Submission to the Special Rapporteur on Health's report on Harm Reduction for peace and development.

Submitted by

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 the United Nations.

Contact details: Marcela Jofré, Human Rights Analyst at Harm Reduction International, marcela.jofre@hri.global.

Introduction

Harm Reduction International (HRI) welcomes the opportunity to provide inputs ahead of the Special Rapporteur's report on Harm Reduction for sustainable peace and development. Drawing from previous submissions and other relevant reports,[1] this document will provide valuable information to the Special Rapporteur and will address questions one, two, three, four, six and seven.

Question 1. Challenges and positive developments in the provision of harm reduction services in time of war and political instability: Cases of Afghanistan and Ukraine.[2]

Countries' stability is a precondition for the sustainability of harm reduction efforts. The Global State of Harm Reduction (GSHR) has documented how economic, political, humanitarian, and environmental crises threaten evidence-based and human rights-based drug policies and services.

In Afghanistan, the Taliban retook control of the country in August 2021, leading to a setback to the progress in harm reduction policies that the country had experienced in the last decades. Despite internal conflict and political instability, Afghanistan had been a rare example of success in implementing harm reduction. Since the fall of the Taliban in 2011, harm reduction programs started to be implemented and had progressively improved in terms of availability, quality and accessibility.[3] During the COVID-19 pandemic, the government and NGOs showed resilience, adapting their approach to harm reduction to include take-home methadone and distribution of harm reduction kits containing sterile needles, syringes, condoms, and medicines, among other products.

However, progress stopped when Taliban retook control in 2021, banning all forms of drug production and consumption and adopting a strictly punitive approach to drugs. Since then, there has been a collapse of harm reduction services in five provinces that previously relied on government funding to provide such services, resulting in staff going unpaid, a lack of harm reduction kits, shortages of medicines and other medical equipment, and the shutdown of HIV prevention services. This is compounded by the criminalisation, over-policing, arbitrary arrest of

---

[1] HRI and Release (2024). Joint submission to the OHCHR on the Rights of people of African Descent in the context of Law enforcement. https://hri.global/publications/ohchr-report-inputs-on-law-enforcement-and-racial-and-intersectional-discrimination/; HRI and PRI (2023). Submission to the OHCHR report on access to medicines: Joint Submission on prisons. https://hri.global/publications/joint-submission-on-prisons-to-the-ohchr-report-on-access-to-medicines/; HRI (2023). Submission to the OHCHR report on access to medicines: Inputs on people who use drugs. https://hri.global/publications/ohchrs-report-on-access-to-medicines-and-people-who-use-drugs/; HRI (2022) The Global State of Harm Reduction 2022. https://hri.global/flagship-research/the-global-state-of-harm-reduction/, among others.

[2] Unless stated otherwise, all information provided here refers to HRI (2022). The Global State of Harm Reduction 2022. https://hri.global/flagship-research/the-global-state-of-harm-reduction/

[3] According to HRI's Global State of Harm Reduction 2022, by 2010, up to 28 needle and syringe programmes were operational. In February 2010, the first methadone program was launched, initially supporting 71 people.

and violence against people who use or are associated with drugs and forced "treatment".[4] At the same time, many who relied on opium cultivation and trade for economic survival became severely impoverished, and more and more people who use drugs are reportedly experiencing homelessness.

After the COVID-19 pandemic had stressed the health system and put harm reduction services at risk, Russia's invasion of Ukraine in 2022 deepened the pressure on harm reduction services in Ukraine and neighbouring countries.[5] Community and Civil Society organisations (CSOs)[6] have led responses to the humanitarian crisis; providing shelter and food and securing the evacuation of people who use drugs from Donetsk and Luhansk regions. They also helped to secure the provision of medicines and harm reduction supplies to Ukrainian regions that were cut off from supply chains or where people could not leave their homes. Thanks to their advocacy, OAT protocols were updated and to receive treatment without having to be registered in a particular city.[7] Take-home naloxone doses were also implemented.

Additionally, Ukrainian citizens who fled to neighbouring countries have faced multiple challenges when trying to access harm reduction services. Despite border countries[8] issuing special decrees to ensure the continuation of treatment and access to medicines for Ukrainian refugees, many people who use drugs hide their status and avoid the public health systems due to fear of stigma and discrimination, and bureaucratic hurdles further obstacle or at least delay access to services. Despite the support from local organisations to assist refugees in navigating the health system, the sudden influx of new clients has highlighted deficiencies in existing HIV and harm reduction services and the absence or limited availability of social and psychological support and shelters for people who use drugs.

