Briefing to the Committee on Economic, Social and Cultural Rights on the Consolidated Second-Fourth Reports of Mauritius on the Implementation of the International Covenant on Economic, Social and Cultural Rights

Drug use, HIV/AIDS, and Harm Reduction: Articles 2, 12 and 15.1.b

Submitted jointly by Collectif Urgence Toxida and the International Harm Reduction Association[1]

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[I]n seeking to reduce drug-related harm, without judgment, and with respect for the inherent dignity of every individual, regardless of lifestyle, harm reduction stands as a clear example of human rights in practice. What began as a health based intervention in response to HIV must today be recognised as an essential component of the right to the highest attainable standard of health for people who inject drugs

Professor Paul Hunt, former UN Special Rapporteur on the Right to Health[2]

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I. Overview

People who use illicit drugs are vulnerable to a wide range of negative health consequences as a result of that use, consequences that include infection with blood borne viruses including HIV and hepatitis C. It is well established that unsafe drug injecting practices are a primary driver of HIV and other blood borne viruses in many countries, including Mauritius.[3] This is despite the fact that there exist inexpensive, evidence-based harm reduction interventions – such as the provision of sterile injecting equipment and the prescription of opioid substitution therapy – that have proven effective in reducing the spread of HIV and improving the overall health of people who inject. The effectiveness of such interventions is clear from the fact that HIV–related harm reduction has been adopted in the policies of, *inter alia*, the United Nations system,[4] specific UN programmes and funds,[5] the European Union,[6] the Council of Europe[7] the African Union,[8] the International Federation of the Red Cross and Red Crescent Societies[9] and at least seventy-four countries worldwide.[10]

Section II of this report considers these issues within the framework of the International Covenant on Economic Social and Cultural Rights.

As recognised by the UN High Commissioner for Human Rights, people who use illicit drugs do not forfeit their rights because of the illegal nature of their activities.[11] Indeed, the High Commissioner, the Special Rapporteur on the Right to Health and the Special Rapporteur on Torture have all raised concerns about the failure of States to meet their human rights obligations vis-à-vis people who use drugs and the negative consequences of this failure on both the individual health of drug users and broader public health concerns.

Consideration of illicit drug use, its impacts on both individual and public health and the availability (or lack thereof) of HIV prevention measures clearly fall within the remit of the Committee on Economic, Social and Cultural Rights under Article 12 of the Covenant - the right to the highest attainable standard of physical and mental health. This article is supported by article 15.1.b which guarantees the right of everyone to benefit from scientific progress and its applications, and by article 2 which requires appropriate legislative and budgetary reform to ensure the progressive realisation of these rights.

Section III looks in more detail at the situation in Mauritius

The number of injecting drug users in Mauritius is alarmingly high, estimated at between 17,000 and 18,000 people.[12] The majority of people inject buprenorphine (Subutex), a synthetic opioid. The overall prevalence of HIV in Mauritius has been estimated at 1.8 % by UNAIDS in 2007, representing approximately 12,000 people.[13] In 2005, 92% of new HIV cases were related to unsafe injecting practices.[14]

The government has stated clearly that this is “a cause of major concern for the country”, and has begun to scale up harm reduction services in the form of opioid substitution therapy (OST) with methadone and needle and syringe programmes (NSPs). (**See periodic report of Mauritius**

paras 392 and 399) However, the State report does not detail the problems relating to these services.

Availability, accessibility and quality of HIV prevention services targeted at people who inject drugs in Mauritius remain inadequate. This limits their reach and effectiveness. These problems include, for example, legislative barriers impeding NSP, poor geographical coverage, poor resourcing, limited harm reduction interventions, lack of availability of harm reduction in prisons and a lack of youth specific services.

In 2009, the World Health Organization visited Mauritius to examine these programmes and has made a series of detailed recommendations aimed at improving their availability, accessibility and quality.

There is unequal protection afforded to women who use drugs. Women will be turned away from residential shelters if they are drug users, creating an important protection gap. Men, however, can access two residential shelters regardless of their status as a drug user.

Hepatitis C (HCV) is also a major problem, exacerbated by co-infection with HIV. Availability of treatment for HCV is poor, available only to those who can pay in the private sector. For people who are drug dependent, this is a major barrier to accessing a potentially life-saving treatment.

Lastly, on 24th February, the Prime Minister announced that he intends to reinstate the death penalty for drug offences if he is re-elected.[15] This kind of draconian measure has shown time and again to have no effect on trafficking, while breaching international human rights law,[16] and driving people away from existing services for fear of excessive punishment. Alternative, public health based measures should be considered such as the decriminalisation and prescription of buprenorphine.

