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2nd Harm Reduction Conference in Mauritius: Towards a Client-Centered Approach

20-22 September 2011 | Port-Louis, Mauritius

Advocacy
Document

Responding To The Needs Of
Harm Reduction Clients For
More Effective Service Delivery

July 2012



CUT exists since 2004, and was registered as an NGO in 2007. Members are individuals and organizations working in the field of HIV/Aids and/or Substance Use.

CUT has been advocating for Harm Reduction Services in the country since 2005, and has started implementing Harm Reduction services since 2006. Today, CUT has a dedicated office in Port Louis with a staff of 4 employees and a team of 57 outreach workers working on our Needle Exchange Program (NEP) in 7 different areas of the country. 70% of our field projects are located in urban regions, as People Who Use Drugs (PWUDs) mostly come from there.

NGO MEMBERS OF CUT

Kinouété - LEAD - Chrysalide - Sidatak - Centre Idrice Goomany - Groupe Elan - MIDAS - MCBT - PILS - Collectif Arc-en-Ciel - Media Watch Organisation

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{ Acronyms }

ADSU	Anti Drug and Smuggling Unit
CUT	Collectif Urgence Toxida
FGD	Focus Group Discussion
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HRI	Harm Reduction International
KAP	Key Affected Population
LEAHRN	Law Enforcement and Harm Reduction Network
MDM	Médecins du Monde
MIPUD	Meaningful Involvement of People who use Drugs
MOHQL	Ministry of Health and Quality of Life
MSM	Men Who Have Sex with Men
MST	Methadone Substitution Therapy
NAS	National Aids Secretariat
NDCMP	National Drug Control Master Plan
NEP	Needle Exchange Programme
PWID	Person Who Injects Drugs
PWUD	Person Who Uses Drugs
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

2nd Conference On Harm Reduction In Mauritius: Towards A Client-Centered Approach To Harm Reduction



The Honourable Lormus Bundhoo, Minister of Health and Quality of Life, during his keynote address at the opening ceremony

In October 2009, the first Conference on Opiate Abuse and Harm Reduction Services in Mauritius brought together over 150 participants including civil society, government and the private sector. Local, regional and international actors working in the field of Harm Reduction contributed to a successful conference that took stock of the risks and harms associated with injecting drug use in Mauritius and the Harm Reduction responses being implemented. The second conference, held on September 20th to 22nd, 2011 was a follow up to the first and had for theme: 'A Client Centered Approach to Harm Reduction'.

Its principal objective was to engage participants in a discussion on the ways of improving the quality of Harm Reduction services delivered in Mauritius so as to better cater for the needs of beneficiaries. At the core of Harm Reduction is the respect for human rights, including for People Who Use Drugs (PWUDs) and a concern for public health. Thus, a comprehensive Harm Reduction policy is one that ought to privilege the rights and well being of the client, hence the theme of this conference.

Over the three days of the conference, experts and practitioners from Mauritius, the Indian Ocean and beyond participated in a series of sessions touching on different aspects of Harm Reduction. While Maria Phelan of Harm Reduction International (HRI) noted the persistent lack of financial resources available for the implementation of harm reduction services, Olivier Maguet of Médecins du Monde (MDM) exposed the need for broadening the parameters of Harm Reduction beyond the narrow focus on HIV. He talked of overdose prevention, drug policies, minimising social and economic harms linked to drug use, as well as mental health and community involvement as important aspects of Harm Reduction which are often neglected in the implementation of Harm Reduction programmes.

As per the focus group discussions conducted with PWUDs in the lead up to the conference, it was evident that the relationship between drug policies and harm reduction policies is a problematic one. Thus, the findings of the Global Commission on Drugs, suggesting the failure of the war on drugs, were presented. Furthermore, Greg Denham of the Law Enforcement and Harm Reduction Network (LEAHRN) detailed the benefits of including a Harm Reduction component in the scheme of work of drug enforcement agencies.

Last but not least, Jude Byrne of the International Network of People who Use Drugs (INPUD) spoke of the need for peer involvement in policy making and service delivery related to Harm Reduction programmes. Her participation reinforced the principal theme of the conference: a client centred approach to Harm Reduction. The clear conclusion of this conference was thus that a holistic approach, in line with the 9 principles of the United Nation Office on Drug and Crime - World Health Organisation (UNODC-WHO) joint discussion paper on drug dependence treatment is required at all levels, from policy to service delivery, for the implementation of a client centered approach to Harm Reduction. These principles should also be extended to other fields, in line with the MDM approach mentioned above.