[4] Hakim, Yalda. (2023) Afghanistan: Rounded up from the street into Taliban drug rehab. https://www.bbc.co.uk/news/world-asia-65138423

[5] It is worth noting that before the Russian invasion, Ukraine had been recognised as an example of good practice in access to harm reduction services. For more details see HRI (2020). Global State of Harm Reduction 2020 https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2020/ and HRI (2016). Global State of Harm Reduction 2016 https://hri.global/flagship-research/the-global-state-of-harm-reduction/global-state-of-harm-reduction-2016/

[6] Including All-Ukrainian Association of People who Use Drugs (VOLNA), Light of Hope and Convictus, Eurasian Harm Reduction Network (EHRA), Médecins du Monde, MADRE among many others.

[7] Initially, 15-day take-home doses were provided; later this was extended to 30 days. In the Donetsk region, as of September 2022, only the OAT site in Bakhmut has closed, while sites in Kramatorsk, Slavyansk, Pokrovsk and Druzhkovka continue to operate.

[8] Hungary, Moldova, Poland, Romania and Slovakia

Question 2. Impact of criminalisation, stigma, and discrimination against Black and African descent.[9]

Punitive drug policies negatively impact racialised communities who are disproportionately policed and arrested, sentenced, and incarcerated for drug offences globally, including children and young people of Black and African descent.[10] Often, the inherent innocence and vulnerability of childhood and adolescence are not afforded to them in a process of 'adultification' which is permeated with discrimination and bias. In the UK, practices of stop and search and strip searches disproportionately affect Black young children and teenagers. The Children's Commissioner for England showed that 2,847[11] children were strip-searched in England and Wales between 2018 and mid-2022, finding that black children were up to six times more likely to be searched than the overall child population.[12] Despite the statutory requirements that a responsible adult be present when searching people under the age of 18, data shows that in 52% of the cases, the searches were carried out in the absence of a parent, legal guardian, or social worker.[13]

Discrimination on the grounds of drug use and race is further compounded by gender-based discrimination and gender-based violence by law enforcement. HRI and the South African Network of People who Use Drugs (SANPUD) looked at the experiences of women who use drugs with access to harm reduction in Durban, South Africa, finding that women who use drugs are routinely oppressed, criminalised and dehumanised by law enforcement and prison staff, on account of both their gender and their association with drugs. Despite a clear desire to achieve good health and access harm reduction services, women were continually blocked from doing so by a law enforcement ecosystem that sees them as undeserving of even basic respect and dignity. Women who use drugs, particularly sex workers, were routinely targeted by police, experiencing abusive searches, arbitrary arrests and illegal confiscation and destruction of essential health commodities and personal belongings that have nothing to do with their drug use or related to any criminal offence.[14] Women who use drugs were routinely victims of psychological and physical

---

[9] Unless stated otherwise, all information provided here refers to HRI and Release (2024). Joint submission to the OHCHR for the preparation of the 2024 report on the Promotion of the human rights and fundamental freedoms of Africans and people of African descent against excessive use of force and other human rights violations by law enforcement officers through transformative change for racial justice and equality. https://hri.global/publications/ohchr-report-inputs-on-law-enforcement-and-racial-and-intersectional-discrimination/

[10] The complexities and impacts of punitive drug policies on Black and people of African descents are broader, including mass incarceration, discrimination, and violence. However, the format of the submission makes impossible to address all issues in full.

[11] Of the total of strip-searches, almost a quarter (24%) took place on children aged 10-15. The youngest was eight years old. The vast majority were boys (95%), and black boys accounted for more than a third (37%) of strip-searches.

[12] Olulode. C and Crew.J (2023). Police Strip-searched children as young as eight. https://www.bbc.co.uk/news/uk-65081765#:~:text=Separate%20Home%20Office%20figures%2C%20from,the%20law%20and%20police%20policy.

