Submission to the Office of the High Commissioner for Human Rights on the implementation of the UNGASS joint commitment to effectively addressing and countering the world drug problem with regards to human rights

This submission has been prepared by: PILS.

Validated by Nicolas RITTER - Executive Director

Prevention Information Lutte contre le SIDA (PILS). PILS is the leading HIV NGO based in Mauritius founded in 1996. Today, activities of PILS consist of building capacity of civil society, reaching HIV services to key populations, people living with HIV and Hepatitis C (HCV) and advocating for an enabling legal environment to reach zero HIV transmission.

PILS is a member of Coalition Plus, a non anglophone international union of historical HIV organisations.

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Abbreviations

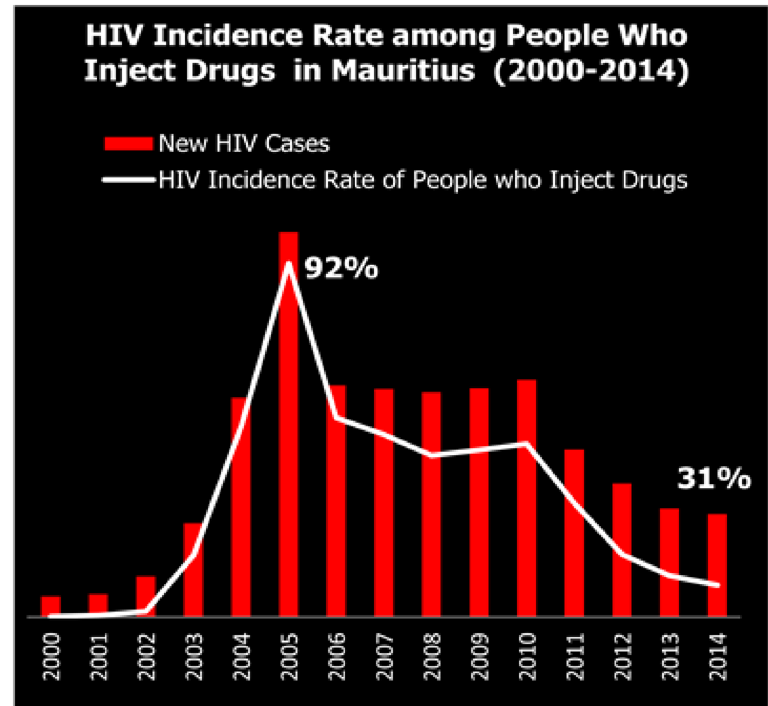
CS	Civil Society
CCM	Country Coordinating Mechanism
DAA	Direct Acting Antiretrovirals
DDA	Dangerous Drug Act
GFATM	Global Fund to fights AIDS, TB and Malaria
KPs	Key Populations
MST	Methadone Substitution Therapy
MoH	Ministry of Health and Quality of Life
NDO	National Drug Observatory
NEP	Needle Exchange Program
NPS	New Psychoactive Substances
OHCHR	Office of the United Nations High Commissioner for Human Rights
PWIDS	People who inject drugs

1. Mauritius highly impacted by opiates

i. Positive impact of MST in Mauritius

Mauritius is been quite famous worldwide these recent years regarding the high levels of opiate use in the country. With a prevalence rate of 1.95% of opiate use[1], At the same time, HIV incidence clearly showed a highly concentrated epidemic among PWIDS and other KPs.

Under civil society pressure, authorities reacted, and Mauritius became the first African country to launch harm reduction services like NEP and MST in a multi-sectoral approach. The graph depicts the impact of these programmes on incidence rate among PWIDS (92% in 2005 to 31% in 2014[2])



According to a study carried out in 2010[3], MST contributed to an improvement in quality of life of MST users, their family environment, as well as their self-esteem. Moreover, during the same period, a decrease in criminality rates has been observed, from 2,650 cases in 2007 to 1,085 in 2012[4]

ii. Impact of ceasing MST induction and MST decentralisation

In January 2015, after a government change, MST was decentralised from hospitals to outside of police stations. On the field, we noted that client-drop out at MST sites accelerated significantly with cases of police brutality[5] at MST sites. Another decision was the setting up of a detoxification programme using suboxone and naltrexone as from January 2016[6], replacing methadone induction for new patients. On the field, we note a high relapse of this new combination[7].Such decisions coincided an increase in crime[8] Media has also been reporting on the chaotic MST dispensing[9]. Shortened dispensing hours were also a cause of

