HARM REDUCTION INFORMATION NOTE - MAURITIUS

COLLECTIF URGENCE TOXIDA
Harm reduction association

HARM REDUCTION INTERNATIONAL

This information note has been compiled by Harm Reduction International (HRI) in collaboration with Collectif Urgence Toxida (CUT) to support Global Fund Grant Cycle 7 processes.

1. Epidemiological data

1.1 People who use drugs and HIV

- There are an estimated 14,000 people living with HIV in Mauritius.[1]
- There are an estimated 12,000 people who inject drugs in the country.[2]
- There were reported declines in new HIV infections of 29% among adult women and 33% among adult men between 2010 and 2021.[3]
- There was a reported 23% increase in AIDS-related deaths between 2010 and 2021.[3]
- HIV prevalence in Mauritius was estimated to be 1.7% in 2020.[4]
- HIV prevalence among key populations is considerably higher than within the general population. It is reported to be 32.3% among people who inject drugs, 28.4% among transgender people, and 17.3% among prisoners.
- Young adults (aged between 15-24) have been identified as a key population for HIV by the Government of Mauritius, with recently increasing cases among this population.[3]
- There has recently been an increase in the use of new psychoactive substances, notably synthetic cannabinoids and synthetic cathinones.[6]

1.2 People who use drugs, viral-hepatitis and co-infection

- 17.7% of people living with HIV and hepatitis C (HCV) co-infection have received HCV treatment.[4]
- HCV prevalence is estimated to be 90% among people who inject drugs.[2]
- Hepatitis B prevalence is estimated to be 3.5% among people who inject drugs.[2]

Key highlight – Epidemiological data shows that people who inject drugs are among the key populations particularly affected by HIV in Mauritius. Harm reduction programming, and especially HIV and HCV testing, diagnosis and treatment services, urgently need to be scaled up.

1.3 HIV prevention and treatment and harm reduction

- HIV testing and status awareness is reported to be 9% among the general population in Mauritius.[3] Among key populations, HIV testing and status awareness is reported to be 10% among sex workers, 18% among men who have sex with men, 40% among people who inject drugs and 80% among prisoners.[3] These values fall short of the targets set out in the 2020 action plan by the Government of Mauritius.[3]
- By the end of 2021, only about 78% of people living with HIV in Mauritius had been tested for HIV and only 18% had an undetectable viral load.[1]
- Only 52% of people who inject drugs that had tested positive for HIV were receiving ART by the end of 2022, while even within closed settings such as prisons, only 4 out of 5 (82%) were receiving ART.[1]
- Condom use is reported to be 45.4% among people who inject drugs.[4]
- There is an explicit reference to harm reduction in national policy in Mauritius.[2]
- There is availability of needle and syringe programmes in the community, which is permitted by the HIV and AIDS Act of 2006.[2, 5]
- Opioid agonist therapy, in the form of methadone and buprenorphine, is available in the community and prison settings.[2]
- In 2018, coverage of opioid agonist treatment (OAT) among people who inject drugs was reported to be 53.6%.[4]
- During COVID-19 related lockdowns, civil society advocacy in some regions led to bans being lifted on NSPs and secondary distribution of syringes by peers.[2]
- There is no peer distribution of naloxone, drug consumption rooms, or provision of safer smoking equipment.[2]
- A Drug User Administrative Panel (DUAP) is currently being established in Mauritius, to divert people who use drugs from the criminal system towards healthcare systems. This would ensure that, rather than facing incarceration, the person can access drug treatment and harm reduction. However, there are still some components that need attention, including uncertainties around what happens if people refuse or do not require treatment (e.g., people using drugs recreationally).

Key highlight – In Mauritius there is a need for continued and increased investment in harm reduction programming to meet the epidemiological need and to reach national targets. Almost half of all people who inject drugs living with HIV are not receiving ART and without scaled up NSP and routine data collection there is a danger of increased new HIV infections amongst people who inject drugs.

1.4 Barriers and challenges to accessing harm reduction services

- While there are laws protecting people living with HIV and people who inject drugs from discrimination, punitive policies and stigma and discrimination remain a challenge that impedes access to harm reduction services.[1]
- Sex work, same-sex sexual acts in private, and the possession of small amounts of drugs are all criminalised.[1,7]
- People who use drugs are incarcerated for possession and consumption of drugs. This results in people who use drugs finding it difficult to find employment because their legal case is recorded on their certificate of character.