[13] Ibid

[14] HRI and South African Network of People who use Drugs (2020). Barriers to harm reduction among women who use drugs. Experiences from Ethekweni (Durban), South Africa. https://hri.global/publications/barriers-to-harm-reduction-for-women-who-use-drugs/

violence, including sexual violence by law enforcement. When trying to report a crime, women were victim of their claims being dismissed by police due to their drug use or engagement in sex work.[15]

Discrimination and violence by law enforcement, is compounded by the lack of comprehensive, updated and disaggregated data on drug law enforcement, including stops and searches, which is a major barrier to identify intersectional discrimination at a domestic level. Even when States collect data on several grounds - such as ethnicity, gender and age - it is usually presented in a siloed way that hinders its analysis with an intersectional approach.

The lack of systematic and disaggregated data on the impact of drug policies is mirrored at the international level. That is the case of the Annual Report Questionnaire (ARQ),[16] which does not measure many impacts – including human rights impacts - of drug policies with an intersectional approach. For example, the questions related to the criminal justice process ask for disaggregation on the basis of sex, age and sometimes citizenship, completely missing the opportunity to systematically cover impact on the basis of other grounds, including race and ethnic origin.

The lack of disaggregated data, especially on the targets of drug law enforcement and the functioning of the criminal legal system, has the effect of making some populations invisible, 'hiding' their experiences, and their being disproportionately impacted. It is also a barrier to the development of evidence-based and human rights-based drug policies and the prevention of violence and discrimination.

Question 3. Initiatives undertaken during the COVID-19 pandemic to provide access to harm reduction.[17]

The COVID-19 pandemic stressed health systems and disproportionately impacted the provision of harm reduction services. However, in some countries, service providers showed resilience by responding quickly and adapting their service delivery. Community-led organizations paved the way towards new service models, including online support and take-home doses of opioid agonist therapy (OAT) and naloxone. These actions ensured many people continued to access essential harm reduction interventions.

---

[15] Ibid.

[16] The international data-collection mechanism used by UNODC to collect evidence on the state of the "world drug problem"

[17] Unless stated otherwise, all information provided here refers to HRI (2022). The Global State of Harm Reduction. 2022. https://hri.global/flagship-research/the-global-state-of-harm-reduction/

In some countries,[18] peer-led services provided take-home doses of OAT including long-acting injectable options (such as depot buprenorphine). Take-home OAT increased access and allowed the continuation of treatments while COVID-19 restriction measures were in place. It also reduced in-person visits to clinics or service centres, improving beneficiaries' experience and reducing the risk of both clients and staff contracting COVID-19. In Nepal, the success of peer-led take-home OAT has led to discussions to revise and update the existing guidelines to incorporate these new practices. In Eastern and Southern Africa, there was an expansion in the provision of take-home OAT between 2020 and 2022. In Sydney, Australia between 24 and 69% of people on OAT had access to take-home doses and telehealth services. Services in Aotearoa-New Zealand relaxed monitoring procedures and increased flexibility in OAT service delivery by dispensing extra take-home options. Civil society sources report that this did not result in an increase in overdoses.

The COVID-19 pandemic accelerated the digitisation of harm reduction information and services, which expanded the pool of clients and made services more accessible. For example, in the United States, the implementation of mail orders improved access to naloxone, particularly for people in rural areas. In Aotearoa-New Zealand, peer-led harm reduction organisations responded quickly to lockdowns turning to online delivery of education and distribution of sterile injecting equipment via post, including provision for safe disposal of used equipment. To date, online services in Australia and Aotearoa-New Zealand have continued, despite the lifting of COVID-19 restrictions. The COVID-19 pandemic also resulted in an increase in the practice of ‘virtual spotting’, whereby people who use drugs can be in touch with a virtual companion (either by phone or online) while using, who can alert emergency services if the person becomes unresponsive. One such programme is the Never Use Alone hotline, which operates 24/7 from the United States.

Harm reduction services have now had time to shift and institutionalise adaptations to service provision. Yet more work is required to guarantee accessibility and availability of quality harm reduction services for everyone.

Question 4. Sustainable financing landscape for harm reduction and the need to divest from punitive policies, invest in social justice.

