Joint Submission to OHCHR's report on human rights challenges in addressing and countering all aspects of the world drug problem

19 May 2023

Submitting organisations:

Harm Reduction International (HRI) is a leading non-governmental organisation Harm Reduction International (HRI) envisions a world in which drug policies uphold dignity, health and rights. We use data and advocacy to promote harm reduction and drug policy reform. We show how rights-based, evidence-informed responses to drugs contribute to healthier, safer societies, and why investing in harm reduction makes sense.
HRI is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

Contact details: Ajeng Larasati, Human Rights Lead, ajeng.larasati@hri.global

Word count: 1,467

I. Introduction

Harm Reduction International (HRI) welcomes the opportunity to provide information on human rights challenges in addressing and countering all aspects of the world drug problem by the OHCHR. This submission focuses on harm reduction for people who use drugs. Particularly, it draws on HRI's research on this topic, and previous submissions, including the joint submission to the OHCHR on human rights in the context of HIV/AIDS, pursuant to HRC Resolution 47/14, dated on February 2022.[1] For information regarding harm reduction services in prisons, please see the joint submission to your office presented in this call for inputs.[2]

II. The harms of drug policy and the war on people

Drug use occurs across all demographics, with an estimated 284 million people using drugs globally.[3] However, drug policies disproportionately impact marginalised populations, including black, brown, indigenous and LGTBQ+. The criminalisation and stigmatisation of certain substances have served to demonise, dehumanise and marginalise the communities who use them. This strategy has been employed globally to harm and repress racialised populations ethnic minority groups, political dissidents, the poor and the dispossessed.[4] Consequently, marginalised populations are often discriminated against, socially excluded and targeted by law enforcement, making drug policy a tool of mass incarceration, repression and social control,[5] which impacts not only on the liberty and health of people directly involved but also the health and safety of their communities. Poverty and homelessness worsen social exclusion and compound the impact of criminalisation. Studies show approximately 25% of people who inject drugs have recent experiences of homelessness or unstable housing.[6]

People who inject drugs are 35 times more likely to acquire HIV than adults who do not. Almost 4 in 10 people who inject drugs have active hepatitis C, and 1 in 12 have active hepatitis B, according to a global systematic evidence review.[7] Transmission of blood-borne viruses, including HIV and hepatitis C and B, which can happen when people share unsterile injecting equipment, are a leading contributor to illness and death among people who inject drugs.[8]

---

[1] Unless stated otherwise, information on this submission is taken from the GSHR and the joint submission.

[2] Joint submission made by Harm Reduction International (HRI), Penal Reform International (PRI), European Prison Litigation Network (EPLN), PromoLex, and Health Without Barriers.

[3] UNODC (2022) World Report 2022, Booklet 2 - Global overview of drug demand and drug supply, DOI https://www.unodc.org/unodc/en/data-and-analysis/wdr-2022_booklet-2.html.

[4]Daniels. C, et al. (2021), Decolonising Drug Policy, *Harm Reduction Journal*, 18:20, DOI https://doi.org/10.1186/s12954-021-00564-7; Harm Reduction International, (2021) The Harms of incarceration, DOI https://hri.global/publications/the-harms-of-incarceration-the-evidence-base-and-human-rights-framework-for-decarceration-and-harm-reduction-in-prisons.

[5]OHCHR, 'Fight against world drug problem must address unjust impact on people of African descent, say UN experts' (Geneva, 14 March 2019), https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24332&LangID=E.

[6] For more information see https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(23)00057-8/fulltext. See also, "Written comments for the Special Rapporteur on the right to adequate housing on the draft Guidelines for the implementation of the right to adequate housing", DOI https://hri.global/topics/intersectional-movements/poverty-and-homelessness/.

[7] https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(23)00057-8/fulltext.

[8] HRI (2022) The Global State of Harm Reduction 2022, p.42, DOI https://hri.global/flagship-research/the-global-state-of-harm-reduction/.