- There are restrictive policies for people living with HIV to immigrate to Mauritius, parental consent is required for adolescents and young people for HIV testing, and there is mandatory HIV testing for some groups.[1]
- The National HIV Action Plan 2023-2027 reports that the increase in AIDS-related deaths between 2010 and 2021 may be related to late HIV diagnosis and treatment access and low ART adherence.[3] Widespread stigma and discrimination towards people living with HIV, particularly for people who inject drugs, is listed among service access challenges, along with poor communication between service providers and short visit times.[3]
- The National HIV Action Plan 2023-2027 highlights the harm reduction programme and poor community involvement as weaker areas within the national HIV response.[3]
- Mauritius no longer meets eligibility criteria for a country grant from the Global Fund and now can apply for a transition grant which reflects the country's ongoing economic growth. The exit of the Global Fund may lead to reduced funding for particular areas including community-led responses.[3]

2. Harm Reduction Financing

- The government of Mauritius funds around 80% of the national HIV programme, including partial funding for harm reduction programmes.[3]
- Mauritius also has a strong history of collaboration with international donors, mostly the Global Fund, to open and expand access to harm reduction and HIV services.[3]
- The most recent Global Fund HIV country grant for Mauritius amounted to USD 2.2 million for 2021-2023. This included support for harm reduction programmes.[8]
- Domestic funding to support HIV services for people who inject drugs and their partners decreased from USD 261,198 in 2018 to a predicted USD 228,000 in 2023.[8]
- Since 2019, the Global Fund has provided the only international donor support for HIV programming for people who inject drugs and their partners in Mauritius.[8]
- Mauritius has a social contracting scheme managed by National Social Inclusion Foundation (NSIF). However only 20% of NSIF's available funding is allocated for the health sector, falling short of what is required. The current scheme sees funding provided based on bids submitted by non-government organisations and does not require alignment with National Health Sector Strategic Plan priorities.[9]
- NSIF has expressed willingness to reform the social contracting model to meet the needs of key populations such as people living with HIV, people who inject drugs and female sex workers. This will require improved governance (resource tracking, predictability, alignment to national strategy, responsiveness to communities and complementarity of the funding – lack of duplication).[9]
- Mauritius has adopted free health care provision to achieve universal health coverage and it includes over 10,000 people from vulnerable communities in the social register such as people living with disabilities, the elderly, the poor – but these does not explicitly include people living with HIV, people who use drugs and other key populations. [9]
- Small key population-led organisations have less access to funds than larger, well-established civil society organisations. This reduces their ability to increase the number of outreach and field staff, which would allow for improved follow-up with people accessing services including people receiving ARV treatment, reducing loss of follow-up. [9]

Key highlight – Mauritius has shown a strong commitment to funding HIV and harm reduction programmes domestically and has worked with international donors to introduce and expand programming. Importantly, the country has a social contracting scheme to channel funding to community-led and civil society organisations and has adopted free health care to achieve UHC. However, both social contracting and free health care should explicitly include people living with HIV and key populations. Importantly, funding must continue through transition and be increased to address key priorities for harm reduction programming, including stigma and discrimination.

3. Advocacy priorities for people who use drugs in Grant Cycle 7

- Advocating for harm reduction services in prisons to be made accessible and developed for people in prisons who use drugs, including a focus on programmes for women, and women with children.
- Capacity building for community-led advocacy.
- Providing for a wider array of opioid agonist therapies (than only methadone and buprenorphine), that will allow a more client-centred rather than a "one-size fits all" approach.
- For the transition period and beyond, advocacy for a multi-sectoral platform that monitors and responds to needs and capacity gaps among networks of people who use drugs.
- Human right protections for women and mothers who use drugs, particularly in relation to contact with child protection services and security services. Advocacy for improvements to these services and capacity building and harm reduction sensitisation among security officers.
- Advocating for removals of legal barriers, including the inclusion of charges such as possession of small amounts of drugs on certificates of character.
- Peer distribution of naloxone among people who use drugs, peer educators and via civil society organisations.

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