Investment in harm reduction falls far short of need.[19] Meanwhile, countries spend over 750 times more on punitive drug policies that underlie the criminalisation and discrimination of people who use drugs and lead to negative health outcomes.[20]

[18] Including Aotearoa-New Zealand, Australia, Myanmar, Nepal, and Slovakia.
[19] For more details visit https://hri.global/flagship-research/funding-for-harm-reduction/failure-to-fund/
[20] https://hri.global/topics/funding-for-harm-reduction/redirecting-funds/

HRI has monitored the funding landscape for harm reduction since 2007 and consistently found that international commitments to end AIDS, tuberculosis and viral hepatitis by 2030,[21] have not galvanised required action in low- and middle-income countries (LMIC).[22]

HRI's recent research shows that in 2022, funding for harm reduction in LMICs was only 6% of the annual amount UNAIDS estimates to be required by 2025.[23] Harm reduction remains overly reliant on a small number of international donors, with increasing reliance on the Global Fund.[24]

Where governments are investing in HIV responses, budgetary support for harm reduction is often neglected. Granular data on government investments in HIV responses is not readily available, however, numerous national reports indicate that funds are directed to ARV procurement, condoms, human resources and behavioural change interventions. The same is true for national health insurance programmes where these are in place. For instance, the national health insurance schemes in Indonesia, Kenya, Nepal and Cambodia include ART, condoms and behavioural change interventions but continue to omit harm reduction. Health Insurance policies in some countries align with punitive policies against people who use drugs and explicitly forbid the inclusion of harm reduction interventions.[25]

HRI's research on six LMICs[26] found that harm reduction and its funding continued to be confined within national HIV responses, and often failed to meet the standard of evidence-based and human rights-based approaches to drug use.[27] All six countries were heavily dependent on external funding agencies, particularly the Global Fund and The U.S. President's Emergency Plan

[21] UNAIDS. (2024) End Inequalities end AIDS. Global AIDS Strategy 2021-2026 https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026-summary_en.pdf; WHO. (2022) Global health sector strategies on, repspectively, HIV, viral hepatitis and sexual transmitted infections for the period 2022-2030. https://www.who.int/publications/i/item/9789240053779

[22] HRI (2021). Failure to Fund: The Continued Crisis for Harm Reduction Funding in Low and Middle-income Countries. https://hri.global/flagship-research/funding-for-harm-reduction/

[23] More detailed information soon to be published in the next report here https://hri.global/flagship-research/funding-for-harm-reduction/

[24] Ibid.

[25] UNAIDS (2022) Key populations are being left behind in universal health coverage: landscape review of health insurance schemes in the Asia-Pacific region. https://www.unaids.org/en/resources/documents/2022/key-populations-universal-health-coverage-asia-pacific

[26] Indonesia, Kenya, Nepal, Nigeria, South Africa, and Uganda.

[27] HRI. (2023). Harm Reduction Financing Landscape Analysis in Indonesia. https://hri.global/publications/harm-reduction-financing-landscape-analysis-in-indonesia/; HRI. (2023) Harm Reduction Financing Landscape in Kenya. https://hri.global/publications/harm-reduction-financing-landscape-analysis-in-kenya/; HRI. (2023). Harm Reduction Financing Landscape in Nigeria https://hri.global/publications/harm-reduction-financing-landscape-analysis-in-nigeria/; HRI. (2023) Harm Reduction Financing Landscape in Uganda. https://hri.global/publications/harm-reduction-financing-landscape-analysis-in-uganda/; HRI. (2023) Harm Reduction Financing Landscape in Nepal. https://hri.global/publications/harm-reduction-financing-landscape-analysis-in-nepal/; HRI. (2023). Harm Reduction Financing Landscape in South Africa. https://hri.global/publications/harm-reduction-financing-landscape-analysis-in-south-africa/

for AIDS Relief (PEPFAR).[28] Three countries had some domestic budget support for harm reduction. In Indonesia, government funding supported the purchasing of methadone at the national level, while provincial government budgets included a small amount of funding for harm reduction programs in two provinces.[29] At the national level, however, domestic funding supports abstinence-based drug rehabilitation programs, despite evidence of ineffectiveness and an associated increased risk of health harms.[30] In Nepal, government funds supported the operational cost of eight OAT sites in public hospitals, however this contribution amounted to less than 1% of the total HIV budget for the period 2019-2020. In South Africa, the government of the Tshwane province provided funding for comprehensive harm reduction programs at 17 sites across four districts. No domestic funding for harm reduction was reported in other three countries (Nigeria, Uganda and Kenya).