¹United Nations Office on Drugs and Crime (UNODC) and World Health Organisation (WHO) (2008); Principles of Drug Dependence Treatment – Discussion Paper, Available at: <http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf>

What Is Harm Reduction?



CUT is an NGO whose aim is the dissemination of Harm Reduction Services as well as Harm Reduction education

Harm Reduction is a relatively new social policy that emerged in response to the spread of HIV among PWUDs in the 1980s. It acknowledges that, despite the strongest efforts to prevent initiation to and continuation of drug use, many people throughout the world continue to use psychoactive drugs and that it is therefore crucial to reduce the risks associated with drug use. Harm Reduction challenges policies and practices that intentionally or unintentionally create or exacerbate risks and harms for PWUDs. These include “the criminalisation of drug use, discrimination, abusive and corrupt policing practices, restrictive and punitive laws and policies, the denial of life-saving medical care and harm reduction services, and social inequities.”²

Perhaps because of its strong affiliation to the fight against HIV & AIDS, Harm Reduction policies and services have remained mostly minimalist³ in practice. This is clearly illustrated in the fact that current international best practices for Harm Reduction is documented in a technical guide pertaining to universal access to HIV prevention, treatment and care for PWIDs.⁴

While it is commendable that such a guide exists, it is equally important that we remain constructively critical of its limitations. The current approach to harm reduction is principally defensive: the argument is one of “avoiding death”. A more progressive argument is needed, one that “promotes life.”

The way forward for broadening the Harm Reduction framework should begin with including the following components in harm reduction strategies as part of the comprehensive package:⁵ Human Rights, Changes in Social and legal Norms, Addressing Mental Health, Overdose Prevention and Management, Community Involvement and Decision, Social and economic prerequisite for access and retention in treatment, Education to Injection.

Overall, a broadened harm reduction paradigm should be one that actively favours and prioritizes life rather than defensively attempts to avoid death through select, targeted interventions.

“

Minimalist and Maximalist definitions of Harm Reduction

«**Minimalist**»: An approach to drug treatment whose focus is on the minimisation of the negative consequences of drug use rather than the elimination of drug use.

«**Maximalist**»: A public health policy which, rather than seeking to eliminate the consumption of psychoactive drugs (or other addictive or dangerous behaviour), has for objective that the principal stakeholders are able to develop the capacity to reduce the negative health, social and economic consequences linked to their behaviour and the restrictions imposed upon such behaviour – for themselves, those around them and society more broadly.

”

² ‘Harm Reduction International Statement on What is Harm Reduction.’ <http://www.ihra.net/what-is-harm-reduction>

³ See Box on Minimalist and Maximalist definitions of Harm Reduction. Ritter, C. (2011). Harm Reduction in Prisons: From Theory to Practice [Powerpoint Presentation Slides] Presented at CUT’s 2nd Conference on Harm Reduction on 21 September 2011, Mer Rouge.

⁴ World Health Organization (2009), (2009) WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (Jointly published with the United Nations Office on Drugs and Crime, and Joint UN Program on HIV and AIDS). [Accessed online at: http://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf]

⁵ Maguet, O. (2011) Enhance HR reference framework: a compulsory prerequisite for a relevant response to people who use drugs. [Powerpoint Slides]. Presented at CUT’s 2nd Conference on Harm Reduction on 20 September 2011, Mer Rouge.

Key Findings Of The 2nd Conference On Harm Reduction In Mauritius :

Empowering Clients And Promoting Peer Involvement Is Key To Inclusive Policies And Effective Services.

Central to Harm Reduction policies and programmes is the idea that PWUDs must not be discriminated against simply because of the choice they have made to use drugs. The marginalization of the community of PWUDs, their systematic rejection by political, economic and social structures actively contribute to increase risks and harms associated with drug use. Empowerment and especially the self-empowerment of PWUDs should form the backbone of any Harm Reduction strategy. This is captured in the MIPUD – Meaningful Involvement of People who Use Drugs – principle which stipulates that no decision concerning drug related issues must be taken without consulting PWUDs.

