



REPUBLIC OF MAURITIUS

## **NATIONAL AUDIT OFFICE**

# **PERFORMANCE AUDIT REPORT**

## **ENHANCING THE EFFECTIVENESS OF INTERVENTIONS RELATED TO DRUG DEMAND AND HARM REDUCTION**

**Prime Minister's Office  
(Rodrigues, Outer Islands and Territorial  
Integrity Division)**

**Ministry of Health and Wellness**

**APRIL 2023**

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## FOREWORD

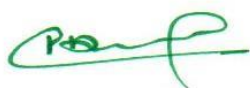
Section 16 (1A) of the Finance and Audit Act requires the Director of Audit to carry out performance audit and report on the extent to which a Ministry, Department or Division is applying its resources and carrying out its operations economically, efficiently and effectively.

I am pleased to submit to the Minister of Finance, Economic Planning and Development, and through him to the National Assembly, this Performance Audit Report titled “Enhancing the Effectiveness of the Interventions related to Drug Demand and Harm Reduction”. Drug addiction is a complex problem and requires a multitude of interventions to minimise its harmful impacts. Government has continuously invested in drug demand and harm reduction activities to reduce these negative impacts. Investments in treating drug use disorders generally lead to reductions in drug-related crimes and costs of criminal justice, law enforcement and healthcare systems.

The objective of this performance audit was to assess whether the interventions of the Ministry of Health and Wellness, under the oversight of the National Drug Secretariat (operating under the aegis of the Prime Minister’s Office), were effective in reducing harm and drug demand. The Report contains audit findings, conclusion and recommendations, including comments from the Prime Minister’s Office (Rodrigues, Outer Islands and Territorial Integrity Division) and the Ministry of Health and Wellness. Both Ministries are recommended to keep focus on outcomes to ensure the effectiveness of their interventions related to drug use prevention, treatment, social integration and rehabilitation.

My Office envisages carrying out a follow-up audit at an appropriate time regarding actions taken by the Ministries in relation to the implementation of the recommendations.

I take this opportunity to thank the Supervising Officers and staff of the Prime Minister’s Office, including the National Drug Secretariat, the Ministry of Health and Wellness, the Ministry of Education, Tertiary Education, Science and Technology, the Mauritius Prison Service, the National Social Inclusion Foundation and the Non-Governmental Organisations for their cooperation and collaboration. I would also like to express my thanks and appreciation to my staff who conducted this audit.



**C. ROMOOAH**

Director of Audit

National Audit Office

**PORT LOUIS**

27 April 2023

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## ABBREVIATIONS AND ACRONYMS

ADSU	Anti-Drug and Smuggling Unit
AIDS	Acquired Immuno-Deficiency Syndrome
CSD	Central Supplies Division
COVID-19	Coronavirus Disease of 2019
HIV	Human Immunodeficiency Virus
HRU	Harm Reduction Unit
HSSP	Health Sector Strategic Plan
IBBS	Integrated Biological and Behavioural Surveillance
MDCC	Methadone Day Care Centre
MoETEST	Ministry of Education, Tertiary Education, Science and Technology
MoHW	Ministry of Health and Wellness
NATReSA	National Agency for the Treatment and Rehabilitation of Substance Abusers
NCD	Non-Communicable Diseases
NDO	National Drug Observatory
NDS	National Drug Secretariat
NDCMP	National Drug Control Master Plan
NEP	Needle Exchange Programme
NGO	Non-Governmental Organisation
NSIF	National Social Inclusion Foundation
PMO	Prime Minister's Office (Rodrigues, Outer Islands and Territorial Integrity Division)
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RH	Regional Hospital
SDG	Sustainable Development Goal
SOP	Standard Operating Procedures
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

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## GLOSSARY

Buprenorphine	Opioid (or narcotic) medication used to treat opioid dependence or for moderate-to-severe pain.
Cannabinoids	Cannabinoids are drugs that share active agents found in Cannabis (Marijuana) or are synthetically developed from those drugs.
Client	Denotes a recipient of healthcare.
Codeine	Codeine is a weak narcotic pain reliever and cough suppressant that is similar to morphine.
Cognitive behavioural therapy	Psychosocial intervention that aims to reduce symptoms of various mental health conditions, primarily depression and anxiety disorders.
Loss to follow-up	Patients who had been inducted but who had stopped the therapy or those who continue to consume their daily doses at the dispensing sites but did not attend the follow-up clinics.
Methadone	Long-acting, commonly used synthetic opioid therapeutic drugs for detoxification or maintenance therapy in opioid dependence.
Methadone Substitution Therapy	Evidence-based intervention for opiate-dependent persons that replaces illicit drug use with medically prescribed, orally administered opiates. It helps to rehabilitate addicts, prevent relapses, reduce other negative effects of addiction and give recovering addicts a better quality of life.
Naltrexone	Medication commonly prescribed to treat opioid addictions reducing the cravings usually caused by drugs.
Opioids	Substances that act on opioid receptors to produce morphine-like effects. Medically they are primarily used for pain relief, including anesthesia.
Pharmacological	Relating to the branch of medicine concerned with the uses, effects, and modes of action of drugs.
Psychoactive drugs	A drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behaviour.
Psychosocial interventions	Programmes that address motivational, behavioural, psychological, social, and environmental factors related to substance use and have been shown to reduce drug use, promote abstinence and prevent relapse.
Suboxone	Suboxone is a medicine to treat dependence on opioid (narcotic) drugs such as heroin or morphine in drug addicts who have agreed to be treated for their addiction. It contains two drugs -buprenorphine and naloxone.

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## EXECUTIVE SUMMARY

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Since the 1980s, substance abuse, drug trafficking and the country's degrading social situation have been a serious concern to Government. To address drug trafficking and abuse, significant costs are incurred annually on enforcement, judiciary, penitentiary and health services. As per the Report of the Commission of Inquiry on Drug Trafficking of 2018, some 38 per cent of persons charged or appearing before courts or brought within the criminal justice system had issues with drug or were drug consumers.

In 2021, it was estimated through surveys that there were some 6,600<sup>1</sup> active 'People Who Inject Drugs' in addition to some 55,000<sup>2</sup> 'People Who Use Drugs' aged between 18 to 59 years. Drug use related disorders are serious health conditions that present a significant burden for affected individuals, their families and communities. Untreated drug use disorders trigger substantial costs to the Mauritian society including lost productivity, increased health care expenditures, costs related to criminal justice and social welfare systems, and other social consequences.

### *Why we carried out this audit*

As per Target 3.5 of the Sustainable Development Goal 3 of the United Nations 2030 Agenda, there is a need to 'Ensure healthy lives and promote well-being for all ages' by strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. The related indicator 3.5.1 measures the national coverage of treatment interventions for substance use disorders.

To reduce the negative impact of drug use disorders, Government has been continuously investing in drug demand reduction (through prevention and treatment activities) and harm reduction interventions. Harm reduction interventions (through Methadone Substitution Therapy and Needle Exchange Programme) have been targeting 'People Who Inject Drugs'. This group of people has a high prevalence of blood-borne diseases which represents a source of contamination for the population. According to a research<sup>3</sup> titled 'Principles of Drug

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<sup>1</sup> Ministry of Health and Wellness, Integrated Biological and Behavioural Surveillance (IBBS) 2020 Survey 'People Who Inject Drugs in the island of Mauritius'- Page 27 published in July 2021. Accessible at [https://health.govmu.org/Documents/Legislations/Documents/PWID\\_FINAL\\_REPORT%20%281%29.pdf](https://health.govmu.org/Documents/Legislations/Documents/PWID_FINAL_REPORT%20%281%29.pdf)

<sup>2</sup> National Drug Secretariat, Prime Minister's Office, 2021, 'National Survey Among People Who Use Drugs', Page 6. Accessible at <https://mroiti.govmu.org/Communique/National%20survey%20among%20people%20who%20use%20drugs.pdf>

<sup>3</sup> National Institute on Drug Abuse (NIDA), United States federal government research institute – Title of publication: Principles of Drug Addiction Treatment: A research-based guide 3<sup>rd</sup> edition. Page 15. Last Updated January 2018. <https://www.drugabuse.gov/>



Addiction Treatment’, the rate of savings to investments in treating drug use disorders can exceed a ratio of 12:1 through reductions in drug-related crimes and costs of criminal justice, law enforcement and healthcare services.

However, during the period 2017-2020, drug-related offences as a percentage of crime offences increased from some 12 per cent to reach 32 per cent. For the same period, on average, 940 persons were admitted annually to public health institutions for treatment in respect of drug-related problems. The admissions included teenagers and a younger segment of the population. During the period 2016-2020, on average, 152 persons aged 15 to 19 years were admitted annually to public health institutions due to complications following intake of illicit substances (including abuse of medicinal products). Those aged 14 years or less stood at an average of 17 annually. Admissions due to the consumption of synthetic drugs have been increasing gradually, representing some 60 per cent of the admission by type of drug consumed in 2020.

It is against this background that the National Audit Office carried out this Performance Audit titled ‘Enhancing the Effectiveness of Interventions relating to Drug Demand and Harm Reduction.’

### *What we did*

One of the key players in implementing both drug demand and harm reduction activities is the Ministry of Health and Wellness through its Harm Reduction Unit. The National Drug Secretariat operating under the aegis of the Prime Minister’s Office (Rodrigues, Outer Islands and Territorial Integrity Division) is the apex organisation with the responsibility to ensure the overall coordination of all drug control activities in Mauritius. This coordination is necessary to ensure greater collaboration and synergy among partners, with a view to achieving greater results and impact.

We assessed whether the interventions of the Ministry of Health and Wellness, under the oversight of the National Drug Secretariat, were effective in reducing harm and drug demand.

We sought to find out whether:

1. the Drug Use Prevention activities were adequate and effective;
2. the Drug Use Disorder Treatment, Rehabilitation and Social Integration activities were adequate and effective;
3. the coverage in respect of Harm Reduction interventions was adequate and effective; and
4. there was adequate oversight by the National Drug Secretariat over Drug Demand and Harm Reduction interventions to reduce the harmful consequences of drug use disorders.

Different methodologies were used to gather and analyse data, understand the audit area, along with obtaining sufficient, relevant and reliable audit evidence to support the conclusion and recommendations.

## *What we found*

Our findings relate to the audit scope which covered the period January 2016 to May 2022 and was supplemented with information relating prior to January 2016. Additional information and comments received from the Prime Minister's Office and the Ministry of Health and Wellness in July 2022, August 2022, October 2022, March 2023 and April 2023 have been included in the Report.

### **1. Adequacy and Effectiveness of Drug Use Prevention Activities**

In respect of drug prevention activities carried out by the Ministry under the oversight of the National Drug Secretariat and in collaboration with other stakeholders, our findings were as follows:

- The Ministry's drug prevention activities were directly aligned with the requirements of the Master Plan and were performed by a team of trained officers. However, its drug prevention programmes and activities carried over the past years were not accompanied by a monitoring and evaluation component. Inclusion of this component in the prevention programmes would have ensured alignment with good practices and provided the assurance that the programmes were adequate and effective in preventing the consumption of drugs, particularly among the younger segment of the population. As per the National Survey Among 'People Who Use Drugs' published in December 2021, the median age of 'People Who Use Drugs' was 30 years. This meant that fifty per cent of 'People Who Use Drugs' were estimated to be aged 30 years or less.
- By considering its mandate limited to that of a coordinating body, as opposed to what was prescribed in its Terms of Reference, the National Drug Secretariat did not ensure that drug prevention activities of different stakeholders were evidence-based and carried out in line with international standards and best practices.
- The National Social Inclusion Foundation was included as a stakeholder in the Drug Prevention Committee as it was a funding agency for Non-Governmental Organisations' projects which included drug prevention activities in educational institutions, workplaces and the community. However, the Foundation had put much emphasis on financial monitoring instead of assessing whether the intended benefits were realised out of the funding provided to these Non-Governmental Organisations.
- Phase 1 of the 'Get Connected Programme' was implemented in 24 secondary schools as a pilot project. Phase 2, which started in January 2020, was negatively impacted by the closure of schools over several months due to COVID-19. As of August 2022, the evaluation of the pilot project was not completed and there was no visibility on when same would be completed and when the programme would be fully deployed to the remaining schools.

- In June 2020, the Drug Prevention Committee chaired by the National Drug Secretariat decided to develop a Standardised Drug Prevention Programme, concurrently with the ‘Get Connected Programme’ which would cover a larger student population (i.e., Grade 9 onwards). ‘People Who Use Drugs’ started with cannabis at a very young age (11-17 years) and this evidence warranted the implementation of a prevention programme for students at a very young age. The development of this complementary Standardised Drug Prevention Programme to induce a larger proportion of school population was stalled due to the unresolved issue as to which entity should lead the process. As of September 2022, it was estimated that some 64,000 students would not benefit from this programme due to the unresolved issues on who should lead same.
  
- A Youth Empowerment Programme Against Drugs was led by the Ministry in partnership with major stakeholders for the implementation of drug prevention programme in 24 drug prone areas across the island. The second phase of this programme was considered crucial, whereby activities had to be sustained against drugs in each region. This had to be monitored by the Prevention Team of the Harm Reduction Unit of the Ministry. As of May 2022, neither an assessment of the training already provided was initiated nor communication was maintained with the trained members of the cohort in each region.

## **2. Adequacy and Effectiveness of Drug Use Disorder Treatment, Rehabilitation and Social Integration Activities**

The Drug Use Disorder Treatment, Rehabilitation and Social Integration activities of the Ministry were aligned with good practices. However, there were performance gaps in their implementation which undermined their coverage and effectiveness.

### *Drug Use Disorder Treatment*

- The Ministry had aligned its treatment services with the key principles and standards for the treatment of drug use disorders as recommended by the United Nations Office on Drugs and Crime. It had also adopted the recommended modalities and approaches for the treatment of drug abuse. There were several issues relating to the administration of treatment which impacted negatively on its effectiveness.
  
- There was a reasonable level of information about the prevalence of drug use and misuse, and the supply of treatment for drug misuse was reasonably well measured. However, there was limited information on the extent to which the coverage and demand for treatment by drug misusers were being met.
  
- There was a missed opportunity by the Ministry to assess the demand for treatment and subsequent referral to treatment to benefit from reductions in drug-related crimes and costs of criminal justice, law enforcement and healthcare systems.

- The measurement of timeliness of providing Methadone Substitution Therapy and setting of related targets to monitor this key performance indicator were not considered by the Ministry. Monitoring of waiting time is important to ensure that it is kept within reasonable limits and to provide inputs for capacity planning to accommodate additional clients. The overall effect would be to decrease the likelihood of ‘People Who Use Drugs’ losing their resolve to start treatment or resuming substance misuse due to long waiting lists for induction.
- In December 2020, the Harm Reduction Unit reported that ‘People Who Use Drugs’ had to wait a lot before they could be embarked on the methadone treatment programme and they were more likely to stop coming for their pre-induction counselling. Hence, opportunities to extend treatment to them were lost. As at end of January 2022, induction into Methadone Substitution Therapy (from the completion of screening), across all the Methadone Day Care Centres, was assessed to take at least one week and up to 10 weeks.
- The Ministry had attempted to reduce the waiting time for induction. Still, as of end of August 2022, the waiting time ranged between one to six weeks across the four Methadone Day Care Centres.
- The Ministry deployed significant resources to dispense methadone daily to some 6,500 clients who had already been induced to methadone under the Methadone Substitution Therapy Programme. Despite all the manpower, materials and logistics invested in the system of dispensing of methadone, several problems impacted negatively on the expected outcome of the therapy. These included overcrowding, loitering and diversion of methadone at several dispensing sites, and the perceived stigmatisation of clients.
- The Ministry devised several methods to attend to these problems, but met several challenges during their implementation. These methods included the decentralisation of dispensing of methadone to public health institutions, dispensing of methadone in plastic cups to reduce methadone diversion and the ‘Take-home-dose’ pilot project.
- As of March 2022, there has been a relative increase in the number of clients who were being serviced at public health institutions (some 13 per cent of total clients on methadone). However daily methadone doses for at least two-thirds of the clients (4,415 out of 6,534) were still being dispensed in the yards of police stations and which required mobilisation of significant resources. The Ministry had not prepared any plan on how to relocate these clients to places which would require less resources, reduce the perceived stigmatisation and enhance support towards their rehabilitation and social integration.
- The Ministry had not provided updates on the outcome of these two pilot projects - dispensing of methadone in plastic cups and ‘Take-home-dose’.

- As per the Protocol for the Methadone Substitution Therapy Programme of the Ministry, clients on Methadone Substitution Therapy should be regularly followed up to enhance the associated medical and psychosocial management aspects. In 2017, only some 25 per cent of the clients were reported to be attending medical follow-up. As of May 2022, based on information gathered from the Methadone Day Care Centres and Addictology Units during site visits, there was no marked improvement in the percentage of clients on methadone attending follow-up.
- Records kept in the Methadone Day Care Centres and Addictology Units did not provide adequate information on how feedback from dispensing nurses and local pharmacists was included in the medical files of those not attending follow-ups, and how new treatment or management plans were adopted. Absence of these records and feedback devoid the Ministry of the visibility on the extent to which these patients were really benefiting from the therapy.
- Some 1,200 ‘People Who Inject Drugs’ or ‘People Who Use Drugs’, as of 31 December 2021, had undergone detoxification at the Mahebourg Detoxification Centre. This figure includes 227 repeaters who were treated up to three times and even four times. During the period 2019-2021, some 17 per cent of those admitted interrupted their treatment and were discharged against medical advice. Some 75 per cent of the 440 patients treated with Suboxone over the two-year period (January 2016-December 2017) had subsequently enrolled on Methadone Substitution Therapy programme instead of following the detoxification treatment.
- The multi-disciplinary staff at the Detoxification Centre could not provide to the National Audit Office a prescribed Detoxification Treatment Protocol comprising guidelines on treatment plans, pre-admission and post discharge follow-up to minimise the risk of interruption of treatment and relapse.
- The Nénuphar Centre, providing treatment to younger ‘People Who Use Drugs’, did not have an official treatment protocol accompanied by individualised treatment plans for these patients.
- No detailed assessment was carried out by the Nénuphar Centre to ascertain the treatment outcome since it started its operation in August 2018. A survey was carried out by the Centre for an 11-month period (January – November 2021). Out of the 40 admissions during that period, some 40 per cent were lost to follow-up. Some 40 per cent of the admissions maintained their abstinence from drugs over a period of more than six months. However, the survey did not cover aspects such as the proportion of those who were abstinent and held stable employment, resumed studies and had a better quality of life. Ascertainment of these aspects would have provided feedback on the outcomes of the treatment provided by this Centre.

### *Rehabilitation and Social Integration Activities*

- The Ministry's interventions, relating to drug misuse, focused mainly on medically assisted therapy. The psychological aspects, which were equally important, were left to Non-Governmental Organisations, which most of the time were offering basic counselling and support services.
- In 2020, the Ministry designed a pilot project titled 'Psycho-socio-rehabilitation' for 'People Who Use Drugs' as a rehabilitation programme to help them develop skills and attitudes to make long-term changes toward reintegration in the mainstream of society. However, as of May 2022, the pilot project was not implemented.
- The coverage of social reinsertion and rehabilitation of ex-detainees was low compared to the large population of ex-detainees.

### **3. Adequate Coverage and Effectiveness of Harm Reduction Interventions**

- Though the Ministry invested significantly in harm reduction treatment through the Methadone Substitution Therapy, it did not ensure that those uptaking the treatment were adequately followed up to remain in treatment. Some 4,600 clients who were inducted to methadone, since the start of the programme in 2006, were lost to follow-up. The loss to follow-up included an unknown number of clients who could have passed away and the remaining not traced to assess whether they were receiving any alternative treatment in respect of drug abuse. The Ministry did not devise an appropriate strategy to identify those who could be potentially reinstated to treatment.
- The Ministry reported that harm reduction interventions through Methadone Substitution Therapy and Needle Exchange Programme has been effective in reducing illicit drug use and curbing the incidence of HIV in Mauritius. The 2020 Integrated Biological and Behavioural Surveillance survey indicated that HIV prevalence among 'People Who Inject Drugs' in Mauritius, has continued on its decreasing trend. However, no survey had been carried out in respect of reduction in illicit drug use among those on Methadone Substitution Therapy given that some 75 per cent on the therapy were reported not to be attending follow-up.
- The Ministry did not have a precise record of the total number of beneficiaries under the Needle Exchange Programme. This record was important to assess the coverage of the Needle Exchange Programme services and whether it was at a reasonable level to minimise the risk of transmission of blood-borne diseases by 'Person Who Inject Drugs'.

#### **4. Oversight by the National Drug Secretariat over Drug Demand and Harm Reduction Interventions**

According to its terms of reference, the National Drug Secretariat which was set up as an apex body in March 2019, had to plan, coordinate, oversee, monitor and ensure evaluation of all drug control-related policies, programmes and interventions to achieve greater coherence, results and impact. This apex body was expected to provide advice on the strategic vision and overall policy direction on all drug control-related matters. In respect of funding aspects, it had to advocate and mobilise the resources needed to achieve the goals and objectives set. However, the following gaps were identified in respect of the National Drug Secretariat's responsibilities relating to policy formulation, mobilising of resources, coordination, monitoring and evaluation of interventions:

- The Strategic Objectives 4.4 of the National Drug Control Master Plan 2019-2023 recommended the formulation of a national drug policy to reduce harmful social and health consequences among 'People Who Use Drugs'. Though the National Drug Secretariat acknowledged the need for a policy against substance abuse in specific sectors, it did not consider the fulfilment of the requirement to formulate a drug policy to reduce harmful social and health consequences among 'People Who Use Drugs'.
- There was no clarity on the precise amount of resources being mobilised to finance drug demand and harm reduction interventions compared to expenditures on control over drug supply. The absence of clarity on expenditures relating to drug demand and harm reduction did not ensure that the right balance was being realised in the allocation of resources among competing drug control interventions.
- As per its mandate, the National Drug Secretariat had to ensure evaluation of all drug control related policies, programmes and interventions to achieve greater coherence, results and impact. In areas of harm reduction and treatment, the National Drug Secretariat did not ensure that the Ministry carried out evaluations to ascertain that the outcomes of its activities maximised the intended benefits. Similarly, it did not ensure that evaluations were carried out by the National Social Inclusion Foundation before the allocation of grants to Non-Governmental Organisations for prevention and rehabilitation activities.

In April 2023, the Prime Minister's Office emphasised on the following:

- The National Drug Secretariat became fully operational in June 2020, after the recruitment of technical staff and the lockdown period from mid-March to end of May 2020. The second lockdown in 2021 had also severely impacted on the work of the National Drug Secretariat.
- The National Drug Secretariat can only evaluate the implementation of the National Drug Control Master Plan which will come to an end in December 2023. Action is being taken to enlist the services of a Consultant to evaluate whether the strategies and interventions

have been effective and desired outcomes have been achieved before embarking on the preparation of a new Master Plan for the next five years.

### *What we conclude*

The Ministry's commitment to reducing harm and drug demand is evidenced by its sustained investment in interventions which mainly focused on prevention and medically assisted therapy. It is taking initiatives to increase treatment capacity to extend coverage and provide additional evidence-based treatment options relating to changing drug consumption patterns. Its harm reduction interventions were successful in reducing the prevalence of specific blood-borne diseases.

However, the effectiveness of several aspects of the Ministry's drug demand and harm reduction interventions are impaired by long outstanding issues which are not being adequately addressed in a timely manner. Though drug addiction is considered as a chronic and relapsing disease, the Ministry did not provide the required attention on important areas of treatment, follow-up, psychosocial and social integration of its patients. Also, it did not evaluate its interventions, particularly in drug prevention and treatment activities, with a view to take necessary corrective actions and hence enhance their effectiveness.

On the other hand, the National Drug Secretariat as an oversight body, is persistently attempting to coordinate all the activities of several stakeholders, for greater collaboration and synergy among them, with a view to achieving greater results and impacts. It has taken several important initiatives to enhance the effectiveness of drug demand and harm reduction interventions. However, the National Drug Secretariat considers that it is not an enforcement body and is not mandated to assess the performance of the stakeholders involved. It considers that it lacks the legal authority to enforce the execution of all activities recommended in the Master Plan. The Committees which it chairs are useful discussion forums but are not always accompanied by implementation of several key activities and the ascertainment of their outcomes. Keeping focus on outcomes is critical for this apex body which is expected to provide adequate oversight, to ensure that the intended benefits of interventions are timely realised in a cost-effective manner.

### *What we recommend*

Key interventions of the Ministry are still challenged by issues outstanding since several years like the loss to follow-up of methadone clients and diversion of methadone. These issues undermined the effectiveness of the Methadone Substitution Therapy Programme. As regards the initiatives to introduce detoxification at the Mahebourg Detoxification Centre and treatment of youngsters at the Nénuphar Centre, a similar problem of loss to follow-up is being encountered. In priority, the Ministry should address the issue of loss to follow-up in order to increase the effectiveness of its interventions.



The National Drug Secretariat has a wide mandate and is making persistent efforts to exercise its oversight role with the resources available to meet its objectives. However, it did not keep adequate track of the implementation of the activities and their outcomes. It needs to have an end-to-end perspective<sup>4</sup> of all activities being undertaken by the stakeholders to ensure that they maintain focus on results.

### ***Implementation of Drug Use Prevention Activities***

- (i) The Ministry should incorporate a monitoring and evaluation component in its drug prevention activities in order to align its interventions with international good practices.
- (ii) The results of the pilot project ‘Get Connected Programme’, when available, should be discussed at the level of the National Drug Secretariat and necessary adjustments should be made to the programme.
- (iii) The National Drug Secretariat needs to determine which entity should lead and develop the Standardised Drug Use Prevention Programme at the earliest. This will ensure that the related prevention activities are carried out among a larger population of students before completion of their secondary schooling.
- (iv) The status on the Youth Empowerment Programme Against Drugs should be ascertained by the National Drug Secretariat and actions should be initiated to implement the second phase.

### ***Drug Use Disorders Treatment***

- (i) A survey should be carried out to identify what proportion of ‘People Who Inject Drugs’, (estimated at 6,600 in December 2020), is currently on Methadone Substitution Therapy Programme. Also, information on those 4,600 ‘People Who Inject Drugs’ and who were inducted on the programme since 2006 but were lost to follow-up, has to be compiled. This would provide the necessary input to assess whether necessary treatment coverage was being provided to meet the requirement of Indicator 3.5.1 of Sustainable Development Goal 3 ‘Ensure healthy lives and promote well-being for all ages.’
- (ii) The Ministry should set targets for maximum waiting time for methadone induction, and consider reallocating clients in between the Methadone Day Care Centres to reduce waiting time for induction to the Methadone Substitution Therapy Programme.
- (iii) A capacity planning needs to be carried out by the Ministry to cater for prospective

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<sup>4</sup> An organisation with an end-to-end perspective has clarity about how its processes work, how they fit together, and how they interlink with those of other bodies. Decisions are made for the benefit of the whole rather than parts of the system. (Extract from- “Managing business operations – what government needs to get right” September 2015, Page 24 of the United Kingdom National Audit Office publication. Accessible at: <https://www.nao.org.uk/insights/managing-business-operations-what-government-needs-to-get-right/>).

clients for treatment as some 55,000 ‘People Who Use Drugs’, in addition to the estimated 6,600 ‘People Who Inject Drugs’, have already been estimated in December 2021. The overall effect would be, in the longer term, to decrease the likelihood of ‘People Who Use Drugs’ losing their resolve to start treatment or resuming substance misuse due to long waiting lists for induction.

- (iv) The ‘Take Home Dose’ is an appropriate initiative which will reduce the amount of resources required daily for dispensing methadone on sites, overcrowding and loitering around these sites, and diversion of methadone. However, the initiative was still on pilot stage since October 2021 and needs more attention from the Ministry in order to roll it out for a larger segment of methadone clients.
- (v) The Ministry should develop a prescribed Treatment Protocol for detoxification, similar to the Methadone Substitution Therapy Protocol, comprising guidelines on treatment plans, pre-admission and post discharge follow-up to minimise the risk of interruption of treatment and relapse. A similar protocol should be developed for treatment being provided at the Nénuphar Centre.
- (vi) Non-Governmental Organisations should be engaged to a larger extent in the follow-up of clients on Methadone Substitution Therapy, post-detoxification treatment and rehabilitation. Commitment to this scope of activities should be one of the key requirements for them to obtain funding from the National Social Inclusion Foundation.

### ***Rehabilitation and Social Integration Projects***

- (i) The Ministry should reconsider the implementation of the Pilot Project for ‘Psycho-socio-rehabilitation’ for ‘People Who Use Drugs’ as a first step towards developing a more comprehensive rehabilitation programme.
- (ii) The Project ‘Collaborative Training and Social Integration of Detainees’ should be given prompt attention by the National Drug Secretariat with the collaboration of the Ministry and Non-Governmental Organisations. Activities related to the social reinsertion and rehabilitation of ex-detainees should be re-examined and expanded to provide a larger coverage.

### ***Coverage of Harm Reduction Interventions***

In order to confirm the effectiveness of its harm reduction interventions, the Ministry should carry out a survey among those clients on Methadone Substitution Therapy and benefiting from the Needle Exchange Programme. This would help to ascertain the proportion of clients still on the therapy and the programme. Relevant information would be obtained in respect of those who were still consuming illicit drugs, still involved in crimes, and those in employment, with improved health and independent living. This information would provide feedback to enhance

treatment, social integration and rehabilitation interventions.

### ***Oversight by the National Drug Secretariat***

- (i) The Terms of Reference of the National Drug Secretariat specifies that the latter should advise on the adoption of evidence-based drug policies, strategies and programmes. The National Drug Secretariat should ensure that policies required in specific sectors of substance abuse are appropriately formulated and implemented. For example, a policy decision is required on whether methadone clients are expected to be on methadone for an indeterminate duration that could be lifelong, or moved towards gradual detoxification in long term.
- (ii) The costs associated with harm and drug demand reduction should be easily identifiable to support policy decisions. Accordingly, a programme budget should be developed and expenditure on the various services should be tracked against budgets. In order to provide accountability for performance, the outturns should be published and be subject to scrutiny by relevant stakeholders.
- (iii) The National Drug Secretariat should initiate a cost-benefit analysis to be carried out to enable policy and program managers to make informed decisions. This will help to identify the resources allocated for drug abuse treatment policies and programmes and whether more funds should be directed toward demand and harm reduction or law enforcement, and what is the proper balance between healthcare and criminal justice when it comes to lowering rates of drug abuse, particularly among young people.
- (iv) To enhance its oversight role, the National Drug Secretariat should identify all activities, as recommended in the Master Plan, which are behind schedule or not performed. These performance gaps should be reported to the High-Level Drug and HIV Council for necessary corrective actions.
- (v) The National Drug Secretariat should ensure that the activities of Non-Governmental Organisations are assessed by the National Social Inclusion Foundation at pre and post-funding stages. It also needs to ensure that the resources allocated match with the expected level of support required from them.