Section IV sets out key recommendations relating to these issues and necessary to achieve the progressive realisation of the right to the highest attainable standard of health for people who inject drugs in Mauritius.

II. Harm Reduction and the International Covenant on Economic Social and Cultural Rights

Harm reduction and the right to health (Article 12)

Harm reduction interventions – including needle and syringe exchange programmes (NSPs) and the prescription of opioid substitution therapy (OST) such as methadone – have found considerable support among numerous UN human rights mechanisms, particularly in the context of HIV prevention and the right to the highest attainable standard of health.

The **Committee on the Economic, Social, and Cultural Rights**, has recommended on several occasions that States Parties scale up their harm reduction programmes in order to meet their obligations under Article 12.

For example:

- In its Concluding Observations on Ukraine (2007), the Committee stated that it was "gravely concerned at…the limited access by drug users to substitution therapy," and recommended that the state party "make drug substitution therapy and other HIV prevention services more accessible for drug users."[17]

- In the context of the obligation to progressively realise the right to health, the Committee stated in its Concluding Observations on Tajikistan (2006) "that the State party establish time-bound targets for extending the provision of free testing services, free treatment for HIV and harm reduction services to all parts of the country."[18]

- In its Concluding Observations on Poland (2009), the Committee highlighted its concern at the limited access to HIV antiretroviral treatment, particularly among people who use drugs. It also raised its concern that "only a small number of drug users have access to substitute drug dependence treatment, and that such treatment is even more limited for those in detention".[19]

Both methadone and buprenorphine (the main medications used in OST) are included on the **WHO model essential medicines list**. The Committee has noted that the right to health includes access to essential medicines.[20]

In 2009, the **UN High Commissioner for Human Rights** added her office's support to harm reduction as a rights based response to injection driven HIV, stating that

> Individuals who use drugs do not forfeit their human rights. These include the right to the highest attainable standard of physical and mental health (including access to treatment, services and care)…a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV. [21]

The obligation of States to provide access to harm reduction interventions has also received strong support from the **UN Special Rapporteur on the Right to the Highest Attainable Standard of Health**. For example, the former Special Rapporteur Prof Paul Hunt, stated that,

> [I]n seeking to reduce drug-related harm, without judgment, and with respect for the inherent dignity of every individual, regardless of lifestyle, harm reduction stands as a clear example of human rights in practice. What began as a health based intervention in response to HIV must today be recognised as an essential component of the right to the highest attainable standard of health for people who inject drugs.[22]

Following his country mission to Sweden in 2006, Prof Hunt specifically called upon the Government to implement harm reduction programmes as a matter of priority.[23]

The current Special Rapporteur, Anand Grover, has also expressed strong support for harm reduction programmes.

> State Parties have obligations under international law and in particular under Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR) to prevent epidemics. Therefore, states have an obligation under international law to pursue harm reduction strategies. Under the same provision, State Parties also are obliged to realize the right to highest attainable standard of health, particularly for marginalized communities, such as drug users. This means that drug user communities are entitled to, opioid substitution therapy and drug dependence treatment, both inside and outside prisons. This right has to be realized universally.[24]

In 2009, the **UN Human Rights Council** adopted a resolution on human rights and HIV/AIDS that explicitly supported harm reduction interventions, including needle and syringe exchange.[25] The resolution reflected existing Commitments made at the **General Assembly** in 2001 and again in 2006. In 2010, the **UN Commission on Narcotic Drugs** adopted a resolution giving its strongest support to date to the comprehensive package of interventions for HIV prevention treatment and care among injecting drug users – including NSPs and OST. Both **ECOSOC** and the **UNAIDS Programme Co-ordinating Board** have also endorsed these interventions.[26]

The issue of harm reduction and the right to health in prisons has been has been a particular concern of UN human rights monitors. The **Committee on Economic Social and Cultural Rights** has explicitly stated in its General Comment on the Right to Health, that States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees.[27] In 2007, the Committee recommended that Ukraine "continue its efforts and take urgent measures to improve the accessibility and availability of HIV prevention to all the population and the treatment, care and support of persons living with HIV/AIDS, including in prisons and detention centres… and make drug substitution therapy and other HIV prevention services more accessible for drug users."[28]

Following his recent country mission to Kazakhstan, the **UN Special Rapporteur on Torture**, Prof Manfred Nowak, recommended that the Government make clean needles and syringes and opioid substitution therapy available in prisons.[29]

Harm reduction, scientific progress and progressive realisation (Articles 15.1.b and 2)

The realisation of the right to health in the context of injection driven HIV and harm reduction is further supported by Articles 15.1.b and 2. Together, these articles support the implementation of health systems for HIV prevention that are available, accessible, acceptable and of high quality.