Furthermore, in service delivery, there ought to be peer involvement as well. A peer is someone who identifies with the community and is accepted by the community. Therefore, a peer is more likely to access and gain the trust of his/her community than would an outsider. This helps to build community connectivity, which in turn promotes the empowerment of the community and individuals. This is vital to challenging stigmatization.

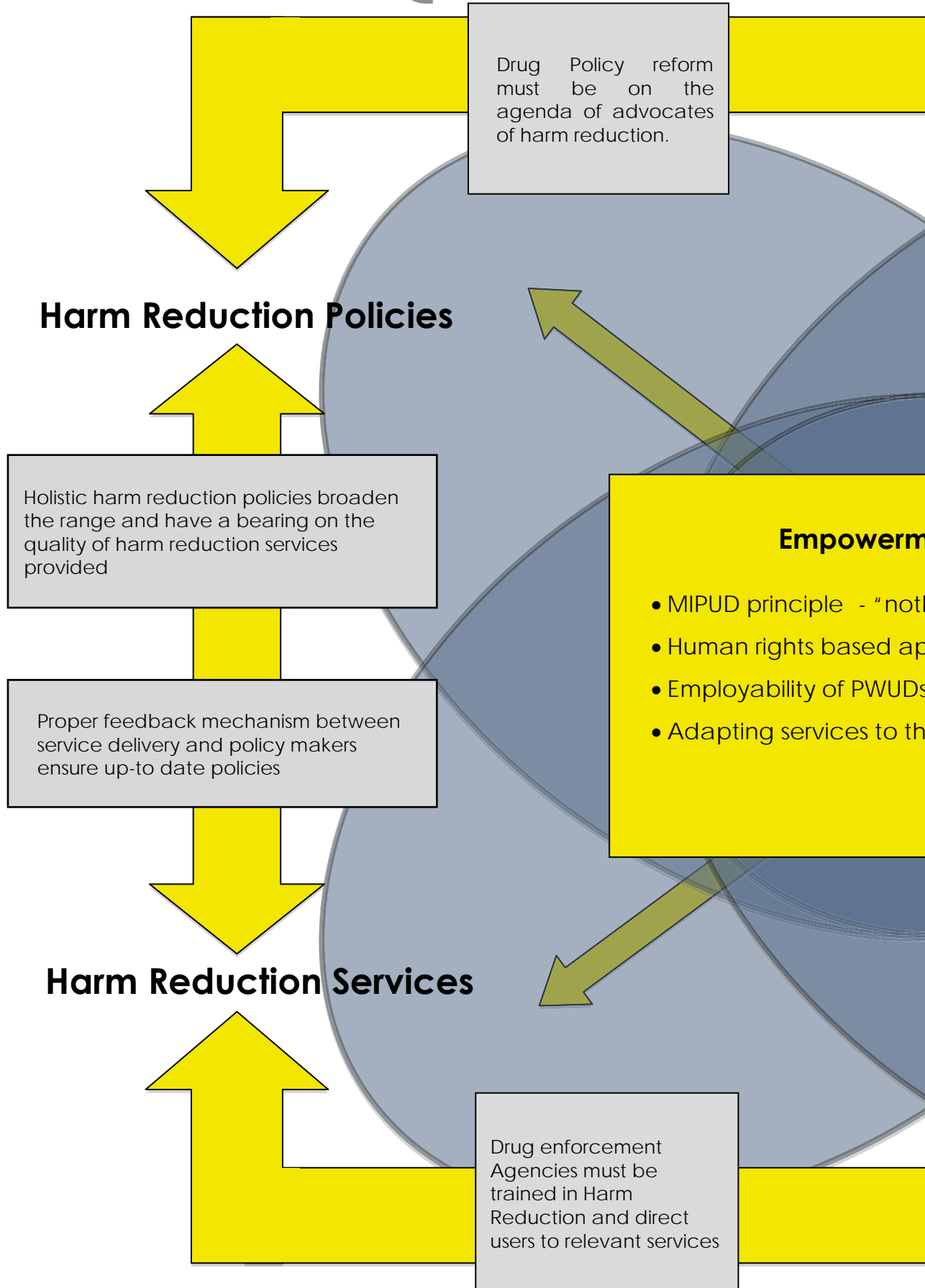
Relying on PWUDs who have chosen abstinence can be problematic. Firstly, the drug market and drug habits are extremely fluid. What was true two years ago, will likely be invalid now. People who actively use drugs will know what is happening in the street: this is critical information for designing and implementing programmes which are adapted and effective. Secondly, ex-PWUDs who have turned to abstinence are often inhabited by an evangelical zeal, prompting them to attempt “converting” people who actively use drugs. This attitude often deters PWUDs from accessing Harm Reduction services.