III. Harm reduction as a human right and global overview[9]

Harm reduction is understood as a comprehensive package of evidence-based interventions underpinned by public health and human rights, including policies, programmes and practices that aim to minimise the negative health, social, and legal impacts associated with drug use and drug policies such as needle and syringe programmes (NSPs), Opioid Agonist Therapy (OAT) and naloxone for overdose management.[10]

Universal and equitable access to harm reduction is a human right obligation. It is recognised as a vital component of the right to the highest attainable standard of health for people who use drugs,[11] from which States' obligations derive, specifically, ensuring availability, accessibility, acceptability and quality of harm reduction services, removing barriers to access services such as stigmatisation and criminalisation, among others. Denial of harm reduction services, including in detention settings, violates the prohibition against torture and other cruel, inhuman and degrading treatment.[12]

Despite evidence affirming that harm reduction is cost-effective and safe lives,[13] and regardless of UN agencies recommending its implementation, harm reduction services remain limited. Globally, in 2022, the Global State of Harm Reduction (GSHR 2022) identified:

- 105 countries reported to include supportive references to harm reduction in national policy documents;
- 92 countries implementing at least one NSP;
- 87 countries with at least one OAT;
- 16 countries with legal and operational Drug Consumption Rooms (DCR);
- 35 countries made take-home naloxone available, while 21 countries operate peer-distribution naloxone programmes;
- 9 countries offer NSP in prisons[14]; and
- 59 countries make OAT available in prisons;

---

[9] Unless specified otherwise, the information provided in this section refers to the HRI (2022) The Global State of Harm Reduction 2022, DOI https://hri.global/flagship-research/the-global-state-of-harm-reduction/.

[10] Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations (WHO, 2022) https://apps.who.int/iris/rest/bitstreams/1453332/retrieve.

[11] UN Committee on Economic, Social and Cultural Rights (2000), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art.12). DOI https://www.refworld.org/pdfid/4538838d0.pdf; International Centre on Human Rights and Drug Policy, UNOHCHR, UNAIDS, WHO, UNDP (2019). International Guidelines on Human Rights and Drug Policy. DOI https://www.humanrights-drugpolicy.org/site/assets/files/1640/hrdp_guidelines_2020_english.pdf; UN System Chief Executives Board for Coordination (2018), United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration, CEB/2018/2; United Nation (2020) Statement by the UN expert on the right to health on the protection of people who use drugs during the COVID-19, DOI https://www.ohchr.org/en/statements/2020/04/statement-un-expert-right-health-protection-people-who-use-drugs-during-covid-19.

[12] Human Rights Committee (2015), Concluding observations of the seventh periodic report of the Russian Federation, UN Doc. CCPR/C/RUS/CO/7, para. 16; Méndez J. (2013), Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/22/53, para. 55.)

[13] Harm Reduction International and HRAsia (2021) Divest. Redirect. Invest. The case for redirecting funds from ineffective drug law enforcement to harm reduction – spotlight on six countries in Asia, DOI https://hri.global/publications/divest-redirect-invest-the-case-for-redirecting-funds-from-ineffective-drug-law-enforcement-to-harm-reduction-spotlight-on-six-countries-in-asia/.

[14] After the GSHR's publication, HRI confirmed that also France have implemented NSPs in at least on prison in Montpelier.

For the first time since 2014, the GSHR has found an increase in the number of countries implementing key harm reduction services.[15] This growth has been driven by new NSPs opening in five countries in Africa, as well as new countries having officially sanctioned drug consumption rooms DCRs.[16] Three countries have introduced OAT for the first time.

Despite the existence of harm reduction services, the GSHR reports that coverage and scale of harm reduction are still limited, and great inequalities remain within and between regions and countries in terms of access. While the vast majority of countries in Eurasia, North America and Western Europe implement both NSP and OAT, these programmes are more absent than they are present in all regions of Africa, Latin America and the Caribbean, and the Middle East. Only North America, Oceania, Western Europe, and Mexico have officially sanctioned DCRs, and even in these countries, support may be from local or state governments rather than at the national level.

IV. Accessibility of services

Although the provision of harm reduction has improved since 2020, accessibility and quality remain significant issues. Globally, people who use drugs continue to face criminalisation, stigma and discrimination that prevents access to services.[17] Human rights violations continue to be committed worldwide in the name of drug control. These include the denial of access to harm reduction services, including through the criminalisation of drug paraphernalia[18], the prohibition of OAT (for example, in Russia), and discrimination against people who use drugs in the provision of HIV and viral hepatitis care.[19] Such punitive approaches hinder access and drive people away from essential services, leading to unsafe practices which could increase their risk of transmissible diseases such as HIV and hepatitis. Furthermore, certain populations experience these barriers particularly acutely, most notably, women, LGBTQI+ people, people who are migrants or refugees, young people, and Black, Brown, and Indigenous people.