Article 15.1.b guarantees the right of everyone to benefit from scientific progress and its applications. In the context of injecting driven HIV, this means the right to benefit from evidence-based, scientifically proven interventions that can prevent, treat and control HIV/AIDS and that can control and treat drug dependence and drug related harm. NSPs and OST have a considerable scientific evidence base demonstrating their effectiveness at reducing injecting-related risk behaviours.[30]

Article 2 obliges States Parties to take steps to the maximum of available resources to progressively achieve the full realisation of the rights contained in the Covenant, without discrimination. This requires appropriate budgetary planning and allocation of resources for the prevention of injecting driven HIV. In this regard, it should be noted that NSPs and OST have proven to be very cost effective across a range of settings, in both the community and in places of detention.

Article 2 also requires legislative reform in order to create a legal and policy environment conducive to the scale up of these services and the removal of barriers to access and coverage to improve accessibility.

III. Drug use, HIV and the right to health in Mauritius

> *The Committee recommends an in depth study and analysis of the situation of...drug abuse, and how State party can best protect and ensure the economic, social and cultural rights of the population of Mauritius affected by those problems.*
>
> **UN Committee on Economic Social and Cultural Rights, Concluding Observations, Mauritius, 1994**

> *The [HIV] infection rate in the population in general is 0.5%, while the prevalence rate in the group with high-risk behaviour such as sex workers, injecting drug users and prison inmates is more than 5%. Since 2001 the HIV epidemic in Mauritius has taken an upward trend, with an annual 100% rise in new infections. The trend since 2003 demonstrated that injecting drug use (IDU) is considered as the main driver to the epidemic, with 92% of new infections among injecting drug users in 2005. This mode of transmission is a cause of major concern for the country.*
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> **Second-Fourth periodic Report of Mauritius, para 392**

The number of injecting drug users in Mauritius is alarmingly high. According to the Rapid Situation Assessment (RSA) carried out in 2004, the number of people who inject drugs has been estimated between 17,000 and 18,000.[31] This amounts to almost 2% of the adult population. The majority of people inject buprenorphine (Subutex), a synthetic opioid. The UN Office on Drugs and Crime has thus ranked Mauritius 2nd in the world in terms of per capita opiate consumption.[32] Another study carried out in late 2009 using the Respondent Driven Sampling (RDS) method, evaluated the number of injectors at approximately 10,000, which still represents a significant level in injecting within an adult population of this size.[33]

The first case of HIV in Mauritius was registered in 1987, and the figures remained very low until the year 2000, when the HIV infection rate rose significantly within the injecting drug using community. This reached its peak in 2005 where, as noted in the periodic report of Mauritius (para 392), 92% of new HIV cases were related to unsafe injecting practices.[34] In 2007, UNAIDS estimated the overall prevalence rate in the country to be 1.8%, representing approximately 12,000 people.[35] This contradicts the State party's report which estimates general prevalence at 0.5% (Para 392)

The Government has recognised the need to address this issue of serious public health and human rights concern. Harm reduction programmes in the form of NSPs and OST with methadone were introduced in the country on a pilot basis in late 2006. This is to be welcomed and very much encouraged. Today, HIV-related harm reduction is gradually being scaled up, but coverage is not sufficient, with programmes reaching only a minority of those in need.

According to the AIDS Unit of the Ministry of Health & Quality of Life (MOHQL), there were 2,054 people on opioid substitution therapy (with methadone) in January 2010, and about 5,500 people who inject had access to needle and syringe programmes. According to the RDS Survey, 36.5%of people who inject drugs have reported obtaining injecting equipment through such programmes.[36] The level of coverage of harm reduction services is sufficient to halt and begin to reverse the injecting driven HIV epidemic in the country.

World Health Organization Mission to Mauritius, 2009

The Government's commitment to addressing the issue of injecting driven HIV and other drug related harms is evidenced in the invitation for the World Health Organization's harm reduction experts to visit Mauritius to assess the NSP and OST programmes. There were many positive factors, including:

- The initiation of NSP and OST (with methadone) – both recent developments
- Strong political commitment to these issues
- Committed staff
- Legislative change

However, there were a number of key factors affecting the availability, accessibility and quality of these services including:

- Lack of necessary funds - according to WHO, targets could not be met with existing resources
- Lack of adequate data collection, and monitoring and evaluation
- Poor geographical coverage
- Police interference with NSPs
- Age restrictions on access to OST
- Lack of NSP and OST in prisons

The WHO report makes a series of recommendations for the improvement of HIV prevention services for people who inject drugs. The Government should build on its progress in these areas and commit to ensuring the implementation of these recommendations with a view to the progressive realisation of the right to health in the country.