The Scope Of Harm Reduction Policies And Services Must Be Broadened By Engaging All Concerned Stakeholders.

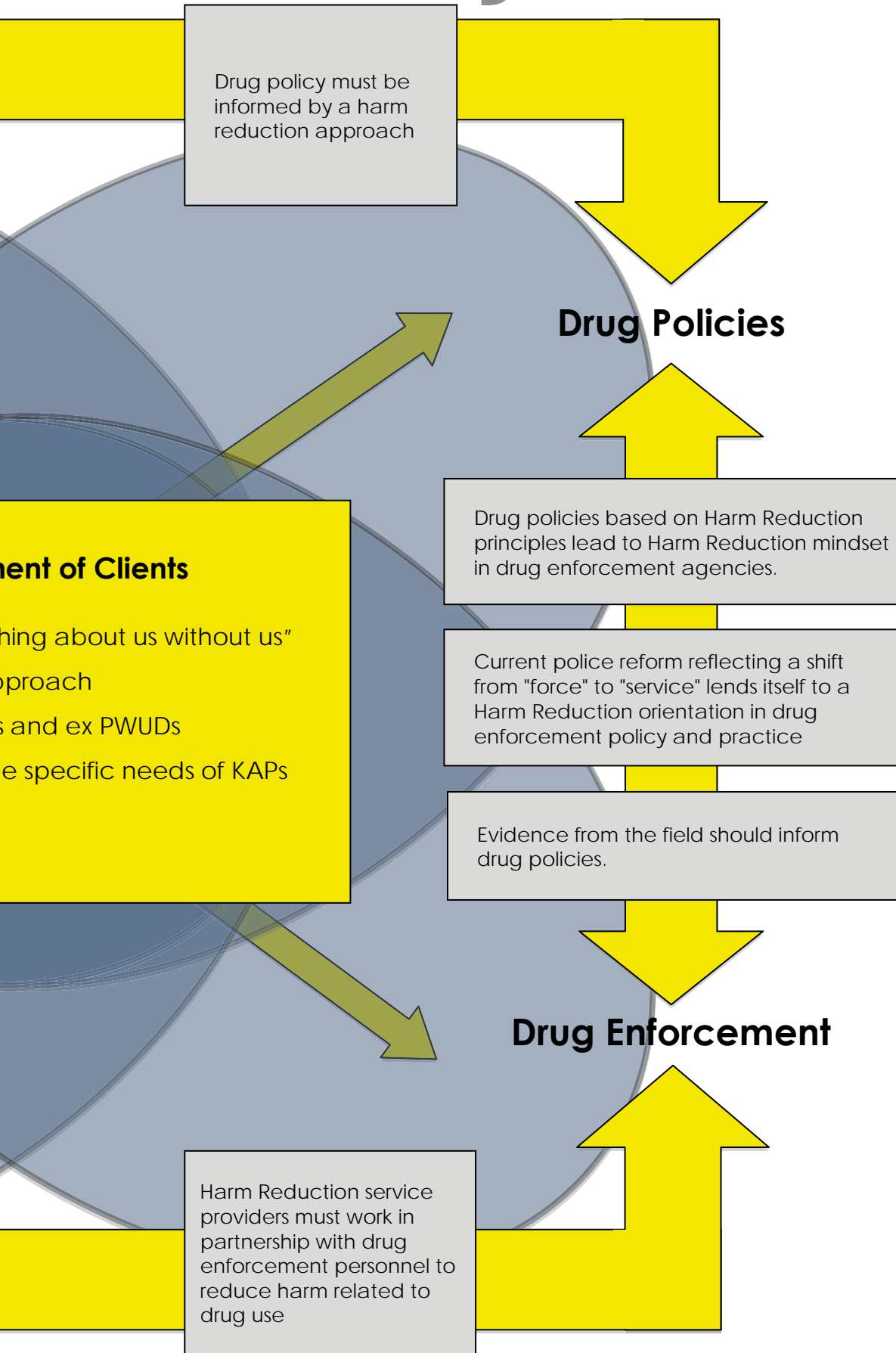
Since 2006, the Mauritian government has taken steps to define and implement Harm Reduction programmes. This was seen to be a necessary measure in the face of the alarmingly high prevalence of HIV among PWUDs. Currently, the two main government agencies working on Harm Reduction strategies are the National Aids Secretariat (NAS) and the Ministry Of Health And Quality Of Life (MoHQL). Looking forward, it will be important to strengthen linkages with other departments such as the State Law Office, Law enforcement agencies, the Ministry of Social Security and the Ministry of Social Integration. The creation of a national and multi-sectoral task force on Harm Reduction, regrouping relevant stakeholders, including PWUDs will be an important step in meeting this objective.

