Submission to the OHCHR analytical study on key challenges in ensuring access to medicines, vaccines, and other health products.

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Submitting organisation

Harm Reduction International (HRI) is a leading non-governmental organisation that envisions a world in which drug policies uphold dignity, health and rights. We use data and advocacy to promote harm reduction and drug policy reforms. 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 United Nation.

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Introduction

Harm Reduction International (HRI) welcomes the opportunity to provide inputs ahead of the OHCHR analytical study on key challenges in ensuring access to medicines, vaccines and other health products, pursuant to resolution 53/13.

Addressing the barriers faced by persons or groups in situations of vulnerability or marginalization in accessing medicines, vaccines and other health products, this submission will focus on access to harm reduction as an essential element of the right to the highest attainable standard of health; and on the main challenges experienced by people who use drugs in accessing essential harm-reduction medicines and other health services. This work draws on HRI's research on this topic and previous submissions, including the 2023 latest submissions to the Special Rapporteur on the Right to Health on drug policy and harm reduction and drug policy and prison population. The submission also expands on the 2023 submission to the OHCHR pursuant to resolution 52/24 and the joint submission to the OHCHR on human rights in the context of HIV/AIDS, pursuant to HRC Resolution 47/14, dated February 2022. For information related to people deprived of liberty please refer to the joint submission with Penal Reform International presented to your office in this call of inputs.

Unless stated otherwise, all information provided in this submission refers to HRI's Global State of Harm Reduction 2022 and its 2023 updated briefing.

Access to essential medicines and services and drug control: barriers to accessing harm Reduction , and controlled medicines for pain relief

In 2021 an estimated 296 million people used drugs worldwide, and 13.2 million people injected drugs. People who inject drugs are at increased risk of HIV, tuberculosis (TB), and viral hepatitis B and C (HBV and HCV), in addition to overdose. Of those who inject drugs 1.6 million is living with HIV, accounting

for approximately 10% of new HIV infections globally.[1] Unsafe drug injection continues to be a key contributing factor to the global epidemic of hepatitis C, with WHO estimating between 23% and 39% of new hepatitis C infections are attributable to drug injection.[2]

Universal and equitable access to harm reduction is an essential component of the right to the highest attainable standard of health for people who use drugs both in the community and in detention settings; from which States' obligations derive, specifically ensuring availability, accessibility, acceptability and quality of harm reduction services.[3] In March 2023, the need to ensure access to harm reduction services was recognised by the Human Rights Council in resolution 52/24, and the recent High Commissioner report on human right challenges in addressing the world drug problem includes harm reduction as a key strategy for a human right approach to drugs use and policies. The World Health Organization (WHO) also recognises harm reduction as an effective life-saving strategy,[4] recognising morphine, methadone and buprenorphine -drugs commonly used to treat opioid dependence - in the list of Essential Medicine Programme.[5]

These and other drugs on the list, such as antiretroviral drugs, are also essential for the treatment of HIV, HCV, and TB, and for pain management and relief. As stated by the OHCHR's recent report on human right challenges in addressing the world drug problem, affordable access to and adequate availability of internationally controlled essential medicines for palliative care, cancer treatment and drug dependency, and other treatments, also constitute core minimum obligations of the right to health. However, as some are classified as "controlled substances" under the international drug conventions, their availability for medical purposes is often excessively limited or restricted despite there being no basis for this in international law[6]. More than 80 per cent of the world's population, living mainly in low- and lower-middle-income countries, have no access to internationally controlled essential medicines to address serious health related suffering associated with severe pain, palliative care needs, treatment of substance use disorder, and other conditions. Lack of training of the health workforce, unduly restrictive regulations, and "fear of addiction" are the main impediments to opioid availability.[7]

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[1] UNODC (2023) World Drug Report. Doi https://www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2023.html; https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/people-who-inject-drugs

[2] UNODC (2023) World Drug Report. Doi https://www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2023.html

[3] Art. 12 International Covenant on Economic, Social and Cultural Rights. Doi https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights; See also:

Paul Hunt, (2007) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/4/28/Add.2. Doi https://digitallibrary.un.org/record/594900?ln=en; Anand Grover(2010) Report of the Special Rapporteur on everyone to the enjoyment of the highest attainable standard of physical and mental health. A/65/255, para. 55; CESCR (2015), Concluding Observations on the combined initial and second periodic reports of Thailand Doi https://digitallibrary.un.org/record/798125?ln=en; CESCR (2015) Concluding observations on the combined initial and 2nd periodic reports of Thailand : Committee on Economic, Social and Cultural Rights E//C.12/THA/CO/1-2 Doi https://digitallibrary.un.org/record/798125?ln=en; International Centre on Human Rights and Drug Policy/UNDP, International Guidelines on Human Rights and Drug Policy; OHCHR (2023) Report on human rights challenges in addressing and countering all aspects of the world drug problem. Doi https://daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=A/HRC/54/53&Lang=E; among others.

[4] https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/people-who-inject-drugs

[5] WHO (2023) The selection and use of essential medicines 2023. World Health Organisation Model List of Essential Medicines. Doi https://www.who.int/publications/i/item/WHO-MHP-HPS-EML-2023.02

[6] Sander. G. HIV, HCV. TB, and Harm Reduction in Prisons. Human Rights Standards and Monitoring at the European International Levels.*Harm Reduction International.* p 13 Doi https://hri.global/news/new-report-and-monitoring-tool-hiv-hcv-and-harm-reduction-in-prisons/

[7] OHCHR (2023) Report on human rights challenges in addressing and countering all aspects of the world drug problem. Para 16. Doi https://daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=A/HRC/54/53&Lang=E

HRI has monitored and periodically reported on the state of harm reduction services and policies around the world since 2008, identifying as 2023:

- 109 countries with explicit positive reference to harm reduction in national policy;[8]
- 92 countries implementing at least one Needle and Syring Programme (NSP);[9]
- 88 countries with at least one service providing Opioid Agonist Therapy;[10]
- 17 countries with legal and operational Drug Consumption Rooms (DCR);[11]
- 35 countries which make take-home naloxone (a life-saving drug which reverses the effects of an opioid overdose) available, and;[12]
- 23 countries where peer-distribution naloxone programmes operate.[13]

Despite HRI's findings showing an increase in the number of countries implementing key harm reduction services for the first time since 2014,[14] the availability, coverage, quality, and accessibility of services remains dire, with just 2% of the 15 million people who inject drugs globally reportedly living in a country with high coverage of both OAT and NSP.[14] Additionally, HRI's monitoring of funding landscape shows a dearth of funding for life-saving services, with harm reduction only getting 5% of the funding needed to meet estimated services 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; thus lack of funding (often reflecting lack of political will) should be acknowledged as a key barrier to access.[15]

People who use drugs continue to face criminalisation, stigma and discrimination that prevents access to services.[16] Although over 36 countries have removed criminal sanctions for drug possession for personal use, punitive responses to drugs remain a key contributing factor to prison overcrowding, with drug offences accounting for 22% of the global prison population.[17] Contrary to global trends towards abolition of the death penalty, as of 2022, 35 countries still retain the death penalty for drug offences, with 285 people executed which represents and 118% increase from 2021 and an 850%

[8] 10 countries in Eastern and Southern Africa, 12 countries in Western and Central Africa, 20 countries in Western Europe, 26 countries in Eurasia, 14 countries in Asia, 15 countries in the Middle East and North Africa, 6 countries in Latin America and the Caribbean, 2 in North America and 4 in Oceania.

[9] Six more countries have implemented NSPs since 2020, namely Burundi, Cote d'Ivoire, Democratic Republic of the Congo, Guinea, and Uganda. Additionally, in Seychelles, NSPs have been available since 2016, but this was unreported in previous editions of the Global State of Harm Reduction.

[10] In 2023, Egypt commenced the implementation of OAT programmes.

[11] HRI acknowledges that the legal status of DCRs varies globally. The Global State of Harm Reduction includes in its count those facilities that have official backing from state authorities at either the national, sub-national or city level. Since 2020, four more countries implemented DCRs, namely Greece, Iceland, Mexico and the United States. Colombia has recently launched a new drug consumption room in Bogota this year.