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[1] United Nations Office on Drugs and Crime (UNODC), 2009. World Drug Report, Pg 235. Available at http://www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf

[2] Ministry of Health & Quality of Life (MOHQL), January 2015. Statistics on HIV/Aids

[3] APMG (Aids Project Management Group), 2010. *Evaluation Report*

[4] Data obtained from Police Force, & presented by MOHQL at HIV/Aids Indian Ocean Colloque in Mauritius(2013)

[5] https://www.lemauricien.com/article/toxicomanie-des-patients-sous-methadone-victimes-brutalite-policiere/

[6] https://www.lemauricien.com/article/la-methadone-remplacee-suboxone-et-naltrexone-la-polemique-n-pas-terminee/

[7] Unofficial reports from PILS clients and NGO partners

[8] Unofficial reports from Police and communications from media on high criminality rates

[9] https://www.lexpress.mu/article/330903/distribution-methadone-hors-controle-bambous

concern for MST beneficiaries and staff; treatment programmes were neither accessible nor confidential. Furthermore, police officers at the stations where MST is provided are not trained on the MST program.

2. Enabling legal environment for people who use illegal drugs

The DDA promulgated in 2001[10] classifies heroin and methadone as dangerous drugs and prohibits distribution of injecting equipment and paraphernalia. This directly contradicts the HIV/AIDS policy framework. Although the HIV Act caters for NEP, Police uses the DDA solely as ground to arrest people using illegal drugs.

Mauritius has a high recidivism rate of 68% in 2015 and 2016[11] . Since the introduction of harm reduction services in 2005, it is the first time that human rights, public health and inclusion of people who inject drugs (under the CCM of the Global Fund country programme) have been put in the forefront. Nevertheless, drug arrests are still rampant with a focus on cannabis users. From 2014 to 2017, 2336 people have been arrested under the DDA. Cannabis conviction remain the highest reason for drug arrest[12].

In Mauritius, cannabis is under Schedule 1 under the DDA and is sold between $35-58/gram and today we have seen a rapid emergence of cheaper, more accessible NPS. While our government is using the UN Conventions and have adopted a zero-tolerance policy[13] against all drug offences, ***it is key that there is a call from OHCHR and other UN bodies to assess the socio economic, human rights and health impacts of drug laws in countries.***

3. Needle Exchange Programme

NEP was initiated by CS in mid-2006 and later supported by GFATM through the MoH as from 2010. In 2016, MoH asked all NEP clients to provide their NIC number and to disclose their identity. This is a direct threat to this programme as drug use is highly criminalised.

Criminalisation of drug use in Mauritius contributes to the HIV and HCV epidemic and threating the positive impacts of harm reduction programmes.

4. Poverty and access to basic human rights

The Certificate of Character Act 2012[14], replacing the Morality Certificate, captures most of criminal records, including all drug related offences. This is often requested for employment purposed, leading to refusal of formal employment and consequently to poverty among the most vulnerable ones in our society. ***Our situation provides evidence that drug use criminalisation fuels poverty and is a barrier for people who use drugs to access their basic human rights such as rights to decent work, housing and fuels stigma at health and social services.***

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[10] http://apps.who.int/medicinedocs/documents/s18370en/s18370en.pdf
[11] http://prisons.govmu.org/English/statistics/Pages/Recidivism.aspx
[12] http://prisons.govmu.org/English/statistics/Pages/drug-offences-Male.aspx
[13] National Drug Observatory, Mauritius, August 2016
[14] http://dpp.govmu.org/English/Documents/Legislation/certchar2012.pdf