The final report is not public, however, and the State party should be asked for a copy in advance of its meeting with the Committee.

Below we focus on seven broad areas of concern to our organisations.

Needle and Syringe Programmes – barriers to availability and access

NSPs have been made available since 2006, and Mauritius has been the first country in the entire African region to implement such a projects. At that time, the programme was run by CUT, but there was no legal framework to support it.

Since then, the HIV/AIDS Act has been adopted[37] which provided a legal framework for NSPs. However, the HIV/AIDS Act is in conflict with the Dangerous Drug Act 2000 (DDA) when it comes to the issue of possession of syringes. The DDA (Section 341C) criminalises all types of drug paraphernalia, which infringes the smooth running NSPs.

As a result of this legislative conflict, police surveillance and harassment impedes the operation of NSPs operated both by non-governmental organisations and by the Government. Cases of police arrests of outreach workers due to the possession of syringes have been reported. The ADSU (Anti Drug and Smuggling Unit) of the Mauritian narcotics police, also make frequent rounds on NSP sites, thus discouraging people who inject drugs from attending, as well as discouraging them from bringing their used needles to the NSP for safe disposal.

In some areas of the country there are no NSPs at all meaning that some people who inject have no access to HIV prevention services due to their location.

Harm reduction in prisons

The high prevalence of HIV infection and drug dependence among prisoners and detainees, combined with the sharing of injecting equipment, make prison a high risk environment for the transmission of HIV and other blood-borne viruses. Statistics in 2008 showed that 25% of prisoners (754 out of 3,032) were sentenced for drug offences.[38] However, as people who use drugs often commit petty crimes in order to finance their drug use, the number of people who use drugs in prisons is far higher. According to the Drug Control Master Plan, 70% of all prisoners are serving sentences due to a drug related crime.[39]

Despite this high proportion of people who use drugs in Mauritian prisons, NSPs are not available. People who are being prescribed methadone may continue treatment upon admission to prison, and this is to be welcomed, but it is important that this treatment be offered also to people

regardless of whether or not they were accessing it in the community. Currently, OST may not be *initiated* in prison.

Under international law, persons in detention retain all rights except insofar as these are necessarily limited by the fact of incarceration. This includes the right to the highest attainable standard of health. Consequently, it is recognised that people in prisons have a right to access to equivalent health services and care as persons outside prisons, and that denial of such services is not a necessary or justified aspect of incarceration.[40] It should be noted that prison needle and syringe programmes have been implemented successfully in other prison systems, and have not been shown to increase drug use or to pose a risk of injury to staff or to risk prison safety in other ways.[41]

Harm reduction services for young people

Statistics on drug use among young people vary. According to one study in 2007, 10.5% of Mauritian adolescents have had an experience with heroin, and 5.1% with injected buprenorphine.[42] Another study commissioned by a private company (Rogers Group) for the National AIDS Secretariat and UNAIDS reported that 4% of young people aged 15—24 use hard drugs (defined, in this case, as heroin, cocaine, ecstasy buprenorphine), of which 2.5% admitted injecting heroin, buprenorphine or an equivalent drug.[43]

Young injectors are at a higher risk of HIV infection because of their lack of familiarity with safe injecting techniques, and their stigmatisation by authorities and health care services. Young people who inject drugs, particularly occasional injectors, often do not identify with older drug users and do not see themselves as 'dependent'. As such they are less likely to attend existing services and require youth specific interventions.[44]

Moreover, age restrictions prevent access to harm reduction services. A specific recommendation of the WHO following its mission to Mauritius was to address age barriers relating to OST.

Equal protection for women who use drugs (Articles 2 and 3)

Protection for people who use drugs in the form of residential shelters is unequal between men and women. At present there are no residential facilities for women in need of a shelter and who are drug dependent. Women seeking shelter in a residential facility are asked a series of questions - if they admit being a drug user they are directed instead to a detox centre. However, the only detox centre available for women in Mauritius has a waiting list, and it is impossible for a woman to show up without prior notification. Therefore, in practice women cannot access residential shelters. This poses a real threat to women who use drugs and who live on the streets or who are at risk of domestic violence. There are, however, two night shelters open to men irrespective of their status as a drug user. This imbalance must be addressed.