Effective harm reduction interventions rely heavily on community-led services and civil society organisations. For transition away from international donor funding to be effective, governments must be able to provide funds directly to these organisations, which usually requires social contracting mechanisms to be in place.[31] Few countries currently employ social contracting to fund harm reduction interventions.[32] Donor and international agency support is crucial for supporting governments to introduce and improve social contracting mechanisms and for the advocacy and technical support required to ensure that community-led and civil society organisations are supported to provide harm reduction. Countries usually do not have effective mechanisms in place to transition from donor to domestic funding for harm reduction. This has led to the interruption of services, including OAT and psychological support and concerns for the sustainability of harm reduction services are reported in Albania, Bosnia and Herzegovina, Bulgaria and Romania.[33]

[28] Ibid

[29] Kota Makassar and Bandung

[30] There has been a decrease in harm reduction funding in Indonesia in recent years, as a result of data showing a reduction in the estimated number of people who inject drugs, as well as the fear experienced by people who inject drugs when accessing the public health services.

[31] For more information on social contracting and funding models visit https://hri.global/wp-content/uploads/2023/04/SOCIAL-CONTRACTING_FINAL.pdf

[32] For example, India, South Africa and Thailand.

[33] Drug Policy Network See. (2019). Emergency situation concerning the sustainability of harm reduction services in Albania, Bosnia and Herzegovina, Bulgaria and Romania. https://dpnsee.org/2019/11/09/emergency-situation-concerning-the-sustainability-of-harm-reduction-services-in-albania-bosnia-and-herzegovina-bulgaria-and-romania/

In contrast to insufficient investment in harm reduction, countries continue to invest vast amounts in punitive responses to drug use. Over US$100 billion is spent each year around the world. Some of this support has even come from aid budgets, with almost a billion dollars (more than USD 974 million) spent on the official OECD category of "narcotics control" in recipient countries between 2012-2021.[34] This surpasses the amount spent through aid budgets on areas more aligned with global health and poverty reduction goals, such as labour rights and household and food security programmes.[35] At least USD 70 million between 2012-2021 was spent in countries that have the death penalty for drug-related offenses. Such funding has undermined global development goals and "do no harm" principles. The consequences include mass incarceration and overpopulated prisons, death sentences, civilians killed during counter-narcotics operations, poor farmers' livelihoods destroyed, rights violated by forced "treatment" programmes, discrimination, and barriers to health care.[36]

Mathematical modelling showed that redirecting 7.5% of the funding for punitive drug policies to harm reduction would result in a 94% reduction in new HIV infections among people who inject drugs and a similar reduction in HIV-related deaths by 2030.[37] With small shifts in how states spend existing resources, it is possible to virtually eliminate HIV among people who inject drugs by 2030.[38]

Question 6. Elements and principles for good integrated harm reduction services.[39]

Integrated services are central to the right to health of people who use drugs, and its provision is a binding obligation for States.[40] Integrated services provide multiple services at once, making it easier for people to access and 'move' between them. In doing so, they can address the complex needs of their clients 'simultaneously, rather than in parallel or sequential fashion,' thus

[34] Provost. C, Daniels. C, Gurung. G, Cook. C. (2023) Aid for the War on Drugs. https://hri.global/publications/aid-for-the-war-on-drugs/

[35] The key donors include US, EU, Japan, and the UK.

[36] Provost. C, et. al. (2023) Aid for the War on Drugs. https://hri.global/publications/aid-for-the-war-on-drugs/

[37] Cook et al (2016) A no-brainer for ending AIDS: the case for a harm reduction decade. Journal of the International AIDS Society.

[38] HRI has studied the cases of Jamaica, India ad Oregon, where the redirection of resources has led to more investment in health and social care. For more information visit https://www.investinjustice.net/

[39] Unless stated otherwise, all information provided here refers to HRI. (2021). Integrated and Person-Centred Harm Reduction Services. https://hri.global/publications/integrated-harm-reduction-services/

[40] For example, Art. 12 of the International Covenant on Economic, Social and Cultural Rights recognises the right to the highest attainable standard of physical and mental health; The UNAIDS Strategy (2021-2026), it commits countries to ensuring access to 'quality, integrated HIV treatment and care that optimises health and wellbeing, highlighting the need for 'fully recognised, empowered, resources and integrated community-led HIV responses; The Political Declaration of the 2021 UNGA High Level Meeting on HIV and AIDS commits member States to providing context specific integrated services for HIV and other communicable diseases, non-communicable diseases, sexual and reproductive health, gender-based violence, mental health, alcohol and drug use, legal services among others; the WHO guidelines addressing HIV among people who use drugs recommends "comprehensive packages" of HIV services for people who inject drugs, including needle and syringe programmers, opioid therapy, and HIV, viral hepatitis and tuberculosis, among other services.