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background

The illicit<sup>5</sup> use of psychoactive drugs is dangerous for the health of individuals and society. These psychoactive substances act on the brain, inducing changes in behaviour and emotional status and can cause severe psychological disorders. Drug use related disorders are serious health conditions that present a significant burden for affected individuals, their families and communities. Untreated drug use disorders trigger substantial costs to society including lost productivity, increased health care expenditures, costs related to criminal justice and to social welfare, and other social consequences. The social cost of illicit drug use is estimated at 1.7 per cent of the gross domestic product in some countries<sup>6</sup>.

Providing effective treatment and care services for drug use disorders as part of an integrated and well-coordinated treatment system is therefore an investment in the health of people with drug use disorders. It is also an investment in the healthy and safe development of families, communities and countries.

As per Target 3.5 of the Sustainable Development Goal (SDG) of United Nations 2030 Agenda, there is a need to ‘Ensure healthy lives and promote well-being for all ages’ by strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. The related indicator 3.5.1 measures the national coverage of treatment interventions (pharmacological, psychosocial, rehabilitation and aftercare services) for substance use disorders.

#### *1.1.1 Aspects of drug trafficking and use problem in Mauritius<sup>7</sup>*

Mauritius has experienced a serious drug use and trafficking problem since the 1980s. The country has been the target of drug trafficking networks and an upsurge in drug trafficking is being observed. Drug use is also quite significant on the island, especially cannabis and heroin. Since October 2013, the country has witnessed an emergence of the use of new synthetic cannabinoids drugs.

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<sup>5</sup> An illicit drug is one that is illegal to have (for example, cannabis, heroin, and cocaine), and the non-medical use of drugs that are legally available such as painkillers and sleeping pills.

<sup>6</sup> United Nations Office on Drugs and Crime 2016 Report; Executive Summary Page xxii accessible at <https://www.unodc.org/wdr2016/>

<sup>7</sup> As per the National Drug Control Master Plan 2019-2023 titled ‘A safer and healthier Republic of Mauritius with effective policies for drug control’. Paragraph 1.3 Page 9. Accessible at <https://dha.govmu.org/Lists/DocumentsLinks/Attachments/15/National%20Drug%20Control%20Master%20Plan%20Master%2004092019%20pdf%20final.pdf>

### ***1.1.2 Statistics on number of persons using drugs in Mauritius***

According to the 2020 Integrated Behavioural and Biological Surveillance (IBBS) study, the number of People Who Inject Drugs (PWID) in the Island of Mauritius was estimated at 6,600 active injecting drug users. In December 2021 results of the first large-scale, nation-wide survey provided insights into the extent of drug use among people who use illicit non-injection drugs. In this ‘National Survey Among People Who Use Drugs’ the mean population size of people who use non-injecting drugs was estimated at 55,000, based on the total population of those aged between 18 and 59 years (some 740,000) in Mauritius (excluding Rodrigues). Excluding the PWID, the People Who Use Drugs (PWUD) made up about 7.4 per cent of the population between the ages of 18 and 59 in Mauritius.

### ***1.1.3 Tackling the drug use problem in Mauritius through the National Agency for the Treatment and Rehabilitation of Substance Abusers***

In 1996, the National Agency for the Treatment and Rehabilitation of Substance Abusers (NATReSA) was set up following the restructuring of the defunct Trust Fund for the Treatment and Rehabilitation of Drug Addicts. NATReSA was expected to complement Government’s action in having a drug/substance-free society by the prevention of substance abuse, treatment and rehabilitation of substance abusers and facilitating their integration in the mainstream society through a multi-disciplinary approach. However, in 2016 it was dissolved<sup>8</sup>.

Since then, the Harm Reduction Unit (HRU) of the then Ministry of Health and Quality of Life included the activities of the defunct NATReSA in its ongoing programmes on prevention, treatment and rehabilitation of substance abusers.

### ***1.1.4 Addressing Drug Supply, Drug Demand and Harm Reduction through the National Drug Control Master Plan 2019-2023***

In September 2015, Government established a Commission of Inquiry on Drug Trafficking. Its terms of reference, among others, included the following: inquire into, and report on, all aspects of drug trafficking in Mauritius, including the scale and extent of the illicit drug trade and consumption in Mauritius and its economic and social consequences and also the sources/points of origin/routes of illicit drugs, the channels of entry and distribution of drugs in Mauritius and the channels of entry and distribution of drugs in prisons. The findings and recommendations of the Commission which was published in July 2018 were taken into consideration in the implementation of the National Drug Control Master Plan 2019-2023.

The National Drug Control Master Plan 2019-2023 (referred as NDCMP), formulated in January 2019, identified major gaps in the national response to the problem of drug trafficking and abuse. Table 1 refers to some of the major gaps and areas of improvement identified.

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<sup>8</sup> Second Reading of The National Agency for the Treatment and Rehabilitation of Substance Abusers (Repeal) Bill (No. III of 2016) in the National Assembly.

**Table 1 Major gaps and areas of improvement identified in the NDCMP 2019-2023**

<i>Major gaps</i>	<i>Areas of improvement</i>
<ul style="list-style-type: none"> <li>- There was no overarching national architecture for all drug-related issues.</li> <li>- Gaps in the legislative framework and the absence of an effective disclosure mechanism prevented the smooth running of operations and ensuring a high level of effectiveness.</li> <li>- In the field of drug use prevention, stakeholders often worked in silos with little shared vision, joint planning, cooperation or coordination, with ad hoc activities and no monitoring and evaluation or impact assessment.</li> <li>- The rehabilitation and social reintegration of former PWUD or those on treatment have not received sufficient attention or the funding they deserve.</li> <li>- The Ministry was providing Methadone Substitution Therapy to 5,000 PWID out of a total estimated PWID population of 10,000.</li> </ul>	<ul style="list-style-type: none"> <li>- NGOs can play a more significant role in providing psychosocial support to PWUD/PWID before Methadone Substitution Therapy induction starts, and during the induction, maintenance and detoxification phases, including in prison settings</li> <li>- Evidence-based Drug Use Disorders treatment and related services available to non-injecting users including psychosocial support be also provided to PWID.</li> </ul>

*Source: National Drug Control Master Plan 2019-2023*

The NDCMP is aligned with SDG 3 and includes measures to reduce the drug supply<sup>9</sup>, drug demand and associated harm caused by drug use. Drug demand reduction comprises activities, namely drug use prevention, drug use disorders treatment, rehabilitation and social reintegration. Harm reduction complements drug demand reduction by focusing on activities which help to reduce the adverse health, social and economic consequences associated with drug use.

### ***1.1.5 Institutions Responsible for addressing Drug Demand and Harm Reduction***

The key player in implementing both drug demand and harm reduction activities is the Ministry of Health and Wellness. The National Drug Secretariat (NDS) operating under the aegis of the Prime Minister’s Office (Rodrigues, Outer Islands and Territorial Integrity Division) (PMO) is the apex organisation with the responsibility to ensure the overall coordination of all drug control activities in Mauritius for greater collaboration and synergy among partners, with a

<sup>9</sup> Reduction of drug supply activities comprise law enforcement activities related to combat entry, production and cultivation of illicit drugs together with those enhancing the effectiveness of regulatory financial institutions to address drug-related offences, money laundering and corruption. (as per Strategic Pillar 1, described in the National Drug Control Master Pan 2019-2023, paragraph 3.1 Page 32)

view to achieving greater results and impact. Several Non-Governmental Organisations (NGOs) are pioneers in drug use prevention, treatment, rehabilitation and harm reduction and are key partners in the national drug response and operate on different fronts.

## 1.2 Audit Motivation

To address drug trafficking and abuse, significant costs are annually incurred on enforcement, judiciary, penitentiary and health services in Mauritius. An average of some Rs 250 million was spent on the Police Service over the past three years to combat drug supply, excluding those spent on the Customs Anti-Narcotics Section of the Mauritius Revenue Authority. Some 38 per cent of persons charged or appearing before courts or brought within the criminal justice system had issues with drug use or were drug consumers<sup>10</sup>. Also, 20 per cent of the prison population consisted of drug addicts, some 68 per cent of drug offenders in prison had re-offended. In February 2018, there were 269 male offenders who had already been convicted for drug offences and Government had to provide some Rs 77.5 million annually for their incarceration.

During the period 2017-2020, drug-related offences as a percentage of crime offences increased from some 12 per cent to reach 32 per cent. Some 81 per cent of PWID contacted during the IBBS survey 2020 reported they have ever been arrested by Police, out of whom 64 per cent have been arrested for drugs, 21 per cent for larceny and finally seven per cent for violence. Out of those who have ever been arrested, 76 per cent have ever been sent to prison. In respect of the estimated 55,000 PWUD, some 28 per cent of the sample contacted during the survey have ever been arrested for drug use and among those who were ever arrested, 46 per cent were incarcerated.

During the period 2016-2020, on average, 169 persons aged 19 or less were admitted annually<sup>11</sup> to public health institutions due to complications following intake of illicit substances (including abuse of medicinal products). Those aged 14 years or less stood at an average of 17 annually. Admissions due to the consumption of synthetic drugs have been increasing gradually, representing some 60 per cent of the admission by type of drug consumed in 2020<sup>12</sup>.

The estimated 6,600 PWID had a high prevalence of blood-borne diseases. This represented a

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<sup>10</sup> Report of the Commission of Inquiry on Drug Trafficking of 2018 Page 202 Paragraph 17E.4, Page 57 Paragraph 4.2.25. Accessible at <http://download.pmo.govmu.org/Commission%20of%20Enquiry%20on%20Drug%20Trafficking%20Report.pdf>

<sup>11</sup>As per computation carried out on data published in National Drug Observatory Reports 2016, 2017,2018,2019 and 2020.

<sup>12</sup> In 2020, 54 per cent of the admission were persons aged 20 to 29 years old, while 12 per cent were aged 15 to 19 years old. Out of the 44 deaths related to intake of drugs in 2020, 21 victims were below 30 years old. A total of 1135 new cases registered for drug addiction in five of the public Addictology Units, out of which some 72 per cent were 30 years old or less. Source: National Drug Observatory Report 2020. Page 40-47.

source of contamination for the population.

Drug use disorders often take the course of a chronic and relapsing disorder. This implies that treatment and rehabilitation services must work with patients over the long-term often for years and sometimes during a patient's entire life-maintaining contact, offering crisis interventions and support when needed and at different levels of intensity. At national level no statistics are kept in respect of SDG indicator 3.5.1 to indicate the coverage of drug abusers requiring treatment, and the total annual costs of prevention, treatment and rehabilitation.

Also, there were few official reports published on the extent to which the prevention, treatment, rehabilitation and harm reduction activities were preventing drug use, relapse and supporting substance abusers to rehabilitate themselves. The overall impact of these activities was to improve the well-being of the individual drug abusers, reduce the adverse effects on their families and community, and reduce the financial costs of enforcement, judiciary, penitentiary and health services.

It is against this background that the National Audit Office carried out this Performance Audit titled 'Enhancing the Effectiveness of Interventions relating to Drug Demand and Harm Reduction'.

### **1.3 Audit Objective**

The audit assessed whether the interventions of the Ministry of Health and Wellness, under the oversight of NDS, were effective in reducing harm and drug demand.

The audit was designed by formulating three audit questions and the answers to these questions supported the conclusion against the objective. The audit questions are as follows:

1. Were the interventions of the Ministry of Health and Wellness in respect of Drug Demand Reduction adequate and effective?
  - Were the Drug Use Prevention activities adequate and effective?
  - Were the Drug use Disorder Treatment, Rehabilitation and Social Integration activities adequate and effective?
2. Was the coverage of Harm Reduction interventions adequate and effective?
  - Was there adequate and effective coverage of Methadone Substitution Therapy (MST) Programme?
  - Was there adequate and effective coverage of Needle Exchange Programme (NEP)?
3. Was there adequate oversight over drug demand and harm reduction activities?
  - Was a drug policy formulated to address the harmful social and health consequences among PWUD?
  - Were there adequate funding arrangements to support drug demand and harm



- reduction activities?
- Were there adequate coordination, monitoring and evaluation of drug demand and harm reduction interventions?

A Problem Tree Analysis, in Appendix I, depicts the key aspects of the drug problem based on which the three audit questions were formulated. Appendix II presents the list of the related audit sub-questions and their referencing to the findings paragraphs of Chapter Three.

#### **1.4 Audit Scope**

The focus was on drug use prevention, drug use disorders treatment, rehabilitation and social integration and harm reduction activities implemented by the Ministry of Health and Wellness (referred as the Ministry) under the Master Plan in Mauritius (excluding Rodrigues and Outer Islands). Examination was also extended to partnering NGOs, other Ministries and Departments who collaborated with the Ministry over the abovementioned activities. The scope also included the oversight role of NDS in ensuring that these activities met their objectives.

All activities related to drug supply directly or indirectly were excluded. Also, capacity assessments on infrastructure, technological aspects, logistics and human resources deployed were excluded.

The audit covered the period January 2016 to May 2022 and was supplemented with information relating to the period prior to January 2016. Additional information and comments received from the Ministries in July 2022, August 2022, October 2022, March 2023 and April 2023 have been included in the Report.

#### **1.5 Audit Approach**

The audit was conducted in accordance with the International Standards of Supreme Audit Institutions (ISSAI) 3000 Performance Auditing Standard of the International Organisation of Supreme Audit Institutions (INTOSAI). A combination of two approaches was used to determine the nature of the examination to be carried out, and is described as follows:

- a system-oriented approach to examine the proper functioning of the management system at the Ministry in relation to the provision of prevention, treatment and rehabilitation services.
- a result-oriented approach to assess whether the outcome or output objectives have been achieved by the Ministry and NDS as intended in the NDCMP.

A ‘top-down perspective’ was used to formulate the audit questions from the audit objective. As per this perspective, the audit focused on the flow of high-level strategy (the NDCMP)

approved by Government, down to the management of its components with emphasis on implementation, monitoring and evaluation. A ‘Whole of Government Approach’ was also adopted (Appendix III refers).

The measurement of effectiveness was based on to what extent the objectives have been met and the prevalence of conditions necessary to ensure the achievement of these objectives<sup>13</sup>.

## **1.6 Audit Methodology**

Different methodologies were used to gather and analyse data, understand the audit area, along with obtaining sufficient, relevant and reliable audit evidence that support the conclusion and recommendations.

Data was gathered mainly from files and documents. This was complemented by interviews, site visits and a survey to confirm information in files and to ascertain and assess processes being carried out. Quantitative and qualitative data obtained from interviews, document reviews and during visits were compiled and analysed, to provide competent evidence to support the conclusion and recommendations. Trend analysis was used to identify and interpret the impact of interventions over the examined period. Sampling and benchmarking were also carried out. Content analysis was extensively used.

### ***1.6.1 Documents reviewed***

Information relating to legislations, policies, strategies, structures, methodologies, protocols, projects and processes was collected through review of files, documents and databases available at the Ministry, NDS, selected NGOs, Mauritius Prison Service, Probation and Aftercare Service, and the Health & Wellness Directorate of the Ministry of Education, Tertiary Education, Science and Technology (MoETEST).

### ***1.6.2 Personnel interviewed***

Interviews and meetings were carried out with key personnel at senior management and operational levels of the key players and collaborating entities involved in drug use prevention, drug use disorders treatment, rehabilitation and social integration and harm reduction activities. Appendix IV refers.

The interviews and discussions were used to confirm the information obtained from documents reviewed, and to supplement information that was not available in the reviewed documents and explore potential suggestions to bridge the performance gaps identified.

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<sup>13</sup> Guidance ‘GUID 3910 Central Concepts for Performance Auditing, paragraphs 42 and 46’. Accessible at <https://www.issai.org/wp-content/uploads/2019/08/Guid-3910.pdf>

### **1.6.3 Site Visits**

Site visits were carried out at all four Methadone Day Care Centres (MDCCs) and three Addictology Units (Dr A.G Jeetoo Hospital, Long Mountain Hospital and Mahebourg Hospital). Three detoxification and rehabilitation centres were also visited: Mahebourg Hospital Detox Centre, Centre Nénuphar of Long Mountain Hospital and Centre Frangipane Rehabilitation ward of Brown Sequard Mental Health Care Centre. Two NGOs offering counselling, referral and psychosocial support were visited. These visits enabled the ascertainment of the processes involved, discussions on relevant aspects of management, interventions, outputs and outcomes related to drug demand and harm reduction.

### **1.6.4 Sampling**

Purposive sampling was used to focus on specific issues relating to drug use disorders treatment, that would be more appropriate to answer the audit questions. Details on the sampling units are in relevant paragraphs of the Findings Chapter to support the conclusion.

## **1.7 Assessment Criteria**

The main criteria used as a basis for evaluating the evidence collected, developing audit findings, and reaching conclusion on the audit objective and the related audit questions were extracted from:

- The NDCMP Strategic Objectives and their related Output, Outcome and Targets/ Indicators;
- The United Nations Sustainable Development Goal 3;
- The Ministry’s relevant Treatment, Rehabilitation and Harm Reduction protocols and guidelines; and
- Good practices and guidelines of the United Nations Office on Drugs and Crime (UNODC), and the World Health Organisation (WHO).

Details on additional assessment criteria used are described in the relevant paragraphs in the Report.

## **1.8 Data Validation Process**

The Ministry of Health and Wellness and the PMO (Rodrigues, Outer Islands and Territorial Integrity Division) were provided with the Report to comment on its factual accuracy, the conclusion drawn based on the findings and the implications of the recommendations.

## **1.9 Structure of the Audit Report**

The remaining part of the Report covers the following:

- Chapter Two describes the audit area, the processes, structures, roles and responsibilities of key players and relevant stakeholders;
- Chapter Three presents the audit findings based on the three specific audit questions;
- Chapter Four provides the audit conclusion; and
- Chapter Five presents the recommendations based on the audit findings and conclusion.

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## CHAPTER TWO

### DESCRIPTION OF THE AUDIT AREA

*This Chapter describes the audit area, structures, roles and responsibilities of key players and other stakeholders involved in drug demand and harm reduction. Key aspects of the current system for drug use prevention, drug use disorders treatment, rehabilitation and social reintegration processes are also described.*

#### 2.1 Introduction

Drugs in Mauritius have always been a matter of concern for different Authorities. Drug demand reduction is a shared, multi-sectoral, responsibility of the Government and a range of civil society stakeholders. The success of drug demand reduction strategies depends upon a broad base of support and common action from all stakeholders. The objectives, roles and responsibilities of each stakeholder and the process for drug demand and harm reduction are described.

#### 2.2 Legal Framework

Mauritius has ratified the United Nations Drug Control Conventions as well as the 2000 Convention on Trans-National Organized Crime. It is also a signatory of both the African Union and the South African Development Community Drug Control Protocol. The existing legal frameworks to control drug supply and demand reduction are:

- The Dangerous Drug Act 2000 (amended in August 2003)
- The Pharmacy Act 1983
- The Financial Intelligence and Anti Money Laundering Act 2002
- The Prevention of Corruption Act 2002
- The HIV and AIDS Act 2006
- The Mental Health Care Act 1998

#### 2.3 Strategies and Policies

- *National Drug Control Master Plan 2019-2023*

A National Drug Control Master Plan (NDCMP) 2019-2023 has been formulated with the assistance of the UNODC. In 2019, the Government validated and launched the Master Plan which was based on four pillars: supply reduction, demand reduction, harm reduction and a coordination mechanism relating to legislation, implementation framework, monitoring and

evaluation, and strategic information. The key elements of the four pillars are outlined in Table 2.

Table 2 Key elements of the four pillars of the National Drug Control Master Plan 2019-2023	
Pillars	Key elements
<b>Pillar 1:</b> Drug Supply Reduction	<i>embracing law enforcement and financial crimes</i>
<b>Pillar 2:</b> Drug Demand Reduction	<i>drug use prevention, drug use disorders treatment, rehabilitation and social reintegration</i>
<b>Pillar 3:</b> Harm Reduction	<i>Methadone Substitution Therapy and the Needle Exchange Programme</i>
<b>Pillar 4:</b> Coordination Mechanism	<i>Legislation, Implementation Framework, Monitoring &amp; Evaluation and Strategic Information.</i>

*Source: National Drug Control Master Plan 2019-2023*

The NDCMP summarises the key national goals, defines implementation priorities and allocates responsibilities and resources for the national drug control efforts.

The Master Plan identifies the need for the following: A national body at the apex of Government with the authority to act as the national convener across all sectors involved; plugging of gaps in the legislative framework; an intelligence sharing platform among the law enforcement agencies; strengthen structural and organisational operations of the Anti-Drug and Smuggling Unit (ADSU) and Customs; accelerating actions against the emerging threat of New Psychoactive Substances (Synthetic Drugs); and focus on the rehabilitation and social reintegration of PWUD or those on treatment.

➤ *Health Sector Strategic Plan 2020-2024*

The Health Sector Strategic Plan 2020-2024 (HSSP) proposes a comprehensive set of actions to re-engineer and revamp health delivery services. The strategic objectives of the HSSP are grouped around goals to improve the provision of health services. One of the Strategic Goals is to prevent and reduce the negative health and social consequences of substance use and addiction.

Strategic interventions are, inter alia, directed towards:

- review of drug prevention programmes to cater for the needs of specific vulnerable populations;
- re-structuring and strengthening of addictology services in all Regional Hospitals;
- scaling up of detoxification programmes for recovery and enhancing accessibility to the MST Services;

- reducing stigma and discrimination and promoting social re-integration;
- implementation of the health-related actions under the NDCMP;
- setting up of Integrated Care Centres for the management of HIV, Hepatitis C Virus and drug abuse in all Health Regions;
- introduction of Biofeedback Therapy and Experiential Therapy; and
- enhancement of Holistic Therapy in collaboration with NGOs and scaling up SMART Recovery to control addictive behaviours.

➤ *National HIV and AIDS Policy 2010*

PWID inadvertently increase HIV and AIDS vulnerability and risk. Methadone Substitution Therapy programme has absorbed some 60 per cent injecting drug users.

Prior to the NDCMP, the agenda of the HRU was driven by the National HIV and AIDS Policy. Harm reduction strategies (MST and NEP) were considered an essential component of HIV and AIDS prevention strategy for risk minimisation. Thus, expenses related to harm reduction activities were incurred under the item ‘Treatment and Prevention of HIV and AIDS’.

## **2.4 Sustainable Development Goals and the Prevention and Treatment of Substance Abuse**

Following the adoption of the Sustainable Development Goals (SDG) 2030 Agenda by UN in 2015, the Republic of Mauritius, as a member state, committed itself to its implementation. One of the SDG Goals is to strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and the harmful use of alcohol. Indicator 3.5.1 of the SDG emphasizes on having coverage<sup>14</sup> of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders. Strengthening treatment services entails providing access to a comprehensive set of evidence-based interventions (laid down in the international standards and guidelines) that should be available to all population groups in need. The indicator specifies the extent to which a range of evidence-based interventions for treatment of substance use disorder are available and are accessed by the population.

Box 1 describes the basic concepts of treatment of substance use disorders, psychosocial and Rehabilitation and Aftercare interventions.

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<sup>14</sup> Method of computation: Number of people who have received different treatment interventions in the last year divided by the actual number of the target population (people with substance use disorders measured as the total number of problem drug users). Source: SDG indicator metadata accessible at <https://unstats.un.org/sdgs/metadata/files/Metadata-03-05-01.pdf>



**Box 1 Basic concepts of treatment of substance use disorders, psychosocial and Rehabilitation and Aftercare interventions**

*Treatment of substance use disorder refers to any structured intervention that is aimed specifically to a) reduce substance use and cravings for substance use; b) improve health, well-being and social functioning of the affected individual, and c) prevent future harms by decreasing the risk of complications and relapse. These may include pharmacological treatment, psychosocial interventions and rehabilitation and aftercare.*

*Psychosocial interventions refer to programmes that address motivational, behavioural, psychological, social, and environmental factors related to substance use and have been shown to reduce drug use, promote abstinence and prevent relapse. For different drug use disorders, the evidence from clinical trials supports the effectiveness of treatment planning, screening, counselling, peer support groups, cognitive behavioural therapy, motivational interviewing, community reinforcement approach, motivational enhancement therapy, family therapy modalities, contingency management, counselling, insight-oriented treatments, housing and employment support among others.*

*Rehabilitation and Aftercare refer to interventions that are based on scientific evidence and focused on the process of rehabilitation, recovery and social reintegration dedicated to treat drug use disorders.*

*Source: United Nations Department of Economics and Social Affairs, Statistics Division, SDG Indicators, Metadata Repository.<sup>15</sup>*

## **2.5 UNODC/WHO - Prevention and Treatment of Drug Abuse**

United Nations Office on Drugs and Crime (UNODC) Prevention, Treatment, and Rehabilitation Section supports Member States in addressing drug use and drug use disorders as any other health condition, that is by implementing drug use prevention strategies and providing treatment, health care, social protection and rehabilitation services, including for children and adolescents, based on scientific evidence, human rights and gender considerations. Another area of work is promoting access to controlled drugs for medical purposes, whilst preventing diversion and abuse.

The World Health Organisation (WHO), in partnership with UNODC which is recognised as the leading UN Entity for countering the world drug problem, has a pivotal and unique role in addressing the public health and human rights dimensions of global issues related to drugs. WHO strives to address three interconnected challenges: ensuring access to needed controlled medicines for medical use; preventing and managing the harms associated with drug use; and providing universal access to effective treatment and care for people with drug use disorders.

<sup>15</sup> Paragraph 2 – Concepts. Accessible at <https://unstats.un.org/sdgs/metadata/files/Metadata-03-05-01.docx>

## **2.6 Funding for Drug Demand Reduction and Harm Reduction**

The Drug Demand Reduction and Harm reduction programmes are funded by Government mainly through allocated budgets to MoHW and several other Ministries/ Departments (Table 16 refers, in paragraph E.3). As from February 2019, NGOs providing treatment and rehabilitation to PWUD and which are registered with the National Social Inclusion Foundation (NSIF) receive an annual grant. Contribution is also received from the Global Fund for specific items.

## **2.7 Studies and Surveys**

The Ministry of Health and Wellness has been undertaking IBBS studies among PWID every two years since 2009. The studies were conducted by the National AIDS Secretariat, the AIDS Unit and the HRU of the MoHW. NGOs and all other stakeholders involved in the fight against HIV and AIDS were invited to have their inputs in the preparation of the survey. The main objectives of the IBBS Surveys are to monitor the trend of the HIV Epidemic among the Key Affected Populations and review the strategies in place. As of December 2020, five surveys were carried out among PWID respectively in 2009, 2011, 2013, 2017 and 2020.

## **2.8 Roles and Responsibilities of Key Players**

The roles and responsibilities of key players are described in the following paragraphs. Stakeholders Analysis at Appendix V illustrates the involvement of each stakeholder in drug demand and harm reduction strategies based on its roles, responsibilities and accountability.

### ***2.8.1 Prime Minister's Office (Rodrigues, Outer Islands and Territorial Integrity Division)***

#### ***2.8.1.1 High Level Drug and HIV Council***

A High Level Drug and HIV Council was set up in December 2018, under the aegis of the Prime Minister's Office (Rodrigues, Outer Islands and Territorial Integrity Division) (PMO). The Council has a key role to provide a strong, efficient and effective national response to drugs and HIV and to oversee the implementation of the NDCMP and the National Action Plan for HIV/AIDS 2017-2021 of the MoHW. The main objectives of the Council amongst others are to:

- propose, formulate, review and validate national policies on Drugs and HIV;
- make recommendations, as appropriate, and provide guidelines on issues related to Drugs and HIV to the National Drugs Secretariat and the National AIDS Secretariat, respectively;
- ensure that allocation of funds for purposes of implementation of Drugs and HIV-related programmes are effectively administered and accounted for;

- initiate, facilitate and monitor the preparation and dissemination of information and educational materials and any communication on strategies related to Drugs and HIV;
- facilitate and monitor research in Drugs and HIV- related fields; and
- advise and make recommendations, as appropriate, on changes and amendments which it considers necessary to legislation or policies in the furtherance of its objectives.

#### *2.8.1.2 National Drug Secretariat*

The NDCMP provides for a governance structure for its implementation and this includes the establishment of a National Drug Secretariat (NDS) which was set up in March 2019. NDS acts as an apex body to plan, coordinate, oversee, monitor and evaluate all drug control- related policies, programmes and interventions to achieve greater coherence, results and impact.

NDS is working on the implementation of the four pillars of the NDCMP which are:

- Coordination mechanism, legislation, implementation framework, Monitoring and Evaluation and Strategic Information;
- Drug Supply Reduction;
- Drug Demand Reduction, namely drug use prevention, drug use disorders treatment, rehabilitation and social reintegration; and
- Harm Reduction.

NDS also provides advice on the strategic vision and overall policy direction on all drug control related matters, ensures the coordination, monitoring and evaluation of programmes involving a large spectrum of key actors at national, regional and international levels. It also advocates for and mobilises the resources needed to achieve the goals and objectives set.

The main objectives of NDS are to:

- ensure the overall coordination of all drug control activities in Mauritius for greater collaboration and synergy among partners, with a view to achieving greater results and impact;
- advise the Government on the adoption of evidence-based drug policies, strategies and programmes;
- engage in advocacy to raise evidence-based public or population-specific awareness on the harmful consequences of drug use;
- promote collaboration between law enforcement agencies and financial regulatory bodies to share intelligence and achieve greater efficiencies in combatting drug trafficking and financial crimes;
- promote regional and international cooperation to decrease drug trafficking in the region with bodies such as the UNODC, the Commission on Narcotic Drugs, the Southern Africa Development Community and the Indian Ocean Commission;

- ensure that demand reduction activities, namely the prevention of drug use, the treatment of drug use disorders and the rehabilitation of PWUD including those in prisons, are evidence-based and carried out in line with international standards and best practices;
- ensure that harm reduction activities aiming at reducing blood-borne infections and improving the quality of life of PWUD, and people who are in prisons are evidence-based and carried out in line with international standards and best practices; and
- develop the Implementation Framework and Monitoring Mechanism of the NDCMP and manage the National Drug Observatory in collaboration with Government, NGOs and other stakeholders.

#### *2.8.1.3 National Drug Observatory*

The National Drug Observatory (NDO), which was established in 2015 under the then Ministry of Health and Quality of Life, is now under the purview of NDS. Its main objectives are to monitor illicit drug use, drug abuse and drug trafficking in the country. It also aims at providing evidence-based information for an appropriate response to the drug problem in the country.

#### *2.8.1.4 Mauritius Prison Service*

In 2021, the Prisons Department registered 3,319 admissions, out of which 312 were drug-related cases representing 9.4 per cent of the total admissions.