An important point, deserving of mention is the fact that there is genuine government-civil society collaboration in the design and delivery of Harm Reduction programmes. Both sides have been eager to optimize their expertise and capacities by working together and sharing tasks for the most effective results. However, in view of rendering Harm Reduction services more client-centered and even more effective, it will be important to include in the supply chain - of policy making – programme design –project implementation and service delivery – the participation of PWUDs, including those on the Methadone Substitution Therapy (MST.)

A HOLISTIC HARM REDUCTION MEANINGFUL INVOLVEMENT



STRATEGY BASED ON THE OF PEOPLE WHO USE DRUGS



The Introduction Of Comprehensive Harm Reduction Services In Prison Is A Priority

Although Mauritius has the merit of being the first African country to implement Harm Reduction services, there continues to be an important gap in the availability of these services in prison. Even if MST induction has very recently been introduced in prison, other Harm Reduction programmes like Needle Exchange Program (NEP), or condom distribution is still a challenge for prison inmates. Studies demonstrate that HIV prevalence among the prison population tends to be significantly higher than that in the community.⁶ Thus, while resistance to Harm Reduction in prison is strong, the need for such services is all the more significant.

Resistance to Harm Reduction in prison is based on the perception that it would be in contradiction to legislation, professional aims, moral beliefs or that it would be dangerous: one of the most commonly used arguments is the fear of needle stick injury and viral transmission to the prison staff. However, this is for the most part a myth, as there has been very little evidence-based research validating this argument.

On the other hand, there have been various studies compiled by WHO that have pointed out the effectiveness and lack of unintended negative consequences of NEP in prisons, as well as a decrease in needle sharing, with no increase, or even decrease in drug consumption in prisons with NEP.⁷ With relevant documentation, manuals and training given to prison staff and detainees, the likelihood of injury and viral infection is greatly minimized.

The Question Of Drug Policy Reform Must Form Part Of The Harm Reduction Package

Harm Reduction policies have long been underscored by an overly clinical discourse. This approach has been adopted as it provides an escape route on the controversial question of drug policies. Focusing on the clinical, rather than the legal aspects of drug consumption avoids embarrassing funders and partners who do not wish to antagonize governments that adopt a hard-line on the legal consequences of drug consumption.



In 2009, Mauritius became the first country in sub-Saharan Africa to implement NEP

⁶ Jürgens, R. (2007) Evidence for Action Technical Papers : Effectiveness of interventions to address HIV in prisons, World Health Organisation (WHO), United Nations Office on Drugs and Crime (UNODC) and Joint United Nations Programme on HIV/AIDS (UNAIDS). WHO Press, Geneva. [Accessed online at :http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf]

⁷ *ibid.*

There is increasing consensus among Harm Reduction activists and drug policy experts however that the two fields are un-dissociable. The June 2011 report of the Global Commission on Drug Policy⁸ confirms the view that a radical paradigm shift in global and national drug policies is needed. The theme of the report, highlighting the failure of the “War on Drugs”, proposes that: “Drug policies must be based on human rights and public health principles.”⁹

The implication of this paradigm shift in drug policy is significant for Harm Reduction activism. It is an opportunity to raise the profile of the human rights dimension of Harm Reduction, in line with the report of the Global Commission on Drug Policy stating that: “the global drug problem is a set of interlinked health and social challenges to be managed, rather than a war to be won.”¹⁰

Greg Denham, former law enforcement officer with the National Australian Police and co-founder of the LEAHRN, was invited to the conference to share his expertise working with law enforcement personnel on Harm Reduction issues. Mr. Denham presented the findings of his 12-country review of law enforcement policies with regard to Harm Reduction.¹¹