Hepatitis C treatment

In addition to HIV/AIDS, hepatitis C (HCV) is also a significant public health concern related to injecting drug use. There are approximately 25,000 to 35,000 Mauritians infected with HCV. It can be expected that 20-30% of patients infected with HCV will go on to develop cirrhosis of the liver, typically up to 25 years after the initial infection. This delay in onset of cirrhosis is, however, greatly reduced if the person is an injecting drug user or is co-infected with HIV.[45] The recent RDS Survey has revealed a significant rate of HIV/HCV co-infection in the country. According to the study, 99.7% of all injecting drug users living with HIV have also tested positive to HCV.[46] Hepatitis C can be effectively treated in the majority of cases with a course of medication such as Interferon or Ribavirin.[47] In Mauritius, however, such treatment is very expensive, and only available via the private health sector. For the majority of people who inject drugs it is therefore, in practice, unavailable.

The death penalty for drug offences

On February 24th 2010, the Prime Minister pledged to reinstate the death penalty for drug offences if he was re-elected in the forthcoming May elections.*[48] This draconian measure would have no effect on trafficking. It has not shown to be a deterrent in any country that has retained the penalty for drug offences. Rather, it would contribute to a climate of fear which only serves to add to the reluctance of target groups to come forward for treatment or assistance. It would also add an extra legal barrier, further limiting treatment options (such as the prescription of buprenorphine – see below)

It should be noted that in his speech the Prime Minister explicitly threatened tourists arriving in Mauritius carrying burpenorphine legally prescribed elsewhere. "*We have to be severe*" he said "*Even those who have to take Subutex† under medical prescription will not be spared. It is better that they do not come to Mauritius on holidays with Subutex; they will have to face severe penalties*".[49]

Such comments and policy pledges must be condemned in the strongest terms. They are particularly disappointing given the recent progress on the response to injecting driven HIV in the country.

Buprenorphine prescription – a crime reduction and public health based alternative to severe penalties

Buprenorphine is classified in Schedule II of the Dangerous Drug Act, making it illegal to import and sell this product in the country.[50] This prohibited status is maintained by the Government due to the fact that it is the main drug of injection in the country.‡ However, despite the prohibited

* Mauritius abolished the death penalty in 1995 and voted twice *in favour* of the moratorium on the death penalty at the General Assembly

† Subutex is a brand name for buprenorphine

‡ That his is the case is due to various factors – availability, cost and duration of action. Buprenorphine is a cheaper, more available and more cost effective alternative to other opiates.

status of buprenorphine in Mauritius, its availability on the black market is significant. This means, effectively, that the government has no control over this drug in terms of trafficking and use.

The death penalty and ever harsher sanctions, however, is not the way forward. Indeed, given the state's ratification of the ICCPR (Which states that the death penalty may only be imposed for 'most serious crimes') and CAT (which prohibits cruel inhuman and degrading punishment), it may be illegal. The government should consider, as an alternative, the decriminalisation of buprenorphine and trial prescription programmes for those who are dependent on the drug. Such a programme would be aimed at:

- Reducing the harms associated with people who use drugs coming into contact with the criminal justice system
- Significantly reducing the threat of overdose by strictly administering prescribed doses
- Stabilising people lives by reducing their need to resort to criminality and drawing them into psychological and social services

Buprenorphine is a recognised essential medicine, and prescription guidelines are well established.[51] Buprenorphine is regularly prescribed to people in other countries as a treatment for opiate dependence.

Decriminalisation and prescription of buprenorphine would also have the added benefit of helping to tackle the illicit trade. Demand for illicitly obtained buprenorphine would necessarily be reduced as people are brought into the prescription programme. The market for illicit sales would therefore be significantly damaged without resorting to severe measures that entail acute human rights risks.

IV. Recommendations

In order to achieve the progressive realisation of the right to health for people who inject drugs in Mauritius (articles 2 and 12), and so that this group may benefit from scientific progress and its applications (article 15.1.b) the State party should

1. In co-operation with the World Health Organization and civil society, implement in full the WHO recommendations designed to improve availability, accessibility and quality of harm reduction services – in particular needle and syringe exchange and opioid substitution therapy with methadone. People who use drugs should be a key partner in this initiative.

As a matter of urgency, the State party should:

2. Scale up needle and syringe programmes to all geographical areas. The Government should amend the Dangerous Drugs Act 2000 to remove prohibitions on distributing or carrying drug paraphernalia as these impede HIV prevention services.