A Methadone Induction Unit was set up at the central prison for the induction and dispensing of methadone for PWID in 2011. In February 2015, MST Programme was extended to “Persons on Remand” in the different Prison Institutions. In addition, there are four methadone dispensing sites in the prison system, including one at the Women Prison. A drug rehabilitation unit, Lotus Centre, provides rehabilitation to PWUD at Beau Bassin Central Prison and Eastern High Security Prison.

### ***2.8.2 Ministry of Health and Wellness***

The Ministry of Health and Wellness (MoHW) is responsible for the national health policy. Its vision is that of a healthy nation with a constantly improving quality of life whilst ensuring that the health system is patient-centered, accessible, equitable, efficient and innovative.

The main responsibilities of the Ministry include the following:

- Formulation and implementation of health policies;
- Provision and promotion of preventive, curative, rehabilitative and palliative health services;
- Setting standards and implementing regulations; and
- Management of primary health care centres and hospitals.

The main functions of the Ministry comprise the following:

- to provide free access to affordable primary health and hospital care services including specialised treatment; and
- to improve the wellness of people by attaching importance to primary prevention mainly through: (i) health promotion programmes against Non-Communicable Diseases (NCDs) and their risk factors, (ii) to prevent vector-borne, waterborne and other infectious diseases, including HIV and AIDS through enhanced surveillance and maintenance of hygienic environment.

### ***2.8.2.1 Harm Reduction Unit***

In 2006, Government started harm reduction programmes to reduce the transmission of blood-borne infections among PWID including those in the prison settings.

The mission of HRU is to implement harm reduction strategies in view to curb HIV epidemics among PWUD and break the cycle of drugs aligning efforts along with all stakeholders concerned toward sustainable drug policies focusing on health, human rights, peace and security. The main activities of the HRU include the following:

- Drug Prevention programme in schools, community and at workplace;
- Methadone Substitution Therapy programme;
- Needle Exchange Programme;
- Rehabilitation and Detoxification programme; and
- Psychosocial support counselling.

The Unit comprises Psychiatrists, Medical Health Officers/ Senior Medical Health Officers, Specialised Nurse, Specialised Health Care Assistants, Nursing Officers, Health Care Assistants/ Senior Healthcare Assistants, Social Workers, Medical Social Workers, Peer Educators and NGO Representatives.

### ***2.8.3 Ministry of Education, Tertiary Education and Science and Technology***

The Health and Wellness Directorate has been set up at MoETEST and is driving the drug use prevention programmes in schools. Drug use materials have been infused in a few subjects of the primary school curriculum and the planned curriculum reform in the secondary sector is also an opportunity to expand the drug education component in a larger number of subjects for Grades 7, 8 and 9. The Ministry has embarked on a national drug use prevention programme, 'Get Connected Programme', focusing on 12-14 years old in schools, based on an evidence informed and tested methodology. This programme is implemented in partnership with the private sector, namely the Cim Group and the United Nations Office on Drug and Crime.

#### **2.8.4 Non-Governmental Organisations**

Non-Governmental Organisations (NGOs) play a significant role in supporting the national response to drug control on the health side. NGOs are engaged to participate in the decision making process of drug demand activities.

Rehabilitation services for PWUD in Mauritius are essentially provided by several registered NGOs. They use different therapeutic models, from drug free approach to medically assisted therapies, coupled with psychosocial support as well as rehabilitation and support services. Some of these centres offer residential based services, while others operate on a daycare basis.

As per the NDO Report 2021, the number of new cases registered at 11 NGOs was 2,375 out of which 4 per cent that is 92 cases, were young people below the age of 18. The roles of NGOs with respect to demand reduction and harm reduction activities are set out below:

##### *Methodone Substitution Therapy Programme*

Since its introduction in 2006, this programme is implemented in collaboration with several NGOs in view to curb the propagation of HIV infection among PWID. NGOs play a key role in reaching out to beneficiaries who are unable to attend dispensing sites personally.

##### *Codeine-based Therapy Programme*

Codeine- based therapy was implemented by five NGOs until January 2022. This programme targeted opioid substance abuse but it was not considered as an evidence-based therapy. The 2018 Commission of Enquiry on Drug Trafficking Report recommended its phasing out.

##### *Needle Exchange Programme (NEP)*

The Needle Exchange Programme (NEP) is implemented by the Ministry in collaboration with two NGOs. Out of the 715,773 needles distributed in 2021, NGOs' services accounted for 54 per cent of the distribution, compared to 46 per cent by the Ministry. The allowance to NGOs for the financial year 2020-21 for the provision of needles, syringes and alcohol swabs amounted to Rs 600,000.

#### **2.8.5 National Social Inclusion Foundation**

The National Social Inclusion Foundation (NSIF) is the central body to receive and allocate public funds to NGOs. The Foundation operates under the aegis of the Ministry of Social Integration, Social Security and National Solidarity. The NSIF receives, manages and allocates public funds appropriated by Government through the national budget and CSR funds collected by the Mauritius Revenue Authority (MRA) in accordance with section 50L of the Income Tax Act 1995.

The Foundation works with and through NGOs to undertake programmes and projects in 10

priority areas of intervention, one of which is ‘Dealing with health problems – Substance Abuse’, to the benefit of individuals and families registered under the Social Register of Mauritius (SRM) and of vulnerable groups as defined by its Charter. It aims at generating better social outcomes for the poor and vulnerable groups while ensuring accountability and transparency in the use of public and CSR funds. The NSIF allocates funds to NGOs as per the different Funding Instruments of its Funding Framework. Some Rs 106 million were allocated for the financial year 2020-21 to support approved NGO programmes and projects with regard to ‘Dealing with health problems – Substance Abuse’.

## **2.9 Process Description**

### **2.9.1 Guidelines and Standard Operating Procedures**

The HRU has prepared the following guidelines and Standard Operating Procedures (SOP) that describe the process and structure that must be adopted by Addictology Units and Methadone Day Care Centres to operate and properly perform their daily activities:

- SOP on clinical management of patients with Drug Use Disorders May 2021 (revised December 2021) (Appendix VI refers);
- Protocol for the MST Programme (May 2018); and
- Draft Clinical guidelines for the treatment of opioid addiction using Suboxone and Naltrexone (November 2015).

### **2.9.2 Drug Demand Reduction**

Drug demand reduction activities include prevention, treatment and social reintegration as described briefly in the paragraphs below.

#### ***2.9.2.1 Drug Prevention***

The drug prevention programme is conducted with the collaboration of several stakeholders:

- Harm Reduction Unit of the Ministry

The Ministry through HRU carries out sensitisation campaign, targeting mainly the youth in and out of schools, the workforce and the community at large.

The Drug Prevention Programme carried out by HRU, in line with the NDCMP, concerns mainly strategic pillar 2 – Drug Demand Reduction (Drug use prevention, drug use disorders treatment, rehabilitation and social integration) that aims at empowering the population at large to build its resilience against drugs.

- Ministry of Education, Tertiary Education, Science and Technology – ‘Drug Use Prevention Programme “Get Connected” in Secondary Schools’

An evidence-based Drug Use Prevention Programme which is in line with the international standards for drug use prevention (UNODC and WHO collaboration) has been introduced in secondary schools across the island, as recommended in NDCMP. The target group for the programme are students in Grade 8. The programme uses a life skills concept model with the aim to delay tobacco, alcohol and drug initiation among adolescents. The programme is structured in three parts namely knowledge and attitudes, interpersonal skills and intrapersonal skills which are further divided into twelve units. The key stakeholders involved in this programme are the MoHW and the Private Secondary Education Authority.

- Brigade Pour La Protection Des Mineurs

Brigade Pour La Protection Des Mineurs of the Police Service, collaborates with MOHW and MoETEST, and is involved in the awareness and sensitization campaigns in communities, schools, colleges, universities and NGOs.

- Non-Governmental Organisations

There are several NGOs which are involved in the provision of services to PWUD. There are three NGOs who are active in drug prevention campaigns and programmes.

### ***2.9.2.2 Drug Treatment and Rehabilitation***

#### ***Treatment***

The health consequences of drug use can include a range of negative outcomes such as drug use disorders, mental health disorders, HIV infection, hepatitis-related liver cancer and cirrhosis, overdose and premature death. The greatest harms to health are those associated with the use of opioids and with injecting drug use, owing to the risk of acquiring HIV or hepatitis C through unsafe injecting practices.

Treatment for PWUD involves a combination of pharmacological treatment (medically assisted therapy) and psychosocial support (behavioural therapy). The different types of pharmacological treatment available for PWUD (as illustrated in Appendix VII) are as follows:

- *Suboxone/ Naltrexone- based Detoxification*

The Suboxone-Naltrexone-based detoxification programme started at Mahebourg Hospital, in January 2016, with a 12-bed facility. The residential induction phase lasts for 15 days. Detoxification offers patients the opportunity to achieve a drug-free lifestyle.



➤ *Methadone Substitution Therapy*

Methadone Substitution Therapy is an evidence-based intervention for opiate-dependent persons that replaces illicit drug use with medically prescribed, orally administered opiates. It helps to rehabilitate addicts, prevent relapses, reduce other negative effects of addiction and give recovering addicts a better quality of life.

MST was introduced in 2006 as a strategy to prevent HIV transmission among PWID. Methadone services are provided at dedicated Methadone Daycare Centres, at public health institutions and through mobile caravans.

***Institutions involved in Drug Treatment***

➤ *Public Health Institutions*

Hospital services provide treatment for substance use disorders for PWUD in acute phase.

➤ *Brown Sequard Mental Health Care Centre*

The Brown Sequard Mental Health Care Centre, a 660-bed psychiatric hospital, provides treatment to people using drugs with co-morbid conditions.

➤ *Addictology Units*

An Addictology Unit has been set up since September 2016 in each of the five regional hospitals: SSRN Hospital, Dr. A.G Jeetoo Hospital, Dr Bruno Cheong Hospital, Victoria Hospital and Mahebourg Hospital. The Units are under the responsibility of a psychiatrist leading a multidisciplinary team comprising a Medical and Health Officer, Nursing Officer, Psychologist, Social Worker, Counsellor amongst others. The aim is to give assistance, medico-psychosocial support, as well as referral services for people who misuse alcohol and other drugs.

All children and young people with a drug addiction problem have their primary assessments done at the Addictology Units. If those young patients are found not to be responding well to treatment, then they are referred to the HRU.

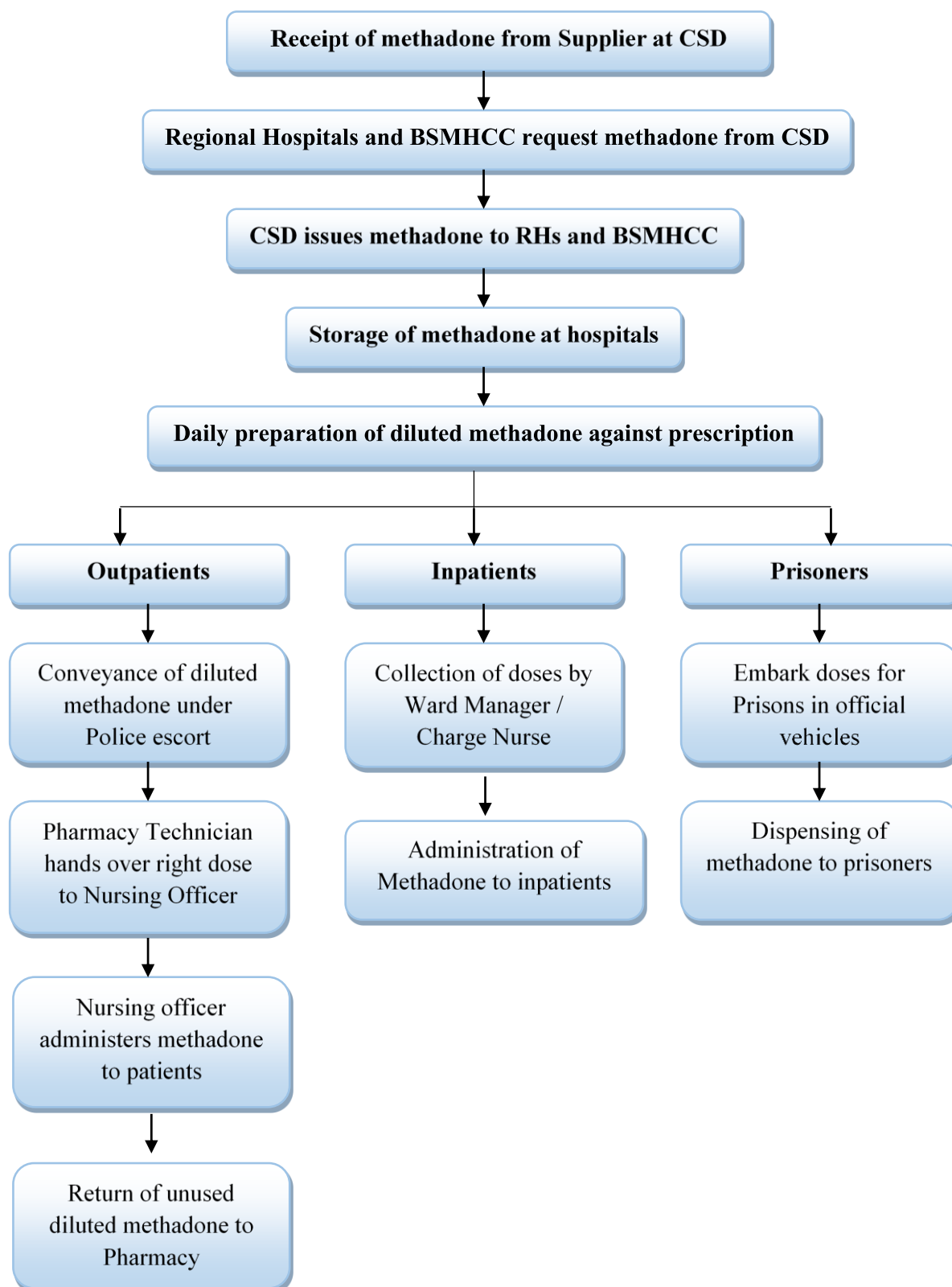
➤ *Pharmacy Section*

The pharmacy sections of the regional hospitals and BSMHCC request for methadone from the Central Supplies Division and prepare daily diluted doses against prescriptions to be dispensed at the 48 dispensing sites. Table 3 shows the dispensing sites and corresponding number of clients.

<b>Table 3 Number of clients as at March 2022 by dispensing region</b>				
<b>Dispensing Region</b>	<b>Number of sites</b>	<b>Number of clients</b>		
		<b>Male</b>	<b>Female</b>	<b>Total</b>
Region 1 – Dr. A. G. Jeetoo Hospital	12	2,192	117	2,309
Region 1 – BSMHCC	8	978	59	1,037
Region 2 – SSRN Hospital	9	699	28	727
Region 3 – Flacq Hospital	7	636	10	646
Region 4 – J. Nehru Hospital	3	313	5	318
Region 4 – Mahebourg Hospital	2	349	17	366
Region 5 – Victoria Hospital	6	1,025	53	1,078
Region 5 – Yves Cantin – Rivière Noire	1	48	5	53
	<b>48</b>	<b>6,240</b>	<b>294</b>	<b>6,534</b>
<i>Source: NAO Analysis of Ministry of Health and Wellness Records</i>				

The process flow chart in respect to request of methadone from Central Supplies Division, preparation of diluted doses and dispensing is illustrated in Figure 1.

Figure 1: Process flow of methadone preparation and dispensing



Source: NAO Analysis

### ***Mahebourg Detoxification Centre***

The Opioid Detoxification Centre at Mahebourg Hospital was opened in January 2016. Its main objective is to conduct heroin detoxification using reducing doses of Suboxone and Naltrexone in a protected ward environment over a two-week period to help people with heroin dependence achieve a drug free lifestyle. The total attendance at the Centre, for the year 2020, was 179. The treatment process at the centre is illustrated at Appendix VIII.

### ***Rehabilitation***

#### ***Nénuphar Centre***

Since 2018, the Nénuphar Centre at Long Mountain Hospital provides Treatment and Rehabilitation services on a six-week residential basis for minors and young people under the age of 24.

A multi-disciplinary team is involved to ensure psychosocial support services to the patients thereby facilitating the rehabilitation process for the ultimate reintegration in the mainstream society. The team comprises Medical Officers, Nurses, Health Care Assistants, representatives of NGOs, Psychologists and Social Workers and each member has a specific role to ensure continuity of care in the community after discharge from the centre.

#### ***Non-Governmental Organisations***

Rehabilitation services for PWUD in Mauritius are essentially provided by several registered NGOs. They use different therapeutic models, from drug free approach to medically assisted therapies, coupled with psychosocial support as well as rehabilitation and support services. Representatives of NGOs attend patients regularly during MST initiation in the context of rehabilitation and social integration.

### **2.9.3 Harm Reduction**

The Harm Reduction International defines Harm Reduction as: “policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits PWUD, their families and the community.”<sup>16</sup> The main Harm Reduction programmes available in Mauritius are the Needle Exchange Programme and the Methadone Substitution Therapy.

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<sup>16</sup> Harm Reduction International, 2010. What is Harm Reduction, A position statement from the International Harm Reduction Association. Accessible at [https://www.hri.global/files/2010/08/10/Briefing\\_What\\_is\\_HR\\_English.pdf](https://www.hri.global/files/2010/08/10/Briefing_What_is_HR_English.pdf)

### *2.9.3.1 Needle Exchange Programme*

The Needle Exchange Programme (NEP) is implemented by MOHW in collaboration with two NGOs. Since 2007, the Ministry has carried out NEP throughout the island. As of May 2022, distributions are carried out at 45 sites (37 sites by the Ministry and eight sites by two NGOs). Services are provided via several modalities, which include: MoHW “caravans”- two large vehicles that clients must enter to receive services, and NGO services which include “fixed sites” – providing services at regular locations on the street, “backpack outreach” – which involves teams of outreach workers going door to door. In 2021, a total of 715,773 needles and 701,497 syringes were distributed among PWID.

### *2.9.3.2 Methadone Substitution Therapy Programme*

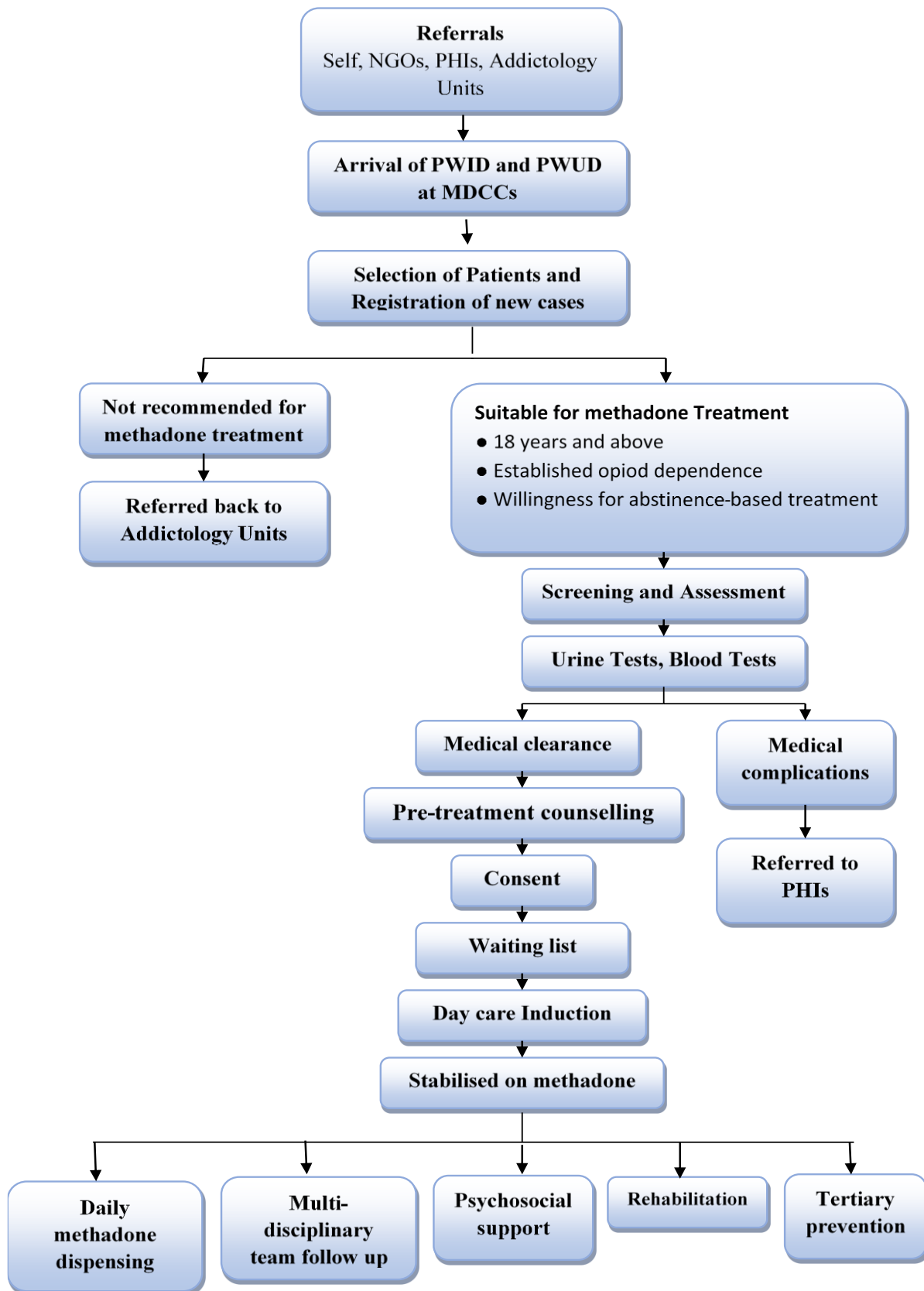
The MST programme started in November 2006. Over 11,100 PWUD have been induced on methadone, between November 2006 and March 2022. As at March 2022, there were 6,534 persons on the MST programme, out of which 294 were females. Daily methadone dispensing was conducted at 48 different sites across the island, including four dispensing points within the Prison Service.

MST is harm reduction oriented and the process to follow the induction on methadone is a three-pronged approach as follows:

- Selection and recruitment phase from Addictology Units, NGOs, Probation and After Care Services. Clients are selected and recruited based on specific selection criteria;
- Induction phase – This is a daycare phase of one week during which the methadone dose is individually titrated to the needs of the client with a view to alleviate withdrawal symptoms; and
- Follow-up phase – Clients are stabilised on dose of methadone and receive their daily dose of methadone under supervision at various dispensing points. The medical follow-up for renewal of prescription and other health care problems are conducted at methadone daycare centres. The psychosocial follow-up is carried out by NGOs.

Methadone Induction is usually conducted in group of 10-12 persons. The process for selection, induction and follow-up is illustrated in Figure 2.

Figure 2: Process Flow of Methadone Substitution Therapy Programme



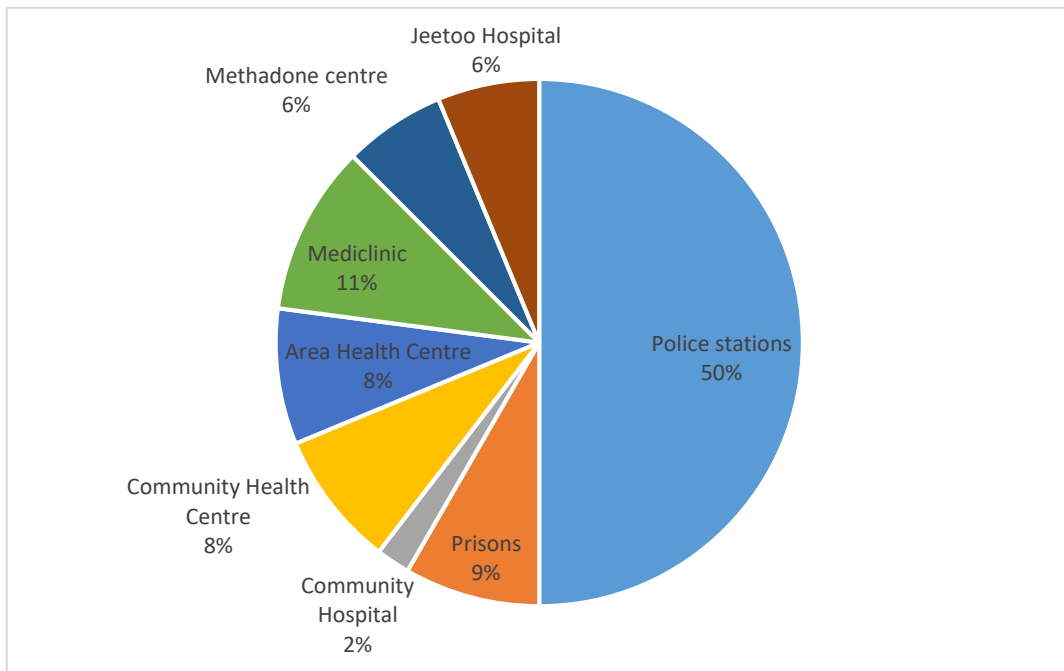
Source: NAO Analysis

➤ *Methadone Daycare Centres (MDCCs)*

There are four MDCCs which are operational at Sainte Croix, Bouloux Cassis, Frangipane – Beau Bassin and Mahebourg. As of March 2022, 11,319 PWUD have been induced on methadone.

➤ *Dispensing Sites*

Every day at around 06 00 – 08 00 hours, diluted methadone is dispensed in bottles to some 6,500 PWUD, in 48 dispensing sites, in public health settings, Area Health Centres, Community Health Centres, community sites, Police Stations and medi-clinics. Figure 3 refers.



Source: NAO Analysis

*Figure 3: Dispensing sites classified by type*

## CHAPTER THREE

### FINDINGS

*This Chapter presents the audit findings on whether the Ministry was effective in its interventions towards reducing harm and drug demand in collaboration with other stakeholders, under the oversight of the National Drug Secretariat (NDS).*

#### 3.1 General

The findings are organised into five sections, as per the audit questions and sub-questions, to answer the audit objectives. The sections are as follows:

Section A	<i>Implementation of Drug Use Prevention Activities</i>
Section B	<i>Drug Use Disorders Treatment</i>
Section C	<i>Rehabilitation and Social Integration</i>
Section D	<i>Harm Reduction Interventions</i>
Section E	<i>Oversight by the National Drug Secretariat</i>

#### SECTION A: Implementation of Drug Use Prevention Activities

*This section examines whether interventions under the Drug Prevention Programme were adequate and effective. The different activities carried out under the Drug Prevention Programme in educational institutions, community and workplaces, and the measures put in place to ensure their adequacy and effectiveness were examined.*

##### A.1 Introduction

According to the International Standards on Drug Use Prevention<sup>17</sup>, an effective national drug prevention system delivers an integrated range of interventions and policies based on scientific evidence, taking place in multiple settings and targeting relevant ages and levels of risk. Given the complex interplay of factors that make children, youth and adults, alike, vulnerable to substance use and other risky behaviours, it is not possible to address such vulnerabilities by simply implementing a single prevention intervention, which is often isolated and limited in its time frame and reach. An effective prevention system therefore comprises strategies with a mix of environmental and developmental components, with a minor component focusing on information.

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<sup>17</sup> International Standards on Drug Use Prevention, Second updated edition. Vienna: United Nations Office on Drugs and Crime and the World Health Organization, 2018. Licence: CC BY-NC-SA 3.0 IGO - Page 41. Accessible at [https://www.unodc.org/documents/prevention/UNODC-WHO\\_2018\\_prevention\\_standards\\_E.pdf](https://www.unodc.org/documents/prevention/UNODC-WHO_2018_prevention_standards_E.pdf)



This Section is organised as per following paragraphs:

- Paragraph A.2 examines whether the drug use prevention activities of the Ministry in collaboration with other stakeholders were adequate, aligned with international standards and good practices, and implemented effectively as per the requirements of the NDCMP, under the oversight of NDS.
- Paragraph A.3 examines whether the effectiveness of the collective prevention activities of the Ministry and other stakeholders was assessed by NDS.
- Paragraph A.4 examines the implementation of the ‘Get Connected Programme’, and the development of a parallel ‘Standardised Drug Prevention Programme’.
- Paragraph A.5 examines the execution of drug prevention programme through the Youth Empowerment Programme.

## **A.2 Alignment of Drug Use Prevention Activities with International Standards and Good Practices**

### *Key findings*

*According to the Ministry, drug prevention activities were directly aligned with the requirements of the Master Plan and were performed by a team of trained officers. However, drug prevention programmes and activities carried over the past years were not accompanied by any monitoring and evaluation component. Inclusion of this component in the prevention programmes would have ensured alignment with good practices and provided the assurance that the programmes were adequate and effective in preventing the consumption of drugs, particularly among the young segment of the population.*

- *As per the National Survey Among People Who Use Drugs of December 2021, the median age of People Who Use Drugs was 30 years and 29 per cent of those using illicit drugs were between ages 18 to 24 years.*
- *During the period 2016-2020, on average, 169 persons aged 19 or less were admitted annually to public health institutions due to complications following the intake of illicit substances (including abuse of medicinal products). Those aged 14 years or less stood at an average of 17 annually.*

In respect of Drug Use Prevention, it was reported in the NDCMP that the relevant stakeholders often worked in silos with little shared vision, joint planning, cooperation or coordination, with ad hoc activities and no monitoring and evaluation or impact assessment. Evidence-based prevention methods were not always used and there was no standardised drug prevention methodology while targeting specific age group. In order to bridge the gap, a Standardised National Drug Use Prevention Programme had to be developed to guide prevention activities

which would render the individual, the family, the community and the society at large more resilient to substance use.

The Ministry has been carrying out drug prevention activities prior to 2016, in educational institutions, in the community and at workplaces. These comprised awareness, sensitisation programmes and educational sessions. During the period 2018-2021 some 50,000 students in schools and some 49,000 participants in the community and workplaces were reported to have attended these activities. Details on the types of prevention activities and targeted audiences are as per Appendix IX. Radio and television programmes, and mass media/social media campaigns were also conducted. These activities were, according to the Ministry, directly aligned with the requirements of the NDCMP and were performed by a team of trained officers.

- *Statistics related to the effect of drug consumption among younger segment of the population*

In 2020, the number of deaths related to the intake of drugs<sup>18</sup> was 44, out of which four were in the age group 15-19 years. The corresponding number of deaths in 2021 was 46<sup>19</sup>, comprising six deaths in the age group of 18 to 24. As per the National Survey Among People Who Use Drugs of December 2021, the median age of PWUD was 30 years and 29 per cent of those using illicit drugs were between ages 18 to 24 years. Also, many persons interviewed during the qualitative research<sup>20</sup> of this Study stated that many young persons were using drugs.