[12] Afghanistan, Albania, Aotearoa-New Zealand, Australia, Austria, Canada, Czechia, Cyprus, Denmark, Estonia, France, Germany, Georgia, India, Italy, Iran, Ireland, Kenya, Kyrgyzstan, Lithuania, Mexico, Myanmar, Moldova, Mozambique, Norway, Puerto Rico, Portugal, Slovenia, Spain, Sweden, South Africa, Tajikistan, Ukraine, United States of America, and United Kingdom.

[13] Afghanistan, Aotearoa-New Zealand, Australia, Austria, Canada, Georgia, Germany, India, Italy, Iran, Kenya, Kyrgyzstan, Mexico, Myanmar, Puerto Rico, Portugal, South Africa, Slovenia, Tajikistan, United States of America, and the United Kingdom. Updated information shows that Colombia and Moldova have recently began peer distribution naloxone.

[14] Of these 15 million people, it is estimated that 2.8 million are women; 0.4% of people who inject drugs identify as transgender.

[15] Serebryakova. L, Cook. C and Davies.C (2019). Failure to Fund. The continued crisis for harm reduction funding in Low- and Middle-Income Counties. *Harm Reduction International.* Doi https://hri.global/wp-content/uploads/2022/10/HRI-FAILURE-TO-FUND-REPORT-LOWRES.pdf

[16] Harm Reduction International (2022), 50th Session of the Human Rights Council: Drug Policy Highlights. DOI https://hri.global/publications/50th-session-of-the-human-rights-council-drug-policy-highlights/.

[17] Penal Reform International and Thailand Institute of Justice, (2023) Global Prison Trend 2023, page 17. DOI https://www.penalreform.org/global-prison-trends-2023/

increase from 2020. Additionally, 303 people sentenced to death and more than 3000 currently in death row for drug offences worldwide.[18]

Another significant challenge to the access to harm reduction is the criminalisation of the use and possession of drug paraphernalia,[19] which not only hinders the provision of essential medicines and services, but also reinforces stigmatisation and discrimination. In 2018, UNAIDS reported that in ten countries the mere "possession of a needle or syringe without a prescription could be used as evidence of drug use or cause for arrest."[20] One example is that of the United Kingdom, where it is a criminal offence to supply or offer an object for providing or preparing controlled drugs[21], including "crack pipes", "grinders", and "spoons", among others.[22] Despite safer smoke kits being essential harm reduction equipment, both for engaging people who use stimulants with harm reduction services and reducing transmission risks for HIV, hepatitis C and tuberculosis, its distribution is illegal in the country. The only exemption is aluminium foil, which is the only harm reduction equipment that is distributed for smoking.[23] Russian national policy explicitly mentions the introduction of measures to ban substitution therapy programmes, prevent "legalisation of drugs", and "unjustified expansion of the use of narcotic analgesics" for pain relief[24]. As such, the provision of OAT is prohibited, to the detriment of the health of people who use drugs. As a part of the implementation of the new drug policy strategy-2030, the distribution of "drug propaganda" (including online) is illegal in the country. The very concept of "drug propaganda" is very vague and can be used to prosecute not only organisations providing harm reduction services, but also independent media, as well as writers and musicians, making it hard to inform on safe drug use.[25] Notably, according to HIV Justice Worldwide, Eastern Europe and Central Asia has the second highest number of laws criminalising HIV exposure, non-disclosure and transmission, with Belarus, Russia and Uzbekistan having particularly high numbers of criminal cases related to these laws. Similarly, according to UNAIDS, as of 2022, at least 21 countries' policies exclude people who use drugs from receiving anti-retroviral treatment (ART), despite the lack of any health justification for it.[26]

Another structural challenge to access to harm reduction services are strict and exclusionary accessibility rules rooted in overly medicalised approaches to harm reduction. In some Eurasian countries, for example, enrolment in a programme is only allowed with a psychiatrist's or other supporting documentation and a government-issued identity document, which in some cases, such as

[18] For more detailed information, see Girelli, Jofré and Larasati (2022). The Death Penalty for Drug Offences: Global Overview 2022. Doi https://hri.global/flagship-research/death-penalty/

[19] Drug paraphernalia is commonly understood as any equipment, tool or object used to produce, conceal, and use drugs, including syringes and pipes.