An estimated 3.2 million women inject drugs worldwide, constituting around 20% of all people who inject drugs. However, their needs remain gravely under-addressed in most contexts. In countries where harm reduction services are available, they are overwhelmingly gender-blind and do not integrate sexual and reproductive health (SRH) services (including pregnancy tests, antenatal care, or other pregnancy-related services), leaving women underserved. In parallel, HRI's partners report services to address gender-based violence or protect women at risk, sometimes excluding women on account of drug use.[20] Research shows that integrating SRH services in harm reduction services, and promoting the active participation of women who use drugs in design, monitoring and provision of services, can be highly beneficial, enabling women who use drugs to access multiple services in one, non-judgmental setting where their specific needs are understood and addressed. In 2018, the Guttmacher-Lancet Commission on

[15] Since 2020, six more countries provide NSPs, including Burinfi, Cote d'Ivoire, Democratic Republic of Congo, Guinea and Uganda. Three more countries provide OAT, namely Algeria, Mozambique and Uganda and four more countries implemenred DCRs being Greece, Iceland, Mexico and United States.
[16] This include Mexico that had been operation without formal approval since 2018 but now has approval from local authorities.
[17] Harm Reduction International (2022), *50th Session of the Human Rights Council: Drug Policy Highlights.*
[18] Such as syringes and pipes.
[19] Harm Reduction International et al. (2022), '50th Session of the Human Rights Council: joint oral statement on the right to health' [internet, cited 22 August, 2022]. Available from https://www.hri.global/contents/2215.
[20] https://hri.global/wp-content/uploads/2022/10/HRI_-_Human_rights_HIV_AIDS_47_14-1.pdf.

Sexual and Reproductive Health and Rights (SRHR) provided a new, comprehensive and integrated definition of SRHR, outlining that components of SRHR should be universally available and that all of the services identified therein can be incorporated into harm reduction services, and vice versa.[21]

More integrated harm reduction services would also mean greater access. Integrated harm reduction services refers to sites/organisations that provide one or more 'traditional' harm reduction services alongside other health and social services, such as those seeking to address mental health, housing insecurity, or gender-based violence. They are effective from a health perspective, more accessible than traditional services, and cost-effective. For integrated services to realise their full potential, a key element is the leadership and involvement of people who use drugs in their design, management, and implementation.[22]

V. Funding policies[23]

HRI's monitoring of the funding landscape for harm reduction shows a dearth of funding for life-saving services. Few international donors fund harm reduction, and their investment appears to be shrinking. In low- and middle-income countries (LMI countries), funding for harm reduction is only 5% of the level needed to meet the estimated service needs for people who inject drugs by 2025. The gap between the required funding and the available funding has only grown wider in recent years. HRI's research in 2016 found it would be possible to fully fund the harm reduction response by redirecting just 7.5% of the funds spent on drug law enforcement towards harm reduction. Globally, USD 100 billion is spent on drug law enforcement, and just USD 131 million is spent on harm reduction in LMI countries.

Of particular concern is the shrinking investment in advocacy for harm reduction, particularly community-led advocacy. Opportunities for funding harm reduction advocacy via multi-country grants from the Global Fund have significantly reduced, despite their positive impact. Without advocacy for national investment in harm reduction, services in low- and middle-income countries will continue to be reliant on a shrinking pool of international funding.

This lack of funding is not inevitable but rather the direct outcome of political choices on the distribution of resources, rooted in a predominantly punitive approach to drugs. A solution to this funding gap, which would be critical in meeting the societal enablers targets, would be the redirection of funds from ineffective drug law enforcement to harm reduction. Redirecting just a small proportion of drug law enforcement spending towards harm the reduction would have a dramatic impact on new HIV infections and make the global goal to end AIDS among people who use drugs by 2030 achievable.[24]

[21] Ibid.
[22] Ibid.
[23] Unless states otherwise, this section refers to Harm Reduction International, Serebryakova L, Cook C, Davies C (2021), *Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries*.
[24] https://hri.global/wp-content/uploads/2022/10/HRI_-_Human_rights_HIV_AIDS_47_14-1.pdf.