addressing the person holistically rather than from a single disease or need.[41] This means moving beyond the narrow frame of preventing and treating infections and overdoses through biomedical and behavioural interventions. It encompasses a variety of health and social services tailored to the needs of the people they are serving, including, but not limited to; prevention, diagnosis and treatment for blood-borne diseases, alongside broader health, social and legal services. Central to this practice is the acknowledgement that the health consequences of drug use cannot be addressed in isolation but must be considered in a social, economic, and legal context.

There are different forms of integration of services and the type of integration will depend on the context and needs of the people they are serving. A fully integrated "one-stop shop" provides a full range of services in the same place by one multidisciplinary team, ensuring services are complementary. A service can also function as an entry point to a network of service providers, leading to more specialised health care and social and legal support.

HRI has identified some key elements of integrated services to successfully address the needs of people who use drugs and their communities.

- Integrated services must have a person-centred approach, which considers the person as an autonomous whole, not reducible to their drug use or specific medical conditions, but with intersecting needs linked to their personal and social determinant of health.
- Services providers must meet people accessing their services whenever they are at in their life, in a non-judgmental and non-discriminatory way.
- Service integration is about making services accessible and empowering people to use them, without pressure or obligation.
- Integrating harm reduction services must provide safe spaces where people can simply exist in comfort, regardless of whether they will access any service at the end.
- The involvement and leadership of community in the design and delivery of services is central for integrating harm reduction.[42]

As a result of the holistic care and support provided by integrated harm reduction services, they can contribute to building self-worth, pride, and solidarity, tackling the effects of stigma and discrimination. People-centred approach also give more control over how individuals manage their drug use and access health and social services, which makes it more effective in reaching historically marginalised groups, including women who use drugs, LGBT+ people and sex workers. Integrated services allow people to navigate services easily and receive the support they need.

[41] Soto TA, Bell J, Pillen MB. (2004). For The Hiv/aids Treatment Adherence HO, Group CS. Literature on integrated HIV care: a review. AIDS Care 2004;16(sup1):43–55.
[42] Peer leaders in integrated services have a unique insight into the lives and experiences of individuals accessing services and can use that to provide compassionate and non-judgmental services.

The leadership of peers eases the building of trusting relationships and ensures that people are treated as human beings, not just patients. Working closely with users of services and the community improves the range and quality of services.[43] As integrated services know the realities and struggles of people accessing services, which allows them to adapt quickly in the face of an emergency or crisis and ensure the continuity of essential services for people who use drugs.[44]

Evidence shows that integrated harm reduction services increase engagement and improve health outcomes. They are more effective in increasing the number of people accessing harm reduction and primary care services. Where sexual and reproductive health and harm reduction services have been integrated, engagement in both has increased. Where needle and syringe programmes provide HIV and viral hepatitis testing and linkage to care, they make a significant contribution to the number of people who know their status and enroll in treatment.

Question 7. Examples of integrated services for populations that have been historically criminalized, stigmatized and discriminated against in the context of drug use and drug laws and policy.[45]

There are numerous organisations providing integrated harm reduction services for targeted specific groups, who have been historically criminalised and/or marginalised, including the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) in Australia, AIDS Community Care Montréal in Canada, CRESCER in Portugal and SPARSHA in Nepal, among others.

CAHMA in Australia, provides integrated harm reduction services and runs a programme called Connection which is specifically tailored to the needs and practices of Aboriginal and Torres Strait Islander communities, while maintaining full integration with the rest of CAHMA's services. CAHMA is a peer-led organisation composed of people with current or past experience of drug use. Most of the staff are trained to work across the programmes and the organisation operates in a way that minimises barriers (such as paperwork) to moving between different services. The community drop-in centre is the primary point of contact and it provides a space where people can drop-in without an appointment and relax, talk to peers and have a tea or coffee. Crucially, they can also engage with other services that CAHMA offer or get information about and referrals