[20] UNAIDS (2018), 'Miles to Go: Closing Gaps, Breaking Barriers, Righting Injustices' (Geneva: UNAIDS), 54. https://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf. Among others, this is the case in the Philippines and in US states: Possession of 'drug paraphernalia' is a crime in the Philippines, punished with imprisonment up to four years, and a fine. See Comprehensive Dangerous Drugs Act (2002), Section 12; Some US state laws envisage penalties for possession and distribution of drug paraphernalia; in Florida, for example, possession of drug paraphernalia can be punished with up to one year of jail.

[21] The United Kingdom, Misuse of Drugs Act 1971, Doi http://www.legislation.gov.uk/ukpga/1971/38.

[22] It is not an offence to supply hypodermic syringes. Swabs, citric acid, filters, ascorbic acid and water ampoules of up to 5ml are also exempted as long as they are provided by a doctor, pharmacist or someone working legally within drug treatment services.

[23] Despite the United Kingdom's current paraphernalia laws, a pilot safe inhalation pipe provision programme has started in the country in four areas, with the local police force supporting the intervention, and safer smoking kit distribution will be available in the study's sites for six months in 2023.

[24] https://www.talkingdrugs.org/rossiya-novaya-narkopolitika-v-deystvii/

[25] Bezverkha, Anastasia. (2021) Russia: A new drug policy in action. *Talking drugs.* Doi https://www.talkingdrugs.org/rossiya-novaya-narkopolitika-v-deystvii/.

[26] https://lawsandpolicies.unaids.org/topicresult?i=248&lan=en.

in North Macedonia, involves registering a residential address. This is an often-insurmountable barrier for people who use drugs belonging to already marginalised groups (such as homeless and Roma individuals) and in contexts where widespread discrimination and stigma in healthcare settings discourage people from disclosing their drug use. Similarly, in countries such as Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, and Ukraine, to enrol on OAT or other drug dependence treatment, people need to register in a "drug user register". However, such registration can limit access to jobs and studies and may have repercussions on the custody of children. In Belarus, for example, children are deemed to be in a 'socially dangerous situation' if they are parented by a woman who either uses drugs or is on OAT. In this case a mark is put in the parent's passport and medical records, increasing stigma, discrimination and further perpetuates sexist drug policy; and the woman risks losing custody of the child.

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, who experience compounding forms of discrimination and lack tailored services to meet their needs. The latest systematic review on injecting drug use and harm, and exposure to behavioural and environmental risks among people who inject drugs reported that 25% of people who inject drugs globally had experienced recent homelessness or unstable housing, close to 60% had a history of incarceration, and 14,9% had recently engaged in sex work.[27] Additionally, direct and structural racism leads to Black, Brown and Indigenous people having less access to harm reduction services. This is mainly due to Black, Brown, and indigenous communities being targeted by drug law enforcement agencies and disproportionately detained or imprisoned.[28]

Conclusion and recommendations

In line with international human rights obligations that bind States to provide harm reduction services and essential medicines for all population, and following the information provided through this submission we encourage the OHCHR to recommend Member States to:

1. Guarantee equitable access to harm reduction and essential medicines for all population;

2. Eliminate all legal and policy barriers and stigmatising and discriminatory practices that limit the access to harm reduction and essential medicines for people who use drugs, including through the decriminalisation of drug use, drug possession and drug paraphernalia;

3. Maintain disaggregated data about distribution of harm reduction and essential medicines;

[27] Degenhardt. L, Webb. P, Colledge-Frisby. S, Ireland. J, Wheeler. A, Ottaviano. S, Willing. A, Kairouz. A, Cunningham. E.B, Hajarizadeh. B, Leung. J, Tran. L, Price. O, Peacock. P, Vickerman. P, Farrell. M, J Dore. G, Hickman. M and Grebely. J. (2023). Epidemiology of injecting drug use, prevalence of injecting related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review. *Lancet Global Health. 11:659. Doi https://doi.org/10.1016/ S2214-109X(23)00057-8*

[28] For more details see Joint submission to the Committee on the Elimination of Racial Discrimination. Doi https://hri.global/publications/joint-submission-to-the-un-committee-on-the-elimination-of-racial-discrimination/.