Neither the Ministry nor NDS maintained statistics on the young population among PWUD who were new drug users. During period 2016-2020, on average, 169 persons aged 19 years or less were admitted annually to public health institutions due to complications following intake of illicit substances (including abuse of medicinal products). Those aged 14 years or less stood at an average of 17 annually. In 2021, about two-thirds of drug-related admissions in public hospitals were inpatients in the age band 20-34 years<sup>21</sup>. Those aged less than 20 years stood at 11 per cent, essentially teenagers in the age group 15-19 years. During the same year, out of the 2,375 new cases of PWUD seeking rehabilitative treatment at NGOs Centres, about 92 were under 18 years old.

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<sup>18</sup> As per NDO Report 2020, Page 74. Prior to 2020, the number of drug-related death was not compiled and published. Accessible at <https://mroiti.govmu.org/Communique/NDO%20Report%202020%20-%20Final.pdf>.

<sup>19</sup> As per NDO Report 2021, Page 24. Accessible at <https://mroiti.govmu.org/Communique/NDO%2006.12.22.pdf>

<sup>20</sup> The Study did not include persons less than 18 years due to restriction on consent. National Survey Among People Who Use Drugs of December 2021- Page 47, Paragraph 'People Who Use Drugs Are Young'. Accessible at <https://mroiti.govmu.org/Communique/National%20survey%20among%20people%20who%20use%20drugs.pdf>

<sup>21</sup> As per NDO Report 2021, Page 14. Accessible at <https://mroiti.govmu.org/Communique/NDO%2006.12.22.pdf>

- *Prevention activities not accompanied by a monitoring and evaluation component*

According to good practices recommended by UNODC<sup>22</sup>, drug use prevention programmes are effective when they respond to the needs of a community, involve all the relevant sectors and are based on scientific evidence. These programmes should also incorporate strong monitoring and evaluation components. Appendix X refers to a schematic representation of a national drug prevention system which incorporates rigorous monitoring and evaluation of evidence-based interventions and policies. Also, such programmes are cost-effective as it has been shown that, for every dollar spent, good programmes for the prevention of drug use among youth can save up to 10 dollars.

However, as of April 2022, the drug prevention programmes and activities carried over the past years by the HRU were not accompanied by any monitoring and evaluation component. Inclusion of this component in the prevention programmes would have ensured alignment with good practices and provided the assurance that the programmes were adequate and effective in preventing the consumption of drugs, particularly among the young segment of the population.

### **A.3 Oversight through Drug Prevention Committee chaired by the National Drug Secretariat**

#### *Key findings*

- *By considering its mandate limited to that of a coordinating body, as opposed to what was prescribed in its Terms of Reference, the National Drug Secretariat did not ensure that drug prevention activities of stakeholders were evidence-based and carried out in line with international standards and best practices.*
- *The National Social Inclusion Foundation was included as a stakeholder in the Drug Prevention Committee as it was a funding agency for NGOs' projects which included drug prevention activities in educational institutions, workplaces and the community. However, the latter had put much emphasis on financial monitoring instead of assessing whether the intended benefits were realised out of the funding provided.*

A Drug Prevention Committee was set up under the aegis of NDS in 2020, comprising several stakeholders actively involved in the implementation of drug prevention activities. It was scheduled to meet on a two-monthly basis and was composed of representatives from eight Ministries (including the Ministry of Health and Wellness) and Government Departments/services, and representatives from 12 NGOs.

The next paragraph examines whether the effectiveness of the collective preventive activities of the Ministry and other stakeholders was assessed by NDS.

<sup>22</sup> <https://www.unodc.org/unodc/fr/prevention/index.html>

### *A.3.1 Assessment of Drug Prevention Planning and funding*

At the level of the Drug Preventive Committee, in order to facilitate the implementation of activities, processes were organised under four themes: Capacity Building, Prevention activities in educational institutions, Community-based activities and Prevention activities at workplaces.

During the meetings of the Drug Prevention Committee chaired by NDS, several gaps were identified as follows:

- Most of the stakeholders, did not have a proper plan of action with regard to prevention.
- Planned activities based on the NDCMP were almost non-existent.
- There was an absence of coordination on drug prevention programmes being conducted at educational institutions, resulting in inconsistent coverage.
- There was a lack of trained personnel across NGOs, Ministries and Government Departments/Services.
- Despite collective efforts put by all stakeholders over many years, the issue of drug consumption is still quite alarming.

#### *A.3.1.1 Implementation issues in respect of Multisectoral Drug Related Prevention Activities during 2021*

In response to the lack of planned activities with regard to drug prevention by NGOs, NDS requested each stakeholder to develop and submit a plan of action of activities that they proposed to implement during 2021 at all three levels: educational institutions, community and workplaces. These activities were expected to include informative educational and communication programmes on drug prevention, targeting the youth segment and community as a whole. Such plan would contribute towards enhancing the real impact of prevention activities through proper coordination among stakeholders, optimum use of resources and reach out to a maximum number of young persons who were most vulnerable to drug use.

A template was provided to stakeholders for the record of activities to be implemented, the targeted audience and number of participants, venues and time frame for implementation. It was reported that some stakeholders were reluctant to fill and submit same. As of March 2021, only 20 per cent of the stakeholders submitted their plans and the time of submission had to be extended. It was only in September 2021 that all the submissions were finalised into a document named ‘Multisectoral Drug Related Prevention Activities 2021’.

During Prevention Committees held in September 2021 and April 2022, individual stakeholders gave updates on the implementation of their respective plans. However, there was no assessment as to whether these plans were evidence-based, in line with good practices and international standards, and met the requirements of the NDCMP.

### *A.3.1.2 Assessment of Drug Prevention Activities not carried out by the National Drug Secretariat*

The Terms of Reference of NDS (Appendix XI refers) specifically mentioned that it had to ensure that demand reduction activities, namely the prevention of drug use, the treatment of drug use disorders and rehabilitation of PWUD including those in prisons, are evidence-based and carried out in line with international standards and best practices. However, NDS considered that it was not mandated to assess any NGOs or any other stakeholder based on the following arguments:

- It was only a coordinating body, not an enforcement body;
- It had neither the legal authority to assess the efficacy of the programme of the stakeholders involved in drug prevention activities; and
- Many NGOs have their own mission and vision, and operate under the aegis of religious bodies and charitable institutions. Some NGOs focus on harm reduction while others advocate drug-free therapy, and diverse therapeutic models. Consequently, NDS could not prevent NGOs from implementing any programme or activities which do not fall under the purview of the NDCMP.

By considering its mandate limited to that of a coordinating body, as opposed to what was prescribed in its Terms of Reference, NDS did not ensure that drug prevention activities of stakeholders were evidence-based and carried out in line with international standards and best practices.

### *A.3.1.3 Assessment of the Prevention Activities by the National Social Inclusion Foundation not focused on intended benefits*

As from August 2020, NSIF was included as a stakeholder in the Drug Prevention Committee. This was considered necessary by the Committee, as NSIF being a funding agency for NGOs' projects would provide a better insight and would improve NSIF's ability to deal with projects of NGOs concerned.

As described in paragraph 2.8.5, NSIF is expected to assess the effectiveness of interventions of the NGOs in meeting defined objectives, outputs, outcomes and impact on beneficiaries. This is important to determine key lessons learnt, identify good as well as bad practices and guide future funding. To meet that objective NSIF had designed a monitoring toolkit which focused on the components of the activities of an NGO, financial use of resources, compliance with funding contracts and feedback. Monitoring field visits by NSIF were expected to be carried out for making diagnostic assessments of specific problems and issues encountered during programme implementation and for gauging the strengths and weaknesses of the NGOs.

As of April 2022, NSIF had put much emphasis on financial monitoring instead of assessing whether the intended benefits were realised out of the funding provided. NSIF confirmed that

the focus of its monitoring was geared towards ensuring that NGOs fulfilled their obligations in terms of financial reporting.

#### **A.4 Implementation of School-based Drug Prevention Programme**

##### *Key findings*

- *In June 2020, the Drug Prevention Committee took the decision to develop a Standardised Drug Prevention Programme, concurrently with the ‘Get Connected Programme’ which would cover a larger student population (i.e., Grade 9 onwards). People Who Use Drugs started with Cannabis at a very young age (11-17 years) and this evidence warranted the implementation of a prevention programme for students at a very young age.*
- *The Phase 1 of the ‘Get Connected Programme’ was implemented in 24 schools as a pilot project. As of August 2022, the evaluation of the pilot project was not completed and there was no visibility on when same would be completed and when the programme would be fully deployed to the remaining schools.*
- *Phase 2 of the ‘Get Connected Programme’ which started in January 2020 was negatively impacted by the closure of schools over several months due to COVID-19.*
- *The Standardised Drug Prevention Programme which would target a larger student population was not yet developed as of April 2022.*

Since 2016, the Ministry has been conducting prevention programmes at the level of educational institutions with the assistance of ADSU and NGOs.

The UNODC International Standards on Drug Use Prevention (2015) declared that non-interactive teaching methods like lecturing, providing information only and non-structured dialogue-based sessions did not yield positive results in drug use prevention among children. Instead of adopting approaches that rely on stand-alone, single-event activities, the Standards recommend approaches that embrace ongoing, comprehensive and development stages appropriate strategies.

In this context, MoETEST had embarked on the ‘Get Connected Programme’ a national drug use prevention programme, focusing initially on Grade 8 students, based on evidence informed and tested methodology. The aim was to adopt a comprehensive, structured curriculum for appropriate age groups to build skills in the youth to resist or delay drug initiation. This programme which started in January 2019, is being implemented in partnership with the private sector and the UNODC.

Issues relating to the implementation of the ‘Get Connected Programme’ and the development of a parallel ‘Standardised Drug Prevention Programme’ are presented in the following paragraphs.

#### *A.4.1 Get Connected Programme still at pilot stage and evaluation not carried out*

Under Phase 1, the programme was implemented in 24 schools as a pilot project. Another set of 23 schools, where the programme has not been conducted, was used as a control for evaluation purposes. Pre-tests were conducted in all 47 schools and post-tests done at the end of the 12-week implementation. A full evaluation of this phase was expected in January 2020, allowing for a 12-month post-programme impact maturation.

MoETEST reported that Phase 2 of the programme which started in January 2020 was negatively impacted by the closure of schools over several months due to COVID-19. As it was an interactive programme, it could not be run online. The programme was implemented in an average of only 40 per cent of the selected schools.

As of April 2022, the evaluation of the pilot project to confirm the expected results was not completed, due to the non-availability of the requisite expertise. MoETEST and NDS could not confirm when the evaluation would be completed and when the programme could be fully deployed to the remaining schools.

#### *A.4.2 Standardised Drug Prevention Programme not yet formulated*

The ‘Get Connected Programme’ though being an evidence-based prevention programme was quite bulky<sup>23</sup> and there were difficulties to implement same (12 hours divided into 1-hour sessions) in the school curriculum which was already impacted negatively by COVID-19. The programme focused on only part of the secondary school population (Grade 8 students only), and it would take several years to induct the whole school population into that programme. There was a risk that several thousand students would leave secondary school, without receiving an appropriate induction to a drug use prevention programme.

In June 2020, the Drug Prevention Committee decided to develop a Standardised Drug Prevention Programme, concurrently with the ‘Get Connected Programme’ which would cover a larger student population (i.e., Grade 9 onwards). PWUD started with Cannabis at a very young age (11-17 years) and this evidence<sup>24</sup> warranted the implementation of a prevention programme for students at a very young age.

The Drug Prevention Committee delegated to MoETEST the responsibility of developing the Standardised Drug Prevention Programme targeting students of 15 to 18 years of age. MoETEST chaired a Sub-Committee comprising representatives of several Ministries (including the Ministry of Health and Wellness), Departments and NGOs to initiate the

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<sup>23</sup> As per the notes of meeting of 18 June 2020 held at the Ministry of Education, Tertiary Education, Science and Technology.

<sup>24</sup> As per the ‘National Survey Among People Who Use Drugs’, Page 7.

formulation of this programme. One year later, as of September 2021, no progress was realised on this responsibility allocated to MoETEST. The latter informed NDS that it would no longer lead the development of programme, but rather, NDS should act as the lead agency, as it was in a better position to coordinate the undertakings of all its partners and it had the vital expertise in developing the Standardised Programme.

- *Delays leading to students completing secondary schooling without benefiting from the Programme*

As of April 2022, that is six months later, decision as to which entity would lead this standardised prevention programme had not been resolved though it was proposed that the HRU of the Ministry would take the lead. As of September 2022, some 64,000 students would potentially not benefit from this programme.

In September 2022, MoETEST informed NAO that the likelihood of some 64,000 students not benefiting from an evidenced-based programme is not relevant to the whole concept of implementation of the ‘Get Connected Programme’. Despite the Standardised Drug Prevention Programme has not been formulated for implementation, MoETEST considered the following as relevant:

- (i) Regular sensitisation campaigns by other stakeholders are ongoing;
- (ii) Drug use prevention topics had already been infused within the school curriculum; and
- (iii) The ‘Get Connected Programme’ is a stand-alone programme and is an added intervention to the existing ones.

However, the sensitisation programmes carried out among students by other stakeholders over the years, discussed in paragraph A.2, were shown to have missed out the essential component of monitoring and evaluation. That was necessary to ensure that the sensitisation programmes were effectively contributing towards building skills in the youth to resist or delay drug initiation.

NDS informed NAO that though implementation of the ‘Get Connected Programme’ was heavily impacted by COVID-19 restrictions, and no progress was realised on the formulation of the Standardised Drug Prevention Programme, another programme known as the ‘REBOUND Drug Use Prevention Programme’ is under preparation. It is another evidence-based programme that will be rolled out in early 2023.



## A.5 Implementation of Community-based Drug Prevention Programme

### *Key finding*

*A Youth Empowerment Programme Against Drugs was led by the Ministry in partnership with major stakeholders in respect of the implementation of drug prevention programme in 24 drug prone areas. The second phase of this programme was considered crucial, whereby activities had to be sustained against drug use in each region. This was to be ensured by the Prevention Team of the HRU of the Ministry. As of May 2022, neither an assessment of the training already provided was initiated nor communication maintained with the trained members of the cohort in each region.*

A Youth Empowerment Programme Against Drugs (YEPAD) was led by the Ministry in partnership with major stakeholders namely, the Police Service, the Sugar Industry Labour Welfare Fund, the Ministry of Gender and Family Welfare, the Mauritius Sports Council as well as NGOs. YEPAD was to be implemented in two phases: first phase being ‘Training of Trainers’ and the second phase ‘Networking for follow-up’. The programme was to be coordinated by NDS.

The first phase, costing some Rs 1.2 million, was to be implemented in 24 regions, by the Ministry through a core team of persons knowledgeable and well acquainted with community drug prevention programme and who were active in regions considered as drug prone areas. The team had to identify, mobilise and motivate a cohort of 20-30 persons in each of the earmarked region following which a training programme had to be conducted during five days with the group. Two-thirds of the programme costs were made up of travelling, allowances and refreshment expenses.

The second phase was considered as crucial, whereby activities had to be sustained against drugs in each region. This was to be ensured by the Prevention Team of the HRU of the Ministry. The Prevention Team had to communicate with the trained cohort of 20-30 persons in each region to ensure that the drug prevention activities were being implemented.

The first phase was already completed in 13 regions by end of December 2021. As of May 2022, NDS had neither initiated an assessment of the training already provided nor ascertained what communication the Prevention Team maintained with the trained members of the cohort in each region.

## SECTION B: Drug Use Disorders Treatment

*This section examines whether the interventions of the Ministry of Health and Wellness in respect of drug use disorders treatment were adequate and effective.*

### B.1 Introduction

Drug use disorders can be effectively treated using a range of pharmacological and psychosocial interventions<sup>25</sup>. In the management of drug use disorders, the aim of the treatment is to improve the health and quality of life of people with drug use disorders, and the ultimate objective is to help individuals achieve recovery to the extent possible. Specifically, treatment goals include:

- Stop or reduce drug use;
- Improve health, well-being and social functioning of the affected individual; and
- Prevent future harm by decreasing the risk of complications and relapse.

In response to the general nature of drug use disorders, the Ministry has developed a treatment and harm reduction system which includes:

- Needle exchange services for active users, designed to reduce the incidence of equipment sharing, and consequent cross-infection (examined in Section D);
- Provision of substitute drugs, mainly methadone, aimed at stabilising the substance abuser's situation, and subsequently, where feasible, at reducing the level of drug dependence;
- Detoxification of substance abusers who have reduced their drug dependence to an appropriate level, through incremental reductions in the quantity of drugs used, until drug taking is eliminated;
- Residential rehabilitation programmes for those who are abstaining from drug use; and
- Aftercare support for persons who have successfully completed rehabilitation.

In paragraphs B.2 to B.5 the following aspects are examined:

- Whether the treatment services provided by the Ministry were aligned with good practices;
- The level of provision of treatment and its timeliness;
- Whether social integration and rehabilitation services adequately supported treatment; and
- How the Ministry and NDS evaluated the effectiveness of treatment, social integration and rehabilitation services provided.

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<sup>25</sup> International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing. Geneva: World Health Organization and United Nations Office on Drugs and Crime; 2020. License: CC BY-NC-SA 3.0 IGO. Chapter 2, page 7. Accessible at <https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders>

## B.2 Alignment of treatment services with good practices

### *Key finding*

*The Ministry has aligned its treatment services with the key principles and standards for the treatment of drug use disorders as recommended by the United Nations Office on Drugs and Crime. It has also adopted the recommended modalities and approaches for the treatment of drug abuse. However, there were several issues relating to the administration of treatment which impacted on its effectiveness.*

The Ministry has aligned its treatment services with the key principles and standards for the treatment of drug use disorders as recommended by the UNODC. The key principles are as follows:

- i.* Treatment should be available, accessible, attractive, and appropriate.
- ii.* Ensuring ethical standards of care in treatment services.
- iii.* Promoting treatment for drug use disorders through effective coordination between the criminal justice system and health and social services.
- iv.* Treatment should be based on scientific evidence and respond to the specific needs of individuals with drug use disorder.
- v.* Responding to the special treatment and care needs of population groups.
- vi.* Ensuring good clinical governance of treatment services and programmes for drug use disorders.
- vii.* Treatment services, policies and procedures should support an integrated treatment approach, and linkages to complementary services require constant monitoring and evaluation.

The Ministry has also adopted the UNODC recommended modalities and approaches for the treatment of drug abuse. Appendix XII refers.

However, there were several issues relating to the administration of treatment which impacted on its effectiveness and are discussed in the following paragraphs.

## B.3 Provision of treatment services and their timeliness

In planning an adequate level and timely provision of treatment services, it is useful<sup>26</sup> to identify and distinguish between:

- The underlying prevalence of misuse of drugs, and any significant changes that are occurring in the pattern of misuse;

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<sup>26</sup> Drug Addiction Treatment and Rehabilitation, Comptroller and Auditor General Special Report, Government of Ireland 2009. Page 23, paragraph 2.1. Accessible at [https://www.drugsandalcohol.ie/11582/1/64\\_Drug\\_Addiction\\_and\\_Rehab.pdf](https://www.drugsandalcohol.ie/11582/1/64_Drug_Addiction_and_Rehab.pdf)

- The rate at which individuals with an addiction problem present for treatment i.e., the demand for treatment; and
- The level of provision of treatment i.e., the supply of treatment.

In the following paragraphs the coverage of treatment in relation to the prevalence of drug abuse, supply and demand for treatment are described.

### *B.3.1 Prevalence of drug abuse and coverage of treatment*

#### *Key findings*

- *As of May 2022, there was a reasonable level of information about the prevalence of drug use and misuse, and the supply of treatment for drug misuse was reasonably well measured. However, there was limited information on the extent to which the coverage and demand for treatment by drug misusers were being met.*
- *There was a missed opportunity by the Ministry to assess the demand for treatment and consequent referral to treatment to benefit from reductions in drug-related crimes and costs of criminal justice, law enforcement and healthcare systems.*

Prior to the ‘National Survey Report on people who use drugs’ of December 2021, there was no study on the extent to which non-injecting drug use was prevalent. What was available was data on PWID through the periodical IBBS which started in 2009. As of December 2020, five surveys had been carried out.

- *No statistics kept in respect of Indicator 3.5.1 of SDG*

Indicator 3.5.1 of SDG emphasises the assessment of coverage<sup>27</sup> of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders. At the national level no statistics was kept in respect of the target to indicate the coverage of substance abusers requiring treatment.

Since the introduction of MST in 2006, the number of clients induced on MST stood at 11,319 as at end of March 2022. However, only 6,534 clients were on MST, whereas 4,616 clients were lost to follow-up. The loss to follow-up included an unknown number of clients who could have passed away and the remaining not traced to assess whether they were receiving any alternative treatment.

As regards PWUD, the December 2021 survey revealed that just over a quarter of them had ever sought treatment. As at December 2020, the Ministry did not assess what

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<sup>27</sup> Method of computation: Number of people who have received different treatment interventions in the last year divided by the actual number of the target population (people with substance use disorders measured as the total number of problem drug users).

proportion of the 6,600<sup>28</sup> active drug-injecting persons avail themselves of treatment being offered, and whether the current treatment coverage was adequate and matched the recommended target of UNODC.

- *Missed opportunity to assess demand and referral for treatment*

As of May 2022, there was a reasonable level of information about the prevalence of drug use and misuse, and the supply of treatment for drug misuse is reasonably well measured. However, there was limited information on the extent to which the demand for treatment by drug misusers was being met.

From a public budget perspective, evidence-based treatment of drug use disorders is a smart investment, as the costs of treating drug use disorders are much lower compared to the costs of untreated drug dependence<sup>29</sup>. The rate of savings to investments can exceed a ratio of 12:1 through reductions in drug-related crimes and costs of criminal justice, law enforcement and healthcare<sup>30</sup>. There was a missed opportunity by the Ministry to assess the demand for treatment and consequent referral to treatment to benefit from reductions in drug-related crimes and costs of criminal justice, law enforcement and healthcare systems.

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<sup>28</sup> Source: Latest figure available as of May 2020 from IBBS 2020 survey 'People Who Inject Drugs in the island of Mauritius' - Page 27 published in July 2021. Accessible at [https://health.govmu.org/Documents/Legislations/Documents/PWID\\_FINAL\\_REPORT%20%281%29.pdf](https://health.govmu.org/Documents/Legislations/Documents/PWID_FINAL_REPORT%20%281%29.pdf)

<sup>29</sup> UNODC Report - WHO International standards treatment Drug Use Disorders 2020 – Page 16 paragraph 3.2. Accessible at <https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders>

<sup>30</sup> National Institute on Drug Abuse (NIDA), United States federal government research institute – Title of publication: Principles of Drug Addiction Treatment: A research-based guide 3<sup>rd</sup> edition. Page 15. Last Updated January 2018. <https://www.drugabuse.gov/>

### B.3.2 Timeliness of treatment as a Key Performance Indicator

#### Key findings

- *As of May 2022, the measurement of timeliness of providing Methadone Substitution Therapy and setting of related targets to monitor this key performance indicator was not considered by the Ministry. Monitoring of waiting time is important to ensure that it is kept within reasonable limits and to provide inputs for capacity planning to accommodate additional clients. The overall effect would be to decrease the likelihood of PWUD losing resolve to start treatment or resuming substance misuse due to long waiting lists for induction.*
- *In December 2020 the Harm Reduction Unit reported that People Who Use Drugs had to wait a lot before they can be embarked on the methadone treatment programme and hence they were more likely to stop coming for their pre-induction counselling and were lost.*
- *The Ministry had attempted to reduce the waiting time for induction. As end of January 2022, across all the MDCCs, it could take at least one week and up to 10 weeks to be inducted on MST from the completion of screening. The waiting time was one to six weeks as of end August 2022.*

Given the nature of addiction to drugs and the sequence of treatments usually required, any delay in assessing and providing treatment to a substance abuser might increase the likelihood that the latter may lose the resolve to start treatment or resume substance misuse. Consequently, waiting time for assessment and treatment is a key performance indicator.

- *No target set for waiting time for treatment*

As of May 2022, waiting time period which could be considered reasonable for treatment had not been set by the Ministry to monitor the timeliness of providing treatment. The annual National Drug Observatory Reports provide information on the Ministry's specialised services set up within the five health regions in view to provide treatment and psychosocial support to PWUD namely through the four MDCCs and five Addictology Units. However, the waiting time for receiving treatment, more importantly in all the MDCCs, though partly compiled and computed was not reported. In respect of the Suboxone-Naltrexone-based Detoxification Programme at Mahebourg Hospital and Nénuphar Centre at Long Mountain Hospital, waiting lists were not prepared on the grounds that there was always capacity to provide treatment for referrals after assessment. However, the Ministry did not maintain a list of all those eligible and referred for admission for treatment in these two centres, to match with the list of those who were eventually admitted and received treatment.

In the next paragraph the waiting lists for the MST Programme treatment in the four MDCCs are analysed.

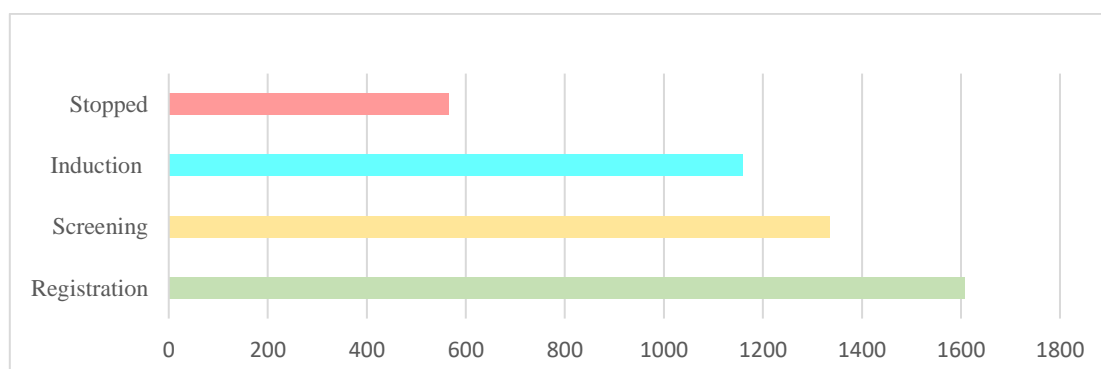
### B.3.2.1 Long Waiting list for treatment in respect of Methadone Substitution Therapy (MST)

The MST Programme is based on a multi-stage process namely the induction phase, the dispensing phase, and the follow-up phase. From the point of view of a drug abuser seeking treatment for an addiction problem, a timely response is important. The most important measure of timeliness is the time that elapses from initial presentation for treatment, that is screening until treatment commences, that is induction. Generally, where substance abusers are aware of the long waiting time to access treatment services, they may be deterred from presenting for assessment which precedes the multi-stage process.

In December 2020<sup>31</sup>, the HRU reported that PWUD had to wait a lot before they could be embarked on the methadone treatment programme and hence they were more likely to stop coming for their pre-induction counselling and were lost. The following paragraphs present an analysis of waiting lists and waiting times based on the data available as of March 2022.

#### (i) One to 10 weeks waiting time for induction on MST as per Active Waiting List

Prior to induction, clients must be registered and screened, and this process can span over some four weeks. After induction, clients are followed up and they may voluntarily stop the treatment. The number of clients who were registered, screened, inducted and had stopped MST during 2021 are as per Figure 4.



Source: NAO Analysis based on data obtained from Ministry of Health and Wellness

Figure 4: Number of clients who were registered, screened, inducted and had stopped MST in MDCCs during 2021

The four MDCCs have a total weekly capacity of inducting some 40 to 48 clients on MST Programme. An active waiting list is prepared each month by the MDCCs based on figures for the number of patients awaiting to be inducted for the last six months, after the completion of their screening. Only the Sainte Croix MDCC partially compiled and maintained a set of data in respect of waiting lists for the period 2019-2021, that could enable the identification of trends or patterns in the waiting time at this centre.

<sup>31</sup> As per Notes of Meeting of the Treatment and Rehabilitation Committee held on 16 December 2020.

As of end January 2022, there was a total of 372 clients on the waiting lists for inductions relating to the period August 2021 to January 2022 (as per Table 4 below).

<b>Table 4 Number of clients on MDCCs Waiting List at end of January 2022</b>			
	<b>Male</b>	<b>Female</b>	<b>Total</b>
Sainte Croix MDCC	113	1	114
Bouloux MDCC	55	10	65
Frangipane MDCC	145	0	145
Mahebourg MDCC	45	3	48
<b>Total</b>	<b>358</b>	<b>14</b>	<b>372</b>

*Source: Ministry of Health and Wellness records*

A client had to wait up to a maximum of four weeks for induction at the Mahebourg MDCC while it was up to ten weeks at the Sainte Croix MDCC.

As of end January 2022, across all the MDCCs, it could take at least one week and up to 10 weeks to be inducted on MST following the completion of screening.

The Ministry informed NAO that two centres have recently been opened which provided additional capacity to reduce waiting time. According to the Ministry, there was a pattern which recur and lead to long waiting lists for induction at the start of a year, and were as follows:

- At the beginning of the year, there is a high demand for induction because many people like street vendors and hawkers who work in December’s festive season become free to join the methadone programme.
- There is also a class of patients who make New Year resolutions to stop taking drugs and enrol themselves in the methadone programme in early January. However, many of them defer their medical appointments offered, claiming that they are working and do not have free time.
- There is also a massive enrolment of new patients willing to get induced in January because they are short of money to fund their drug habits after the festive season.

As of end of August 2022, the total number of clients on waiting lists at the four MDCCs was 204. Based on an average induction rate of 34 clients monthly<sup>32</sup>, it would take an average of one to 6 weeks to induct all the 204 clients on MST.

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<sup>32</sup> An average of 34 clients was inducted on MST across the four MDCCs during August 2022.



(ii) *Inactive Waiting list indicated potential clients not taking benefit of treatment*

At all the MDCCs, there were inactive waiting lists of clients. These lists refer to PWUD who presented themselves for treatment but did not attend the MST induction stage. These comprise PWUD who:

- a. Presented themselves at one of the MDCCs after being referred by NGOs or by self-referral, with the intention to embark on the MST. After the first registration, they never returned for the subsequent steps leading to inductions.
- b. Collaborated during several visits to provide their medical and psychiatric history, underwent medical examination and received counselling on the treatment. But they never returned to the concerned MDCC.
- c. Did not pursue the ensuing steps, although blood tests and additional medical examinations were carried out, and were untraceable.
- d. Received pre-admission counselling and their accompanying relatives who would provide support were also counselled on the treatment. But on the day of admission, they did not turn up and were untraceable.