3. Implement pilot prison needle and syringe exchange and opioid substitution therapy programmes based on international best practice standards

4. Remove age barriers to accessing opioid substitution therapy and develop youth-friendly harm reduction services tailored to the specific needs of young people who use drugs

5. Remove restrictions on access to residential shelters for women who use drugs

6. Make hepatitis C treatment freely available to all injecting drug users

7. Immediately rescind the proposal to re-introduce the death penalty for drug offences and consider instead public health based alternatives such as the decriminalisation and prescription of buprenorphine.

ENDNOTES

[1] Collectif Urgence Toxida (CUT) is a network of different NGOS and individuals concerned with Substance Abuse and HIV/AIDS in Mauritius. CUT started to meet as a platform in 2004, to advocate for Harm Reduction Strategies in the country, and was officially registered in 2007. CUT is the only NGO in Mauritius working solely on Harm Reduction, specifically on the project implementation, as CUT has launched the first Needle Exchange in the country in 2006. We now manage several NEP sites throughout the country. CUT is also working on the advocacy level, and we organized in October 2009 the First Conference on Opiate Abuse and Harm Reduction in Mauritius in order to produce an advocacy document for our decision makers. The International Harm Reduction Association (IHRA) is on of the leading international NGOs promoting policies and practices that reduce drug-related harms, a mandate that has a significant intersection with human rights issues. Drug-related harms in this context include not only increased vulnerability of people who use drugs to HIV and hepatitis C infection, but also includes poor access to healthcare, discrimination, police harassment, imprisonment, invasion of privacy, social marginalization and, in some countries, capital punishment. IHRA is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

[2] Foreword, Global State of Harm Reduction (2008) http://www.ihra.net/GlobalStateofHarmReduction

[3] See International Harm Reduction Association, the Global State of Harm Reduction 2008: Mapping the response to injection driven HIV and hepatitis C epidemics http://www.ihra.net/GlobalStateofHarmReduction

[4] UN General Assembly, Declaration of Commitment on HIV/AIDS, 2 August 2001, UN Doc No A/RES/S-26/2, paras 23, 52, 62 http://www.un.org/ga/aids/docs/aress262.pdf

Preventing the Transmission of HIV Among Drug Abusers. A position paper of the United Nations System. Annex to the Report of 8th Session of ACC Subcommittee on Drug Control 28-29 September (2000)
http://www.ihra.net/uploads/downloads/50best/HIVPrevention/HIVTop50Documents18.7.pdf

Commission on Narcotic Drugs Resolution 45/1, Human immunodeficiency virus/acquired immunodeficiency syndrome in the context of drug abuse
http://www.unodc.org/pdf/document_2002-04-25_1.pdf

Commission on Narcotic Drugs Resolution 46/2, Strengthening strategies regarding the prevention of human immunodeficiency virus/acquired immunodeficiency syndrome in the context of drug abuse
http://daccessdds.un.org/doc/UNDOC/GEN/V03/837/76/PDF/V0383776.pdf?OpenElement

Commission on Narcotic Drugs Resolution 47/2, Prevention of HIV among drug users
http://www.unodc.org/pdf/resolutions/cnd_2004_47-2.pdf

Commission on Narcotic Drugs Resolution 48/12, Expanding the capacity of communities to provide information, treatment, health care and social services to people living with HIV/AIDS and other blood-borne diseases in the context of drug abuse and strengthening monitoring, evaluation and reporting systems
http://daccessdds.un.org/doc/UNDOC/GEN/V05/912/35/PDF/V0591235.pdf?OpenElement

Commission on Narcotic Drugs Resolution 49/4, Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users
http://daccessdds.un.org/doc/UNDOC/GEN/V06/526/23/PDF/V0652623.pdf?OpenElement

[5] UNODC (2008) Reducing the adverse health and social effects of drug use: A comprehensive approach.
http://www.unodc.org/documents/prevention/Reducing-adverse-consequences-drug-abuse.pdf WHO, UNAIDS & UNODC (2004) Policy Brief: Provision of sterile injecting equipment to reduce HIV transmission. Geneva, World Health Organization, 2004
http://www.who.int/hiv/pub/advocacy/en/provisionofsterileen.pdf ; WHO, UNAIDS & UNODC (2004) Position Paper - Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention. Geneva, World Health Organization 2004
http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf;
World Health Organization (2007) Model List of Essential Medicines, 15th list March 2007.
http://www.who.int/medicines/publications/EssMedList15.pdf
WHO, UNAIDS & UNODC (2004) Policy Brief: Reduction of HIV Transmission in Prisons, Geneva, World Health Organization, 2004
http://www.who.int/hiv/pub/advocacy/en/transmissionprisonen.pdf