5. **Access to Hepatitis diagnosis and treatment**

97% of people who inject drugs are tested positive for HCV in Mauritius[15]. Despite effective DAA treatments being available in public hospitals for free, no genotyping and viral load tests are done among PWIDS and MST users. Some years back in 2013, HCV treatment was provided to people who had been infected by blood transfusion only. ***Ineffective drug laws such as the Mauritius DDA is not enabling the distribution of paraphernalia by healthcare workers to prevent HCV transmission. We appeal to OHCHR to encourage countries to set up multisectoral committees for the drafting and implementation of national Hepatitis testing, treatment and care and reviewing and amending legal barriers.***

6. **Access to health rights for women and children using drugs**

Women who inject drugs have significantly higher HIV infection rates than men: HIV prevalence among women is 61.8% while men is 42.5%[16]. However, in the current methadone programme, there is only approximately 3.6 % females and 8% at NEP.

Drug prevention for young people has remained a challenge. In the absence of a National Drug Control Master Plan, drug prevention is currently being done by former/rehabilitated drug users or religious leaders. No evaluation has been conducted to measure the impact of sessions. No targeted programmes to reach out and support young people who use drugs have been developed.

There are no youth-friendly centre or services for young people using drugs. The needle exchange programme and the MST are not available to minors and the protocols fail to include young people who use drugs.

It is important to acknowledge the ongoing inequalities between different genders in enjoying economic and social rights. Women continue to face structural challenges in accessing harm reduction services, in turn making them more vulnerable to engaging in criminal activities for lack of licit alternatives.

In addition to effective and monitored prevention strategies, it is important to ensure access to age-appropriate treatment and harm reduction services which constitutes a key aspect of fulfilling the rights of the child as well as the right to health.

7. **Closed settings**

More than half of prison population consists of drug offenders[17] , with 2 inmates out of 3 going back to prisons. No surveys have been carried out to investigate on frequency and intensity of unsafe practices in prisons. Inmates still are not receiving NEP services, access to condoms and HCV treatment.

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[15] IBBS 2013 among people who inject drugs in Mauritius

[16] Integrated Biological Behavioural Survey for People who inject drugs, 2013

[17] National Human Rights Commission, Mauritius, Annual Report 2017

Other discriminatory practices which exist in Mauritian prisons are access to methadone induction: only selected prisons in Mauritius provide methadone induction and access to MST induction is also challenging for female inmates[18]***. It is key that OHCHR assess the independence and capacity of National Human Rights Commissions, including units that work in prisons and ensure HIV prevention and harm reduction are scaled up in closed settings.***

8. National Drug Observatory

The Mauritian Government submitted its first NDO report in 2016 published by the MoH. No additional funding or human resources had been dedicated to this body and the process lacked independence and coordination. No population or youth surveys had been done and no indicators were created to identify problematic drug users. Similarly, no indicators were developed to investigate on perceived availability of drugs such as price and purity of illegal drugs. Investigation around drug related deaths and pulmonary oedema caused by drug overdose were not done. Prison statistics around HIV and HCV incidence and prevalence of inmates, drug related overdose and drug related death in closed settings had not been reported.

A strong NDO recurrent studies and Monitoring and Evaluation are tools for the authorities to strategize on effective policies and measure the socio-economic and public health impacts of current drug laws and policies.

Conclusion

Repressive drug laws and policies have been guiding Mauritius based on its commitment to implement requirements stipulated in UN Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances in 1988 and other regional conventions such as the SADC Drug Control Protocol.

Wrong political decision in 2015, jeopardized this progress as we can see by the end of 2017 a substantial increase of new HIV cases and an increased rate of HIV among PWID: **38.6% of new HIV cases were from PWIDs[19].** Our situation is the proof that ceasing to use public health and human rights lenses has negative health and social impacts. We call for OHCHR to play a key role to ensure that Governments are held responsible for protecting human rights within drug laws and policies and provide evidence of effective drug policies through regular assessments. As many countries are now moving towards drug law reforms, we appeal to the OHCHR and other UN bodies to base their indicators of effective drug policies on health, human rights, security, supply and demand reduction instead of solely basing their indicators on drug seizures and incarceration.

[18] Unofficial information from Human Rights Commission in Mauritius
[19] http://health.govmu.org/English/Documents/2018/HIVDec%202017.pdf