For the period June 2017 to March 2022, there were some 800 clients on the inactive list of the Sainte Croix MDCC<sup>33</sup>. Some of the reasons associated with the inactive list by the Ministry's and NGOs' personnel were as follows:

- a. Several PWUD were not aware of the pre-induction procedures and were unwilling to comply with the same.
- b. Drug addiction, being a complex disease, several clients were not able to maintain their resolve for treatment during the registration, screening and counselling processes.
- c. As a First In and First Out principle was adhered to the MDCCs, several clients faced the challenge of waiting several weeks before being inducted into treatment and could not maintain their resolve for same.

(iii) *No Measurement of Timeliness and Setting of Target for MST clients*

The Ministry had attempted to reduce the waiting time for induction. In 2017 the induction period was reduced from two weeks to one week, which increased the inducting capacity of the then three MDCCs. In June 2021, an additional induction centre 'Frangipane MDCC' started its operation at the BSMHCC. However, the measurement of timeliness of providing

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<sup>33</sup> Only Sainte Croix MDCC maintained a list of inactive clients dating as far back as 2018.

MST and setting of related targets to monitor this key performance indicator was not considered.

This monitoring is important to ensure that waiting time is kept within reasonable limits and to provide inputs for capacity planning to accommodate additional clients. The overall effect would be to decrease the likelihood of PWUD losing resolve to start treatment or resuming substance misuse due to long waiting lists for induction.

### ***B.3.3 Dispensing of Methadone under the Methadone Substitution Therapy***

#### *Key findings*

- *The Ministry deployed significant resources to dispense methadone daily to some 6,500 clients who had already been induced to methadone under the MST Programme. Despite all the manpower, materials and logistics invested in the system of dispensing of methadone, there were several problems which negatively impacted on the expected outcome of the therapy. These included overcrowding, loitering and diversion of methadone at several dispensing sites, and stigmatisation of clients.*
- *The Ministry devised several methods to attend to these problems, but met several challenges during their implementations. These included the decentralisation of dispensing of methadone to public health institutions, dispensing of methadone in plastic cups to reduce methadone diversion and the ‘Take-home-dose’ pilot project.*
- *As of March 2022, there has been a relative increase in the number of clients who were being serviced at public health institutions (some 13 per cent of total clients on methadone). However daily methadone doses for at least two-thirds of the clients (4,415 out of 6,534) were still being dispensed in the yards of police stations and required the mobilisation of significant resources. As of May 2022, the Ministry had not prepared any plan on how to relocate these clients to places which would require less resources, reduce the perceived stigmatisation and support rehabilitation and social integration.*
- *As of August 2022, the Ministry had not provided updates on the outcome of the two pilot projects (dispensing of methadone in plastic cups and ‘Take-home-dose’).*

The Ministry deploys significant resources to dispense methadone daily to some 6,500 clients who had already been induced to methadone under the MST Programme. The dispensing is carried out daily irrespective of weather and sanitary conditions across the island. As of 31 December 2021, daily methadone dispensing was conducted at 46 sites across the island, namely 18 sites within the Ministry’s health care system, four within the Prison Service and 24 in the yards of police stations.

Despite all the manpower, materials and logistics invested in the system of dispensing of methadone, several problems negatively impacted the expected outcome of the therapy. These

included overcrowding, loitering and diversion of methadone at the dispensing sites, and stigmatisation of clients. The Ministry devised several methods to attend to these problems, and the status of progress achieved is discussed in the following paragraphs.

### *B.3.3.1 Overcrowding, loitering and stigmatisation of MST clients*

Use of abusive language and aggressive behaviour against dispensing personnel<sup>34</sup>, inadequate security by police<sup>35</sup>, overcrowding and loitering around dispensing sites were frequently reported to<sup>36</sup> and by the Ministry<sup>37</sup>.

In July 2015, the intake of new clients on the programme was halted because of the numerous complaints regarding loitering and antisocial behaviours of some beneficiaries at the dispensing sites<sup>38</sup>. However, around 4,500 clients, who were on maintenance at that time, continued to have their doses and the related services. In 2014, there were 18 dispensing sites, mainly located in the backyard of police stations, which gradually increased to 48 as of May 2022.

The decentralisation to Primary Health Care (PHC) Settings (such as medi-clinics, area health centres, community health centres) enabled the dispensing of methadone over an extended period and to overcome stigmatisation of clients on methadone. Those clients receiving their doses in the yard of police stations considered themselves stigmatised as their addictions were being considered a criminal offence as they had to call daily at the police station. Also, they ran the risk of being spotted outside a police station by a friend, a relative or even their employers who would then find out about their addictions. The decentralisation increased the access of the clients to better medical care, allowed for better psychosocial management and increased the chances for rehabilitation and social integration.

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34 Notes of Meeting in connection with Security concerning Distribution of Methadone of 24 July 2019, – Ministry’s File on Methadone Dispensing. Notes of Meeting of 20 January 2022 – Ministry’s File on Methadone Dispensing.

35 Letter from HRU to Ministry dated 31 August 2021 titled ‘Methadone Dispensing’

36 ‘Take Home Dose Brief’ dated February 2021 from the Harm Reduction and Addictology Units (Ministry’s File MHO\_METH\_DISP\_HOME)

37 Annual Report on Performance FY 2019-20 \_Ministry of Health and Wellness, Page 51. Accessible at <https://health.govmu.org/Documents/Legislations/Documents/Annual%20Report%20on%20Performance%20for%20Financial%20Year%202019-2020.pdf>

38 National Drug Observatory Report June 2017 Page 28. Accessible at [https://health.govmu.org/Documents/Main%20Page/New/NDO\\_MOH\\_FINAL\\_JOSE\\_VERSION\\_05July\\_2018\\_Brown.pdf](https://health.govmu.org/Documents/Main%20Page/New/NDO_MOH_FINAL_JOSE_VERSION_05July_2018_Brown.pdf)

The initiatives of decentralising and integrating methadone dispensing met several challenges<sup>39</sup> which were as follows:

- i. The opening hours of PHC centres did not match the preferred time of methadone clients. They preferred to have their doses earlier (between 6 to 8 am) to overcome their cravings and suit their transport arrangements and enable them to attend to their work.
- ii. Clients who came after 8 am (the opening time of PHC centres) are those who did not have to attend work and have a higher tendency to linger and loiter around.
- iii. Selection of clients who would not disrupt the normal operation of PHC centres was not an easy task given the complex nature of drug addiction.

In response to these challenges, the Ministry envisaged sending only newly inducted clients to the PHC centres.

As of March 2022, there has been a relative increase in the number of clients who were being serviced at the PHC centres (some 13 per cent of total clients on methadone). Table 5 refers.

<b>Table 5</b>		
<b>Number of Clients on Methadone by type of Dispensing Sites</b>		
	As at end of December 2021	As at end of March 2022
Medi-clinics	136	151
Area Health Centres	157	195
Community Health Centres	461	475
Community Hospital	54	53
<b><i>Total Clients in Health Settings</i></b>	<b>808</b>	<b>874</b>
Methadone Daycare Centres	542	553
Community Sites	389	390
Prisons	295	302
Police Stations	4,419	4,415
<b>Total</b>	<b>6,453</b>	<b>6,534</b>
<i>Source: NAO Analysis of Ministry of Health and Wellness Records</i>		

Daily methadone doses for at least two-thirds of the clients (4,415 out of 6,534) were still being dispensed in the yards of police stations and required the mobilisation of significant resources. As of May 2022, the Ministry had not prepared any plan on how to relocate these clients to places which would require fewer resources, reduce the perceived stigmatisation and support rehabilitation and social integration.

In August 2022, the Ministry informed NAO that these ‘crowds of people’ in proximity of dispensing sites have been reduced, over the years, to sporadic groups of people loitering in town centres, in municipal gardens or near attraction parks. Outreaching, managing and dispersing of loiterers is ongoing and conducted in collaboration with the help of peer educators

<sup>39</sup> Letter from Harm Reduction Unit of 27 October 2021, - Ministry’s File on Methadone Dispensing.

### *B.3.3.2 Diversion of methadone impacting negatively on MST*

The Ministry had put in place SOP to handle methadone dispensing along a chain of steps, starting with receipt from supplier up to consumption by individual clients. The purpose of one of the SOP, SOP 13 ‘Dispensing of diluted Methadone to out-Patients’, was to ensure that each patient on Methadone received his/her accurate dose in a timely manner at dispensing points and in compliance with provisions of the Dangerous Drugs Act 2000. It covered good distribution practices and specified the roles of the dispensing personnel and Police Officers offering general security service at dispensing points.

Despite the introduction of the SOP, annually several cases of methadone diversion were officially reported at the level of the Ministry. During a visit to one NGO, records examined revealed that PWUD who wanted to be referred to the MST of the Ministry for the first time, were already consuming methadone obtained through diversion from the dispensing points. For the five-month period examined (March-July 2021), there were at least twenty such cases identified by NAO.

The Ministry attempted to reduce methadone diversion to improve the success of the MST in the following ways:

- i. As per the SOP, a client must consume the methadone contained in a small flask on spot and dispose the empty flask immediately in a disposable bin, under the supervision of the dispensing personnel. But this protocol was not always complied with. For example, in November 2020, the Pharmaceutical Services reported to the Ministry that during a seven-day period (5 to 11 November 2020), a total of 1,076 flasks were not returned from the six dispensing sites. These flasks were taken away by the clients despite police presence.
- ii. In order to avoid clients taking away the methadone vials without consuming same on the dispensing sites, the Ministry initiated a pilot project of dispensing methadone in plastic cups as from January 2022. Plastic cups containing the methadone could not be easily carried away. The pilot project was expected to cover sites with a small number of clients and dispensing under close monitoring.

As of May 2022, the outcome of the pilot project had not been assessed and no update was provided by the Ministry in its reply of August 2022.

### *B.3.3.3 Results of implementation of the ‘Take-home dose’ Pilot project still outstanding*

Good practices<sup>40</sup> recommend the facilitation of take-home dosages for patients to increase adherence to Opiate Substitution Therapy (OST) and improve its effectiveness, particularly for

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<sup>40</sup> Harm reduction for people who use drugs, March 2020 Geneva, Switzerland, The Global Fund- Page 8- 9. Accessible at <https://harmreductioneurasia.org/wp-content/uploads/2021/01/covid-19-best-practices-eng.pdf>

those who may not live close to the OST service, or those with jobs, children, or other responsibilities that do not allow them to travel to the clinic every day.

Accordingly, in October 2020, a Methadone Take Home Project was envisaged. In June 2021 a ‘Take-home-dose’ pilot project was conceived for patients stable on MST for at least one year. The objectives of the pilot project which was expected to be carried out during the period January-April 2022, were as follows:

- Progress patients through their rehabilitation of opiate addiction;
- Work towards normalising patient’s lifestyles;
- Decrease overcrowding at dispensing sites;
- Decrease burden on Health Services; and,
- Lessen the burden of patients having to travel by public transport to dispensing sites.

As of May 2022, the results of the pilot project were still outstanding and no update was provided by the Ministry in its reply of August 2022.

#### ***B.3.4 Follow-up of clients of Methadone Substitution Therapy***

##### *Key findings*

- *As per the Protocol for the Methadone Substitution Therapy Programme of the Ministry, clients on Methadone Substitution Therapy should be regularly followed up to enhance the associated medical and psychosocial management aspects. However, in 2017 only some 25 per cent of the clients attended medical follow-up.*
- *As of May 2022, based on information gathered from MDCCs and Addictology Units during site visits, there has been no marked improvement in the percentage of methadone clients not attending follow-up.*
- *Also records kept at MDCCs and Addictology Units did not provide adequate information on how feedback from dispensing nurses and local pharmacists were included in the medical files of those not attending follow-ups, new treatment or management plans adopted. The Ministry had limited visibility on whether they were really benefiting from the therapy.*

One of the challenges in the implementation of MST was the loss to follow-up of those who had been inducted but had stopped the therapy or those who continue to consume their daily doses at the dispensing sites but did not attend the follow-up clinics.

As per the Protocol for MST, the frequency of follow-up is as follows:

- (i) Weekly in the first month after discharge from induction;

- (ii) Fortnightly over the subsequent month;
- (iii) Then monthly, 2-monthly or 3-monthly depending on the level of stability and needs of the patient; and
- (iv) The patient is encouraged to attend the drop-in facility at the four methadone treatment centres in case of any difficulties with treatment.

In 2017, the HRU<sup>41</sup> reported to the Ministry that the percentage of methadone clients attending MDCCs had remained around 25 per cent. The majority of clients were lost to follow-up, or more precisely non-attending follow-up and termed as ‘OPD non-attenders’. The HRU recommended that methadone clients attend medical follow-up clinics once monthly in the first instance whereby a Medical Officer would attend to them on an outpatient basis and their methadone prescriptions handed to them. Then they would hand over their prescriptions to the respective pharmacy Departments from where their methadone doses were prepared for dispensing.

The recommendations would have ensured that methadone clients would attend the medical follow-up regularly, which would contribute to improving the psychosocial aspect of the methadone programme. The recommendations were not implemented.

- *Performance gaps identified in the implementation of MST*

As of May 2022, the following performance gaps were identified:

- (i) There was a practice of continuously prescribing daily methadone doses without the clients undergoing any medical examination at regular intervals as required by the MST protocol and legislation.
- (ii) Attendances for follow-up at MDCCs and Addictology Units were continuously low, indicating inadequate psychosocial follow-up on MST clients.
- (iii) The available follow-up capacities in MDCCs and Addictology Units were underutilised.
- (iv) NGOs were not complementing adequately MDCCs and Addictology Units in respect of follow-up of clients on MST.

The details are discussed in paragraphs below.

- *No effective mechanism to gather feedback on those clients not attending follow-up*

A walk-through of the process of the MST protocol indicated that there was no effective mechanism to gather adequate and reliable information on those not attending follow-up over a long period of time. Also, records kept at MDCCs and Addictology Units did not provide adequate information on how feedback from dispensing nurses and local pharmacists were

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<sup>41</sup> Letter dated 12 May 2017, Ministry’s file MHO/METH/ CLIEN V2

included in the medical files of those not attending follow-ups, new treatment or management plans adopted.

The Ministry informed NAO that the main objective for patients on MST is to rehabilitate them, as much as possible, to achieve normal activities of daily living with social and economic empowerment. Through this form of community rehabilitation, patients are encouraged to go to work, take responsibility towards their finance management and budgeting, and stay away from criminal activities which are used to fund their drug habit. So, as patients get more and more stable, they attend follow-up less frequently. Although prescriptions have to be signed every 10 days, patients are not seen every 10 days. Many patients are seen based on their clinical or psychosocial needs. It is very difficult to arrange for 6,600 patients to be seen every 10 days before being issued with prescriptions, taking into consideration that they have been stable on methadone maintenance for years or even more than a decade.

Also, according to the Ministry, the cases of patients not attending follow-up are thoroughly discussed among the multidisciplinary teams. Risks and benefits of treatment and omission of treatment are weighed against the need for rehabilitation through work attendance and other activities. If the HRU felt that there are unmanaged risks that outweigh the benefits, patients are immediately recalled, and a new management plan is adopted.

#### *B.3.4.1 Renewal of methadone prescriptions without clinical examination of methadone clients*

Under the Dangerous Drug Act, the prescription of methadone, classified as a dangerous drug, cannot exceed 10 days. In respect of the majority of clients who did not attend follow-up and hence could not be medically examined, their prescriptions for methadone were continuously renewed every 10 days.

Urine testing for illicit /unauthorized substances is mandatory for clients on Methadone Substitution. In case they are tested positive on three occasions during follow-up, they are liable to be expelled from the MST programme. However, the Ministry did not exercise the option of expelling those who tested positive. During site visits at Sainte Croix MDCC, inspection of a sample of “Urine Tests Charting” records revealed that several patients attending the follow-up were still consuming illicit drugs in addition to benefiting from daily methadone doses.

#### *B.3.4.2 Collaborative psychosocial follow-up by NGOs, Addictology Units and MDCCs*

As per the Protocol for the MST Programme, psychosocial follow-up had to be ensured by a multi-disciplinary team led by a Psychiatrist comprising a Medical Health Officer /Senior Medical Health Officer, Psychologist, Nurse, Health Care Assistant, Medical Social Worker and a representative of the concerned NGO. As of May 2022, based on information gathered from MDCCs and Addictology Units during site visits, the percentage of methadone clients not attending follow-up still remained at a high level. The number of attendances and clinical



examinations by psychiatrists varied among the different units and centres and are described in the following paragraphs.

(i) *Low Attendance at Addictology Units*

During the period 2019-2021, the total attendance at Addictology Units were some 3,900 annually. Attendance for follow-up remained higher at the Addictology Unit of Dr Bruno Cheong Hospital (Flacq) as compared to the Addictology Unit of Dr A.G Jeetoo Hospital (Port Louis). The average monthly attendances per Addictology Unit is as per Table 6.

<b>Table 6</b> Average monthly attendances at Addictology Units during period 2019-2021					
	<b>Dr AG Jeetoo Hospital</b>	<b>Victoria Hospital</b>	<b>Long Mountain Hospital</b>	<b>Mahebourg Hospital</b>	<b>Dr B. Cheong Hospital</b>
<b>2021</b>	14	33	86	105	192
<b>2020</b>	32	29	51	75	108
<b>2019</b>	34	33	63	71	76

*Source: NAO analysis based on data submitted by the Ministry of Health and Wellness*

A further analysis of records over a six-month period in 2021 showed that attendances for follow-up at Dr A.G Jeetoo Hospital was relatively very low as compared to other Addictology Units. In respect of two months (October and December 2021), only one patient attended the Addictology unit monthly. Table 7 refers.

<b>Table 7</b> Average monthly attendances at Addictology Units during six-month period (July- December 2021)					
<b>Year 2021</b>	<b>Dr A.G Jeetoo Hospital</b>	<b>Victoria Hospital</b>	<b>Long Mountain Hospital</b>	<b>Mahebourg Hospital</b>	<b>Dr B. Cheong Hospital</b>
July	29	52	97	104	223
August	19	33	127	104	211
September	2	38	107	105	193
October	1	33	84	111	223
November	4	13	71	111	181
December	1	30	64	94	158
<b>Monthly Average</b>	<b>9</b>	<b>34</b>	<b>92</b>	<b>105</b>	<b>199</b>

*Source: NAO analysis based on data submitted by the Ministry of Health and Wellness*

(ii) *Average of one Client examined by Psychiatrists during period January 2021-March 2022 at Mahebourg and Bouloux MDCCs*

The multi-disciplinary team at each MDCC was led by a Psychiatrist in respect of all three phases of the MST. The number of clients examined by Psychiatrists at the four MDCCs varied over a period of 15-month ending 31 March 2022 as shown in Table 8.

Table 8 Number of clients examined by Psychiatrists at MDCCs during 15-month period ending 31 March 2022						
MDCC	January-December 2021 (12 months)	January 2022	February 2022	March 2022	Total for 15-month period	Monthly Average
Mahebourg	4	0	3	3	10	1
Bouloux	11	0	0	0	11	1
Ste Croix	401	67	29	12	509	34
Frangipane	271	58	35	32	331*	48

*\*Examination at Frangipane MDCC started in August 2021, average computed over 7 months*  
*Source: Ministry of Health and Wellness*

The average number of clients examined on a monthly basis at Sainte Croix and Frangipane MDCCs was above 30 whereas it was only one for both Bouloux and Mahebourg MDCCs. This indicated that the use of specialist psychiatric resources was underutilised.

(iii) *Collaboration of NGOs for follow-up of clients at MDCCs and Addictology Units*

The NGOs are among the first contact for PWUD where they are mainly provided with motivational support, psychosocial support and referral for treatment. Among several services which they provide, the following are considered as core services in respect of which they received funds from NSIF:

- Clients referred to different services and centres based on their addiction and medical conditions.
- Follow-up and after care, in addition to sessions at MDCCs regarding MST.
- Support towards rehabilitation and reintegration in family and society.

As confirmed during meetings with NGOs and the personnel of MDCCs and Addictology Units, NGOs complemented the role of the Ministry through their contact, relations and network with the MST clients. They are familiar with the environment of the clients and intervened outside the working hours of the multi-disciplinary teams of MDCCs and Addictology Units.

- *Inadequate follow-up of clients by NGOs*

Tests were carried out by NAO on two samples to confirm whether NGOs carried out follow-up on clients whom they referred to the MDCC for the MST. Two samples of clients were selected from a list of clients inducted at Sainte Croix MDCC during 2021. These clients were referred by two NGOs and the results were as follows:

1. *Test 1*: In respect of a sample of 40 clients referred by the NGO, the latter had not kept contact with the clients after the induction stage. Only 20 of the clients could be contacted by the NGO during the test to receive feedback, the remaining 20 were untraceable.

2. *Test 2*: In respect of a sample of 11 clients referred by another NGO, the latter had not kept contact with these clients after the induction stage. Table 9 shows the outcome of when attempts were made to contact these 11 clients.

Table 9 Outcome when attempts were made to contact clients on phone	
Client	Response
1	Mother informed that her son is on MST, but she suspects that he is consuming heroin.
2	Client stated he is in good health and trying to reduce methadone dose.
3	Mother informed on phone that her son is better and coping with MST.
4	Could not contact client due to change in phone number.
5	Client stated he is coping with MST and is back to his daily routine and is having good understanding with family.
6	Not responding to calls.
7	Not responding to calls.
8	Brother stated that client is stable, in good health and working.
9	Mother stated that her son is working but the MST dose is insufficient, and son suffering from withdrawal syndrome. MDCC was informed.
10	Not responding to calls.
11	Could not contact client due to change in phone number.
<i>Source: NAO analysis of information collected during site visit /survey</i>	

About 50 per cent of the clients contacted in the two samples could not be contacted through phone calls to obtain feedback. Both NGOs stated that it required manpower and logistics to maintain follow-up on those whom they referred to the MDCC. According to them, the funding they receive from NSIF had to be allocated to other core activities and the remaining funds was insufficient to spend on follow-ups.

During meetings with the representatives of other five NGOs at HRU, the former stated that they had similar challenges regarding manpower and logistics to follow-up clients on MST.

NSIF informed NAO that disbursements to NGOs were made in instalments subject to satisfactory monitoring and reporting of performance. Also, NGOs were required to submit a mid-term progress report and a closure report with details of activities implemented, beneficiaries reached and outputs /outcomes.

However as mentioned at paragraph A.3.1.3, NSIF had put much emphasis on financial monitoring instead of assessing whether the intended benefits were realised out of the funding provided.

## B.4 Treatment through the Suboxone-Naltrexone-based Detoxification Programme

### *Key findings*

- *As of 31 December 2021, some 1,200 People Who Inject Drugs/People Who Use Drugs have undergone detoxification at the Mahebourg Detoxification Centre. This figure includes 227 repeaters who have been treated up to three times and even four times. During the period 2019-2021 some 17 per cent of those admitted interrupted their treatment and were discharged against medical advice.*
- *Some 75 per cent of the 440 patients treated with Suboxone over the two-year period (January 2016- December 2017) had subsequently enrolled on MST programme.*
- *As of May 2022, the multi-disciplinary staff at the Detoxification Centre could not produce to NAO a prescribed Detoxification Treatment Protocol comprising guidelines on treatment plans, pre-admission and post discharge follow-up to minimise the risk of interruption of treatment and relapse.*

In January 2016, the Suboxone Detoxification Programme was introduced at the Detoxification Centre of Mahebourg Hospital following the suspension of new intakes of clients on MST in July 2015. As the heroin drug dependent clients were presenting to treatment at a younger age, detoxification with suboxone<sup>42</sup> rather than maintenance on methadone was the preferred treatment method for this age category.

In January 2017, the results of an assessment of 246 patients who followed the detoxification treatment were as follows:

- 55 per cent of the patients were drug free at end of January 2017.
- Some 80 per cent of the treated patients held stable employment.
- Among those 45 per cent who were not totally drug free, there had been a reduced consumption of opioid drugs, better quality of life and ability to hold employment.

However, heroin addiction being a chronic relapsing disease, there was a likelihood that treated patients would more likely to relapse again, necessitating re-admission for detoxification<sup>43</sup>. The HRU had to work in collaboration with the Addictology Units to achieve the following:

- Work with drug free patients (following detoxification) to prevent them from relapsing back into drug addiction; and

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<sup>42</sup> Suboxone contains two drugs -- buprenorphine and naloxone -- and is approved to treat opioid dependence, also called opioid use disorder. Naloxone is an opioid antagonist added to buprenorphine to block the effects of the opioid medication. Accessible at <https://www.ema.europa.eu/en/medicines/human/EPAR/suboxone>

<sup>43</sup> In July 2022, the Ministry informed that the assessment was extended up to December 2017 whereby the out of the 440 patients treated with Suboxone over the two-year period, the majority (some 75 per cent) subsequently enrolled on MST programme.

- Work with relapsed patients to motivate them back into treatment and into a drug free lifestyle.

The following paragraphs examine whether treatment was carried out as per established official detoxification protocol and treatment plans is examined.

#### *B.4.1 Official detoxification protocol for treatment not submitted*

In November 2015, a draft ‘Clinical guidelines for the treatment of opioid addiction’ was prepared by a Technical Committee comprising resource persons (psychiatrists, doctors and nursing staff) of the Ministry. The guidelines referred to detoxification with buprenorphine<sup>44</sup> and relapse prevention with naltrexone<sup>45</sup>, and had to be vetted by international UNODC experts before its implementation in Mauritius. These clinical guidelines were considered necessary as often relatives of patients held unrealistic expectations regarding the outcome of opioid addiction treatment and were disappointed when they found their close ones could not give up their opioid use or recommenced heroin use after detoxification treatment. The detoxification programme as per the guidelines would not be considered as a stand-alone treatment, but rather as an intermediate step towards long-term abstinence. Relapse prevention strategies would be pivotal to the success of the programme. The draft clinical guidelines comprise the following components: proposed pathway of care, screening and assessments of patients, treatment protocols, admission of patients, psychological therapies, post-discharge care and relapse prevention strategies, and treatment of special groups.

As per records kept by the Ministry and provided to NAO as of April 2022, the draft guidelines were not identified to have been further discussed, and vetted as an official protocol by the Ministry. As of May 2022, the multi-disciplinary staff at the Detoxification Centre could not produce to NAO a formalised protocol comprising all the components of the draft guidelines to administer the detoxification treatment, as opposed to the official protocol for MST.

In July 2022, the Ministry informed NAO that meetings were held in 2016 to revise the draft guidelines, approve and endorse same as an official protocol. However, same were not made available for confirmation.

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<sup>44</sup> Buprenorphine is an opioid (or narcotic) medication used to treat opioid dependence or for moderate-to-severe pain.

<sup>45</sup> Naltrexone is commonly prescribed to treat Opioid addictions. By blocking the harmful effects of Opioids, the medication reduces the cravings usually caused by the drugs.

#### *B.4.2 Official treatment plan for detoxification not available*

As per good practices<sup>46</sup>, the choice of treatment and development of an individualised treatment plan for a person with a drug use disorder should be based on: a detailed assessment of treatment needs; the treatment's appropriateness to meet the needs; the patient's acceptance of the treatment, and its availability. All patients should have individualised treatment plans that include some short-term goals while taking a long-term perspective.

During a visit at the Detoxification Centre it was noted that individual 'Treatment Plans' were not prepared and maintained for the clients. Though individual treatment records were kept, good practices<sup>47</sup> recommend that a treatment plan is developed cooperatively with the person seeking treatment, the plan is followed, and that treatment expectations are clearly understood. Such a plan promotes a continuing care approach with the treatment intensity varying according to person's changing needs, and provides the best results.

During the six-year period (January 2016- December 2021), there had been 1,229 admissions at the Centre involving 1,002 new cases and 227 repeaters. Sample tests on the records revealed that there were at least 15 patients who had been re-admitted up to three times for detoxification and five patients re-admitted up to four times. There was one case where a patient had been re-admitted up to seven times.

The Centre did not maintain a waiting list for treatment. Clients were admitted after screening and assessment as and when they presented themselves for treatment. Sample checks over admissions during a three-year period (2019-2021) revealed that out of 579 admitted, 101 patients interrupted their treatment and sought discharge against medical advice (DAMA). The reasons included misbehaviour and consumption of drugs during admission.

#### *B.4.3 Inadequate follow-up of patients who benefited from detoxification treatment*

The HRU and the Addictology Units were challenged in their tasks of working with drug free patients (following detoxification) and relapsed patients to motivate them back into treatment and a drug free lifestyle.

A survey on a sample of 20 patients who underwent treatment during 2021 was carried out to assess whether they attended follow-up at the Mahebourg Hospital Addictology Unit. As per available records, some 75 per cent did not attend post-treatment follow-up.

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<sup>46</sup> International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing. Geneva: World Health Organization and United Nations Office on Drugs and Crime; 2020. License: CC BY-NC-SA 3.0 IGO, page 38

<sup>47</sup> Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) Page 12, Revised January 2018, National Institute on Drug Abuse; National Institutes of Health; U.S Department of Health and Human Services. Accessible at <https://nida.nih.gov/sites/default/files/675-principles-of-drug-addiction-treatment-a-research-based-guide-third-edition.pdf>

A further sample test was carried out on patients who were referred by the Dr A.G Jeetoo Hospital Addictology Unit for treatment at the Detoxification Centre, to ensure whether they attended the Unit for post-treatment follow-up. Most of the patients in the test sample did not attend follow-up and could not be contacted by the personnel.

Those patients who could not be contacted, were not referred to NGOs who could have tried to establish contact and refer them back for follow-up. During meetings with NGOs representatives, the latter explained that they could not always carry out follow-up properly due to insufficient human resources and logistics.

#### *B.4.4 Outcomes of treatment not regularly assessed*

As of May 2022, no assessment had been carried out to ascertain the outcome of treatment provided by the Centre since the last assessment of 2017. This could have provided valuable feedback on what corrective actions need to be taken to maximise benefits in relation to the resources applied in treatment. For example, better insight could have been available on the following:

- Why some 17 per cent of patients admitted had interrupted their treatment during 2019-2021;
- Repeated admissions of several patients; and
- The need to include NGOs in the process of follow-up of patients.

### **B.5 Treatment and Rehabilitation for minors and young people at Nénuphar Centre**

#### *Key findings*

- *The Nénuphar Centre did not have an official treatment protocol similar to that of the Methadone Substitution Therapy, accompanied by individualised treatment plans for patients.*
- *No detailed assessment was carried out by the Centre to assess the outcome since it started its operation in August 2018. A survey was carried out by the Centre for the 11-month period (January-November 2021). Out of the 40 admissions during this period, some 40 per cent were lost to follow-up and some 40 per cent maintained their abstinence from drugs over a period of more than six months. However, the survey did not cover aspects such as the proportion of those who were abstinent, held stable employment, resumed studies and had a better quality of life.*

Since August 2018, the Nénuphar Centre at Long Mountain Hospital has been offering Treatment and Rehabilitation services on a six-week residential basis for minors and young people under the age of 24.