[6] EU Drugs Action Plan 2005-2008
http://eur-lex.europa.eu/LexUriServ/site/en/oj/2005/c_168/c_16820050708en00010018.pdf
EU Drugs Strategy 2005-2012

http://ec.europa.eu/justice_home/fsj/drugs/strategy/fsj_drugs_strategy_en.htm

[7] Council of Europe, Parliamentary Assembly Resolution 1576 (2007) For a European convention on promoting public health policy in the fight against drugs
http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta07/ERES1576.htm Council of Europe, Recommendation R(98)7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Healthcare in Prison, adopted 8 April 1998, 627th Meeting of the Ministers' Deputies; Council of Europe, Recommendation R(93)6 of the Committee of Ministers Concerning Prison and Criminological Aspects of the Control of Transmissible Diseases including AIDS and Related Health Problems in Prison, adopted 18 October 1993, 500th Meeting of the Ministers' Deputies; Council of Europe, P.A. Standing Committee, Recommendation 1080 (1988) On a Co-ordinated European Health Policy to Prevent the Spread of AIDS in Prison; Council of Europe, Recommendation R(2006)2 of the Committee of Ministers on the European Prison Rules, adopted 11 January 2006, 952nd Meeting of the Ministers' Deputies

[8] Special Summit of the African Union on HIV, Tuberculosis and Malaria, Abuja, 2-6 May 2006 http://www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/SP_PRC_ATM3I_AU_Social_and_Cultural_Factors.pdf

[9] Rome Consensus for a Humanitarian Drug Policy (2005) Italian Red Cross and Senlis Council, signed to date by approximately 110 national Red Cross and Red Crescent Societies
http://www.senliscouncil.net/modules/media_centre/press_conferences/rome_public_health/rome_consensus

[10] Harm reduction policies and practice worldwide, International Harm Reduction Association, March 2009
http://www.ihra.net/Assets/1556/1/HarmReductionPoliciesandPractiveWorldwide5.pdf

[11] High Commissioner calls for focus on human rights and harm reduction in international drug policy, Press release, 10 March 2009

[12] Sulliman, F.T, Ameerbeg, S.Dhannoo, M.I (2004), Report of the Rapid Situation Assessment and Responses on Drug Use in Mauritius & Rodrigues, NATReSA (under the aegis of the UNODC).

[13] UNAIDS (Available at http://www.unaids.org/en/CountryResponses/Countries/mauritius.asp, retrieved in March 10)

[14] HIV Sentinel Surveillance Survey, MOHQL, Mauritius

[15] http://www.lematinal.com/news/local-news/3316-Ramgoolam-Mort-aux-trafiquants-de-Subutex.html

[16] See R. Lines (2007) The Death Penalty for Drug Offences: A Violation of International Human Rights Law, International Harm Reduction Association

[17] Concluding observations of the Committee on Economic, Social and Cultural Rights to Ukraine, 2007 paras 28, 51

[18] Concluding observations of the Committee on Economic, Social and Cultural Rights to Tajikistan, 2006, para 70

[19] Concluding observations of the Committee on Economic, Social and Cultural Rights to Poland, 2009, paras 27 & 30

[20] Committee on Economic, Social and Cultural Rights, General Comment No 14, para 12 (a)

[21] High Commissioner calls for focus on human rights and harm reduction in international drug policy, Press release, 10 March 2009

[22] Foreword, Global State of Harm Reduction (2008) http://www.ihra.net/GlobalStateofHarmReduction

[23] UN Doc no A/HRC/4/28/Add.2 paras 60-62

24 Foreword, Harm Reduction and Human Rights: The Global Response to Drug-Related HIV Epidemics (2009) http://www.ihra.net/GlobalResponse

25 Human Rights Council Resolution 12/27 on "The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)"

[26] See International Harm Reduction Association and Human Rights Watch, Building Consensus: A Reference Guide to Human Rights and Drug Policy, March 2009, Section 1, UN Legal and Policy Statements on Harm Reduction
http://www.ihra.net/Assets/1544/1/BuildingConsensus.pdf

27 Committee on Economic, Social and Cultural Rights, General Comment No 14, para 34

28 Concluding observations of the Committee on Economic, Social and Cultural Rights to Ukraine, 2007, para 51

[29] UN Doc No. A/HRC/13/39/Add.3, paras 29 and 85(b)