[43] For example, ensuring a culturally safe environment for Indigenous communities makes services more accessible and acceptable to people who may otherwise be marginalised.
[44] For example, despite the implementation of tough measures during the COVID-19 pandemic, integrated harm reduction services showed resilience. Even where integrated and person-centred harm reduction services have closed, they were able to remain in contact with their service population during the pandemic, adapted quickly and provided COVID-19 prevention and treatment alongside with their core services. For example, Pink House in Bulgaria provided COVID-19 information, face masks, disinfectant, and food, even while their drop-in centre was forced to close temporarily.
[45] For more detailed information visit https://hri.global/publications/integrated-harm-reduction-services/

to services provided elsewhere. For the Connection programme, the drop-in centre has three self-identified aboriginal workers whose aim is to ensure a culturally safe environment and build trust and rapport between staff and people accessing services. Alongside the other services at CAHMA, The Connection arranges wellbeing groups and group art workshops built around Aboriginal techniques (that are open to both Aboriginal and non-Aboriginal clients).

On-site health services are complemented by extensive outreach, consisting of an outreach barbecue and primary health clinic at a different location five days per week. People from marginalised groups can have a meal at the barbecue and engage with CAHMA peer workers, building a trusting and supportive environment. At the same time and location, Directions Health Services attend with a mobile clinic, where people can access the same primary health services that are available at the weekly drop-in clinic.

In turn, CRESCER provides harm reduction services tailored for around 2,000 people annually, including people who use drugs and people experiencing homelessness in Lisbon, Portugal. In 2002, they began an outreach project, É UMA RUA ('It's a street'), and in 2013 they established a drop-in centre, Espaço Âncora ('Anchor Space'), and a housing programme called É UMA CASA.

There are also services that incorporate a gender approach to the services they provide. AIDS Community Care Montreal runs a programme called Kontak, which is a harm reduction programme by and for gay, bisexual and queer men who have sex with men, with a special focus on people who use drugs during sex and sex parties (often known as chemsex or party'n'play). Each project operates independently, but with strong pathways of referral and access between them according to their client's needs. SPARSHA Nepal focuses on providing harm reduction services for people living with HIV and has opened a specific drop-in centre for women, serving almost 200 women called L'Espace les Jasmins which offers a space exclusively for women who inject drugs and their children. It also offers a range of services for women in vulnerable situations and forms part of the harm reduction response to hepatitis C and HIV among women who inject drugs. Women who inject drugs – who are often experiencing the double stigma of being a woman who uses drugs as well as marginalisation and rejection from family and wider society – use the space for socialising and sharing experiences.

Conclusion and recommendations.

Universal and equitable access to harm reduction is a human right obligation. It is recognised as an essential component of the right to the highest attainable standard of health for people who use drugs, 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 of drug use and other practices, among others. Denial of harm reduction services, including in detention or closed settings, violate human rights obligations and in some cases may amount to torture and other cruel, inhumane, and degrading treatment[46].

In line with the international standards, information provided in this submission and in addition to the recommendations outlined in A/HRC/56/52, we encourage the SR to recommend Member States to:

a) Decriminalise drug use and drug possession and promote evidence-based and health- and human-rights centred alternatives to incarceration;
b) Recognise harm reduction as an essential element to the right to health in national policies and strategies, which must be protected under all circumstances, including health emergencies, war or humanitarian crisis;
c) Guarantee equal access to harm reduction services and programmes, including integrated services, in a no-discriminatory and non-stigmatizing way and consider the particular needs of the most vulnerable and marginalised groups, such as Black, Brown and indigenous population, LGTBQ+ people, sex workers, women among others;
d) Guarantee the meaningful participation of civil society, community-led organisations and people who use drug in all process of drug policy decision-making, including the design and implementation of harm reduction interventions;
e) Eliminate all form of forced drug dependency treatments;
f) Critically evaluate States' spending on drug control, divest from punitive drug control, and invest in evidence-based harm reduction programmes -beyond HIV prevention and treatment- ensuring the availability of funding for peer-led and community-led harm reduction initiatives, research, and innovation;
g) Support and fund civil society, community-led and peer-led harm reduction interventions, and;
h) Eliminate all legal and practical barrier to accessing harm reduction services, including those that affect marginalise populations including Black, Brown and ethnic minorities and indigenous populations, migrants, women, homeless and people living in poverty.

[46] 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.); 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/.