The Centre did not have an official treatment protocol similar to that of the MST, accompanied by individualised treatment plans for patients.

An analysis of the admissions during the period August 2018-December 2021, revealed that the proportion of patients below 18 years and those repeatedly admitted was significant. For example, in 2020, 60 per cent of those admitted were below 18 years and some 33 per cent had repeated admissions. Table 10 refers.

Table 10		Details on patients admitted during period 2018-2021	
Period	Details on number of admissions age of patients	New / Repeated admissions	Remarks on drug consumption
August-December 2018	47 admissions <i>19 patients were less than 18 years old</i>	<i>7 patients admitted more than once</i>	62 per cent of those admitted stated having consumed cannabis as well as synthetic drugs
2019	99 admissions <i>58 patients were between 13 to 18 years old</i>	46 New and <i>53 Repeated admissions</i>	
2020	65 admissions <i>39 admissions were between 13 to 18 years old</i>	43 New and 22 <i>Repeated admissions</i>	Synthetic drugs predominantly consumed by patients
2021	68 patients admitted <i>9 patients below 18 years</i>	<i>11 patients admitted more than once</i>	

*Source: NAO Analysis based on Ministry of Health and Wellness and National Drug Secretariat Records*

A test on a sample of twenty patients discharged during 2019-2021 revealed the following:

- Some 50 per cent of patients when discharged were attending follow-up regularly;
- Some 20 per cent of patients were lost to follow-up;
- Some 30 per cent of patients were not attending follow-up regularly;
- Some 45 per cent of patients were at least admitted three times. Two patients were admitted six times and one up to 10 times.

Table 11 refers.



Table 11	Details on Patients admitted and attending follow-up		
Patient Serial Number in Sample	Age of Patient	Number of Admissions	Remarks on follow-up
1	16	1	Regularly attending follow-up
2	18	1	Regularly attending follow-up
3	15	3	Regularly attending follow-up
4	20	2	Regularly attending follow-up
5	15	2	Lost to follow-up for the last 7 months
6	19	2	Regularly attending follow-up
7	21	1	Lost to follow-up for the last 8 months
8	20	1	Lost to follow-up for the last 5 months
9	20	2	Regularly attending follow-up
10	15	10	Regularly attending follow-up
11	19	4	Regularly attending follow-up
12	21	3	Regularly attending follow-up
13	18	2	Regularly attending follow-up
14	19	6	Lost to follow-up for the last 12 months
15	18	3	Not attending follow-up regularly
16	22	1	Not attending follow-up regularly
17	21	6	Not attending follow-up regularly
18	19	4	Not attending follow-up regularly
19	21	3	Not attending follow-up regularly
20	18	2	Not attending follow-up regularly

*Source: NAO Analysis based on Ministry of Health and Wellness Records*

No detailed assessment was carried out (similar to that carried out at Mahebourg Detoxification Centre in 2017) by the Centre to assess the outcome since it started its operation in August 2018. A survey was carried out by the Centre for an eleven-month period (January-November 2021). Out of the 40 admissions, some 40 per cent were lost to follow-up and some 40 per cent maintained their abstinence from drugs over a period of more than six months. However, the survey did not cover aspects such as the proportion of those who were abstinent, held stable employment, resumed studies and had a better quality of life.

## SECTION C: Rehabilitation and Social Integration

*The section examines the aspects related to the social integration and rehabilitation of People Who Use Drugs (PWUD).*

### C.1 Introduction

Drug use problems are often associated with significant difficulties in the personal lives of PWUD. The problems may include a breakdown in family life and personal relationships, financial problems, low educational achievement, and loss of employment or accommodation. Where these difficulties arise, other forms of social support and reintegration interventions may be required for the treatment of drug addiction is to be effective in the long-term.

In this section, the collaboration of the Ministry with other stakeholders to put in place a well- structured programme for the social integration and rehabilitation programme for people who have been using drugs and ex-detainees is discussed.

### C.2 Rehabilitation Programme in the community

#### *Key findings*

- *The interventions of the Ministry focused mainly on the medically assisted therapy and the psychological aspects were left to Non-Governmental Organisations, which most of the time were offering basic counselling and support services.*
- *In 2020, the Ministry designed a pilot project for 'Psycho-socio-rehabilitation' for People Who Use Drugs as a rehabilitation programme to help them develop skills and attitudes to make long-term changes toward reintegration into mainstream society. However, as of May 2022, the implementation of the pilot project was still outstanding.*

The rehabilitation and social reintegration of former PWUD or those on treatment have not received sufficient attention or the funding they deserve<sup>48</sup>. The Strategic Objective 2.8 recommended the strengthening of the rehabilitation and reintegration services to PWUD/PWID within mainstream society.

- *Rehabilitation Programme and Plan not available*

As per the notes of meetings of the Drug Treatment and Rehabilitation Committee of February and June 2020, a structure for a Rehabilitation Programme had been set up at the level of the HRU. Also, a Rehabilitation Plan was reported to have already been formulated and which required scaling up. However, as of May 2022, neither the Programme nor the Plan was made available to NAO.

<sup>48</sup> The National Drug Control Master Plan 2019-2023- Page 31.

- *Implementation of Pilot Project for Rehabilitation of PWUD still outstanding*

A Pilot Project for the rehabilitation of PWUD was envisaged in January 2020 by the Ministry<sup>49</sup> on the following grounds:

- (i) the Ministry was focusing mainly on the medically assisted therapy and the psychological aspects of treatment were exclusively left to NGOs which most of the time were offering basic counselling and support services.
- (ii) With the emergence of synthetic drugs, the provision of high quality, comprehensive psychosocial care and rehabilitation services has become more pressing than ever, given that young adolescents who experienced synthetic substances could fall easy prey to other more addictive substances.

The Pilot Project was designed to address three core strategic interventions alongside medically assisted therapy and were namely psychological therapy, occupational therapy and socio-economic empowerment.

The Project with a duration of two years was proposed to start in July 2020. As of May 2022, its implementation was still outstanding.

As opposed to the findings of the NDCMP and the Report of HRU of January 2020, the Ministry contended in July 2022 that psychosocial rehabilitation has been implemented at both MDCCs and Residential Rehabilitation wards for a long time. Structured rehabilitation programmes are carried out by the Ministry's health professionals as well as staff and counsellors from NGOs.

### **C.3 Social Integration and Rehabilitation of detainees and ex-detainees**

#### *Key finding*

*The coverage of social reinsertion and rehabilitation of ex-detainees was low compared to the large population of ex-detainees.*

The prison population has a disproportionately high percentage of the most marginalised groups, such as PWUD and those who engage in sex work<sup>50</sup>. Some 38 per cent of persons charged or appearing before courts or brought within the criminal justice system had issues with drugs<sup>51</sup>.

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<sup>49</sup> Report of the Harm Reduction Unit of January 2020 titled 'Rehabilitation Programme for People Who Use Drugs'

<sup>50</sup> The National Drug Control Master Plan 2019-2023. Paragraph 2.15, Page 24

<sup>51</sup> As per the Report of the Commission of Inquiry on Drug Trafficking of 2018. Paragraph 17E.4. Page 202.

- *Increasing trend in reported drug-related offences, arrests and convictions during 2017-2021*

During the period 2017-2021, the number of reported offences and arrests effected in the Republic of Mauritius has been increasing as shown in Table 12.

Table 12		Drug offences reported, arrests, convictions and on remand during period 2017-2021				
	2017	2018	2019	2020	2021	
Drug Offences Reported <sup>52</sup>	3,719	4,267	4,906	5,268	4,826	
Arrested for Drug Offences (by ADSU)	2,294	2,774	3,064	3,387	3,658	
Convicted by Court and admitted to prison	295	327	326	249	312	
Admitted in remand pending trial	n/a	n/a	2,957	n/a	n/a	
<i>n/a: not available</i>						
<i>Source: Digest Crime, Justice and Security Year 2020 of Statistics Mauritius and Prison Service.</i>						

The prison population comprised those who had been convicted and those who were on remand<sup>53</sup>.

Table 13 shows the number of adult convicts admitted by number of previous imprisonments in the Republic of Mauritius during period 2017-2021. Out of every two admissions, at least one admission related to two or more previous admissions.

Table 13 Number of adult convicts admitted by number of previous imprisonments in the Republic of Mauritius during period 2017-2021					
Number of admissions	2017	2018	2019	2020	2021
No Previous	1,318	1,080	1,202	929	939
One	743	557	655	563	461
<i>Two or more</i>	<i>2,190</i>	<i>1,990</i>	<i>2,041</i>	<i>1,836</i>	<i>1,901</i>
Total	<b>4,251</b>	<b>3,627</b>	<b>3,898</b>	<b>3,328</b>	<b>3,301</b>
<i>Source: Digest Crime, Justice and Security Year 2020 of Statistics Mauritius</i>					

The Prison Service did not keep statistics on how many of the re-offenders relate to drug cases during the period 2017-2021<sup>54</sup>.

The Master Plan recommended that more detainees should be induced to MST, psychosocial support and reinsertion by NGOs be maintained together with the enhancement of Rehabilitation Programmes at Lotus centres at Beau Bassin and Eastern High Security prisons. A Memorandum of Understanding (MOU) between Mauritius Prison Service, NGOs and the Ministry of Social Integration, Social Security and National Solidarity was recommended to dispense vocational and other relevant training to detainees to prepare them for release and to

<sup>52</sup> includes importation, cultivation, dealing and possession.

<sup>53</sup> those who were arrested and admitted to prison pending the settlement of the court cases.

<sup>54</sup> As per information received from personnel of the Prison Service during site visits.

facilitate their integration in society.

In the following paragraphs, the implementation of these recommendations is discussed.

### **C.3.1 Re-induction of detainees to MST after a break of three years**

A Methadone Induction Unit was set up at the Central Prison since December 2011 for inducing and dispensing of methadone to eligible person who use drugs. Medical personnel of the HRU attend this Methadone Induction Unit on a weekly basis. Detainees who entered prisons while enrolled on a community methadone substitution programme were encouraged to continue their MST treatment during their incarceration period. As of December 2018, some 350 detainees had been induced on methadone at prison level. The induction of new detainees was stopped over several years. Induction of new detainees was reported to be reintroduced in March 2022.

### **C.3.2 Implementation of the programme for the training and social integration of detainees not yet started**

In June 2020 it was reported<sup>55</sup> that the MOU had already been drafted and the legal vetting was in process. One year later, in August 2021, it was reported<sup>56</sup> that the MOU had already been signed and a coordination committee had been set up in respect of same. Through the MOU, the Project ‘Collaborative Training and Social Integration of Detainees’ could be implemented to pursue the economic empowerment and reinsertion of detainees with a view of facilitating their social integration. The following would be achieved through:

- Treatment and rehabilitation services of detainees involved in substance abuse;
- The integration of detainees into mainstream society;
- Sensitisation campaign with the public to accept ex-detainees as part of society by working in close collaboration with organisations within civil society;
- Provision of life skills training in prison with detainees who will be released shortly; and,
- Implementation of specific programmes aiming at starting a micro business/and or employment.

As of May 2022, the Project had not started at the Prison Service.

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<sup>55</sup> As per meeting of 11 June 2020 of Treatment and Rehabilitation Committee

<sup>56</sup> As per meeting of 10 August 2021 of Treatment and Rehabilitation Committee

### C.3.3 Rehabilitation programme at the Lotus Centre adversely impacted

A Drug Rehabilitation Unit, the Lotus Centre, provided rehabilitation activities to PWUD at Beau Bassin Central Prison and Eastern High Security Prison. Several programmes were designed and implemented for the rehabilitation of detainees and are as per Table 14.

<b>Table 14 Rehabilitation Programmes at the Lotus Centre</b>		
<b><i>Information Desk</i></b>	<b><i>Counselling</i></b>	<b><i>Psychosocial Support</i></b>
1. Information – Education – Communication 2. Drug Prevention Programme 3. Peer Support Structure	1. Faith-based Therapy 2. Psychological Support 3. Service D’Ecoule	1. Individual Counselling 2. Group Therapy 3. Pre-Release Programme 4. Post- Release Programme
<b><i>Fitness Programme</i></b>	<b><i>HIV/AIDS</i></b>	<b><i>Health Issues</i></b>
1. Keep Fit 2. Yoga & Meditation 3. Tai Chi Chuan	1. Treatment Literacy 2. HIV Rapid Test 3. Seminars 4. Psychological Support	1. Harm Reduction 2. Methadone Substitution Therapy (MST) 3. Induction MST 4. Hepatitis C, Tuberculosis COVID -19
<b><i>Collaborators:</i></b> NGOs, Ministry of Health & Wellness (AIDS Unit; HRU) and Religious Bodies		
<b><i>Source:</i></b> Mauritius Prison Service		

However, several issues were identified which impacted on rehabilitation and social re-insertion of detainees as follows:

(a) *Practical difficulties encountered in respect of detainees on remand and with a relatively short length of stay in prisons*

Most of the prisoners related to drug cases were on remand pending the settlement of their court cases. For example, in 2019, on average, 246 detainees were admitted monthly for drug cases while those convicted were on average 27 monthly. The Prison Service encountered practical difficulties to plan and implement rehabilitation activities for those on remand as their length of stay could not be ascertained in advance.

Even in respect of those who were convicted and their lengths of stay were known, on average, 75 per cent of the detainees were sentenced to six months or less imprisonment. Table 15 refers. This also caused practical difficulties to plan and implement rehabilitation activities for them.

Table 15 Convicts admitted to prisons for imprisonment up to six months during period 2017 – 2021 (Republic of Mauritius)					
	2017	2018	2019	2020	2021
Number of convicts admitted to prisons <sup>57</sup>	3,205	3,003	3,343	2,965	3,106
Imprisonment up to six months	2,459	2,209	2,439	2,260	2,544
Percentage of convicts with up to six months imprisonment	77	74	73	76	82

*Source: NAO Analysis of the Digest Crime, Justice and Security Year 2020 of Statistics Mauritius*

*(b) Coverage of reinsertion and rehabilitation activities for ex-detainees was low*

During the period 2019-2021, neither NSIF nor NDS assessed the coverage of the rehabilitation activities reported to be carried out by NGOs and their outcome. Though there were interventions to rehabilitate ex-detainees, the coverage was low compared to the number of detainees who were imprisoned and released subsequently. Details of some social re-insertion and rehabilitation activities as per information gathered from Prison Service are as follows:

- (i)* The Prison Service reported that one NGO (not benefiting from grants from NSIF) had supported the dispensing of masonry courses to some 40 detainees at Petit Verger Prison. The course was also coupled with life skills programme, employability programme and other relevant support which helped towards the resettlement of those detainees. Individual case management was administered by the NGO. After their imprisonment, the detainees were being supported and assisted to seek employment with an established list of prospective employers.
- (ii)* Another NGO (benefiting from a grant from NSIF) had a programme which targeted the reduction of recidivism of inmates, juveniles and re-integration of ex-inmates and juveniles. As per its project document to support the request for funds from NSIF in 2021, it planned to target some 400 beneficiaries (ex-detainees, ex-juveniles and their families) and 80 detainees at Lotus Centre of Melrose Prison.

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<sup>57</sup> Excludes: Fine defaulters are convicts sentenced to imprisonment for non-payment of fines; they either stay in prison according to the amount owed or are released as soon as they pay the fines.

## SECTION D: Harm Reduction Interventions

*This section describes the harm reduction services provided and examines the implementation of the Needle Exchange and Methadone Substitution Therapy (MST) programmes.*

### D.1 Introduction

Comprehensive harm reduction services—including needle/syringe exchange programmes, drug dependence treatment, overdose prevention with naloxone, and testing and treatment for HIV, tuberculosis, and hepatitis B and C—have been demonstrated to reduce the incidence of bloodborne infections, problem drug use, overdose deaths and other harms<sup>58</sup>.

Needle Exchange Programme and Methadone Substitution Therapy are two of the Harm Reduction programmes provided by the Ministry. These two programmes were reported to be effective in reducing the HIV epidemic that has long been driven essentially by PWID.

The following paragraphs describe the issues relating to whether the Ministry was effective in providing and maintaining adequate coverage and uptake of harm reduction interventions.

### D.2 Providing and maintaining adequate coverage and uptake of Methadone Substitution Therapy

#### *Key finding*

*Though the Ministry invested significantly in harm reduction treatment through the Methadone Substitution Therapy, it did not ensure that those uptaking the treatment were adequately followed up to remain in treatment. Some 4,600 clients who were inducted to methadone were lost to follow-up. The Ministry did not devise an appropriate strategy to identify those who could be potentially reinstated to treatment.*

A One Stop Shop at Bouloux MDCC was operational since December 2019 where patients who were on MST and infected with HIV, were being offered treatment under the same roof. Anti-Retroviral Treatment was being dispensed for these patients at the pharmacy of Bouloux Area Health Centre.

- *Inadequate uptake of treatment by PWID and PWUD*

According to the 2017 IBBS Survey, about one-third of the people who were actively injecting drugs were at the same time on the methadone substitution programme. People

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<sup>58</sup> The UNAIDS report Health, Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People Who Use Drugs (2019). Accessible at [https://www.unaids.org/en/resources/documents/2019/JC2954\\_UNAIDS\\_drugs\\_report\\_2019](https://www.unaids.org/en/resources/documents/2019/JC2954_UNAIDS_drugs_report_2019)



with 15-24 years of injecting drug practices accounted for 44 per cent of PWID. None of those with one year or less of injecting drug use, were reported to be on methadone. About half of PWID have received some kind of treatment and/or psychological support for problems associated with drug injecting use.

As per the 2020 IBBS Survey, nearly half of PWID had ever received treatment or psychological support and only about one-third of them were currently under treatment. Methadone Substitution Treatment was the most popular treatment, adopted by an estimated 30 per cent of the total number of PWID. Other treatments comprised outpatient counselling, detoxification, self-help group and residential rehabilitation treatment.

As per the December 2021 'National Survey Among People Who use Drugs', just over one-quarter of PWUD have ever sought treatment for non-injecting drug use. Some 22 per cent of PWUD have ever experienced blackout or flashbacks, 79 per cent have experienced withdrawal symptoms, 13 per cent experienced medical problems and 10 per cent overdosed as a result of drug use.

The following were noted in respect of uptake of the treatment:

- (i) An estimated 50 per cent of PWID did not avail themselves of treatment in respect of their drug use.
- (ii) Only about one-third of PWID was estimated to be on MST.
- (iii) Though some 79 per cent of PWUD had ever experienced withdrawal symptoms, the majority of them had not sought treatment.

Though the Ministry invested significantly in harm reduction treatment through the MST, it did not ensure that those uptaking the treatment were adequately followed up to remain in treatment. As mentioned in paragraph B.3.1, some 4,600 clients who were inducted to methadone were lost to follow-up. The Ministry did not devise an appropriate strategy to identify those who could be potentially reinstated to treatment.

Also, the Ministry could have monitored its performance over time by setting targets for its drug dependence treatment in relation to harm reduction for PWID. As of December 2021, the percentage of active drug injectors on MST was around 30 per cent (as per the 2020 IBBS Survey mentioned above) which was in the medium range scale of 20 to 40 per cent<sup>59</sup> coverage level. Extension of MST to a larger number of PWID could attain or even exceed the 40 per cent high target level achieved in countries with well-established MST programmes.

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<sup>59</sup> WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users- page 21. Accessible at <https://www.who.int/publications/i/item/978924150437>

According to the Ministry, the retention rate<sup>60</sup> of people enrolled on the MST programme is indicative of the success of the programme. Instead of calculating the retention rate on people who has been inducted since 2006 (some 11,300 as of March 2022), a smaller sample was used. As of July 2022, the retention rate was 81 per cent in respect of a cohort of 700 patients (those inducted between 01 June 2017 and 31 July 2018), which the Ministry found to be favourably comparable with those in European countries.

### **D.3 Provision and maintenance of adequate coverage and uptake of Needle Exchange Programme**

#### *Key finding*

*The 2020 Integrated Biological and Behavioural Surveillance survey indicated that HIV prevalence among People Who Inject Drugs in Mauritius, has continued on its decreasing trend. However, no survey had been carried out in respect of the reduction in illicit drug use among those on Methadone Substitution Therapy given that some 75 per cent on the therapy did not attend follow-up.*

Since 2006, the Ministry has been carrying out the NEP throughout the island. NEP is the distribution of clean needles and syringes, as well as other accessories and additional services to PWID. The additional services include male and female condom distribution, rapid HIV testing, pre- and post-counselling, and referrals to other welfare and health services. The main aim of NEP is to reduce transmission of HIV and other blood-borne viruses via sharing of injecting equipment, and also to minimise other harms related to injecting drug use.

Needle and syringe exchange were delivered through mobile caravans by the Ministry. The two NGOs maintained fixed sites, one mobile caravan and also employed backpack outreach workers and peer educators for the distribution. Mobile caravans, backpack outreach and field workers covered the NEP sites in discreet locations to maximise confidentiality and encourage attendance. Through these means, services were provided to existing and potential new clients where hard-to-reach and ‘hidden’ populations (e.g., sex workers, Men having Sex with Men and women who inject drugs) need services.

The Ministry provided all the required injection equipment and funding for field workers’ allowances. As of December 2020, NEP services were being provided at 45 sites (37 sites by the Ministry and 8 sites by two NGOs.).

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<sup>60</sup> The proportion of persons still on MST programme after adjusting for those who passed away and drop-outs.

*(a) Gaps in coverage and uptake of NEP facilities*

The following were observed in respect of NEP as per two last IBBS Survey carried out, using Respondent Driven Sampling:

1. The 2017 IBBS Survey estimated the size of PWID to be around 6,000 and only some 52 per cent (estimated 2,900 PWID) were on NEP. Some 41 per cent of the PWID who were not on NEP, bought their equipment from pharmacies.
2. The 2020 IBBS Survey (published by the Ministry in July 2021) estimated the size of PWID to be around 6,600 active injectors and their awareness and use of NEP were as follows:
  - Some 11 per cent of the PWID have never heard of NEP.
  - About 35 per cent heard of NEP, but never attended the programme
  - Some 17 per cent attended NEP but were not on the program during the survey.
  - The remaining, some 37 per cent, were on NEP.
3. Out of the 52 per cent who either heard of NEP but never attended the programme or had attended NEP but not using it during the survey, the underlying reasons were as follows:
  - Some 38 per cent bought their injecting equipment from pharmacies.
  - About 29 per cent were not interested.
  - Some 23 per cent found the NEP site too far.
4. There has been a considerable reduction of 60 per cent in HIV prevalence among PWID during the period 2011-2020. However, the infection rate of 21 per cent among PWID was still considered high concentrated infectivity.
5. Hepatitis C was still very high (90 per cent) among PWID, not only because of the obvious reason that injecting practices are known to favour high and rapid transmission of this virus, but also as a result of drug users staying for many years on injecting practice.
6. In 2020, many PWID continued with risky behaviours, exposing themselves and their peers to HIV and hepatitis C infections. In a period of less than three months, around one-quarter of them had shared previously-used needles/syringes, while one-quarter of this subgroup had respectively more than four injecting partners. Furthermore, in a year they had an average of 12 needle sharing partners.
7. Most PWID having started non-injecting drugs had eventually moved to injecting method after two years or more. Non-injecting drugs are extensively used by PWID and act as the potential gateway to injecting drug practice. Synthetic drugs are gradually laying its grasp among PWID, apart from other non-injecting drugs.

The above observations indicated that the effectiveness of the NEP was impacted by the following two significant gaps:

- (i) There was a 41 per cent gap between access to new sterile needles/syringes and their utilisation, and
- (ii) A 40 per cent gap between awareness and utilisation.

As of May 2022, the Ministry had not yet initiated measures to close the gaps between access and utilisation, and awareness and utilisation.

*(b) Precise information on NEP beneficiaries not maintained*

During the period 2017-2020, the Ministry and an NGO distributed some 3.2 million syringes/needles under the NEP. The Ministry distributed annually an average of 400,000 while the NGO distributed an average of 392,000 syringes/needles. In addition to providing the syringes/ needles, the Ministry also paid a monthly allowance of Rs 50,000 to the NGO.

In February 2018, the HRU reported that there was an ongoing issue about the real number of PWID being provided with syringes/ needles by the NGO. In respect of the syringes/ needles provided by HRU on behalf of the Ministry, precise records on the identities of the PWID were kept and updated annually. In contrast, the NGO did not provide the identities of the beneficiaries to whom it was providing the syringes/needles. Instead of providing the number of the beneficiaries with precise details on their identities, it provided only the number of attendances during the deliveries made. This rendered verification by the Ministry impossible, and there appeared to be a duplication of NEP services among the beneficiaries.

As of May 2022, in the absence of precise records at NGOs, the Ministry did not have a precise record of the total number of beneficiaries under NEP. This record was important to assess the coverage NEP services and whether it was at a reasonable level to minimise the risk of transmission of blood-borne diseases by PWID.

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## SECTION E: Oversight by the National Drug Secretariat

*This Section examines whether there is adequate coordination, monitoring and evaluation of the activities related to harm and drug demand reduction.*

### E.1 Introduction

In the NDCMP, a governance structure was recommended which included NDS for the implementation of the associated strategic objectives. NDS was set up as an apex body in March 2019. In that perspective it had to plan, coordinate, oversee, monitor and ensure evaluation of all drug control-related policies, programmes and interventions to achieve greater coherence, results and impact. NDS was expected to provide advice on the strategic vision and overall policy direction on all drug control-related matters. In respect of funding aspects, it had to advocate and mobilise the resources needed to achieve the goals and objectives set.

Equally important are two of its main objectives which are to ensure that:

- Demand reduction activities, namely the prevention of drug use, the treatment of drug use disorders and the rehabilitation of PWUD including those in prisons, are evidence-based and carried out in line with international standards and best practices.
- Harm reduction activities aiming at reducing blood-borne infections and improving the quality of life of PWUD, and people who are in prisons are evidence-based and carried out in line with international standards and best practices.

The following paragraphs examine the oversight role of NDS with focus on drug demand and harm reduction interventions.

### E.2 Formulation of a national drug policy to reduce harmful social and health consequences among People Who Use Drugs

#### *Key finding*

*The Strategic Objectives 4.4 of the NDCMP recommended the formulation of a national drug policy to reduce harmful social and health consequences among PWUD. As of May 2022, the formulation of this policy had not been considered by NDS.*

The Strategic Objectives 4.4 of the NDCMP recommended the formulation of a national drug policy to reduce harmful social and health consequences among PWUD. Generally, a national drug policy is a commitment to a goal and a guide for action. It expresses and prioritises the medium to long-term goals set by the Government and identifies the main strategies for attaining them. It also acts as a formal record of aspirations, aims, decisions and commitments. Without such a formal policy document there may be no general overview of what is needed. As a result, some Government measures may conflict with others, because the various goals and responsibilities are not clearly defined and understood. Every drug policy needs a master

plan, each component of the policy needs a detailed strategy and specific action plans.

- *The National HIV and AIDS Policy 2010 as a relevant example of policy*

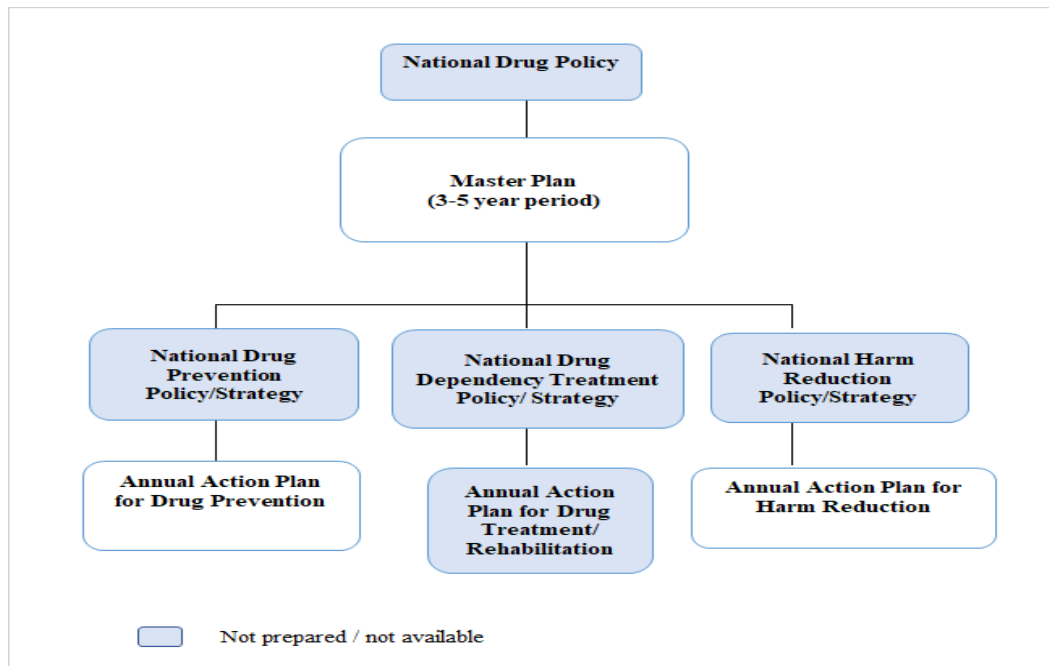
A relevant example is the National HIV and AIDS Policy 2010 which was developed by the National AIDS Secretariat for the control of HIV/AIDS. This policy document provides regulations and guiding principles on topics ranging from prevention of new infections and behaviour change, treatment, care and support for infected and affected persons, advocacy, legal issues and human rights, monitoring and evaluation, research and knowledge management and policy implementation by various stakeholders in the national response.

- *Operation Plan for one year only instead of five years*

As of May 2022, as required by NDCMP, the formulation of a drug policy to reduce harmful social and health consequences among People Who Use Drugs (PWUD) had not been considered by NDS. The NDCMP defined the strategic objectives which had to be achieved under each pillar, the activities, outputs, indicators and outcomes for a five-year period. It included an operational plan for Year 1 only with the amount budgeted for each objective set. In contrast, the National AIDS Secretariat had prepared a National Action Plan (NAP) for HIV/AIDS over period 2017-2021 and annual operational plans are prepared based on the NAP with clear monitoring indicators set. Similarly, in July 2020, the Ministry prepared a National Action Plan to reduce the harmful use of alcohol for the period 2020-2024 based on its HSSP 2020-2024.

- *NDS acknowledged the need for a policy against substance abuse in specific sectors*

Figure 5 illustrates the policies, strategies and action plans available as of May 2022 in respect of drug demand and harm reduction.



Source: NAO Analysis, WHO – ‘How to develop and implement a national drug policy’<sup>61</sup>  
 Figure 5: Policies and Strategies on Drug Control

In July 2022, NDS informed NAO that:

- NDCMP represented the National Drug Policy;
- It acknowledged the need for a policy against substance abuse in specific sectors;
- The drug phenomenon is a dynamic issue and new challenges and threats keep coming up like the recent synthetic drug problem or other emerging illicit substances or new trafficking mechanisms put in place by drug traffickers;
- Policies and strategies need to be revisited regularly to respond to the drug problem in a holistic manner; and
- After 2023, the NDCMP will be revisited in the light of new challenges and programmatic gaps.