[30] See for example, U.S. Institute of Medicine (2006), Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence, September 2006
Full text at http://books.nap.edu/catalog.php?record_id=11731#toc
Hunt N (2003) A review of the evidence-base for harm reduction approaches to drug use. London: Report commissioned by Forward Thinking on Drugs – A Release Initiative.
http://www.ihra.net/uploads/downloads/50best/HIVPrevention/HIVTop50Documents1.1.pdf

World Health Organization (2004) Evidence for Action Technical Papers: Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users. Geneva, World Health Organization 2004 http://www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf
World Health Organization (2004) Evidence for Action Technical Papers: Effectiveness of drug dependence treatment in HIV prevention, Geneva, World Health Organization 2004 http://www.emro.who.int/aiecf/web203.pdf
Canadian HIV-AIDS Legal Network (2004) Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience. Canadian HIV-AIDS Legal Network. http://www.ihra.net/uploads/downloads/50best/HIVPrevention/HIVTop50Documents8.5.pdf
World Health Organization, Evidence for Action Technical Papers, Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies, WHO/UNODC/UNAIDS, 2007 http://www.who.int/hiv/idu/oms_%20ea_nsp_df.pdf
World Health Organization, Evidence for Action Technical Papers, Interventions to Address HIV in Prisons: Drug Dependence Treatments WHO/UNODC/UNAIDS, 2007 http://www.who.int/hiv/idu/EADrugTreatment.pdf
[31] Sulliman, F.T, Ameerbeg, S.Dhannoo, M.I (2004), Report of the Rapid Situation Assessment and Responses on Drug Use in Mauritius & Rodrigues, NATReSA (under the aegis of the UNODC).
[32] UNODC. Available at www.unodc.org/documents/wdr/...2009/WDR2009_eng_web.pdf
[33] UNGASS Country Progress Report 2010. Available at http://data.unaids.org/pub/Report/2010/mauritius_2010_country_progress_report_en.pdf
[34] HIV Sentinel Surveillance Survey, MOHQL, Mauritius
[35] UNAIDS. Available at http://www.unaids.org/en/CountryResponses/Countries/mauritius.asp
[36] Johnston L., Integrated Behavioural & Biological Surveillance Survey among Injecting Drug Users in Mauritius, 2009.
[37] HIV/AIDS Act 2006. Available at www.ilo.org/public/english/protection/trav/aids/laws/mauritius1.pdf
[38] http://www.gov.mu/portal/site/prisons/menuitem.703fa58c898ac13ff4a9e75b0bb521ca/
[39] Drug Control Master plan 2004-2009, Mauritius, UNODC, available at http://www.gov.mu/portal/goc/ssns/file/master.doc
[40] United Nations General Assembly, *Basic Principles for the Treatment of Prisoners*, UNGA Resolution 45/111 (14 December 1990), Article 5
[41] WHO, UNODC & UNAIDS, Effectiveness of interventions to address HIV in prisons, 2007
[42] Youth Risky Behaviour Survey, Mauritius Institute of Health, 2007
[43] National Study on Knowledge, Attitudes, Behaviours and Beliefs related to HIV/AIDS among the Youth (15 to 24 years old) of Mauritius, National AIDS Secretariat, UNAIDS, Mauritius Available at http://www.box.net/shared/l20h1fl4tv
[44] See Young people and injecting drug use in selected countries of Central and Eastern Europe, Eurasian Harm Reduction Network, 2009
[45] Dr. Z. Joomaye, (President of HEP Support NGO), CUT Conference on Opiates and Harm Reduction Services in Mauritius, Oct 09
[46] Johnston L., Integrated Behavioural & Biological Surveillance Survey among Injecting Drug Users in Mauritius, 2009.
[47] http://www.hcvadvocate.org/hepatitis/factsheets_pdf/Inf%20and%20Rib.pdf
[48] http://www.kotzot.com/news/navin-ramgoolam-mauritius.html; http://www.lematinal.com/news/local-news/3316-Ramgoolam-Mort-aux-trafiquants-de-Subutex.html
[49] http://www.defimedia.info/articles/6935/1/PM-promises-death-penalty-law-before-election/Page1.html
[50] Dangerous Drug Act 2000 (41/2000). Available at http://www.gov.mu/portal/sites/icac/legislations.htm
[51] See for example Operational guidelines for the management of opioid dependence in the South-East Asia Region, WHO, 2008 http://www.searo.who.int/LinkFiles/Publications_guidelines_management_opioid__in_SEAR.pdf; EMCDDA, Buprenorphine - treatment, misuse and prescription practices, 2005 http://www.emcdda.europa.eu/publications/selected-issues/buprenorphine; Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.