as issues of supreme priority that need to be addressed with urgency, extraordinary countermeasures and even democratic rule-breaking. With the spread of Covid-19 , these processes are extremely topical to see not only how the 'main' (health) threat is identified, but also to what extent it ends up to include a number of secondary issues for instrumental purposes. In so doing, we argue, failures to guarantee the right to health can be more easily justified, and the right to health becomes instrumental to restricting other rights.

The Covid-19 crisis is also a discursive phenomenon, whose meaning is negotiated everyday by a plurality of stakeholders: politicians, institutions, experts, journalists, medical professionals, among others.[55] In other words, the way in which the 'threat' and the responses to it are framed, constructed and discursively addressed, by whom and for whom, is part and parcel of the 'crisis management' as a whole, and not least of all healthcare itself. It is a way to treat the virus, albeit outside of hospitals and medical centres. Not surprisingly, war-related terminology was and still is commonly used to frame the discourse on the pandemic, both in public discourses and in the media, as well as by the public at large.

In August, on the anniversary of 'the Revolution of the King and the People', Mohamed VI delivered an unusual discourse.[56] Whereas the paternalistic and nationalist appeals are not a novelty, his heavy and pessimistic tone is new in itself. Describing a raging pandemic and an

'unfinished fight' which still takes place in a 'difficult and unprecedented context', the monarch recalled the 'perfect symbiosis between the Throne and the people', regardless of the many vicissitudes that punctuated the country's national history. However, he quickly transferred the responsibility of Covid-19 to a 'significant fringe of the population that does not respect the preventive health measures adopted by the public authorities' while criticising head-on this 'inadmissible relaxation'. Consequently, the monarch linked this irresponsible and potentially dangerous behaviour with the failures of State's efforts, not least the aid granted to poor families. 'This support cannot continue indefinitely, because the aid granted by the state exceeds its resources', threatened the monarch.

After the appeal to reconstitute a 'responsible citizen' in the Covid-era, Mohammed VI announced with unprecedented pessimism that the deterioration of the health situation does not leave room for optimism, and that 'whoever, dear people, tells you the opposite is a storyteller'. Unlike burden-sharing, what we might deem as a 'shock strategy' takes responsibility away from the State and weighs in on unspecified irresponsible citizens. In part, the clear narrative focused on prevention unavoidably has to counterbalance the well-known deficiencies of the system. At the same time, in this chaotic juncture, the king's words remind the collectivity who is the subject to trust, thereby reinforcing the status quo.

Securitising the Pandemic (II): Press Freedom as Collateral Damage

As mentioned in the previous section, the right to health can be more easily instrumentalised under exceptional circumstances to crack down on other rights. Globally, the consequences of the pandemic go well beyond the health sector. In Morocco, under the guise of combating Covid-19, freedom of expression was the collateral damage. Aware of its poor health equipment and infrastructures faced with a major virus outbreak, Morocco quickly realised that the Covid-19 crisis had to be managed especially outside of hospitals. The 'psychological management of the crowd' has been a priority in order to guarantee a 'fair' stress level: A balance between the fear of the virus so as to respect the restrictive measures on the one hand, and the sense of safety thanks to the authorities' handling of the crisis on the other hand. In this context, dissident voices questioning official versions are potential 'loose mines'.

Since the very beginning, the regime enhanced its control over public spaces, not only by imposing social distancing and banning all public gatherings and demonstrations, but also by increasing media control. In doing so, Morocco is not the only one; the NGO Reporters Without Borders points that the health emergency provided many countries with the opportunity to seize public spaces, enhance censorship, and deliberately promote misinformation.[57] Against journalism 'in quarantine', the *Observatoire19* (Observatory 19)[58] was launched to assess the impact of the pandemic on journalism and monitor it. Indeed, one of the first measures undertaken by the Moroccan MoI was to prohibit journalists, except those of the official media and private radio stations, from carrying out their work during the curfew (from 7pm to 5am) in the month of Ramadan.[59] A decision deemed discriminatory by the National Union of the Moroccan Press

(SNPM) and which aroused great anger from the majority of journalists, forcing the MoI to quickly reverse this strange decision.[60] Furthermore, many journalists were harrassed while doing their job, even if they belong to official media that are usually less exposed to arbitrary treatment. Notably, on 7 May two reporters from the state Amazigh TV channel were physically and verbally attacked by the *caïd* (a local representative of the MoI) in the town of Tilfet, not far from the capital Rabat, while they were covering the problematic supply of consumer goods to local markets in the context of the Covid-19 pandemic.[61]

Further evidence of the attempts to restrict freedom of expression is Bill 22.20 to fight fake-news on social networks and cybercrime. Apparently proposed by the Minister of Justice from the Socialist Union of Popular Forces (USFP), after a meeting with the RNI's leader Aziz Akannouch, the confidential bill was leaked on social networks on 27 April, thus eliciting unanimous condemnation.[62] Nicknamed as the 'loi muselière' or 'loi bavette' (muzzle law) for its intent to criminalise some forms of expression and dissent like the calls to boycott a product,[63] it sparked an outcry on the web, which forced the government to give up and postpone it until the end of the lockdown.[64]

What Covid-19 did not stop were arbitrary arrests of outspoken journalists and activists on charges that seem backed by scant evidence but which are punctually linked to sexual or espionage offences. Namely, Soulaiman Raissouni, editor-in-chief of the daily newspaper *Akhbar Alyaoum* was arrested near his house in Casablanca on charges of sexual assault in May.[65] Likewise, Omar Radi, a free-lance investigative journalist, was arrested on espionage and rape charges in July. In the meantime, the trial of history professor Maati Monjib on espionage is still pending after the umpteenth postponement. To sum up, other rights risk to be securitised by grabbing the national consensus over confinement measures and taking advantage of the distraction of many under the guise to safeguard - though with other means - the right to health, so inextricably intertwined with the right to life.

Conclusion

The unexpected Covid-19 health emergency has put health systems, social security and welfare systems and social cohesion to the test. It has probably revealed more about existing barriers to the enjoyment of a basic right such as the right to health, and heralded new challenges for the future, and about our systems of governance more generally. In Morocco, this pandemic confirmed the anchoring of the Makhzen and further exposed the fragility of the health system in terms of infrastructure, personnel and social security system. Indeed, the Moroccan situation is all the more critical given that the Covid-19 crisis comes in a year of drought, always a sensitive time for the country.

At the same time, and despite the surprise of many politicians in discovering the decay of the public health system - a late discovery that suggests occasional instrumentalisation - the awareness of the need for a thorough review of the system with long-term structural reforms already existed.

While everywhere one hopes for the best while preparing for the worst, it is time to more decisively move away from theory and proclamations to practice.

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[65] Soulaiman Raissouni is the third such case from *Akhbar Alyaoum*, a critical voice in the Moroccan media landscape. Arrested in February 2018, Taoufik Bouachrine, a columnist and pusblisher of the newspaper is serving a 15-year sentence on multiple charges including human trafficking, sexual assault, and prostitution. Likewise, Hajar Raissouni, working for the same newspaper, faced trial on charges of premarital sex and illegal abortion. After a public outcry, she was 'pardoned' by the king.