### E.3 Funding arrangements for Drug Demand and Harm Reduction Interventions

#### *Key findings*

- *As of May 2022, there was no clarity on the precise amount of resources being mobilised to finance drug demand and harm reduction interventions compared to expenditures on control over drug supply.*
- *The absence of clarity on expenditures relating to drug demand and harm reduction did not ensure that the right balance was realised in the allocation of resources among drug control interventions.*

<sup>61</sup> WHO – ‘How to develop and implement a national drug policy. Accessible at <https://www.who.int/publications/i/item/924154547X> Chapter 2 Page 11



As per the NDCMP, the core budget required for the implementation of the Plan would come from Government and would be mainly derived from the annual budgets allocated to Ministries and Departments. This would be supplemented by the Corporate Social Responsibility (CSR) Foundation funds managed by the Ministry of Finance and Economic Planning and Development, presently NSIF. It was expected that other international development partners may contribute to specific items through grants or direct implementation.

The objectives of the Ministry as per the HSSP 2020-2024 include:

- Implementation of the recommendations of the NDCMP; and
- Prevention and reduction of the negative health and social consequences of substance use and addiction.

However, neither the budgetary estimates of the Ministry nor that of other Ministries/Departments (identified as lead agencies for specific tasks) have dedicated programmes for expenses related to drug demand reduction or harm reduction. In its Report of November 2020, the Public Accounts Committee drew the Ministry's attention to the importance of matching strategies and action plans with available financial resources. Box 2 refers.

**Box 2 Extract from PAC Report of November 2020**

*The budgetary estimates of the Ministry of Health do not have a dedicated section for tackling the drug scourge. There exists only a single budget line for the year 2017-18 and two budget lines for the year 2018-19 items. These are included under the sub-section "Treatment and Prevention of HIV and AIDS", whereas this issue goes far beyond HIV and AIDS.*

Table 16 shows the expenditure on drug control activities under respective items for concerned Ministries and Departments.

Table 16		Expenditure in respect of drug control activities over last five years				
	Estimates 2021-22	2020-21	2019-20	2018-19	2017-18	
	Rs m	Rs m	Rs m	Rs m	Rs m	
<b>Ministry of Rodrigues, Outer Islands and Territorial Integrity</b>						
National Drug Secretariat	7	3.6	2.1	-	-	
<b>Ministry of Health and Wellness</b>						
<b>Treatment and Prevention of HIV &amp; AIDS</b>						
<i>Purchase of methadone, bottle flasks and allowances to peers</i>	N/A	15.3	6.3	3.6	2.5	
<i>Multisectoral response to HIV/AIDS Programme</i>	25	22.1	16.5	15.5	18.7	
<i>Rehabilitation Programme for Alcoholics and Drugs (Grant to NGOs)</i>	-	-	9.2	17	17	
<i>Synthetic Drugs Prevention Programme</i>	8.5	0.8	0.2	5.8	-	
<b>Police Service</b>						
Combating Drugs	264.2	248.8	291.6	251.4	235.9	
<b>Global Fund</b>						
	\$507,303	\$124,912	N/A	N/A	N/A	
		<b>2021 Jan – June Rs m</b>	<b>2020 Jan -Dec Rs m</b>	<b>2019 Jan -Dec Rs m</b>	<b>2018 Jul – Dec Rs m</b>	
<b>Grant to NGOs- National Social Inclusion Foundation (NSIF)</b>		16.3	29.6	30.6	7.6	
<i>N/A – not available</i>						
<i>Source: NAO Analysis based on figures obtained from Treasury Accounting System and NSIF</i>						

The drug demand and harm reduction activities of the Ministry for financial years 2020-21 and 2021-22 were still being included under the sub-section “Treatment and Prevention of HIV and AIDS”. Grants to NGOs for drug demand and harm reduction activities were provided by NSIF.

As of May 2022, there was no clarity on the precise amount of resources being mobilised to finance drug demand and harm reduction interventions compared to expenditures on control over drug supply. As mentioned in paragraph B.3.1, savings to investments in treatment and harm reduction interventions can exceed a ratio of 12:1 through reductions in drug-related crimes and costs of criminal justice, law enforcement and healthcare. The absence of clarity on expenditures relating to drug demand and harm reduction did not ensure that the right balance was realised in the allocation of resources among drug control interventions.

#### **E.4 Coordination, Monitoring and Evaluation of Drug Demand and Harm Reduction Interventions**

##### *Key findings*

*As per its mandate, NDS had to ensure coordination, monitoring and evaluation of all drug control related policies, programmes and interventions to achieve greater coherence, results and impact.*

- *The Committees chaired by NDS were useful discussion forums but were not always accompanied by implementation of several key activities as recommended in the Master Plan.*
- *In areas of harm reduction and treatment, NDS did not ensure that the Ministry carried out evaluations to ensure that the outcome of its activities maximised the intended benefits.*
- *Similarly, in the case of NGOs, it did not ensure that evaluations were carried out by the National Social Inclusion Foundation before the allocation of grants in respect of prevention and rehabilitation activities.*

The oversight of NDS on drug demand and harm reduction comprises, among other components, the coordinating role through thematic meetings of the Prevention Committee, the Treatment and Rehabilitation Committee, and the Harm Reduction Committee.

- *Several key activities not yet carried out*

These Committees chaired by NDS were useful discussion forums but were not always accompanied by implementation of several key activities as recommended in the NDCMP. These included the timely implementation of ‘Multisectoral Drug Related Activities’, design of a Standardised Drug Prevention Programme for secondary institutions, a National Rehabilitation Programme for PWUD and a Harm Reduction Policy.

- *NDS considered itself not mandated to assess performance of all stakeholders*

As per the records examined, NDS, had persistently attempted to coordinate the activities of all relevant stakeholders, for greater collaboration and synergy among them with a view to achieving greater results and impact. However, NDS considered that it was not mandated to assess the performance of the stakeholders and lacked the legal authority to enforce compliance for the execution of activities recommended in the Master Plan.

- *Mid-term appraisal of Master Plan not yet carried out*

NDS did not carry out a mid-term appraisal to assess progress achieved, the activities which were behind schedule and the corrective actions that could have been taken to ensure timely implementation of same. Instead, it maintained a status of the lists of all activities ‘Implemented & Ongoing activities’ and ‘Initiated and Blanks’. The last updated status was that of March 2022.

- *Evaluation of drug control policies, programmes and interventions not carried out*

As per its mandate, NDS had to ensure evaluation of all drug control related policies, programmes and interventions to achieve greater coherence, results and impact. In areas of harm reduction and treatment, NDS did not ensure that the Ministry carried out evaluations to ensure that the outcome of its activities maximised the intended benefits. Similarly, in the case of NGOs, it did not ensure that evaluations were carried out by NSIF before the allocation of grants in respect of prevention and rehabilitation activities.

In July 2022, NDS informed NAO that:

- It was relatively a new body with a wide mandate and that it should be provided with maximum resources so as to be fully effective.
- It was only a coordinating and not an enforcement body and far from being an authority with powers to take actions against stakeholders if they are not achieving the results expected from them.
- It was not mandated to assess the drug prevention programmes and activities of its stakeholders, such as Ministries and Departments and NGOs. It was only through consultations and coordinating meetings that NDS achieves its objectives.
- As soon as it became operational in June 2020, it prioritised its actions and its main objective was to evaluate the situation in a methodological and scientific way. It set up committees and discussed with all partners about the situations as perceived by them and their respective responses. One of its major endeavours was to conduct a first National Survey among PWUD to understand the extent of drug use and other related information.
- It kept track of prevention, treatment and rehabilitation activities of all stakeholders through the National Drug Observatory Report. The main objective of the report is to collect data from all its stakeholders, monitor and assess the drug situation in the country, including Rodrigues and provide reliable data to enable the authorities to respond proactively, efficiently and in a timely manner to drug-related problems.
- Also, the services of a consultant have been enlisted to set up a National Monitoring and Evaluation System which consists of the collection and analysis of illicit drug use data and monitoring of types, patterns and trends of drug trafficking. This system is being implemented on a pilot basis since June 2022.
- As regards evaluation, NDS is working in collaboration with all stakeholders for the formulation of appropriate indicators.

However, NAO noted that these National Drug Observatory Reports were not published in a timely manner. The 2018 Report was published in November 2020, the 2019 Report in January 2021 and 2020 Report in December 2021.

In April 2023, the PMO further informed NAO of the following:

- NDS became fully operational in June 2020, after the recruitment of technical staff and the lockdown period from mid-March to end of May 2020. The second lockdown in 2021 had also severely impacted on the work of NDS.
- A policy is required for implementation of a comprehensive drug programme at the workplace. To this end, a policy has been developed by the Ministry of Labour, Human Resource Development and Training in consultation with the NDS. The proposed policy has not yet been validated. As for the National Drug Control Master Plan (NDCMP) 2019-2023, the Prime Minister's Office (Rodrigues, Outer Islands and Territorial Integrity Division) reiterates that the Master Plan is a comprehensive policy document that provides a sustainable and structured response to the drug scourge, including harm reduction which is one of the strategic pillars of the Master Plan.
- NDS maintains that it has no legal authority or mandate to assess all the programmes implemented by the NGOs which are in the field for so many years.
- NDS can only evaluate the implementation of the National Drug Control Master Plan (NDCMP) which will come to an end in December 2023. Action is being taken to enlist the services of a Consultant to evaluate whether the strategies and interventions have been effective and desired outcomes have been achieved before embarking on the preparation of a new Master Plan for the next five years.
- Measuring outcomes of prevention programmes and treatment of people who use drugs is a complex exercise and requires either comparative prevalence study after some years or cohorts follow up which last for several years, particularly in case of addiction which is a chronic relapsing condition.

## CHAPTER FOUR

### CONCLUSION

*This Chapter concludes against the audit objective based on the analysis and findings supported by audit evidence as elaborated in the previous Chapter.*

The Ministry's commitment to reduce drug demand and harm is evidenced by its sustained investment in interventions which mainly focused on prevention and medically assisted therapy. The Ministry is taking initiatives to increase treatment capacity to extend coverage and provide additional evidence-based treatment options relating to changing drug consumption patterns. Its harm reduction interventions were successful in reducing the prevalence of specific blood-borne diseases.

However, the effectiveness of certain aspects of the drug demand and harm reduction interventions are impaired by long outstanding issues which are not being adequately addressed in a timely manner. Though drug addiction is considered as a chronic and relapsing disease, the Ministry did not provide the required attention in important areas of treatment, follow-up, psychosocial and social integration of its patients. Also, it did not evaluate its interventions, particularly in drug prevention and treatment activities, with a view to take necessary corrective actions and hence, enhance their effectiveness.

On the other hand, NDS argues that it is an oversight body and hence is not involved in enforcement activities. It is persistently attempting to coordinate all the activities of stakeholders, for greater collaboration and synergy among them, with a view to achieving greater results and impact. It has taken several important initiatives to enhance the effectiveness of drug demand and harm reduction interventions. However, NDS considers that it is not mandated to assess the performance of all the stakeholders involved, and does not have the required legal authority to enforce the execution of all the activities recommended in the Master Plan. The Committees chaired by NDS are useful discussion forums but are not always accompanied by the implementation of several key activities and the ascertainment of their outcomes. Keeping focus on outcomes, is critical for this apex body to provide adequate oversight, to ensure that the intended benefits of interventions are timely realised in a cost-effective manner.

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## **CHAPTER FIVE**

### **RECOMMENDATIONS**

*This Chapter presents the recommendations based on the findings and conclusion.*

#### **5.1 General**

Drug addiction is a complex problem and requires a multitude of interventions of the Ministry to minimise its harmful impacts. Several interventions of the Ministry are still challenged by issues outstanding since several years. These include the loss to follow-up of methadone clients and diversion of methadone which undermine the effectiveness of the MST Programme. As regards the initiatives to introduce detoxification and treatment of youngsters at the Nénuphar Centre, a similar problem of loss to follow-up is being encountered. As a priority, the Ministry should address the issue of the loss to follow-up to increase the effectiveness of its treatment interventions.

NDS has a wide mandate and is making persistent efforts to exercise its oversight role with the resources available to meet the objectives set. However, it did not keep adequate track of the implementation of the activities and their outcomes. It needs to have an end-to-end perspective<sup>62</sup> of activities being undertaken by all stakeholders to ensure that they maintain focus on results.

In light of the above, the specific key recommendations to enhance the effectiveness of drug demand and harm reduction interventions are described in the ensuing paragraphs.

#### **5.2 Implementation of Drug Use Prevention Activities**

- (i) The Ministry should incorporate a monitoring and evaluation component in its drug prevention activities in order to be aligned with international good practices.
- (ii) The results of the pilot project ‘Get Connected Programme’, when available, should be discussed at the level of NDS and necessary adjustments to the programme be made.
- (iii) NDS needs to determine which entity should lead and develop the Standardised Drug Use Prevention Programme at the earliest. This will ensure that the related prevention

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<sup>62</sup> An organisation with an end-to-end perspective has clarity about how its processes work, how they fit together, and how they interlink with those of other bodies. Decisions are made for the benefit of the whole rather than parts of the system. (Extract from- “Managing business operations – what government needs to get right” September 2015, Page 24 of the United Kingdom National Audit Office publication. Accessible at: <https://www.nao.org.uk/insights/managing-business-operations-what-government-needs-to-get-right/>).



activities are carried out among a larger population of students before the completion of their secondary schooling.

- (iv) The status of the Youth Empowerment Programme Against Drugs should be ascertained by NDS and actions initiated to implement the second phase, which was considered as crucial.

### **5.3 Drug Use Disorders Treatment**

- (i) A survey should be carried out to identify what proportion of People Who Inject Drugs, estimated at 6,600 in December 2020, are currently on Methadone Substitution Therapy Programme. Also, information on those 4,600 People Who Inject Drugs and who were inducted on the programme since 2006 but were lost to follow-up, has to be compiled. This would provide the necessary input to assess whether necessary treatment coverage was being provided to meet the requirement of Indicator 3.5.1 of Sustainable Development Goal 3 ‘Ensure healthy lives and promote well-being for all ages.’
- (ii) The Ministry should set targets for maximum waiting time for methadone induction, and consider reallocating clients in between the Methadone Day Care Centres to reduce waiting time.
- (iii) Capacity planning needs to be carried out by the Ministry to cater for prospective clients for treatment as some 55,000 People Who Use Drugs, in addition to the estimated 6,600 People Who Inject Drugs, have already been estimated in December 2021. The overall effect would be, in the longer term, to decrease the likelihood of People Who Use Drugs losing resolve to start treatment or resuming substance misuse due to long waiting lists for induction.
- (iv) The ‘Take Home Dose’ is an appropriate initiative which will reduce the amount of resources required daily for dispensing methadone on sites, overcrowding and loitering around these sites, and diversion of methadone. However, the initiative was still in pilot stage since October 2021 and needs more attention from the Ministry in order to roll it out for a larger segment of methadone clients.
- (v) The Ministry should develop a prescribed Treatment Protocol for detoxification, similar to the Methadone Substitution Therapy Protocol, comprising guidelines on treatment plans, pre-admission and post-discharge follow-up to minimise the risk of interruption of treatment and relapse. A similar protocol should be developed for treatment being provided at the Nénuphar Centre.
- (vi) NGOs should be engaged to a larger extent, in the follow-up of methadone, detoxification and rehabilitation of patients, and this should be one of the key requirements for them to obtain finance from the National Social Inclusion Foundation.

#### ***5.4 Rehabilitation and Social Integration Projects***

- (i) The Ministry should reconsider the implementation of the Pilot Project for ‘Psycho-socio-rehabilitation’ for People Who Use Drugs as a first step towards developing a more comprehensive rehabilitation programme.
- (ii) The Project ‘Collaborative Training and Social Integration of Detainees’ should be given prompt attention by NDS with collaboration from the Ministry and NGOs. Activities related to the social reinsertion and rehabilitation of ex-detainees should be re-examined and expanded to provide a larger coverage.

#### ***5.5 Coverage of Harm Reduction Interventions***

In order to confirm the effectiveness of its harm reduction interventions, the Ministry should carry out a survey among those clients on Methadone Substitution Therapy and benefiting from the Needle Exchange Programme. This would help to ascertain the proportion of clients still on the therapy and the programme. Relevant information would be obtained in respect of those who were still consuming illicit drugs, still involved in crimes, and those in employment, with improved health and independent living. This information would provide feedback to enhance treatment, social integration and rehabilitation interventions.

#### ***5.6 Oversight by the National Drug Secretariat***

- (i) The terms of reference of NDS specifies that the latter should advise on the adoption of evidence-based drug policies, strategies and programmes. NDS should ensure that policies required in specific sectors of substance abuse are appropriately formulated and implemented. For example, policy decision is required on whether methadone clients are expected to be on methadone for an indeterminate duration that could be lifelong, or move towards gradual detoxification in the long term.
- (ii) The costs associated with harm and drug demand reduction should be easily identifiable to support policy decisions. Accordingly, a programme budget should be developed and expenditure on the various services should be tracked against budgets. In order to provide accountability for performance, the outturns should be published and subject to scrutiny by relevant stakeholders.
- (iii) NDS should initiate a cost-benefit analysis to be carried out to enable policy and program managers to make informed decisions. This will help to identify the resources allocated for drug abuse treatment policies and programmes and whether more funds should be directed toward demand and harm reduction or law enforcement, and what is

the proper balance between healthcare and criminal justice when it comes to lowering rates of drug abuse, particularly among young people.

- (iv) To enhance its oversight role, NDS should identify all activities, as recommended in the Master Plan, which are behind schedule or not performed. These performance gaps should be reported to the High-Level Drug and HIV Council for necessary corrective actions.
- (v) NDS should ensure that the activities of NGOs are assessed by the National Social Inclusion Foundation pre and post-funding stages. It also needs to ensure that the resources allocated match the expected level of support required from them.

## [Additional Comments from Prime Minister's Office \(Rodrigues, Outer Islands and Territorial Integrity Division\)](#)

### **1. Responsibility of NDS**

NDS cannot be held responsible for everything that has been happening or rather not happening in the field of drug response and for whatever has not been working in terms of outcomes, rehabilitation and prevention through the past years.

### **2. Assessment of programmes/ activities by NDS under the NDCMP**

The NDCMP is meant to be implemented over a period of five years and an evaluation exercise is planned at the end of that time frame. It is advisable that an independent consultant be recruited to conduct the exercise in 2024 and its findings will be taken on board.

### **3. Keeping track of activities and outcomes**

Substance Use Disorder is defined by the World Health Organisation as a 'chronic relapsing condition', and therefore expecting treatment outcomes, like in other diseases or surgeries in terms of numbers having been cured, is not and will never be possible. Factors like prevalence and quality of life are rather useful indicators of programmes effectiveness. As such, first prevalence about drugs use in the country, through the National Survey among People Who Use Drugs, was obtained only in December 2021 and it is only after at least 4 to 5 years that we can measure the outcome of prevention programmes through another national prevalence survey.

### **4. Policy decision on the duration of methadone treatment**

Evidence has shown that methadone substitution therapy on a maintenance model reduces the risk of relapse which otherwise is a common feature of all medically-assisted therapies. Mauritius has adopted the maintenance model since 2006. Moving towards gradual detoxification depends on several factors among which self-motivation of the person concerned remains vital and this approach is adopted at the request of the patient.

## [Additional Comment from the Ministry of Health and Wellness in respect of the policy decision on duration of methadone treatment.](#)

The Ministry informed that in 2015, a campaign was conducted whereby patients who wanted to come off methadone by gradual dose were given the opportunity to do so. During 2016-2022, requests for gradual methadone reduction were often received, and conducted. However, preliminary observations indicated that patients were often not able to complete their methadone dose reduction to become drug free, or if they do so, they often relapse within the following weeks or months. A study on the outcome of slow methadone dose reduction is under way to quantify the extent of a successful outcome.

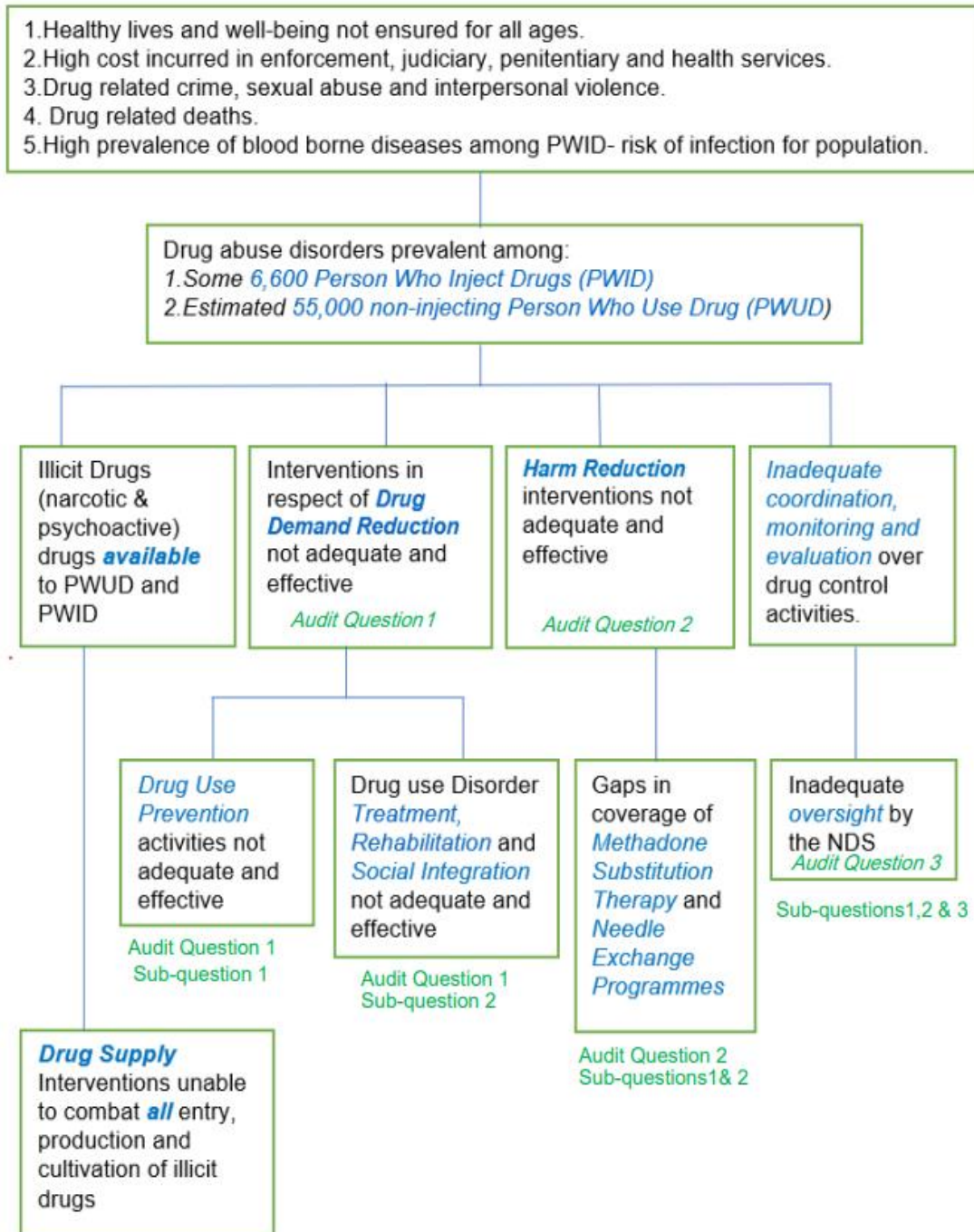
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Problem Tree Analysis

Key Aspects of the Drug Problem in Mauritius and related Audit Questions



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List of Audit Questions, Sub-questions and referencing to Chapter III (Findings)

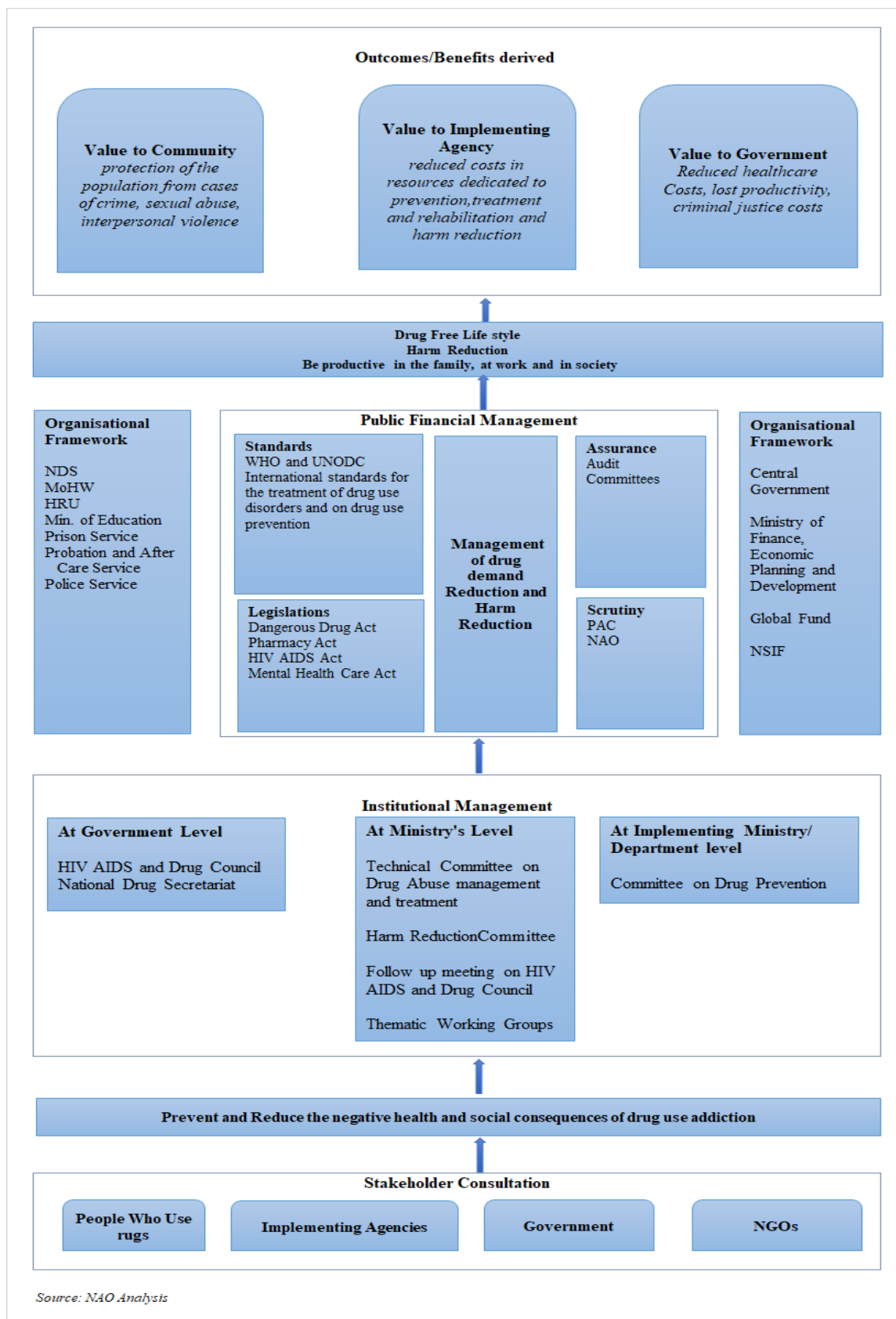
Audit Question 1	Were the interventions of the Ministry of Health and Wellness in respect of Drug Demand Reduction adequate and effective?	
Sub-question 1	<b>Were the Drug Use Prevention activities adequate and effective?</b>	
	i	<i>Were the drug use prevention activities of the Ministry in collaboration with other stakeholders adequate and aligned with international standards and good practices? Paragraph A.2</i>
	ii	<i>Were the drug prevention activities implemented effectively as per the requirements of the Master Plan, under the oversight of NDS? Paragraph A.3</i>
	iii	<i>Were drug prevention activities in the educational sector implemented adequately and effectively through the ‘Get Connected Programme’ and the ‘Standardised Drug Prevention Programme’? Paragraph A.4</i>
	iv	<i>Were drug prevention activities implemented effectively in the community through the Youth Empowerment Programme? Paragraph A.5</i>
Sub-question 2	<b>Were the Drug use Disorder Treatment, Rehabilitation and Social Integration activities adequate and effective?</b>	
	2.1	Treatment
	i	<i>Whether the treatment services provided by the Ministry were aligned with good practices? Paragraph B 3.1</i>
	ii	<i>Whether the coverage of treatment drug use abuse was adequate? Paragraph B 3.1</i>
	2.1.1	Methadone Substitution Therapy Programme
	i	<i>Whether induction into Methadone Substitution Therapy Programme was timely? Paragraph B 3.2</i>
	ii	<i>Whether dispensing of methadone was done effectively and efficiently? Paragraph B 3.3</i>
	iii	<i>Whether follow-up of clients on Methadone Substitution Therapy Programme was adequate and effective? Paragraph B 3.4</i>
	2.1.2	Suboxone-Naltrexone-based Detoxification Programme
	i	<i>Was there an official detoxification protocol inclusive of guidelines on treatment plan? Paragraph B.4.1, B 4.2</i>
	ii	<i>Was there an adequate and effective follow-up on patients? Paragraph B 4.3</i>
	iii	<i>Were the outcomes of treatment assessed? Paragraph B 4.4</i>



Audit Questions, Sub-questions and referencing to Chapter III (Findings)

<b>Audit Question 1 - Sub-question 2 (continued)</b>	<b>Were the Drug use Disorder Treatment, Rehabilitation and Social Integration activities adequate and effective?</b>	
	2.1.3	<i>Treatment and Rehabilitation at Nénuphar Centre</i>
	i	<i>Was there an official detoxification protocol inclusive of guidelines on treatment plan? Paragraph B.5</i>
	ii	<i>Was there an adequate and effective follow-up on patients? Paragraph B.5</i>
	iii	<i>Were the outcomes of treatment assessed? Paragraph B.5</i>
	2.2	<b>Rehabilitation and Social Integration</b>
	i	<i>Was there an effective and adequate Rehabilitation Programme in the community to support Treatment? Paragraph C.2</i>
	ii	<i>Were the Social Integration and Rehabilitation of detainees and ex-detainees adequate and effective? Paragraph C.3</i>
<b>Audit Question 2</b>	<b>Was the coverage of Harm Reduction interventions adequate and effective?</b>	
Sub-question 1	Was there adequate and effective coverage of Methadone Substitution Therapy Programme? <i>Paragraph D.2</i>	
Sub-question 2	Was there adequate and effective coverage Needle Exchange Programme (NEP)? <i>Paragraph D.3</i>	
<b>Audit Question 3</b>	<b>Was there adequate oversight over drug demand and harm reduction activities?</b>	
Sub-question 1	Was a drug policy formulated to address the harmful social and health consequences among PWUD? <i>Paragraph E.2</i>	
Sub-question 2	Were there adequate funding arrangements to support drug demand and harm reduction activities? <i>Paragraph E.3</i>	
Sub-question 3	Were there adequate coordination, monitoring and evaluation of drug demand and harm reduction interventions? <i>Paragraph E.4</i>	

Whole of Government Approach to Harm and Drug Demand Reduction



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### METHODOLOGY- PERSONNEL INTERVIEWED DURING SITE VISITS

Semi-structured interviews and meetings were carried out with key personnel at senior management and operational levels of the main players involved in drug use prevention, drug use disorders treatment, rehabilitation, social reintegration and harm reduction namely:

- Senior management at the Ministry of Health and Wellness and PMO to understand the strategic intent of the Ministry and ascertain progress realised to prevent and reduce the negative health and social consequences of substance use and addiction (Strategic Goal 7 of the Mauritius Health Sector Strategic Plan (HSSP) 2020-2024;
- Personnel of the HRU in respect of description and assessment of activities related to ‘Strategic Pillars 2 and 3: Drug Demand Reduction and Harm Reduction’ of the NDCMP;
- Coordinator and Programme Coordinator of NDS to understand and assess their roles in respect of oversight, coordination, monitoring and evaluation of all drug control related policies, programmes and interventions;
- Advisor/Consultant Psychiatrist appointed by the Ministry of Health and Wellness to understand the medical/ psychosocial aspects of drug addictions and ascertain the standard operating procedures, treatment and rehabilitation protocols of drug use disorders put in place;
- Officers of the Health and Wellness Directorate of MoETEST to understand and assess the “Get Connected Programme” and “Standardised Drug Prevention Programme” to reduce drug demand among secondary schools students;
- Officers of the Prison Service in respect of admissions related to drug-related convictions and rehabilitation of detainees;
- Officers of the following Units at management, supervisory and operational levels:
  - i. Methadone Day Care Centres at Sainte Croix, Cassis, Beau Bassin and Mahebourg in respect of assessment of the MST programme;
  - ii. Mahebourg Detoxification Centre in respect of assessment of the Suboxone-Naltrexone- based detoxification programme;
  - iii. Nénuphar Centre in respect of assessment of the Treatment and Rehabilitation services provided to minors and young people under the age of 24;

#### **Appendix IV- Continued**

- iv. Addictology Units at SSRN Hospital, Mahebourg Hospital and Dr A.G Jeetoo Hospital in respect of assessment of assistance, medico-psychosocial support, as well as referral services for PWUD;
  - v. Pharmacy Unit of Dr A.G Jeetoo Hospital in respect of control over methadone preparation and dispensing;
- Officers of NSIF in respect of funding, monitoring and evaluation of activities of NGOs dealing with drug-related health problems;
  - Officers of the following NGOs working in collaboration with HRU and NDS in respect of their roles in drug use prevention, treatment, rehabilitation and harm reduction activities:
    - i. Help De-Addiction Centre
    - ii. Dr Idrice Goomany Centre
    - iii. NGO Lacaz A
    - iv. Groupe Renaissance Mahebourg
    - v. Centre de Solidarité
    - vi. Collectif Urgence Toxida (CUT)
    - vii. Aides Infos Liberté Espoir et Solidarité (AILES)
    - viii. Association Kinouté

The referral, follow-up and psychosocial activities of these NGOs were assessed.