Through the study, it was found that clear national policies and guidelines are the most effective means of enlisting police support for Harm Reduction: “if it comes down from the top, the police will usually listen.”¹²

8 Global Commission on Drug Policy (2011) War on Drugs: Report of the Global Commission on Drug Policy. [Accessed online: <http://www.globalcommissionondrugs.org/Report>]

9 *ibid.*, p. 5

10 *ibid.*, p. 4

11 Denham G. (2011a) A Review of Policing Policies and Practices that Support the Prevention of HIV Transmission in 12 English Speaking Countries, UNODC

12 Denham G. (2011b) A Review of Published and Available Materials Related to Law Enforcement Policies on Prevention of HIV and Harms Associated with Injecting Drug Use Across 12 Countries [Powerpoint Slides] Presented at CUT's 2nd Conference on Harm Reduction on 21 September 2011, Mer Rouge.

Key Recommendations From The 2nd Conference On Harm Reduction In Mauritius: Towards A Client-Centered Approach

Harm Reduction Policy

A National Drug Control Master Plan (NDCMP) must be made effective, based on consultation with all relevant stakeholders including representatives from civil society, the private sector and government. PWIDs must also participate. A permanent Multi-Sectoral Coordinating Committee on Substance Use, supplemented by Technical Working Groups (Supply Reduction, Demand Reduction & Harm Reduction) must be set up with a mandate to Monitor and Evaluate the NDCMP.

Harm Reduction services must take into consideration the circumstances, habits and limitations of the principal stakeholders. It has been noted for instance, that fixed methadone dispensing points curtail the mobility of MST clients. To redress this flaw in service delivery, NEP and MST clients must be invited to participate in the policy making process when designing Harm Reduction programmes.

The civil society-government partnership is key to elaborating a well-defined feedback mechanism between PWUDs and policy makers. This should be an essential component of the monitoring and evaluation exercise of harm reduction services.

Harm Reduction Services

The safe disposal of used syringes is an absolute priority. Sharp boxes need to be given to NEP beneficiaries for the safe disposal of used syringes – this would give them security vis-à-vis law enforcement personnel. Many PWIDs complain that they feel insecure carrying used needles and syringes when travelling to NEP sites.

There is an urgent need for thorough and effective psychosocial follow up for patients undergoing methadone substitution therapy as well as NEP.

Harm Reduction In Prison

The Roseau Centre needs to be re-opened to provide adequate support to detainees who are active and ex PWUDs. Reintegration needs to begin within prison itself

There must be a continuous exercise of informing and training prison personnel on Harm Reduction. Pamphlets, posters and manuals must always be available and visible in the places where programmes are being implemented.



NEP clients have access to clean needles and sininges, male and female condoms, alcohol pads and dry swabs on CUT's NEP sites

Empowerment Of Clients For A More Client-Centered Approach

Integration of Meaningful Involvement of People Who use Drugs (MIPUD) principle - “nothing about us without us” at all levels of Harm Reduction programming, starting with policy making and all the way through to service delivery.

The empowerment of clients through human rights based approaches is an essential prerequisite to rendering Harm Reduction services more client centered.

All stakeholders, including the private sector, urgently need to address the issue of the employability of ex PWUDs including those undergoing MST. In the longer term, we also need to start thinking of employment strategies for active PWUDs.

Harm Reduction services must be adapted to the specific needs of key Affected Populations. In particular, service providers must render their services more youth friendly by encouraging peer participation in programme design and service delivery.

Drug Policy And Law Enforcement

Law enforcement personnel, and in particular members of the Anti-Drug and Smuggling Unit (ADSU) need to be further sensitized to Harm Reduction policies. There needs to be a shift in attitude and culture within the police force, reflecting a more collaborative stance vis-à-vis Harm Reduction services. This can be implemented through the inclusion of Harm Reduction in the curriculum of police training.

Decriminalizing possession of paraphernalia: It seems illogical in the first place that a country that is officially forthcoming on the provision of Harm Reduction services continues to criminalize the possession of paraphernalia used for administering drugs.

Clear instructions from the Commissioner of Police as to a change in attitude from ADSU officers – should come from the highest level – from the Prime Minister’s office – this is to be put into place immediately. Ideally, there should be a policy, clearly setting out the role of Law Enforcement personnel with respect to Harm Reduction programmes.

Engage public opinion on drug policy reform: A shift in public perception to develop a sociological acceptance of Harm Reduction initiatives will help to exert pressure on policy-makers. Influential stakeholders such as local governments, the media, community leaders and businesspersons must be targeted as a starting point.



CUT's community based container offers basic health services to NEP clients and other residents of the Baie du Tombeau Area

Conclusion

The 2nd conference on Harm Reduction in Mauritius brought together over 200 local, regional and international stakeholders working in the field of substance use for a discussion on how to render existing Harm Reduction services more “client-centered”. The outcome suggests that by placing PWUDs at the very core of policies and services, and furthermore facilitating their meaningful involvement in the policy-making, project design and service delivery, a more holistic approach to Harm Reduction can be implemented.

In Mauritius, the government has been sufficiently forward thinking in making Harm Reduction services – notably methadone substitution therapy and needle exchange programmes – available. Nonetheless, Harm Reduction as a holistic framework for addressing drug related issues is yet to be fully understood by concerned stakeholders. While NEP and MST have been useful in countering the health related harms of drug use, the lack of proper counselling and psychosocial support within these programmes means that the social and economic harms related to drug use are not effectively attended to.

Furthermore, there is an apparent dissonance in the drug enforcement policies currently in place and the willingness to offer Harm Reduction services. The findings of the Global Commission on Drugs suggest, that drug policies based solely on supply reduction and repression have failed to curb drug use. Furthermore, such policies produce negative effects on public health and human rights: it is thus necessary to rethink the orientation of drug policies. It would be opportune and beneficial to the Harm Reduction agenda in Mauritius if civil society, government actors and the private sector were to engage in an open debate on drug policies. Harm Reduction activists must, on their end, begin to take the issue of drug policies seriously, given that they have a bearing on public health and human rights. Drug policy reform ought therefore to be included in the Harm Reduction agenda.

When launching this debate on drug policies, it will be absolutely essential to apply the MIPUD principle: “nothing about us without us”. PWUDs are the principal concerned by both Harm Reduction policies specifically and drug policies more broadly. Their participation at all levels follows the rationale of the Greater Involvement of People Living with HIV (GIPA) principle, currently being practised in Mauritius in the context of the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) and the National Strategic Framework for HIV/AIDS.

It is worth reiterating once more that Harm Reduction in itself, is more than just a set of services and policies: it is a paradigm: an approach to addressing drug related issues that privileges concern for public health and respect for human rights, and which is based on evidence rather than ideology. Thus, if we want a more client-centred approach to Harm Reduction, it is high time to shift paradigm, meaningfully involve PWUDs and launch the debate on drug policy reform.

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Annex: Recommendations of Focus Group Discussions (FGDs) with Mauritian PWIDs

Between August 12 and September 16, five FGDs were held with beneficiaries of CUT's NEP programme. FGD participants were identified by outreach workers working on NEP sites. There were three overarching themes that dominated the focus group discussions:

The threat of police harassment in the vicinity of NEP sites deters PWIDs from accessing the needle exchange service. The most pressing issue is the fact that clients are required to carry used syringes back to the NEP sites for disposal. Most participants said that they felt unsafe carrying the used syringes, as they felt it exposed them to arrest.

Proposed solutions include police reform, provision of flash boxes for the disposal of syringes and legal aid and rights education for PWIDs, so they are more empowered to defend themselves against police abuse.

The MST programme is inefficiently administered. Although recognizing the merits and opportunities that accrue from the availability of public MST, participants who had used the service felt that the way in which the programme was run was inefficient. The restricted hours of distribution and inflexible dispensing points limit the mobility of those on MST. Moreover, PWIDs expressed feeling infantilized by the procedures and treatment they received from doctors: they felt that there was a misconception that PWUDs could not be rational, and so cannot be treated as adults.

Participants said that they would wish to see the MST programme being implemented in a more holistic manner, taking into consideration, and contributing to the empowerment and social integration of PWIDs.

PWIDs are often discriminated against and humiliated when reaching out to public services, such as hospitals. This reinforces their self-perception as a marginalized population, further eroding their chances of social integration. Participants concurred that there needed to be improvements on both ends: hospital staff must be properly trained so as to dissolve prejudices, and PWIDs must on their side ensure that their behaviour is not aggressive or confrontational.

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