## STAKEHOLDERS ANALYSIS

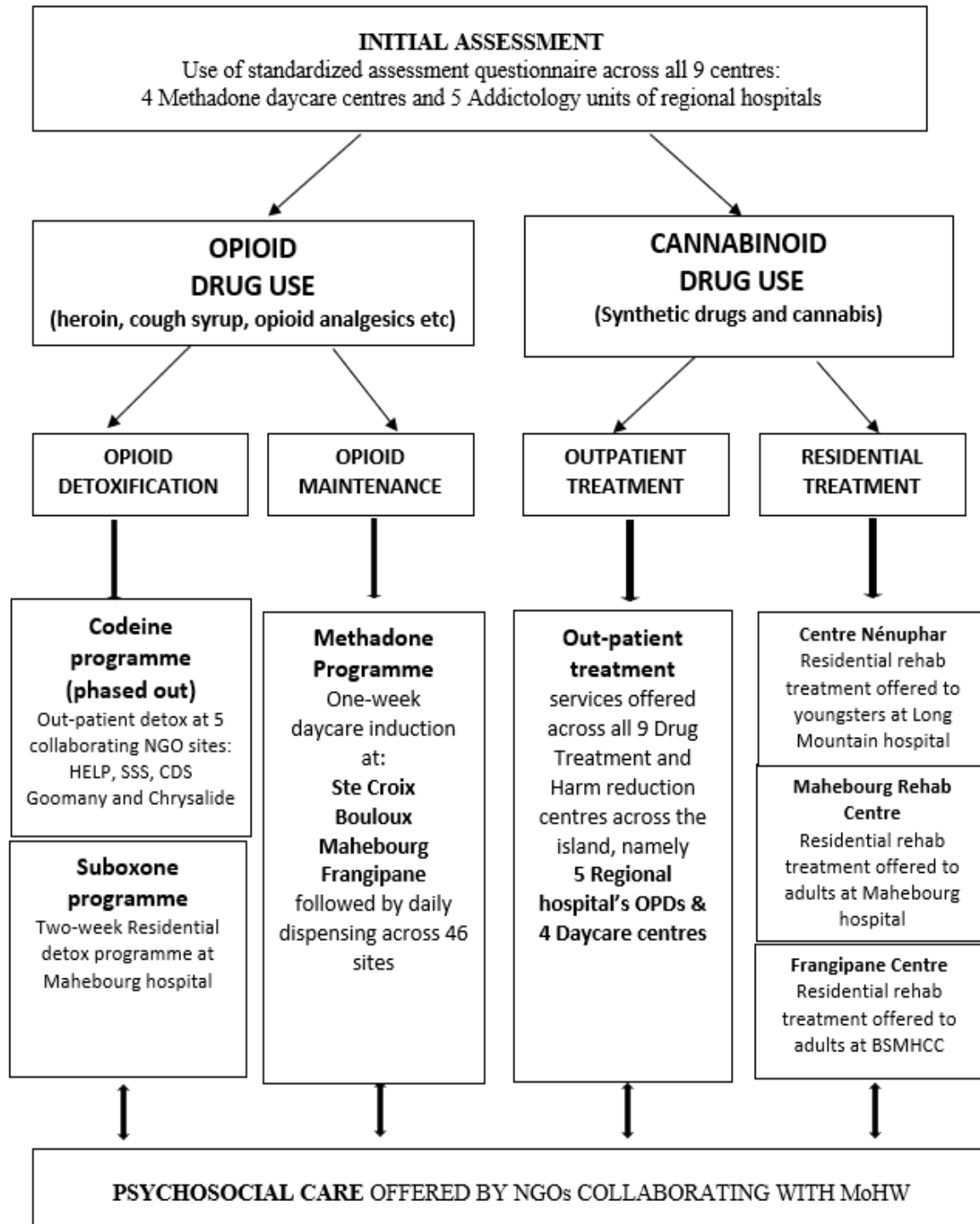
	Stakeholder	Role of the Stakeholder	Interest of the stakeholder	Level of involvement
Internal Stakeholders	High Level Drugs and HIV Council (Prime Minister's Office)	Ensures that the necessary resources are provided and directed to national drug and HIV Programmes	To remove bottlenecks including administrative lags while enhancing coordination and monitoring among stakeholders	High
	National Drug Secretariat (Prime Minister's Office)	Acts as an apex body to plan, coordinate, oversee, monitor and evaluate all drug control-related policies, programmes and interventions to achieve greater coherence, results and impact	Implementation of the NDCMP 2019-2023:	High
	Ministry of Health and Wellness	Acts as implementing agency of the recommendations of the NDCMP 2019-2023	Prevent and reduce the negative health and social consequences of substance use and addiction	High
	Harm Reduction Unit	Implementation of harm reduction programme: drug prevention activities, Methadone substitution therapy programme, detoxification and rehabilitation treatment	Drug prevention, treatment and rehabilitation	High
	Addictology units	Offer treatment, follow-up and referral services to people with Substance Use Disorder (SUD).	Drug Treatment and rehabilitation	High
	Brown Sequare Mental Health Care Centre	Provide harm reduction services to drug offenders Provides treatment to people using drugs with co-morbid conditions	Drug Treatment and rehabilitation	High
	Methadone Day Care Centres	Offering methadone induction programme for People Who Use Drugs.	Drug Treatment	High
	Rehabilitation and detoxification centres	Rehabilitation Ward for minors and young people	Drug Treatment and rehabilitation	High
External Stakeholders	Mauritius Prison Service	Methadone Induction and Drug Rehabilitation Unit - Induction and dispensing of methadone for people who inject drug. Provides rehabilitation to PWUD in Prisons	Drug Treatment and rehabilitation	High
	Ministry of Rodrigues, Outer islands and Territorial Integrity	PACS refer convicted drug users to a prescribed drug detoxification centre and make arrangements for treatment. Follow-up of the offender is effected by PACS with the centre and any non-compliance to treatment is reported to the Referral Court. PACS also delivers talks on drug use prevention to schools and the community.	Drug Prevention, Treatment and rehabilitation	High
	Probation and after Care Service			
	Mauritius Police Service	The Mauritius Police Force Strategic Plan 2015-2018 focuses on fight against trafficking and drug use. Compiles, analyses and disseminates data on drug networks and users. It works in partnership with other units of the MPF and foreign drug law enforcement counterparts, Customs, the public, the private sector and communities to dismantle drug networks.	Drug Supply Reduction and Drug Prevention	High/Medium
	Anti-Drug Smuggling Unit (ADSU)			
	Intelligence Cell			
	Ministry of Social Security	Under the Social Aid Scheme, financial assistance is provided to needy persons, including dependents of people who use drugs following rehabilitation, treatment or serving a term of imprisonment including for drug-related offences.	Drug Treatment and rehabilitation	Medium/High
	Ministry of Social Integration and Economic Empowerment	The National Social Inclusion Foundation (NSIF) is the central body to receive and allocate public funds to NGOs Various organizations collaborate in the context of Community Working Groups led by NSIF to work in identifying and helping people who use drugs and people living with HIV.	Drug Prevention, Treatment and rehabilitation	High/Medium
	Ministry of Education Tertiary Education, Science and Technology	The Health and Wellness Directorate has been set up at MoETEST and is driving the drug use prevention programmes in schools	Drug Prevention	High/Medium
	Ministry of Gender Equality and Family Welfare	mobilizing women, mothers, families and communities to assume a proactive role in drug use prevention for their protection as well as that of their children and their families	Drug Prevention	High/Medium
	Ministry of Youth and Sports	Training on evidence-informed drug prevention, and implementing youth programmes on drug use prevention	Drug Prevention	Medium
Local Authorities	upon request, to raise public awareness on the harmful consequences of drug use. Welfare officers in these centres may also be trained in drug use prevention and basic counselling in the community to improve the well-being of the population.	Drug Prevention	Medium	
Statistics Mauritius	Disseminates data on drug offences from the Police office of Public Prosecutions, the Judiciary, Prison Service and Probation and after care service.	Publication of data	Medium	
Non-Governmental organisations	Provide drug use prevention programmes, refer clients to MoHW for HIV Testing and Counselling and methadone induction and maintenance, provide follow-up and psychosocial support to PWUD.	Drug prevention, Rehabilitation and Harm reduction	High	

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GUIDELINES ON CLINICAL MANAGEMENT OF PATIENTS WITH DRUG USE DISORDERS



Source: MoHW

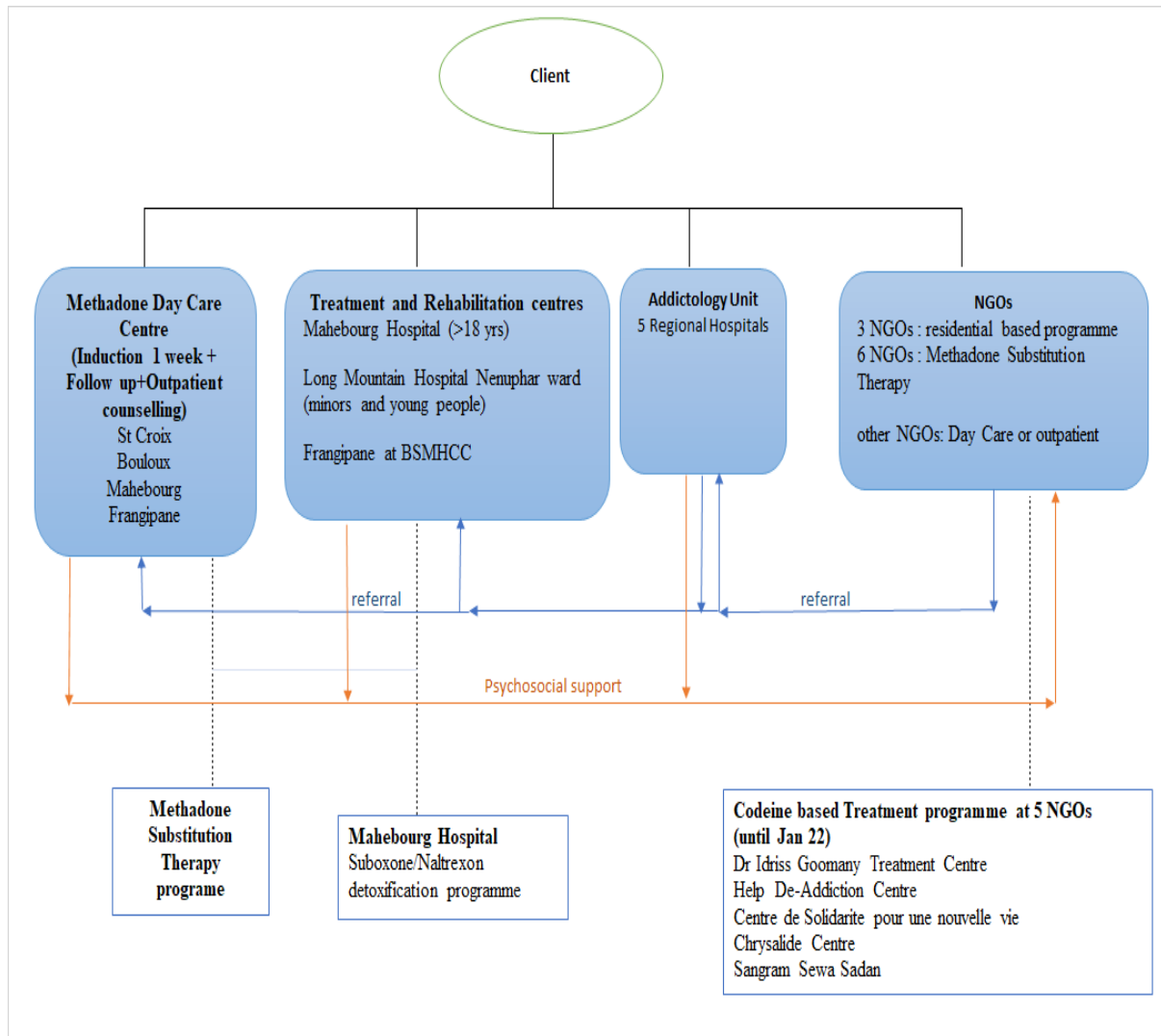


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TREATMENT AVAILABLE FOR PEOPLE WHO USE DRUGS (PWUD)



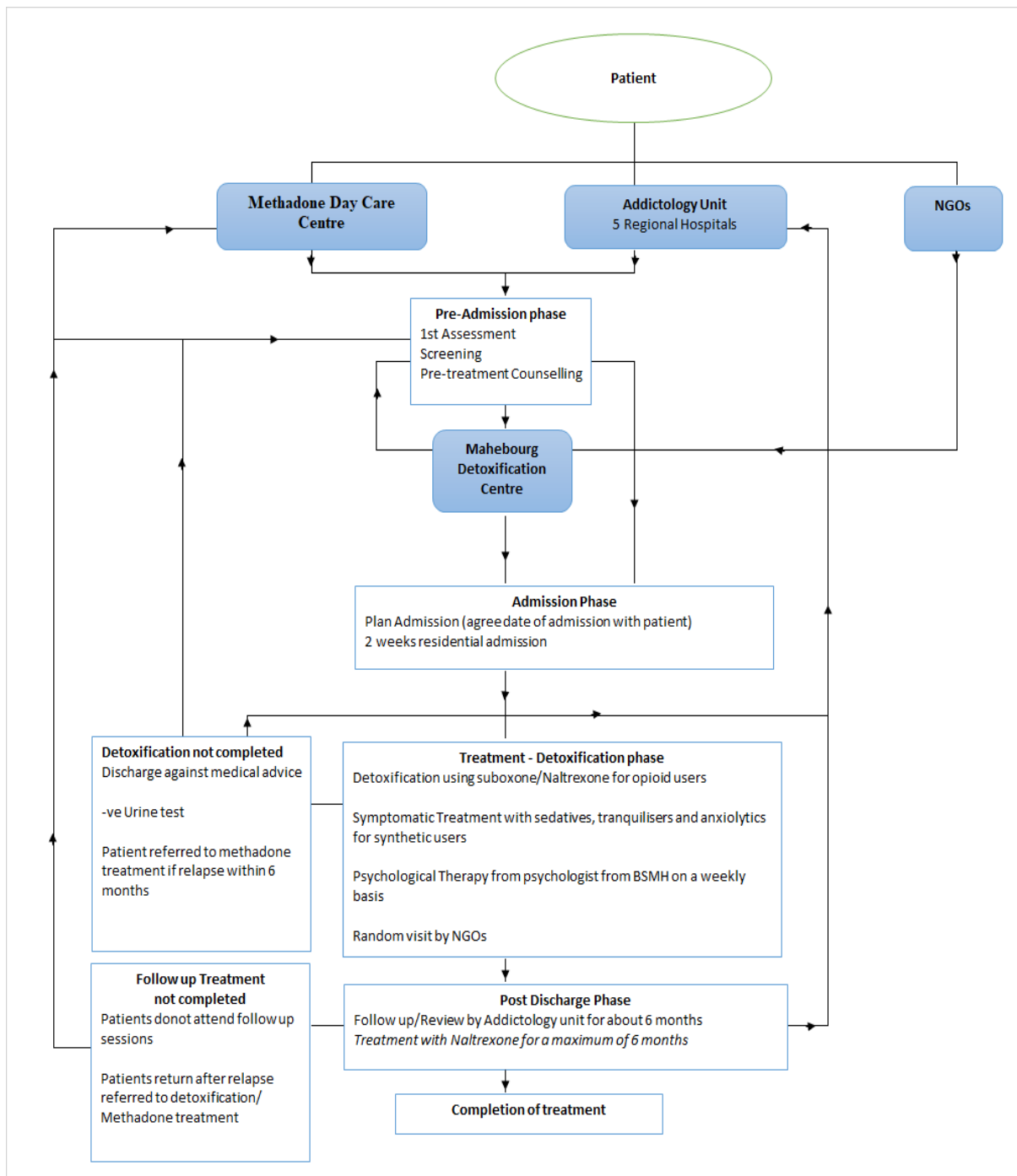
Source: NAO Analysis

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DRUG TREATMENT – DETOXIFICATION PROGRAMME



Source: NAO Analysis

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## TYPES AND NUMBER OF DRUG PREVENTION ACTIVITIES CARRIED OUT BY THE MINISTRY

Types of Drug Prevention Programme conducted by the Ministry during 2018-2021	
1	Organise and conduct Drug prevention Programmes through various strategies in educational and training institutions.
2	Advocate and educate the community at large on the drug scourge in collaboration with the Sugar Industry Labour Welfare Fund.
3	Conduct drug prevention activities with out-school youth, including those in close settings (Correctional Youth Centres, Rehabilitation Youth Centres and Prisons).
4	Sensitising the employees in public and private sectors on drug issues.
5	Training of ancillary, nursing, medical and paramedical personnel with regard to substance use disorder.
6	Capacity building of the Sugar Industry Labour Welfare Fund's Officers.
7	Distribution of Information, Education and Communication materials and supportive tools for implementation of outreach and public events in relation to drug prevention.
8	Reaching out to vulnerable groups/ high-risk areas.
9	Series of Workshop on Prevention against Synthetic Drugs.
10	Relapse Prevention in Methadone Day Care Centres and Detoxification.

*Source: Ministry of Health and Wellness*

Drug Prevention Programme conducted by the Ministry during 2018-2021								
Year	In Educational Institutions			In the Community		At Workplaces		No of Officers
	Number of			Number of		Number of		
	Schools	Classes	Students	Sessions	Participants	Sessions	Participants	
2018	293	995	26,663	306	11,983	266	7,637	10
2019	163	521	15,982	271	9,309	210	5,575	7
2020	89	247	6,677	80	2,636	63	1,568	4
2021	3	4	155	4	228	3	43	4
<b>Total</b>	<b>548</b>	<b>1,767</b>	<b>49,477</b>	<b>661</b>	<b>24,156</b>	<b>542</b>	<b>14,823</b>	

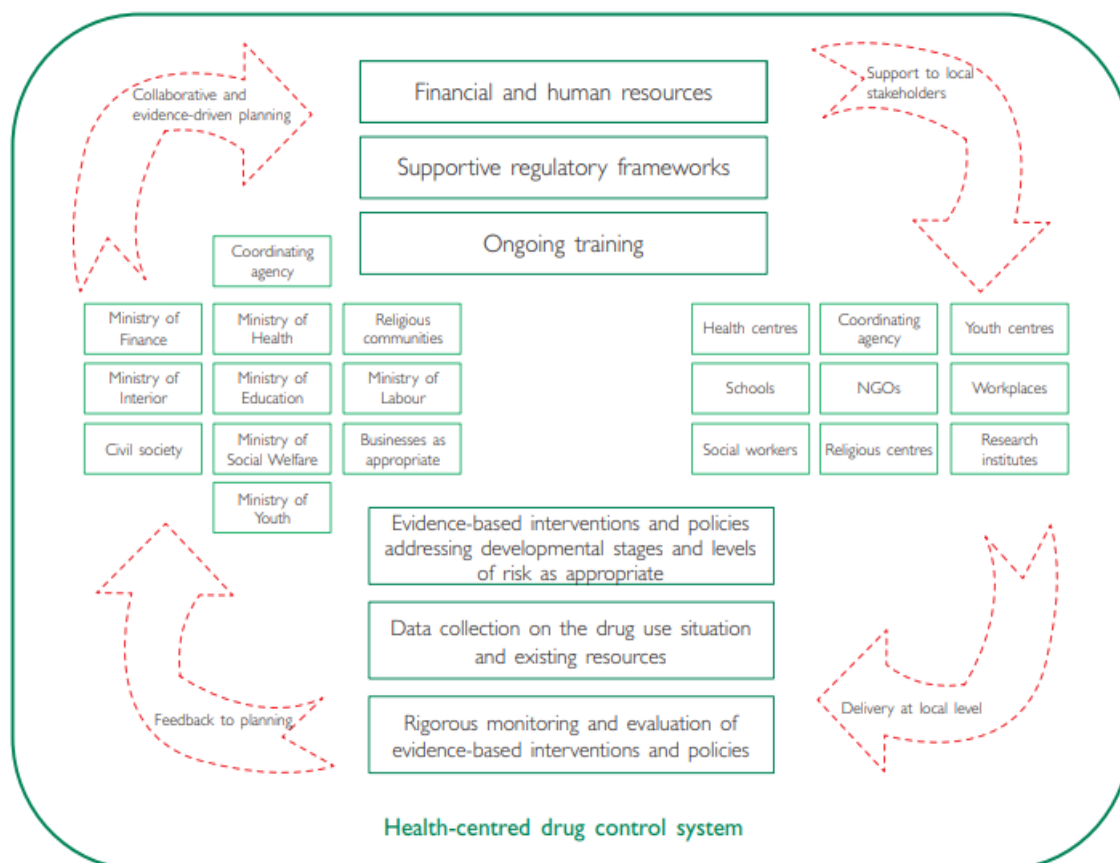
*Source: Ministry of Health and Wellness*

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**Schematic representation of a national drug prevention system comprising rigorous monitoring and evaluation of evidence-based interventions and policies**



*Source: International Standards on Drug Use Prevention, Second updated edition. Vienna: United Nations Office on Drugs and Crime and the World Health Organization, 2018. Licence: CCBY-NC-SA3.0 IGO (Page 48)*



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### NDCMP 2019-2023: Terms of Reference of National Drug Secretariat

The National Drug Secretariat (NDS) is established to counter the threat posed by drug trafficking and drug use in Mauritius to national security and public health and to propose practical measures to protect the well-being of Mauritians. The NDS has a broad multi-sectoral mandate and is set up at the Ministry of Defence and Rodrigues. It will advise on the strategic vision and overall policy direction regarding all drug control related matters, ensure the coordination, monitoring and evaluation of programmes involving a large spectrum of key actors at national, regional and international levels and advocate and mobilize the resources needed to achieve the goals and objectives set. The National Drug Secretariat will inter alia:

- i. Ensure the overall coordination of all drug control activities in Mauritius for greater collaboration and synergy among partners, with a view to achieve greater results and impact;
- ii. Advise the Government on the adoption of evidence-based drug policies, strategies and programmes;
- iii. Engage in advocacy to raise evidence-based public or population-specific awareness on the harmful consequences of drug use;
- iv. Promote collaboration between law enforcement agencies and financial regulatory bodies in order to share intelligence and achieve greater efficiencies in combatting drug trafficking and financial crimes;
- v. Promote regional and international cooperation to decrease drug trafficking in the region with bodies such as the United Nations Office on Drugs and Crime, the Commission on Narcotic Drugs, the Southern Africa Development Community and the Indian Ocean Commission;
- vi. Ensure that demand reduction activities, namely the prevention of drug use, the treatment of drug use disorders and the rehabilitation of people who used drugs including those in prisons, are evidence-based and carried out in line with international standards and best practices;
- vii. Ensure that harm reduction activities aiming at reducing blood-borne infections and improving the quality of life of people who use drugs, and people who are in prisons are evidence-based and carried out in line with international standards and best practices;
- viii. Facilitate and coordinate human resources capacity development to address drug control with the highest competence;
- ix. Coordinate research in the multi-faceted aspects of drug trafficking and drug use to gather the best evidence to respond to the twin threats;
- x. Develop the Implementation Framework and Monitoring Mechanism of the National Drug Control Master Plan; monitor its implementation and evaluate it; and
- xi. Manage the National Drug Observatory, in collaboration with Government and NGO stakeholders to collect, analyse data and publish a brief statistical and analytic bulletin on a quarterly basis and a comprehensive National Drug Observatory Report annually to monitor types, patterns and trends in drug trafficking and drug use, as well as meet the country's international reporting obligations.

The National Drug Secretariat will operate under the aegis of the Ministry of Defence and Rodrigues and will be chaired by the Permanent Secretary of the Ministry. It will be guided by and will report to a High Level Drug and HIV Council chaired by the Prime Minister and comprise the following:

- Ministry of Health and Quality of Life (MOH);
- Ministry of Education and Human Resources, Tertiary Education and Scientific Research;
- Ministry of Foreign Affairs, Regional Integration and International Trade;
- Ministry of Youth and Sports;
- Ministry of Social Security, National Solidarity and Reform Institutions;
- Ministry of Social Integration and Economic Empowerment;
- Ministry of Gender Equality, Child Development and Family Welfare;
- Ministry of Technology, Communication and Innovation;
- Ministry of Justice and Human Rights;
- Ministry of Local Government and Outer Islands;
- Office of the Attorney-General;
- Representatives of Non-Governmental Organizations; and
- Representatives of the Private Sector.

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## UNODC recommended modalities and approaches for treatment of drug abuse

Modalities / Approaches	Key Aspects	Adopted
1. Community-based outreach.	These activities primarily target people who use drugs but are not currently receiving treatment. The core services provided by outreach programmes include basic support, drug-related education, screening and brief interventions, referral for drug dependence treatment and needle exchange services.	<b>YES</b>
2. Screening, brief interventions, and referral to treatment	These interventions are largely aimed at people with drug use problems in non-specialized settings, such as primary care, emergency care, social services and prisons. Such programmes are effective in reducing drug use, particularly among those who are at the early stages of their drug use trajectories.	<b>YES</b>
3. Short-term inpatient or residential treatment	This type of treatment, also known as detoxification, is largely aimed at providing relief from drug withdrawal symptoms and facilitating the stabilization of the patient's physical and emotional state in a safe, protected setting. To prevent relapse, preparations need to begin in this phase of the treatment for activities aimed at ensuring the patient's long-term and sustained engagement in the treatment process.	<b>YES</b>
4. Outpatient treatment.	Outpatient treatment is largely aimed at those individuals who have sufficient social support and resources at home, but who do require long-term pharmacological and/or psychosocial interventions.	<b>YES</b>
5. Long-term residential treatment.	The most common form of long-term residential treatment is the therapeutic community, where patients are expected to stay for an extended duration of between 6 and 24 months. Large-scale reviews have shown that there is little evidence that therapeutic communities offer significant benefits, except if they are operated in prison settings.	<b>YES</b>
6. Recovery management	Recovery management, also known as aftercare or social support, is a long-term, recovery-oriented care model for those who have achieved abstinence through other forms of treatment. The focus is on preventing relapse by supporting change in individuals' social functioning and personal well-being, and by helping them to regain their place in their community. Relapse is an almost inevitable part of recovery.	<b>YES</b>
7. Interventions aimed at reducing the adverse consequences of drug use.	Certain approaches are used for reducing the adverse consequences of drug use rather than directly reducing drug use per se. They are widely employed, in the context of reducing the risk of HIV and other blood-borne viral infections spreading among people who inject drugs. They are: (a) needle and syringe programmes; (b) opioid substitution therapy and other drug dependence treatment; (c) HIV testing and counselling; (d) antiretroviral therapy; (e) the prevention, diagnosis, and treatment of sexually transmitted infection; (f) condom distribution; (g) targeted information, education and communication; (h) prevention, vaccination, diagnosis and treatment for viral hepatitis; and (i) prevention, diagnosis and treatment of tuberculosis.	<b>YES</b>

Source: Paragraph 4.2 of WHO International Standards Treatment Drug Use Disorders April 2020. Accessible at [https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO\\_International\\_Standards\\_Treatment\\_Drug\\_Use\\_Disorders\\_April\\_2020.pdf](https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf)

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